A STRIKE FOR INDEPENDENCE:

How a Missouri School District Generated Two Million Dollars to Improve the Lives of Children

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I. INTRODUCTION

As the nation turns its focus to improving educational outcomes for children, school districts have become increasingly aware of the relationship between a child's educational achievements and their health, social and emotional development. Just as it is often impossible to discretely isolate an individual child's educational, social and health needs, many school districts are now accepting the view that access to health and social service resources is integrally related to educational success. The challenge these communities face is how to finance and structure the provision of services in ways that complement the educational program and link schools and students, their families and communities with appropriate services.

This is a particularly difficult task in times of fiscal austerity. Most school districts continually struggle to raise enough revenue to support teacher salaries, building maintenance and educational programs; they have had few resources left for expanding health and social service supports. Similarly, local health and social service agencies all face budget constraints which force them to find new ways to do more with fewer resources. Fortunately, in some communities, the social reality of escalating problems and the fiscal reality of shrinking resources have been the combined impetus for creative and collaborative solutions which expand beyond traditional boundaries of health, education and social services.

Independence, Missouri is one such community which was chosen by the State of Missouri as a pilot area and has pioneered in the creative use of Medicaid financing to expand innovative school-based initiatives for children and their families. Medicaid is the federal-state health care financing program for low income families and children. It is usually thought of and used as a mechanism to pay for specific medical services for disadvantaged children and families without access to private health insurance. However, Medicaid has the potential to be much more than that. As one of the last remaining federal entitlement programs, over the past several years states

have begun to look to Medicaid as a financing source for a broader array of services for children and families. As part of that trend, the federal government and the states have conceptually redefined Medicaid in a much broader way and have expanded it beyond the traditional structures of a medical care provider reimbursement system. This has required a willingness to accept a wider and more holistic view of health care to incorporate not only treatment for medical conditions and diseases but a focus on prevention, screening, health education and mental health.

Incorporating this broader view of the potential of Medicaid, Independence, Missouri provides a model case study of how to use Medicaid so it benefits the children and families within the community. Over the past three years, the Independence School District has generated more than $2 million from creative use of Medicaid financing, primarily through the Medicaid's Early Periodic, Screening, Diagnosis and Treatment (EPSDT) and administrative case management (ACM) provisions. Independence has used these funds to advance the development of community-based, integrated services for families and children. The work has been hard; and no one—especially those in Independence—would say the work is finished. But the story shows what can be accomplished with strong local leadership, a sound state-local partnership, an ability to forge a productive collaboration between the traditionally separate worlds of health, education and social services, and a willingness to take reasonable risks for the benefit of families and children.

Prior to its recent success, the Independence, Missouri School District had a long history of supporting programs to prepare children for learning and enable them to succeed in school. However, the School District had not been able to address children's health needs adequately, particularly those of poorer children. In the early 1980s, the School District attempted to fill some of the gaps by offering services under the Medicaid EPSDT Program. But the District discontinued the effort, partly due to lack of cooperation from the State's Medicaid program, and partly because the effort was too costly and there were too few services under the State Medicaid program in which the School District could at that time participate.

Two changes made it possible for the Independence School District to embark on this initiative with the Missouri Medicaid program in 1991:

- The first was a changed federal mandate for the preventive child health services under the Medicaid program. Data in the late 1980s demonstrated that less than one-third of all eligible children nationally were receiving preventive care and treatment under the Medicaid program. Since 1967, the Title XIX of the Social Security Act, which established the Medicaid program, had required states to operate EPSDT programs to provide preventive health services to all Medicaid-eligible children under the age 21. The Omnibus Budget Reconciliation Act of 1989 sought to increase the effectiveness of this program and improve the health of poor children by requiring states to increase the percentage of eligible children accessing the EPSDT program from 30 percent to 80 percent by FY 1995.[1] To do this, states were required to take a more active role in improving access of children to preventive health services and in assuring that once screened, children were provided with the full range of health and mental health treatments needed to address diagnosed problems.

- The second was a change in the Missouri State Medicaid program. A new director of the Missouri Department of Social Services was appointed.[2] With this appointment, the Department moved to work cooperatively with school systems to achieve the federal mandate for health care access for low-income children through EPSDT services. The Department concluded that the federal mandate could not be attained without working with and through schools—the most natural channel for reaching children.

Seizing these opportunities, the Independence School District and the State of Missouri have made considerable progress in a relatively short period of time. This case study of their experiences is intended to stimulate other states and local governments and communities to work together toward similarly productive partnerships. Building on the knowledge gained in Independence, it is hoped that other communities can move forward with collaborative ventures to improve not only educational outcomes but the health, emotional and social development of their children.

II. UNDERLYING PRINCIPLES

The Independence experience is not simply a story of pioneering ways to generate new revenue. It shows how communities can combine a commitment to change with program and revenue strategies to improve services for families and children. Four important principles undergird this effort which other communities should consider in their own work.

A. Principle One: Begin with a Programmatic Vision and Agenda

The primary goal of the Independence effort was not simply to raise more revenue for the School District; the main objective was generating new funds to support a comprehensive programmatic agenda. Experience in Independence and other places has shown that creative financing arrangements need to be driven by a programmatic agenda and not the other way around. As local officials moved to develop new programs in Independence, they worked to assure that the new efforts were not independent, isolated opportunities driven solely by available funds. Instead, the entire initiative reflected a commitment by the School District to the comprehensive delivery of services to help children come to school ready to learn. In addition, the District recognized its responsibility to work with parents and other family members, supporting their role as educators of their children and helping them overcome barriers to their effectiveness.

B. Principle Two: Reinvest Monies Gained into Improved and Expanded Services

A centerpiece of the Independence plan was the use of federal Medicaid funding to refinance costs of existing services and administrative activity. The logic of refinancing is simple: maximize available federal entitlement funds to pay for those services now financed exclusively with state and local funds that can legally and legitimately be financed with federal dollars; this then frees up state and local funds for new uses. The most important step in any refinancing effort is insuring that the federal dollars are not simply used to supplant state and local revenue. The trick is to use the previously committed state and local funds to support service improvements and expansions.

What Independence did with the funds says a lot about the commitment of the School District and the community to families and children. Independence **reinvested** its freed funds to support more preventive and comprehensive community services, including services for families and children who were not previously eligible for services under the federal entitlement program. Resources for human service programs are scarce and new monies are rarely available to support the development of a more integrated, more family and more community-based service delivery system that intervenes early and effectively on behalf of children. Independence made a conscious attempt to use expanded Medicaid financing as leverage to support these goals.

C. Principle Three: Build and Sustain State-Local Partnerships

One of the greatest obstacles to the development of community-based service systems that involve the schools and health and social service providers is the jurisdictional problems that arise between state health, education and social service agencies and among federal, state and local governments. Local school districts cannot directly access federal Medicaid funds and many other federal fund sources without the close cooperation of designated state agencies. State agencies can choose to make this a grudging effort or a real partnership. In Missouri, it was a real partnership. Real support for school refinancing strategies require state agencies to change their perspective. They must be willing to look beyond their own agency's needs and the delivery systems that they routinely use. They must recognize the legitimate role that other state and local agencies can play in providing services, and they must work proactively to help agencies understand the legislative and professional language and requirements of programs like Medicaid and work cooperatively to adapt those requirements to new environments.

This is exactly what the Missouri Medicaid program did. Perhaps the most impressive element of the Independence experience is the unique partnership between the State Medicaid program and the School District. As a Missouri Medicaid staff person said, "The right people, with the right motives, came together for the benefit of the school children and their families."[3] They established a trusting relationship, moving beyond the suspicion and disrespect that sometimes exists in state-local relationships. Staff at both the state and local level committed themselves to achieving the goal of implementing the Medicaid Early Periodic Screening Diagnosis and

Treatment (EPSDT) Program and Medicaid Administrative Case Management (ACM) in the schools. They worked together to establish goals, programs, procedures, and funding. Together, they established an interagency agreement which designated the Independence School District as a Medicaid provider—in effect, an agent of the State Medicaid program.

D. Principle Four: Adapt Medicaid To a School Environment

Schools are not traditional providers of medical services and traditional Medicaid procedures, designed for physicians, hospitals and health clinics, are often not well suited to school environments. While it is not possible to short-cut or eliminate basic Medicaid requirements, it is possible to make Medicaid more "school friendly." The Missouri Medicaid program staff knew it would not be a simple task to adapt Medicaid requirements and accountability procedures to the school setting, and the Independence School District knew that it would not be easy to meet the federal and state Medicaid regulations and paperwork requirements. But both were committed to making it work. In addition to the State-local partnership, the federal staff of the Region VII Health Care Financing Administration (HCFA) office were also part of the team that made this work.[4] They served as a technical assistance resource to help the Missouri Medicaid program and the Independence School District determine how best to meet federal requirements in a school environment.

A number of critical design tasks had to be completed. Among the most important and most difficult were procedures for:

- Record-keeping and billing for both EPSDT and ACM. School staff were enrolled and approved as Medicaid providers.
- Time studies of involved school staff for purposes of implementing ACM, were designed and implemented.
- Collaborative relationships with the local medical community.
- Safeguarding confidentiality.

Much of this work required new patterns of working and thinking for both state and school staff. None of it was easy. But they were successful because the two partners—the State program and the School District—were determined to make it work. As a school official said, "Dealing with Medicaid has been very predictable: lots of paperwork, lots of time, but manageable, and helpful to our children."[5]

What happened in Independence, Missouri can be done, and is being done, in other states and other school districts across the country. The following sections provide additional information on the details of the Independence plan from the perspective of the people who did the work. It is intended to shed light on how other communities can increase resources for families and children by creating Medicaid EPSDT partnerships with the schools. It is hoped that the report will encourage such work in communities which, like Independence, are committed to reinvest their new found resources to improve outcomes for families and children.

III. THE INDEPENDENCE SCHOOL DISTRICT AS A MEDICAID PROVIDER OF SERVICE

Independence, Missouri, located in Jackson County, is an eastern suburb of the metropolitan Kansas City area. The City's total population of 115,000 is largely blue collar, with some affluence and some poverty. The Independence School District services about three-quarters of the City's population and includes over 11,000 students, K-12. The 1993-1994 School District budget is approximately $55 million, with a per pupil expenditure of $3,601 (1990-1991), compared with $5,245 nationally.[6] The District has two high schools, an alternative high school, two junior high schools, 13 elementary schools, and three centers for early child development, Head Start, and children with special educational and emotional needs. (See Appendix A for a profile of the Independence School District).

The School District's work on Medicaid financing was part of a much larger and longer term effort. For 15 years prior to the initiation of EPSDT in the schools, the District had worked to change community attitudes toward the schools and schools' role in the community. The District

recognized that their mandate to educate children required that they work within the larger community to address social problems which hamper children's learning.[7]

With this philosophy, the District initiated a series of programs directed at school readiness and promotion of capacity to learn, including:

- *21st Century Schools* which is an integrated cluster of comprehensive child care programs designed by Dr. Edward Zigler, Director of Yale University's Bush Center on Child Development and Social Policy. It serves children from birth to twelve years of age, strives to provide for the social, emotional, physical, and intellectual growth of each child, and consists of six programs: (1) *The Before- and After-School Child Care Program* (1500 families are served); (2) *The Preschool/All-Day Child Care Program* (500 children are enrolled); (3) *The Support Network for Family Child Care Providers*; (4) *The Parents as Teachers Program* (1500 participant families benefit from parent consultations, home visits, group meetings, and other services); (5) *The Direction Service Center* (providing information and referral to the District's families free of charge); and (6) *The Medical Screening and Referral Program* (for children from birth through five years of age, prior to school).

- *Other early childhood and preschool intervention programs* such as: (1) *Head Start* (304 children are enrolled, 10% of whom are disabled; 40 children are in the full day, full year program); (2) *The Head Start Transition Project* (a grant from the U.S. Department of Health and Human Services, providing supportive services to Head Start children in making a successful transition to regular school); (3) *Project Reach* (early childhood special education for preschool children with disabilities); (4) *The Nutrition Education Program* (teaching preschool and primary grade children and their parents about nutrition); and (5) *Even Start* (a targeted, year-round program to teach literacy skills to parents, as well as to provide other support services).

For a fuller description of this family of programs, see Appendix B.

As the District initiated these programs, it worked to assure they were not independent, isolated activities. Taken together, the programs reflect four characteristics in children's services emerging across the country:

- A commitment to *cross-systems non-categorical delivery*. To insure that, the School District has established an Integrated Services Leadership Team, consisting of District

administrative staff, program directors, and program staff. This team meets regularly to coordinate and integrate services to the fullest extent possible, remove categorical barriers and prevent duplication.

- The service approach is *family-centered*. Parents and care takers are involved and empowered; and programs provide supportive as well as rehabilitative services.

- The programs are *community-based*. They are accessible because they are located in a visible community institution, the neighborhood schools. They work in partnership with other community services and agencies.

- They are *prevention oriented*. Particularly with the preschool population, the emphasis is on early identification and referral for appropriate services.

However impressive this array of programs, the District concluded it was not enough. They had a vision of the role of schools that included expanded health and social services, and they decided that EPSDT was the way to achieve this vision. So it was into this family of programs that the District initiated and integrated EPSDT/Medicaid.

The purpose of EPSDT is to insure a comprehensive, preventive health care program for Medicaid-eligible children who are under the age of 21. It seeks to link the child and family to an ongoing health care delivery system. Each element of the program's name combine to make the EPSDT program unique:

- *Early*: assessing a child's health early in life so that potential diseases and disabilities can be prevented or detected in their preliminary stages, when they are most effectively treated.

- *Periodic*: assessing a child's health at regular recommended intervals in the child's life to assure continued healthy development.

- *Screening*: the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention.

- *Diagnosis*: determination of the nature and cause of conditions identified by screenings.

- *Treatment*: the provision of services needed to control, correct, or lessen health problems.[8]

In late 1991, the Independence School District received formal certification as a Medicaid ACM provider from the State, the first school district in the State to receive this status. The District then began to implement three new sets of services to meet the primary and preventive health care needs of the District's children: Outreach and Screening; Treatment; and Administrative Case Management.

- *Outreach and screening.* The District began an intensive *outreach* effort to inform their school population about the importance of preventive health care and identify children and their families eligible to participate in the Medicaid EPSDT program. This involved working with building principals, teachers, secretaries and therapists (who have firsthand knowledge of the children and families in need); contacting individual students and families; sending letters to the families of all enrolled children, including all families whose children qualify for and participate in the school lunch program; speaking at meetings of parents and community groups; accessing appropriate State Medicaid records to identify Medicaid-eligible children residing within the District boundaries and cross referencing this list with the District's elementary school enrollment, special education enrollment, and participants in the Parents-As-Teachers, Head Start, Project Reach, and Even Start programs. Where families and children were potentially eligible for Medicaid, the District worked with the Department of Social Services to support the Medicaid eligibility determination process.

  Screening was initiated in 1992 and provided the following for each screened child: a comprehensive health and developmental history (including both a physical and mental health assessment); a comprehensive unclothed physical examination; appropriate immunizations according to age and health history; laboratory tests (including blood lead level); and health education. Screenings were also set up to meet the child's developmental periodicity schedule.

- *Treatment services.* Also beginning in 1992, the District began providing services to correct or ameliorate physical and emotional conditions identified in the screening process. These services were provided by school staff to the extent this was possible with the School District's existing resources. And children were referred to appropriate providers when the school could not directly provide or pay for services. Services that were provided included: speech, occupational, and physical therapies; psychological services; school health services; social work services; and transition services.

- *Administrative case management (ACM).* The screening and treatment services described above are not unlike Medicaid supported health services in other school districts around the country. More than 30 states are reported to be in some stage of allowing Medicaid claims for specific school screening and treatment services. But the Independence School

District did something few others have done. In cooperation with the State Department of Social Services, they made use of the administrative provisions of the Medicaid program to claim funding for activities which support the EPSDT program. As discussed below, this became the most important revenue generating component of the District's use of Medicaid. The District made use of what is referred to as "EPSDT administrative case management" or ACM to help children and their families receive appropriate services on a timely basis. ACM services included: assisting families in identifying and choosing providers; scheduling appointments and providing transportation; follow-up to assure that the service was provided and assistance in arranging subsequent treatment if needed. In many cases, such activities were already being performed by school personnel under other traditional school accounting classifications. Use of ACM claiming allowed the school to receive reimbursement for these activities when they served to support the EPSDT program. This, in turn, generated significant new revenue which the school could and did reinvest into improved services and supports.

Once the Independence School District became a Medicaid provider, these three sets of services (Outreach and Screening, Treatment, and Administrative Case Management) as provided by the schools of the District, became reimbursable under the Medicaid program. For the 1991-1992 school year, the District received about $50,000 in Medicaid reimbursement for direct services and for ACM. In 1992-1993, the District received about $20,000 quarterly for direct services, and about $200,000 quarterly for ACM, for a total of about $880,000. The District anticipates receiving a total of about $1.3 million in the 1993-1994 school year.

As the Independence School District began to generate Medicaid funds, they made a commitment to reinvest the revenue into the school system to add needed services and staff.[9] The federal funds realized in 1992-1993 were used for the following purposes:

- Six part-time school nurse positions were converted to full-time status, and six additional full-time school nurses were added. (The District now has 22 nurses who act as the Medicaid coordinators and administrative case managers in each of the District's school buildings.)
- Two new speech therapists and an additional school counselor were hired.
- Four audiometers were purchased for hearing screening.

- The District hired a full-time Director of Health Services, and a full-time secretary to assist with the claims and other paperwork.[10]

- The District established a reserve account as security to cover any repayments that might be required by a future Medicaid audit, and to draw on for emerging program needs.[11]

Plans for the 1993-1994 funds include completing the establishment of a full contingent of school counselors for the District (so that every school building will have a resident counselor), and hiring social workers for the schools to provide home-school liaison and intervention and counseling for children and families in crisis.

IV. STEPS IN PROGRAM DEVELOPMENT: MAKING MEDICAID WORK IN THE SCHOOLS

The accomplishments to date reflect work that began four years ago. In 1990, District staff began meeting with Missouri Medicaid program staff to figure out how to begin providing EPSDT services in and through the schools. Dr. Robert Henley, formerly the Superintendent, assigned Dr. James Caccamo, then the Assistant to the Superintendent for Special Programs, to implement the program. Approximately one-third of his time was dedicated to this effort. The School District received a small grant to hire a half-time administrative support person to assist Dr. Caccamo. The following are the program's developmental stages:

A. Goal Setting and Planning Services

The first stage involved setting goals and identifying services for the District's EPSDT program. In other words, the District needed to establish its health care agenda, and develop a plan for how it would meet federal requirements under EPSDT. The process used by the Missouri Department of Social Services to develop a health care agenda is contained in Appendix C. In reviewing its already existing services, and in working with the State Medicaid program and other appropriate community leaders, parents, and human service agencies, the District established as its *overall goal* to set up a program which provides a network to support the

delivery of primary and preventive health care for the children of the District. Toward that end, it established three specific goals and sets of services:

- *Goal #1*: To provide, in or through the school system, *early and periodic screening* of Medicaid-eligible school age children residing in the District who are not receiving this service and, to provide the same for preschool children. The decision was also made to provide screening of all District enrolled children, whether they are Medicaid-eligible or not.

  Screening services include:

  - A comprehensive health and developmental history (which includes a physical and mental health assessment).
  - A comprehensive unclothed physical exam.
  - Appropriate immunizations according to age and health history.
  - Laboratory tests (including blood lead level).
  - Health education (including anticipatory guidance).[12]

- *Goal #2*: To provide *services* to correct or ameliorate physical and mental conditions discovered by the screening process, to the extent that this is possible within the resources of the School District and the realized Medicaid funding, and to refer to appropriate providers when the school cannot or should not deliver the service.

  Services: If the screening results in a diagnosis of a problem, the diagnosis must lead to the development of a plan for treatment. Services that may be provided include, but are not limited to, the following:

  - Counseling.
  - Speech, occupational, and physical therapies.
  - Psychological services.
  - School health services.
  - Social work services.
  - Transition services.

- *Goal #3*: To provide *administrative case management* for the Medicaid-eligible children of the District, since the Board of Education is an authorized Medicaid agent through a formal interagency agreement with the State.

Administrative activities: The purpose of EPSDT *administrative case management* is to assist children and their families in navigating the often confusing system of health and related services in their communities. Since EPSDT screening, diagnosis, and treatment activities are frequently not conducted at one time or in one place, case management is critical to ensure that a child receives appropriate services on a timely basis. Among other activities, case managers:

- Assist families in identifying and choosing providers.
- Use the school as a resource in scheduling appointments and in providing transportation.
- Facilitate contact between the EPSDT program and the family to verify what activities have taken place, to maintain records, and to assure a timely flow of information.
- Conduct follow-up to assure children receive needed diagnosis and treatment.
- Help families maintain contact with providers.
- Provide ongoing service coordination to answer questions and reduce fear and confusion.[13]

Other administrative case management services include:

- Outreach to Medicaid-eligible children and their families to access EPSDT services.
- Assisting with Medicaid eligibility determination.
- Coordination of health screening, examinations, assessments, and evaluations.
- Immunization scheduling.
- Case planning, coordination and follow-up.
- Coordinating prenatal services.
- Coordinating nutrition services.

- Health education and health guidance.
- Interagency coordination.

In addition to deciding what was included in the agenda, certain allowable activities under EPSDT were eliminated. It was decided that the School District would not venture into a fourth possible area of EPSDT services: provision of primary care and other medical services in school-based clinics.[14] There were a number of local reasons for this decision. The costs of running such clinics are significant, and so are the human resource costs of meeting the applicable federal and state standards. Also, the Independence District area was already well supplied with authorized Medicaid providers. Finally, the politics of operating a health clinic in the schools can be daunting, particularly around birth control and abortion issues.

B. Implementation Planning

Once the District identified system goals and the services to be provided, a number of activities remained before it could begin the screening program, direct services, and administrative case management. In all the planning and implementation efforts, the District and the State Medicaid program have and continue to work closely to adapt Medicaid requirements to the school setting. Medicaid staff were perceived as a resource, not a hindrance, in developing workable plans in the least burdensome fashion. Their activities included the following:

1. Negotiating an Interagency Agreement

Before any services could be started, it was necessary for the School District to negotiate a formal interagency agreement with the State Medicaid program. This agreement spelled out the goals and services to be provided, as well as the responsibilities of each agency (see Appendix D, Missouri's Model Interagency Agreement).

2. Outreach, Child Find, and Eligibility Determination Activities

One critical role schools can play in Medicaid/EPSDT is outreach to inform their school population about the importance of preventive health care and to encourage eligible children and families to participate in the EPSDT program. Schools are key links because they are in regular contact with students and parents. Schools involved in outreach efforts may be reimbursed for these activities by Medicaid as part of administrative case management.

As part of the initial planning, *outreach activities* were initiated by the Independence School District early on. This included networking with building principals, therapists, teachers, and secretaries, all of whom have relationships with the school's families and know who is in need; contacting individual students and families through school staff; sending letters to students and their families, including all families whose children qualify for and participate in the school lunch program; and speaking at meetings of parents and community groups.

The District also initiated *Child Find*, a systematic program to identify Medicaid-eligible children currently residing within the School District boundaries. Since the District became an authorized Medicaid agent through an interagency agreement, it could access appropriate State Medicaid records, provided that confidentiality was protected. To identify the number of Medicaid-eligible children who reside within the District boundaries, a computer list of all eligible children in zip codes covering the School District was run. This provided a listing of children, not all of whom were in the District's schools. This list was cross referenced with the District's elementary enrollment, special education enrollment, and participants in the Parents-As-Teachers, Head Start, Project Reach, and Even Start.

The District then worked with the Missouri Department of Family Services (DFS) to *facilitate Medicaid eligibility determination* for eligible children and families. Meetings were and are held periodically with the building principals and the directors of the District's parent education, early childhood, and child care programs to review Medicaid eligibility guidelines, and they were encouraged to refer any family who might be eligible for Medicaid services to the School District's Health Services (see Appendix E, Missouri's Medicaid Eligibility Requirements).

These persons are also asked to meet with each of their staff members about Medicaid eligibility requirements and instruct them to refer any child they believe may qualify. Similar meetings are held with all school counselors. Finally, the County's DFS stationed an eligibility worker in the School District two half-days per month to take applications.

Through outreach, *Child Find*, and facilitation of Medicaid eligibility, it was determined that 42 percent of the children enrolled in the District's schools were Medicaid eligible. It is important to note that these outreach and eligibility-related efforts are not a one time activity and continue today. They must be part of the ongoing outreach work of the District and its schools, since Medicaid enrollment changes constantly.

3. Enrolling Providers and Establishing Medical Partnerships

In order to provide the screening and some of the treatment services that would be discovered through screening, the School District staff had to enroll providers and establish medical partnerships.

To qualify for the provision of direct service to Medicaid-eligible children, school staff had to be approved as Medicaid providers. School-employed providers included school nurses, speech therapists, physical therapists, occupational therapists, school counselors, social workers, and psychologists. A potential provider must hold a valid State certificate, registration, or license and must enter into a participation agreement with the Missouri Department of Social Services (DOSS). Appendix F contains Missouri's Provider Enrollment Information. The School District completed the provider enrollment during the first quarter of the 1991-1992 school year. The process is precise and time-consuming, but was expedited by the DSS Provider Enrollment Unit. Providers received training about allowable activities and about how to complete treatment/ billing forms (see Appendix G, Missouri's Provider Activities and Forms). All enrolled providers receive a monthly newsletter, *Medicaid Information*, which is jointly developed by the State Department of Elementary and Secondary Education and the State Division of Medical Services. This newsletter keeps providers current on developments in EPSDT/Medicaid programs in Missouri public schools.

To bill Medicaid for screening and treatment services, the Medicaid-enrolled children must be referred by a physician. Developing a system for obtaining physician referral is essential. Two kinds of relationships were established:

- The School District made an arrangement with Truman Medical Center East so that children not currently linked to primary care providers are assigned pediatricians through the Center.

- One-fourth of the Medicaid enrolled children attending public school in the District were enrolled Jackson County's Managed Care programs. These were primarily AFDC recipients. Families participating in the program must receive their primary care from their selected health care provider. To serve these children, the District needed a referral from the provider. Missouri Medicaid provided the District with the list of these providers. This required establishing relationships with four managed health care plans and thirty-one physician sponsors.

It has been the District's experience that pediatricians and other physicians serving Medicaid clients are eager to cooperate with the school in expanding services. As primary care physicians, they know first hand the health care needs of low income children and their families.

C. Operating the Screening Program

1. Equipment and Medical Personnel

The District needed to purchase medical equipment necessary for conducting screenings. A grant was obtained from the Victor E. Speas Foundation (the District established a 501(c)(3) Foundation and thus is able to receive tax deductible gifts and grants). Outside medical personnel were needed to conduct the screenings during the program's first year and the Jackson County Health Department agreed to provide the staffing. A public health nurse, a pediatrician from Truman Medical Center East, and a parent educator staffed the screenings held in the 1991-1992 school year.

2. The Screening Procedure and Follow-up

In accordance with EPSDT guidelines, on the screening days, the following are administered: an unclothed physical examination, a comprehensive health and developmental history (including assessment of both physical and mental health development), appropriate immunizations, vision screening, hearing screening, and dental screening. Screenings are conducted by the School District for Medicaid-eligible children. A full screening is reimbursed at $90. Children who are not Medicaid-eligible are only screened on a case-by-case basis at no cost to the family, if a nurse, teacher or other school staff person identifies a potential problem. The following-post-screening procedures were established with the help of the State Medicaid staff:

- If the screening does not demonstrate any problems, the screening information is filed, and the child is placed on a list for screening at the next periodicity interval.

- If, as a result of the screening, an evaluation in one of the areas served by School District providers is recommended, the screening team refers to the appropriate therapist. No prior approval is required for this evaluation. These evaluations could include referral to speech, occupational, physical, or psychological therapy or the special education evaluation process.

- If, as a result of the screening, a full diagnosis in a medical area is recommended, the screening team provides administrative case management to get the family to the appropriate medical provider for the diagnosis and treatment. The team requests that the parents sign a release of information form so that the screening team can discuss the case with the health care provider.

3. Number of Screenings

In the 1991-1992 academic year, two screening sessions were held, one in January and one in April. Twenty-two (22) children were screened, and five referred for further service. The no-show rate at the first screening was over 50 percent. With greater outreach efforts, the no-show rate is now under 10 percent. In the 1993-1994 school year, the District is screening about 22 children a month.

4. Screening Records and Billing

The screening team records the results of the screening, and any required evaluations and treatment, in the child's file. It completes a billing form which is sent to the District's administrative office the same day. The District bills Medicaid monthly for screening services. The District encountered minimal resistance from school and screening staff about recording time and billing. The reason is that the schools previously had been doing this for charges for child care and for insurance reimbursement for special education services.

D. Treatment and Referrals

1. Direct Treatment

If, as a result of the diagnosis, treatment is recommended, and the treatment is to be given by a School District provider, he or she must develop a *plan of care* which is incorporated into a child's *individualized educational plan (IEP)*.[15] The plan of care includes the current level of performance, annual goals, short term objectives, and a method of evaluating when the child has attained the treatment objectives. The plan of care becomes the authorization for services and no prior approval is necessary from the State Medicaid program to begin treatment. However, the IEP must be signed by a physician, nurse, or nurse practitioner, and maintained for audit purposes, and parents must provide written permission before treatment is initiated. The IEP and Medicaid treatment plan must be reviewed annually.

2. Referrals

If a referral is to be made to a provider who is not an employee of the School District, then the District provides administrative case management to insure that the child gets the services and any follow-up that is needed. The School District now has a Health Services Director, who ensures that the referral is made immediately and that administrative case management is coordinated.

3. Record-Keeping

In the provision of treatment services, it is critical that appropriate records be kept so that the program can withstand an audit. Most of the regulations set by the federal and state governments regarding EPSDT/Medicaid were designed for primary health care settings, not for schools. Therefore, the District and the State Medicaid program worked together to develop a school oriented record-keeping protocol. The goal was to meet the regulations without imposing an excessive record-keeping requirement on the District's providers.

The District's various therapists are responsible for the record-keeping, which includes (a) the IEP (with the plan of care addendum, detailing the diagnosis and treatment plan); and (b) a treatment log which briefly states the date and nature of each session (see Appendix G). The treatment log is submitted to the District's Office of Special Programs every two weeks, from which bills to Medicaid are generated. These two forms, plus records of the evaluations, meet the Medicaid documentation requirements.

4. Billing

The District bills Medicaid for reimbursement for screening and treatment services through the Accelerated Submission and Processing Medicaid Claims program (ASAP). Claims are recorded on computer diskette and mailed every two weeks to GTE Data Services, the claims agent for Medicaid. District personnel needed training to learn this program. The billing process includes remittance advice from Medicaid, updating claim status, and instructions for the provider when there has been an error in the bill.

E. Administrative Case Management

1. Services

The last component of the program to be implemented was administrative case management (ACM). ACM includes the following activities: Medicaid eligibility determination; outreach to

Medicaid-eligible children and families to access EPSDT; coordination of screening, examinations, assessments, and evaluations; immunization scheduling; case planning, coordination, and follow-up; coordinating prenatal care services; coordination of nutrition services and information; health education and health guidance; and interagency coordination. Building nurses serve as the primary case manager for the children in their school.

2. Staff

The District identified 182 employees who perform administrative case management services. They include counselors, physical education teachers, school administrators, administrative staff, staffing coordinators, special education and related service providers, nurses, Direction Service Center case managers, Parents-As-Teachers parent educators, 21st Century Program child care providers, home-school coordinators, early childhood special education teachers, and the special education administration and the Crisis Intervention Teams at the secondary schools. All had to participate in training in the administrative case management methodology (see Appendix H, Missouri's ACM Methodology Development Outline).

3. Time Study

Working with the State Medicaid program staff, the District set up a program to conduct a time study one day each month with each of the 182 employees. The day of the month is randomly selected. Staff record their activities, in fifteen minute intervals, under the following categories: general administration and overhead; non-health related activities; screening, care, treatment, and counseling (services provided in the last category are not reimbursable as ACM; these are billed as screening or direct treatment). These log sheets are processed to provide an average percentage of time spent by each category of employee engaged in each activity. (See Appendix I, Missouri's Time Study and Log Sheet).

4. Billing

The formula for billing Medicaid for ACM is the percentage of qualifying employee activities (salaries and benefits) based on the time study multiplied by the percent of eligible Medicaid students in the School District. The School District is reimbursed for approximately 50 percent of this amount since federal law has established Medicaid reimbursement for administrative activities at 50 percent of allowable expenditures. Nurses involved in ACM, because they are skilled medical professionals, are federally reimbursed at 75 percent of eligible claims. Using this formula, the District's administrative office bills Medicaid quarterly.[16]

5. Record-Keeping and Referrals

ACM files are kept for each child. The goal is to coordinate all the services the child needs. Detailed records of telephone conversations, contact with the Department of Family Services and Medicaid, interactions with parents, and observations of children are among the notations in ACM files. Referrals are made daily to the District's Health Services Director by administrators, teachers, program directors, and therapists for such issues as a child needing glasses, suspected child abuse or neglect, or parents who need help in making a doctor's appointment.

F. Where Are They Now, and What's Next?

The School Board and District staff continue their commitment of ensuring that the children of the District are provided EPSDT services and administrative case management. The original goals have not changed and the program continues to expand annually. The following programmatic goals have been set for 1993-1994:

With 1993-1994 revenues, the School District will:

- Complete the staffing of a full contingent of school counselors so that every school building will have a resident counselor and will hire social workers for the

schools to provide home-school liaison and intervention and counseling for children and families in crisis.

- Continue with monthly screenings so that all children's preventive health needs can be met according to the EPSDT periodicity schedule; increase the number of students and preschoolers screened monthly; and study the feasibility of making screenings available on a daily basis. An issue that must be resolved is whether screenings should be rotated among schools in the District to reduce transportation problems, or be housed in a permanent site to minimize confusion and maximize services (for example, offering tests that are not portable).

- Begin a program of immunizations for preschool children in the District. The goal is to approximately double the number of preschool children immunized and achieve 100 percent immunization by 1996.[17]

- Develop a better system for follow-up care so that children can be monitored and rechecked when an illness has been discovered (for example, an inner ear infection discovered at a well clinic examination).

- Involve building principals and other staff more actively in ACM.

- Provide more services through cooperative interagency agreements with state and county public agencies. For example, the School District will work with Jackson County's Department of Mental Health so that social workers can be placed in schools to provide counseling services on site to high risk children and their families rather than referring the children out.

- Develop better means of outreach so that children currently not receiving preventive and primary health care services can get them (for example, working with parochial schools in the District).

- Tie into the Medicaid database to facilitate determination of whether a child is enrolled in Medicaid.

- Develop outcome measures to assess the efficacy of the program (the State Medicaid program plans to require this),[18] including objective data measurements of the program's impact on children and families.

- Develop a better computerized billing system for screening, direct services, and ACM.

V. THE IMPACT OF THE EPSDT/MEDICAID PROGRAM

Although the program has only been fully operational for a short time, it is important to step back and look at the early impacts of the EPSDT/Medicaid program on the School District, the community, the State, and the children and families served.

A. Fiscal Impacts

In three years of operation, Independence will have realized a total of over $2.2 million for new services for children and their families, growing from about $50,000 in 1991-1992 to $1.3 million in 1993-1994. Table 1, below, provides data on the new funding generated by the EPSDT Medicaid Program. Graph 1, on page 26, demonstrates the dramatic growth in revenue over the past three years.

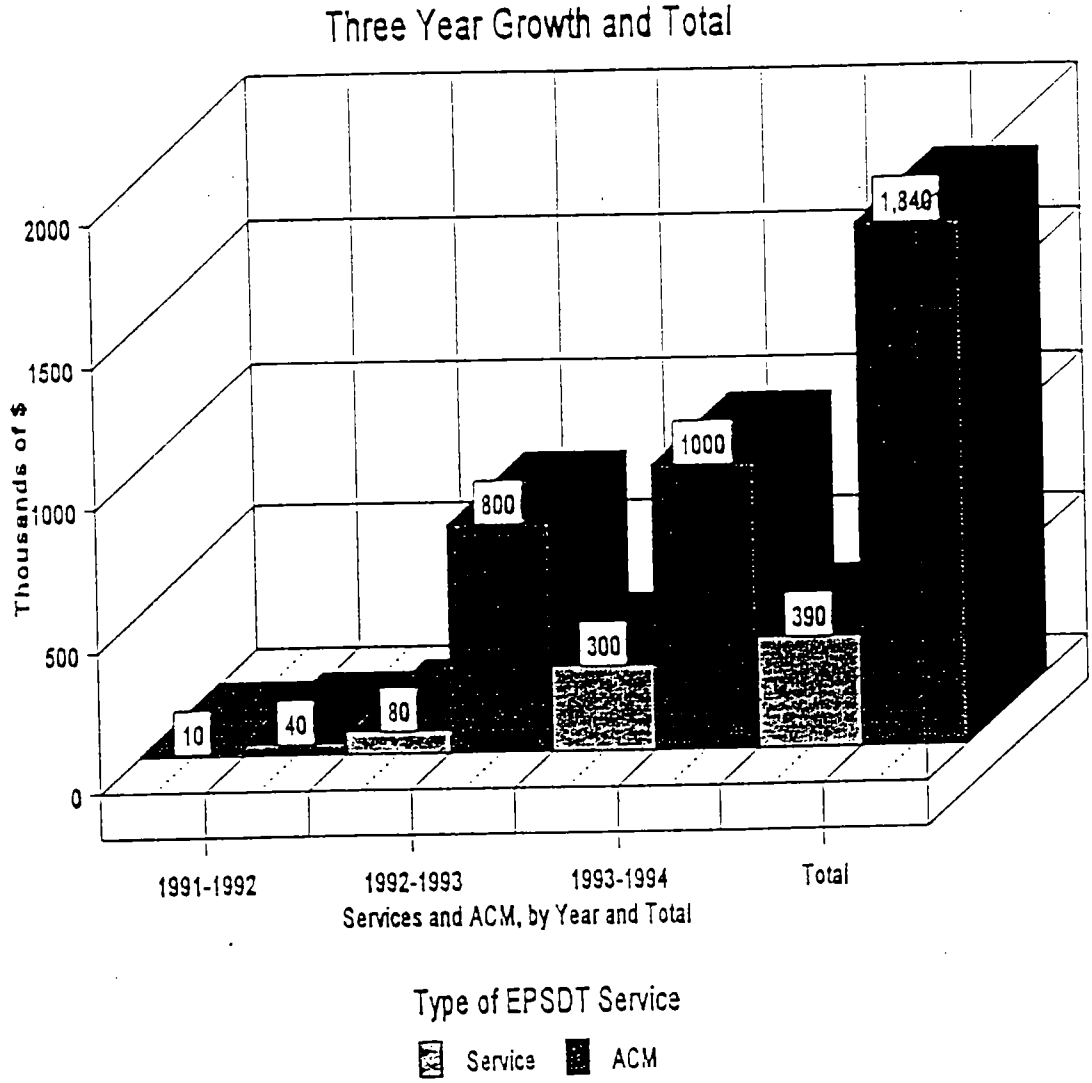
Table 1

Revenue Generated by Independence, Missouri
EPSDT/Medicaid Program (1991-1993)

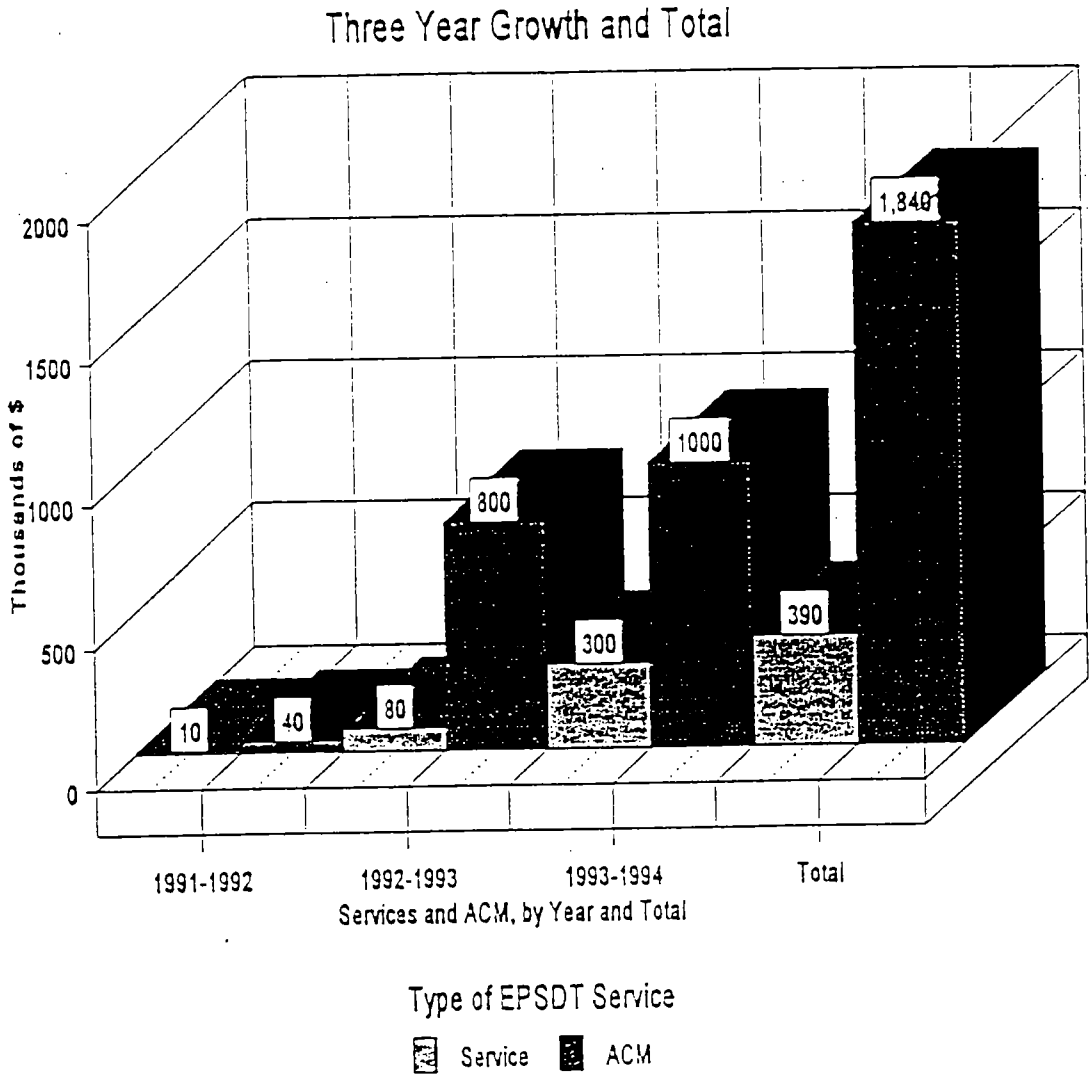
Year	Screening/ Treatment	Administrative Case Management (ACM)	Total
1991-1992	$ 10,000	$ 40,000	$ 50,000
1992-1993	$ 80,000	$ 800,000	$ 880,000
1993-1994	$100,000	$1,200,000	$1,300,000
		TOTAL:	**$2,180,000**

These funds have been used to hire staff, particularly nurses and therapists, to implement expanded services. Nurses were the first hired because of the lack of health services in the schools; this was clearly the hiring priority of the building principals and other school staff.

Independence EPSDT Revenues



Independence EPSDT Revenues



Nurses not only could provide the new health services under the EPSDT agreement, but could also attend to the daily health problems of the children and provide overall health education in the schools. Importantly, the building nurses serve as the primary case managers for the children in their schools, maximizing additional federal reimbursements. Future staff additions will concentrate on other human service needs such as school counseling and crisis intervention for families.

A percentage of the total revenue has been kept in reserve for emerging program needs and as insurance in case of a federal audit. In the same three years, the School District's overall annual budget remained steady, growing slightly each year, while new services were able to be implemented without additional state or local dollars.

B. Children and Staff

The school children and their families clearly are receiving needed health and social services, many for the first time. Both school-age and preschool children are being screened who were not previously; immunizations are being administered, and needed new treatments, both physical and social, are now being delivered. At the same time, the District staff know they must continue to increase the number of screenings and improve their case management.

The District has not yet begun to collect data that will objectively prove the program's client outcomes, such as an increase in the number of children receiving primary care, improved attendance rates, decreased drop out rates, reduction in the number of sick days, improved achievement, reduced family disruptions, and so forth. Clearly this is a need they intend to remedy, particularly as the State Medicaid program begins to require specification of annual outcomes and measurement of those outcomes. Limited data is available but it is not sufficient to prove a cause-effect relationship. For example, in one of the District's schools with a high percentage of Medicaid-eligible children, Benton Elementary, attendance rates have gone from 92 percent in 1991-1992 to 96.3 percent in 1992-1993, but in the absence of any control group, it is impossible to statistically relate the improvement to the new Medicaid services.

More compelling is the anecdotal information coming from principals, teachers, and other school staff. They report regularly on new services being provided to children for the first time, with a quick response time resulting from case management. Children are getting hearing and vision services they never had before, vulnerable children are getting regular medical treatment, and preschool siblings of the children are getting needed services which previously would have waited until they began school. School staff morale is higher. Staff have always seen the health and social problems of the children and their families; however, now school personnel feel they have a real way to help through the EPSDT/Medicaid program.[19]

C. The Community

In some communities in the nation, strong opposition has emerged to schools which have taken on expanded health and social service roles. In Independence, Missouri, however, no such opposition developed. In part, this is due to the proactive role the District has taken for over 15 years. The community evidently believes that it is essential to give children the support needed to maximize their capacity. One demonstration of this community attitude was the vote on a proposed school bond in the District in 1992. It passed overwhelmingly, the first to be approved since the 1950s and provides $21 million for renovations to all schools and computers for schools. The School District believes, based on anecdotal data, that approximately 97 percent of the parents whose children participate in the School District's *21st Century Schools* programs voted, and 95 percent of them voted for the bond. In addition, a tax levy increase of $.13 was also passed.

D. Local and State Agencies and Other School Districts

Because the Independence program is viewed as so successful, other local public agencies are more interested than before in working with the schools. The School District has now initiated interagency agreements with the Department of Family Services (DFS) and the Department of Mental Health (DMH) and worked out procedures for referral and follow up. DFS assigns workers to schools each month to facilitate Medicaid enrollment. DMH is considering assigning social workers to some schools to provide mental health services.[20]

The working relationship between the District and the State Medicaid program remains excellent. Importantly, the State Medicaid program is now working aggressively with other school districts in Missouri to initiate similar EPSDT/Medicaid initiatives. An added benefit has been that over 100 school districts from across the country have now either asked for technical information or visited Independence to learn about this initiative.

E. The State

District staff, in hindsight, believe that one core ingredient was missing when they began which, had it been in place, would have greatly facilitated their efforts.[21] At the time they began, there was no official directive from state policy makers about the validity and importance of EPSDT/Medicaid programs in school. This is now in place through the passage of House Bill No. 564 in 1993 which was endorsed and supported by the governor and the speaker of the Missouri House. These policy makers became convinced of the program's value because of the positive Independence experience. The legislation contains numerous provisions directed at Missouri schools to provide various health care functions, and especially encourages school participation in the EPSDT program and the provision of primary and preventive health care services. It requires that the "most accessible care" be provided to eligible children—that is, services are to be provided where the most children are normally during school hours or where children are most likely to participate with the least obstacles.[22] Further, the legislation directs the State to seek a waiver from the federal government to expand program eligibility.

VI. THE LESSONS LEARNED

School districts across the nation can learn a great deal from the Independence experience in implementing the EPSDT/Medicaid program. It is one model of how state and local governments can work together to effectively expand limited resources. In addition, beyond the specific programmatic elements of this partnership, the Independence example is a case study in breaking down bureaucratic and professional barriers on behalf of children and families.

There are several critical lessons from the factors that the Missouri participants attribute to their success.

A. Getting Started and Maintaining Momentum

In interviews, key staff talked about what they considered to be core "ingredients" that needed to be in place to make it possible to launch a successful EPSDT/Medicaid program. They believe that school districts who want to initiate such a program should work to make sure at the start that certain ingredients are in place. The key factors reinforce the underlying principles presented at the beginning of this paper.

First, the advice of both the School District personnel and the State Medicaid program staff is consistent and blunt that there are schools and school districts that should *not* initiate an EPSDT/Medicaid program. School districts should not consider the EPSDT/Medicaid program if their philosophy is that it is the sole responsibility of parents to attend to the health care needs of children. The operative philosophy must be that schools can and should enter an empowering partnership with the children's families to promote student health and encourage access to primary and preventive health care. For these kinds of initiatives to work, the community must believe that it is appropriate and essential for school personnel to interact regularly with health care providers and parents in the community for the purpose of coordinating student health care.[23]

Similarly, school staff must share this philosophy. EPSDT services must not be viewed as "add-ons" but as essential supports to educating children successfully. Independence District staff believe there was minimal resistance from school staff in starting the EPSDT program because the already existing *21st Century Schools* program fostered this philosophy.

Those states, school districts, and schools who do not have a clear and firm commitment to reinvest reimbursed Medicaid funds back into the schools in order to increase staff to deliver needed health and social services and for continuing systems reform should not participate. EPSDT should not be used solely as a revenue generating scheme for schools. It is not

sufficient to start a program in order to relieve the School District's budget. If the commitment to reinvestment is not present, the program will not be successful. The schools and their personnel, and the community must see the tangible benefits of the partnership. If this occurs, EPSDT/Medicaid can be used as a strategy for the larger goal of strengthening community-based services for children and families through the schools.

Second, the State needs to be wiling to work with the local school district in a partnership and the School District needs to want it to work. In Independence, the leadership of individuals made this possible. The essential ingredient that made the Missouri experience successful was the partnership between the District and the State Medicaid program. Independence staff believe that their work would have been easier if state policy had clearly supported such programs from the start. Bill 564 now provides this. The support of the Governor and State legislators can be instrumental in getting things started. The most concrete result of such a partnership is that it enables state and local staff to work together to adapt Medicaid to the school setting.

B. Stages of Development and Implementation

From interviews and program materials, the following are the suggested stages of development and implementation of a school-based EPSDT/Medicaid program:

1. Create the Critical Mass

Begin with the essential ingredients, discussed throughout this paper to create the critical mass needed to develop the program. The most important of these, in almost everyone's estimation, is that state and local officials must have a vision and be enthusiastic about the initiative. Without this broad commitment as the first stage, a school district will not be able to sustain the energy required, nor will the program survive the tenure of those who initiate it.

2. Establish the School's Health Care Agenda

Once these ingredients are in place, the next stage is to *establish the District's health care agenda.*[24] This should be a collaborative process involving the school board, school staff, community leadership, families, and state, county, and local agencies.

3. Develop an Interagency Agreement and an Implementation Plan

Once the District's health care agenda has been defined, it is time to *develop an interagency agreement* between the School District and the State Medicaid program. A model interagency agreement is contained in Appendix D on pages 21-27. This agreement will define the services the School District intends to implement. Then develop a plan of implementation, using technical assistance from the State's Medicaid program and education departments.

4. Training

Training is the next critical stage. All school personnel, from the building principals to building maintenance staff need to be involved to varying degrees. Training needs to begin with the vision, philosophy, and the place of the program in the larger systems reform of community-based, integrated services, and then proceed to the technical requirements and changes in the District's and schools' way of operating. Critical training issues include Medicaid eligibility, provider enrollment, provider activities, the time study, and using the various forms (see Appendices E through I).

5. Program Implementation

Program implementation should proceed from the relatively simple to the more complex. Independence began with screening, then in-school treatments and referrals to providers in the community, and finally, to administrative case management. Each of these program components will require new administrative challenges (for example, billing).

6. Ongoing Program Development

After the program has been implemented, *focus on improving and nourishing it*, including reinvesting the new revenues back into the program. The emphasis needs to be on measurable outcomes, more productive partnerships with other agencies, outreach, increased screenings and services, and effective case management that achieves regular primary health and mental health care for the children and their families. *Program evaluation* should be a formal and ongoing component of the initiative.

CONCLUSION

The successful collaboration between the Independence, Missouri School District and Missouri Medicaid is an example of a partnership where everyone benefits. The Missouri Medicaid program is helped to meet its mandate to provide health prevention, screening and treatment services to Medicaid-eligible children. The Independence School District is provided the resources to infuse their schools with the support services that children need in order to be productive learners. Children and families in Independence have gained improved access to health care resources and assistance in managing their health and human service problems.

All too often, the day to day demands of operating a school, a local health program or a public human service agency foster barriers against these kinds of successful partnerships. What the Independence example shows is that the results are worth the effort. The combination of a shared vision, a commitment to improving services and a willingness to reduce bureaucratic barriers has paid off for the children and families of Independence. This is perhaps the most important lesson to be learned from this case study.

APPENDICES

A. A Profile of the Independence School District, 1993-1994

B. The Independence "Family" of Educational Support Programs

C. The Missouri Process for Developing a Health Agenda

D. Missouri's Model Interagency Agreement

E. Missouri's Medicaid Eligibility Requirements

F. Missouri's Provider Enrollment Information

G. Missouri's Provider Activities and Forms

H. Missouri's ACM Methodology Development Outline

I. Missouri's Time Study and Log Sheet

Appendix A:
A Profile of the Independence School District, 1993-1994 *

Assessed Valuation		$476,804,938.00
Tax Rate	Teachers Fund	$2.08
	Incidental Fund	$1.10
	Debt Service	$ .18
	Total	$3.36
Budget		$55,347,205.00
Approximate District Population		75,000
Area of District		31 square miles
Student Enrollment K-12		11,182
Average Student/Teacher Ratio		23/1
Number of Certified Staff		655
Total Staff		1,250
Average Teacher Salary		$34,075.00
Per Pupil Expenditure (1990-1991)		$3,601.00
Missouri Classification		AAA
Total Accreditation K-12		North Central

Number of Buildings: two high schools, two junior high schools, 13 elementary buildings, the Noland Child Development Center, the Hanthorn School, and the Oldham Education Center.

School Organization: Preschool, K-6, 7-8, 9-12.

Member Metropolitan Community College District.

*Taken from: *Independence School District: Providing Quality Education Since 1866.*

Appendix B:
The Independence "Family" of Educational Support Programs *

(This description does not include the EPSDT/Medicaid Program.)

- ***21st Century Schools*** is an integrated cluster of comprehensive child care programs designed by Dr. Edward Zigler, Director of Yale University's Bush Center in Child Development and Social Policy. It serves children from birth to twelve years of age and strives to provide for the social, emotional, physical, and intellectual growth of each child, and consists of six programs:

  - *Before-and-After-School Child Care* is provided in each of the 13 elementary schools, and 25% of the enrolled elementary school children participate. 1500 families are served in the program. The program features enrichment activities, snacks, and supervised care. Minimal fees are charged.

  - *The Preschool/All-Day Child Care Program* is designed to provide comprehensive, high quality, affordable, and accessible child care to the Independence Missouri community. The program features school readiness and enrichment activities, meals and snacks, and supervised care. Minimal fees are charged. It is offered in eight of the elementary schools and the Noland School Child Development Center for 3-5 year olds. 500 children are served. It is offered year-round, and has a budget of $1.8 million and 170 employees. Evening service is also provided, free for emergencies, and $1/hour for non-emergencies. Scholarships are available from the County's Department of Family Services. The program also utilizes other programs of the School District, including information and referral, screening, and integrated services for developmentally delayed preschool children.

    The program is constantly expanding. A replication manual has been developed to assist interested schools in starting the program. The School District absorbs the infrastructure costs for the program, such as audits, coordination, and so forth. The major obstacle in program expansion are the start up costs for facilities and equipment; this is partially solved by securing grants and mortgages.

  - *Support Network for Family Child Care Providers* offers training and education for community child care providers. It was initiated because of the School District's commitment to the importance of quality child care and because trained providers assist in school readiness. It also provides access to children receiving day care in the community for preventive and early intervention services prior to school. Monthly training sessions are held, with regular attendance by 65-100 providers.

- *Parents As Teachers* is a national non-targeted program operating in 42 states and the District of Columbia to provide parent education so that parents can help their infants and toddlers develop to the maximum extent possible. It was started by the District in 1981. Currently, 1500 families participate. The program provides the following services for parents of children birth to three: parent consultation through home visits, group meetings, and periodic screenings. Services for parents of children three to five include: group meetings, screening, newsletters, play groups, Parent Resource Centers, and a Children's Library. It is offered free of charge to all families in the Independence School District.

- *The Direction Service Center (DSC)* is a not-for-profit corporation providing *information and referral* to all families in the Independence School District to assist them in securing appropriate services for young children and their family members.

- *The Medical Screening and Referral Program* provides screening and referral for Medicaid eligible children birth through five, prior to school.

Other programs include:

- *Head Start* has been operated by the School District as a delegate agency for the Kansas City Model City Corporation since 1979. 304 children are enrolled in 1993-1994, 10% of whom are disabled. Approximately 40 children are in the full day, full year program (a program requirement is that their parents are employed or attending school full time). The remaining children participate in a four day, four hour, eight month program. In addition to the regular Head Start program which includes process oriented education, family needs assessment, social services, health and mental health services, and nutrition, the program uses the High/Scope cognitively oriented curriculum, and teaches parenting classes, English as a second language, and high school equivalency classes to the parents of the Head Start children.

- *The Head Start Transition Project* is a program of the School District funded by a grant from the U.S. Department of Health and Human Services. The project provides supportive services to the Head Start children and their families in making a successful transition from Head Start to regular public school. Program staff are working with 50 children in 1993-1994 in five of the 13 schools.

- *Project Reach* is the School District's early childhood special education program for preschool children with disabilities. Over 100 children with mild to profound disabilities are served in a continuum of education and service delivery options.

- *The Nutrition Education Program* is the District's project to teach preschool and primary grade children and their parents about nutrition.

- ***Even Start*** is a targeted, year-round program to teach literacy skills to parents living in Chapter I school attendance areas who have a child between birth and seven and who have not completed high school. The program provides adult basic education classes toward the GED. While the parents are in class, the children are in a learning environment. Then the parents and child are brought together for literacy training and interaction. It also provides a number of family support services, such as home visits, family activities, access to the Parent Resource Center, parent support, and a breakfast and lunch program. The project has been made possible by a four year grant from the U. S. Department of Education, and this year is serving about 45 preschoolers and their families.

*This summary of programs has been constructed from Caccamo (1992), Independence School District (1993-1994), program brochures, and on-site interviews conducted December 15-16, 1993 with key personnel.

Appendix C:
The Missouri Process for Developing a Health Agenda*

I. Establishing the District's Health Care Agenda

School districts and schools interested in participating in the Medicaid administrative case management program should contact either of the following state agencies before pursuing any activities associated with the program.

Missouri Department of Elementary and Secondary Education
Division of Special Education
Section of Special Education Administrative Services
P.O. Box 480
Jefferson City, MO 65102
(314) 751-7953

Deputy Director
Missouri Department of Social Services
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500

Although some many not fully realize it, all schools currently play a role in their communities as health care providers. Doing so many have been a direct result of board action where the superintendent has directed the incorporation of certain duties into staff functions. Some activities are required by state statute, i.e., determining immunization status, performing certain activities associated with programs for students with disabilities, etc. Other examples of performing this role may have taken shape as a result of concern by various staff members who expanded their roles based upon their professional training and/or empathy for students and their families, e.g., nurses talking with family practitioners, counselors interacting with family service workers, and so forth.

The scope and depth of a unified health care role of a school district should not be a patchwork of activities with little purpose, organization or predictability. Rather, school districts should determine with other appropriate community leaders, parents, human service agencies and others, the needs which exist in their communities to provide a network which supports the delivery of primary and preventive health care for all children. Having determined such needs, the school district may define the scope and depth of efforts which will be directed at the need,

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*Missouri Department of Social Services, *Medicaid EPSDT Administrative Case Management: Procedures for Missouri Schools*, Jefferson City, MO: Division of Medical Services, August 1993, pp. 5-8.

based upon the district's resources to respond, recognizing that its primary duty is that of providing a quality education to all students. However, can a quality education be provided to a student who comes to school irregularly, or who is often sick when in attendance, is not properly nourished, etc.? Schools have a deep interest in the health care which students need and receive.

The purpose of the Medicaid administrative case management program is to encourage the development of a framework of activities which will result in each Medicaid beneficiary having a "health care home" (an entity person or organization) which assumes the responsibility for knowing the child's health status, what his/her health care needs are, and to delivery the services needed or assist in accessing them from a qualified provider. The program does not place the agent in the role of being the sole provider of the services needed; rather, the agent is the manager of the student's needs in that he/she oversees that primary and preventive services are scheduled and provided, as appropriate. In many cases, this is not unlike what some school districts already do for students without ever having considered the actual role being performed.

Schools and school districts interested in participating in the Medicaid EPSDT administrative case management program must begin with policy and executive leaders (e.g., the Board of Education and top administrative staff) identifying the scope and depth of the health care role which is desirable and possible for the district to play, considering its resources and commitment, and the needs of its community of students. It is not advisable for a school district to pursue the program without first having defined its goals and objectives in this area, as well as its resources, both internal and community-wide. (While not all schools in a district must participate, the district must sign related agreements on behalf of the school or schools which do participate.)

Schools and school districts considering participating in the program are encouraged to ascertain their current commitment to assisting students with their health care needs by evaluating their current commitment using the following continuum. This evaluation should be done by not only district insiders, but include members of the community who work with children and are concerned with their health care needs:

1. Our district is very active in all areas of student health promotion and encouraging accessing primary and preventive health care, when needed. We regularly interact with health care providers in the community for the purpose of coordinating student health care.

2. Our district is somewhat active in these areas but views parents as having the primary role. We interact with community health care providers on an "as needed" basis for individual students.

3. Our district considers parents to be the primary health care managers. We contact them or other health care providers on an emergency basis only.

4. Our district provides for student emergencies and has no interactions with other community health care providers.

This brief process will help elucidate the intention of the school or district to address the health care needs of students. The next steps are to consider what activities and resources are currently directed to the effort; considering these will provide a perspective of how extensive an effort may be needed to reach the intended goal identified above. The following structure should be worked through by the same team involved with the prior task.

My District Promotes Student Health Care Through the Following Means:

1._____
2._____

.....

The Following Staff Positions Are Involved In Promoting The Health Care Program Of This District:

1._____
2._____

.....

Having first answered the broader question of "What is the school's or district's agenda?", the identification of the actual activities and resources directed to achieve the desired role will uncover any discrepancies which may exist between intentions and actions.

Schools should assess the program of health care services they provide, and compare them with the allowable and billable services available to Medicaid beneficiaries through the EPSDT administrative case management program. The following is a list of the services which may be provided for reimbursement to Medicaid beneficiaries by EPSDT case managers.

1. Medicaid Eligibility
2. Outreach to Children and Families to Access EPSDT
3. Coordination of Screening, Examinations, Assessments and Evaluations
4. Immunizations
5. Case Planning and Coordination
6. Prenatal Care Services
7. Nutrition Services
8. Health Education
9. Interagency Coordination

More explanation of each of these categories of activity is provided in Appendix A. These are the types of activities which a school or district must provide in order to participate in the Medicaid administrative case management program. If a school or district selects to participate, it must agree to provide management of the primary and preventive service needs of students in these areas.

It should be clear that in order to effectively implement the Medicaid EPSDT administrative case management program in a school or district at least two primary supports must exist (a) the board of education must endorse and actively promote the effort, and (b) the executive administration must provide the leadership and administrative support required. With these supports in place, the district's agenda and the purposes of the Medicaid EPSDT administrative case management program will be compatible.

Appendix D:
Missouri's Model Interagency Agreement*

Sample Interagency Agreement
(August, 1993 version)

COOPERATIVE AGREEMENT BETWEEN
THE DEPARTMENT OF SOCIAL SERVICES, Division of Medical Services
and
THE School District ~

EPSDT ADMINISTRATIVE CASE MANAGEMENT through the HEALTHY CHILDREN AND YOUTH PROGRAM (EPSDT)

STATEMENT OF PURPOSE

The Missouri Department of Social Services (DSS) through its Division of Medical Services (DMS) and the School District ~, in order to provide the most efficient, effective administration of Title XIX, Early Periodic Screening, Diagnosis and Treatment (EPSDT) aka is the state as Healthy Children and Youth, hereby agree to the conditions included in the Cooperative Agreement. The provision of EPSDT/HCY Administrative Case Management by the School District ~ has been determined to be an effective method of assuring the availability, accessibility and coordination of required health care resources to Medicaid eligible children residing within the boundaries of the School District ~.

The Department of Social Services, Division of Medical Services recognizes the unique relationship that the School District ~ has with the EPSDT/HCY eligible clients and their families. It further recognizes the expertise of the School District ~ in identifying and assessing the health care needs of EPSDT eligible clients and in planning, coordinating and monitoring the delivery of preventive and treatment services to meet their needs. DSS, in order to take advantage of this expertise and relationship, enters into this cooperative agreement with the School District ~ for EPSDT Administrative Case Management.

The Department of Social Services, Division of Medical Services recognizes the School District ~ as the most suitable agent to administer case planning and coordination through EPSDT Administrative Case Management for its EPSDT eligible clients and their families.

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*Missouri Department of Social Services, *Medicaid EPSDT Administrative Case Management: Procedures for Missouri Schools*. Jefferson City, MO: Division of Medical Services, August 1993, pp. 21-27.

The Department of Social Services and the School District – enter into this Cooperative Agreement with full recognition of all other existing agreements which the Department may have developed for services to Title XIX eligible clients living within the School District – 's boundaries and which are currently included in the Title XIX State Plan.

I
MUTUAL OBJECTIVES

1. Assure that all Title XIX eligible clients under the age of 21 and their families are informed of the EPSDT/HCY benefit and how to access it.

2. Assure that assistance is provided to children and their families in determining their eligibility for participation in Missouri's Medicaid plan.

3. Assure early and appropriate intervention and screening so that diagnosis and treatment occur in a timely manner.

4. Establish a medical care home as defined in Section 9 of the General Chapters of the Medicaid Provider Manual, for those Medicaid eligible children receiving EPSDT/HCY service coordination activities.

5. Assure that services are of sufficient amount, duration and scope to correct or ameliorate the condition for which they were determined to be medically necessary.

6. Assure that services are provided by appropriate Medicaid enrolled providers for the correction or amelioration of conditions identified through a full, partial, or inter-periodic EPSDT/HCY screen.

7. All terms of this Agreement and procedures are to adhere to OMB Circular A87.

II
RESPECTIVE RESPONSIBILITIES

DSS agrees to:

1. Reimburse the School District – the Title XIX federal share of actual and reasonable costs for EPSDT administration provided by staff based upon a time-accounting system which is in accordance with the provisions of OMB Circular A87 and 45 CFR parts 74 and 95; expense and equipment costs necessary to collect data, disseminate information and carry out the staff functions outlined in this agreement. The rate of reimbursement for eligible administrative costs will be 50%. The rate of reimbursement for eligible costs qualifying under regulations applicable to Skilled Professional Medical Personnel and their supporting staff (compensation, travel and

training), will be reimbursed at 75% when the criteria of 42 CFR 432.50 are met. Changes in federal regulations affecting the matching percentage and/or costs eligible for enhanced or administrative match, which become effective subsequent to the execution of this agreement will be applied as provided in the regulations.

2. Provide the School District~ access to the information necessary to properly provide the EPSDT Administrative Case Management.

3. Develop and conduct periodic quality assurance and utilization reviews in cooperation with the School District~.

4. Provide initial and ongoing training and technical assistance to staff of the School District~ regarding the responsibilities assumed within the terms of this agreement.

5. Meet and consult on a regular basis, at least quarterly, with the School District~ on issues related to this agreement.

The School District~ agrees to:

1. Provide EPSDT Administrative Case Management as an instrument for the Department of Social Services, Division of Medical Services, to assure the availability, accessibility and coordination of required health care resources to Medicaid eligible children and their families residing within the district's boundaries. The School District~ recognizes that claims for EPSDT Administrative Case Management for Managed Care enrollees are limited to outreach functions and activities which include, but are not limited to those identified in Item A:

   A. Outreach Activities:

      i. identify potential Medicaid eligible children and assist in their eligibility determination;

      ii. inform foster care providers of all Title IV-E eligible children residing within the school district's boundaries of the HCY/EPSDT program;

      iii. inform Medicaid eligible pregnant women about the available of HCY/EPSDT services for children under the age of 21 (including children who are eligible newborns);

      iv. inform the groups cited above of available necessary transportation; provide scheduling assistance; and develop transportation resources as appropriate.

B. Coordination of HCY/EPSDT Screens and Evaluation:

Assistance will be provided to eligible children and their families in establishing a medical care home as defined in Section 9 of the General Chapter of the Missouri State Medicaid Program. Coordination activities include, but are not limited to:

i. making referrals for and scheduling the following EPSDT/HCY screens in accordance with the periodicity schedule set out in Section 9 of the General Section of the State Medicaid Provider Manual:

a) comprehensive health and developmental, including mental health;
b) vision;
c) hearing;
d) dental;

ii. making referrals for and scheduling any evaluations that may be required as the result of a condition identified during the child's screen.

C. Immunizations:

Assistance will be given to eligible children to assure the appropriate immunizations are provided as indicated in Section 9 of the General Section of the State Provider Manual.

D. Case Planning and Coordination:

This activity includes assistance to the client and the family in developing and carrying out a case or service plan. Activities include, but are not limited to:

i. identifying and arranging for medically necessary services to correct or ameliorate conditions identified in the child's Individualized Education Program (IEP) or Individual Family Service Plan (IFSP);

ii. identifying and arranging for medically necessary services required as the result of any regular, interperiodic, or partial EPSDT/HCY screen;

iii. after determining the frequency and duration of these services, secure the prior authorization through the Division of Medical Services;

iv. developing and coordinating the meetings of any interdisciplinary teams that may be able to assist in development and periodic review of the case plan;

v. coordinating the closure of the case, referral to any needed services and realignment of the case plan.

E. Prenatal Care Services:

This activity includes the provision of outreach coordination and prevention services to Medicaid eligible pregnant residents of the school district or at-risk adolescents.

F. Nutrition Services:

This activity includes planning, education, or coordination activities around a Medicaid eligible child's nutritional needs.

G. Health Education:

This activity includes the coordination of health education and anticipatory guidance services. Examples include, but are not limited to, child care development, safety, accident and disease prevention and healthy lifestyles and practices.

H. Interagency Coordination:

This activity includes collaboration efforts to improve the cost effectiveness of the service delivery system, to improve the availability of services, to focus services on specific population groups or to define the scope of each agency's program in relation to the other.

I. Transportation:

This activity includes the provision of transportation and scheduling assistance for diagnostic and treatment services required as a result of a regular, partial or interperiodic HCY/EPSDT screen.

2. Account for the activities of staff providing EPSDT Administrative Case Management in accordance with the provision of OMB Circular A 87 and 45 CFR parts 74 and 95.

3. Provide as requested by the Division of Medical Services, the information necessary to request federal funds available under the state Medicaid match rates.

4. Return to the DSS any federal funds which are deferred and/or ultimately disallowed arising from the administrative claims submitted by DSS on behalf of the School District – .

5. Maintain the confidentiality of client records and eligibility information received from DSS and use that information only in the administrative, technical assistance and coordination.

6. Certify to DSS the provisions of the non-federal share for HCY Administrative Case Management via completion of DMS "Certification of General Revenue" form.

7. Accept responsibility for disallowances and incur the penalties of same resulting from the activities associated with this agreement.

8. Meet and consult with the Division of Medical Services on issues arising out of this agreement.

9. Conduct all activities recognizing the authority of the state Medicaid agency in the administration of state Medicaid Plan on issues, policies, rules and regulations on program matters.

10. Maintain all necessary information to support the claims and provide HCFA any necessary data in the event of an audit.

11. Assure the Department of Social Services that there is an approved cost allocation plan in place.

12. Recognize the preference of the Department of Social Services for the submission of claims on a quarterly basis.

III
PROGRAM DESCRIPTION

EPSDT Administrative Case Management activities provide for the efficient operation of the state Medicaid plan. These activities aid the potential EPSDT eligible recipient to gain eligibility, access screening services, follow-up on referrals to additional medical providers, establish a health care home for the child, develop and coordinate a service plan, follow through on the case plan and assist the family in becoming able to meet its child's needs in such a way that they are able to function at an optimal level with minimal intervention.

EPSDT Administrative Case Management is committed to the least restrictive method of treatment for children and will maintain this as a priority.

IV
PROGRAM EVALUATION PLAN

A task force consisting of a designated representative from each agency shall meet at least quarterly for the purpose of program development, review, evaluation, discussion of problems and to develop recommendation to improve programs for better and expanded services. These activities shall include consideration for:

1. The evaluation of policies, duties and responsibilities of each agency.

2. Arrangements for periodic review of the agreements and for joint planning changes in the agreements.

V
TERMS OF THIS AGREEMENT

The period of this Cooperative Agreement shall be from Start Date~, through End Date~. This agreement may be canceled at any time upon agreement by both parties or by either party after giving thirty (30) days prior notice in writing to the other party provided, however, that reimbursement shall be made for the period when the contract is in full force and effect.

_____ _____

Gary J. Stangler, Director — Date
Department of Social Services

_____ _____

Donna Checkett, Director — Date
Division of Medical Services

_____ _____

Superintendent's Name~ — Date
School district~

Appendix E:
Missouri's Medicaid Eligibility Requirements*

II. STUDENT ELIGIBILITY FOR SERVICES

A. Eligibility and Identification of Students

Individuals are determined to be eligible to participate in the Healthy Children and Youth (HCY) program based upon the income of the households in which they reside and medical need. The Department of Social Services (DOSS), Division of Family Services (DFS), is responsible for determining the income eligibility of persons for Medicaid services.

The following are criteria used to determine income eligibility.

-If the child is under the age of six(6), the household gross income is less than 133 percent of the federal poverty standard, and the household meets state-imposed income criteria, the child is Medicaid eligible.

-If the child was born before October 1, 1983, the household meets the Aid to Families with Dependent Children (AFDC) gross income standard, and the household meets state-imposed income criteria, the child is Medicaid eligible.

Figure 3, Decision Tree to Determine Eligibility for Medicaid, depicts the process used by the DFS in determining financial eligibility. These criteria provide for the possibility of certain children in a household being eligible for services while others are not. Parents may not be aware of the opportunities available to their children through the Medicaid program. School districts are advised to consider developing an awareness program to alert parents to Medicaid eligibility criteria and to encourage them to apply for services for their children.

B. Accessing Student Eligibility Information

The Department of Social Services maintains a computer file containing the names of all Missourians who were at any time in the past two years eligible for Medicaid services. School districts desiring to participate in the HCY program may submit diskettes with appropriate student information to the office of Medicaid Management Information Systems, Division of Medical Services, P.O. Box 6500, Jefferson City, MO 65102-6500. Instructions

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*Missouri Department of Elementary and Secondary Education, *Missouri Public School Medicaid Implementation Guidebook*, Version 1.0, Jefferson City, MO, Division of Special Education, October 1992, pp.23-27.

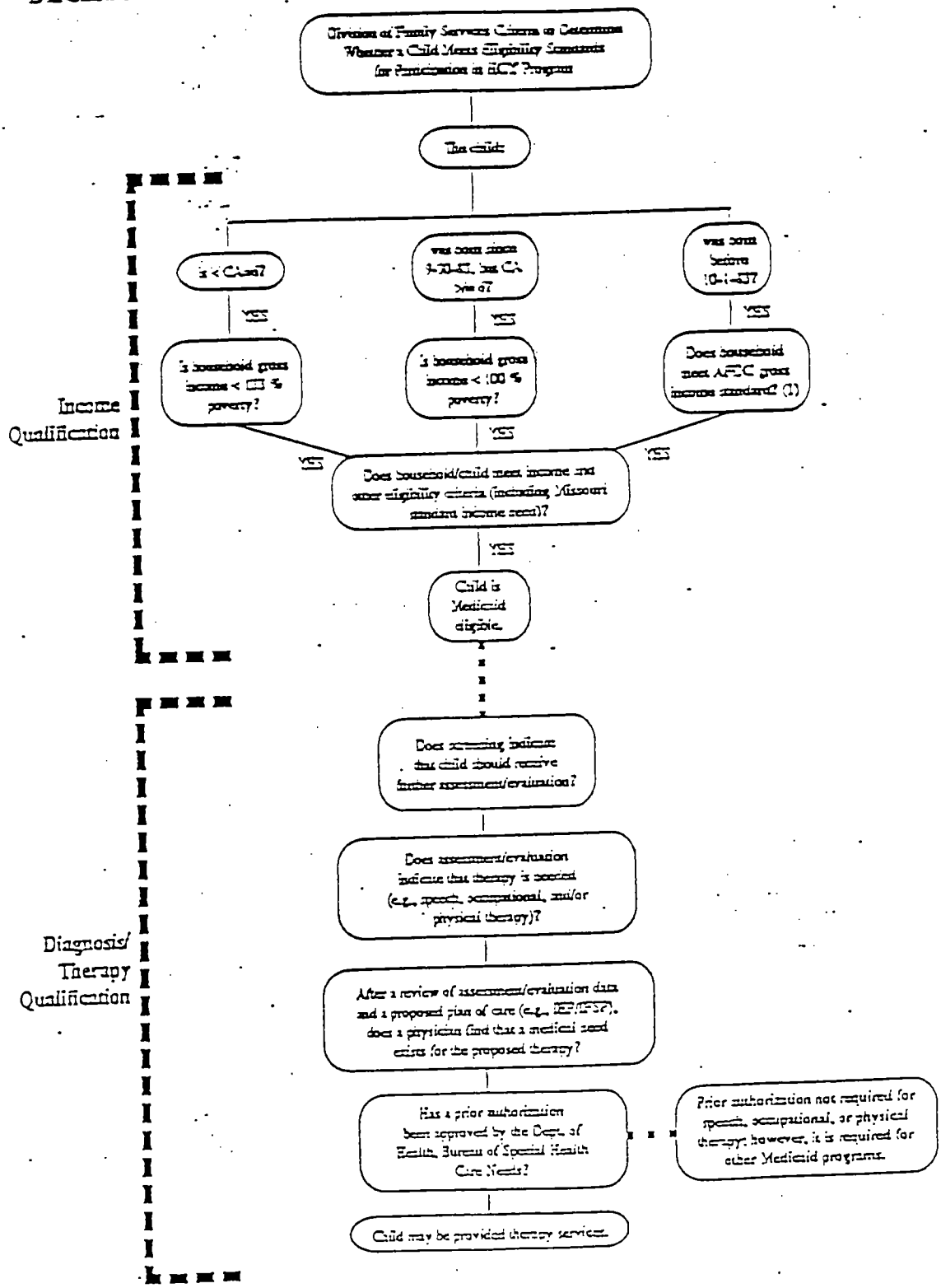
for submitting the diskette follow Figure 3. The information submitted on diskette will be matched against the State Medicaid file. Appropriate student information includes social security number. The use of the social security number ensures an accurate match of eligibility information.

Other ways to verify Medicaid eligibility of students include (a) requesting to see the Medicaid card of students, (b) contacting County Family Services office, (c) using the telephone system called **VERIFY**, or (d) submitting information using the Medicaid Eligibility Information Request form (MO 886-0856), which is included after Instruction to Prepare File of Students. Persons having a provider number and the social security numbers of students may call 219-482-8799 to verify the eligibility of students. Since eligibility changes, it may be necessary to verify eligibility several times during a school year.

The Department of Elementary and Secondary Education and the Division of Medical Services (DMS) have developed an additional automated means to assist districts in updating student eligibility information. This may be done using the DESE claims software which will generate a computer file of students. This file can be submitted to DMS for a match against the State's Medicaid file to obtain the eligibility information about students. The DMS will return the file to the district. The district can then use it with the DESE claims software to generate a report of the differences in the eligibility information on the district's current file and that of the file which was returned from DMS. Districts must be aware that some students on the returned file may or may not be eligible at the actual time of filing a claim.

FIGURE 3

DECISION TREE TO DETERMINE ELIGIBLITY FOR MEDICAID



(1) AFDC gross income standard is approximately one-third of the 100 percent poverty standard.

Re: Instructions for Prepare Computer File of Students
Source: Dr. Rick Hancock or DESE, Division of Special Education
Date: October, 1995 Telephone: (314) [illegible]

Districts considering participating in the Healthy Children and Youth Program (HCY) - Medicaid are interested in ascertaining the number of students enrolled who are Medicaid-eligible. Knowing this will assist district leaders to evaluate the significance of participation.

Superintendents wishing to learn the number of Medicaid-eligible students enrolled in their districts or to update existing eligibility information are asked to prepare a 3 1/2" diskette formated with 3.0 DOS or greater (must be PC compatible) and place on it an ASCII file (not comma-delimited) with the following information for each student to be reviewed. The file will be matched with the State's Medicaid file to determine which students are Medicaid-eligible.

File Format:

county/district code	character of 6 bytes, right justified with left-packed zeros
last name	character of 12, all caps, left justified
first name	character of 5, all caps, left justified
social security number	character of 9 bytes, right justified with left-packed zeros

Diskettes should be sent to Medicaid Management Information Systems, Division of Medical Services, P.O. Box 6500, Jefferson City, MO 65102-6500 and should have a return label with the district name, address, and county/district code clearly identified. Diskettes will be processed on the 20th of each month and returned to district within approximately 10 days of processing. The returned diskette will include the same file data as submitted but with the Medicaid number appended to each record matched by the State's Medicaid file.

Note: These data are treated as confidential, both at the time of submission from districts, and especially when they and the fields concerning Medicaid-eligibility are returned to districts. Please make every effort to maintain the confidentiality of this information. Thank you.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

MEDICAID ELIGIBILITY INFORMATION REQUEST

This form is to request eligibility information only.
Enter one recipient and one service date per line.
SHADED AREAS TO BE USED BY DMS ONLY.

MAIL REQUEST TO:
DIVISION OF MEDICAL SERVICES
RESEARCH UNIT
P.O. BOX 6500
JEFFERSON CITY, MO 65102

1. RECIPIENT NAME	2. RECIPIENT ID.	3. DATE OF BIRTH	4. DATE OF SERVICE	5. SOCIAL SECURITY NO.	6. ERROR MSG. CODE	DMS USE ONLY: ELIGIBILITY STATUS YES	NO	FILE ERROR	FILE UPDATED RESUBMIT AFTER DATE
			PROVIDER COMMENTS						
			PROVIDER COMMENTS						
			PROVIDER COMMENTS						
			PROVIDER COMMENTS						
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			PROVIDER COMMENTS						
			PROVIDER COMMENTS						
			PROVIDER COMMENTS						

NAME OF PROVIDER	TELEPHONE NUMBER	DATE	DMS USE ONLY ▶	DATE OF RESPONSE	PERSON RESPONDING

MO 886-0850 (8 88)   DISTRIBUTION: WHITE - RESEARCH UNIT; CANARY - PROVIDER COPY   SFD-39 (10 88)

Appendix F:
Missouri's Provider Enrollment Information*

I. PROVIDER ENROLLMENT

A. Provider Enrollment Procedures

Before reimbursement may be claimed for services provided by a therapist to Medicaid-eligible students, the therapist must be approved by the Department of Social Services (DOSS), Division of Medical Services (DMS), Provider Enrollment Unit. To obtain approval, a potential provider must hold a valid certificate, registration, or license within the state of practice and must enter into a participation agreement with DOSS, the State's Medicaid Agency. A physical therapist must be licensed by the State of Missouri and an occupational therapist is required to have a Certificate of Registration issued by the State of Missouri. For speech therapists to provide Medicaid-approved services in any setting other than a public school, they must be licensed as a speech pathologist by the State of Missouri. However, DMS has exempted public school speech therapists from this requirement. Speech therapists employed by public school districts are required to have a Speech and Language Specialist certificate issued by the Department of Elementary and Secondary Education (DESE). Provider enrollment forms can be obtained from the Provider Enrollment Unit, Division of Medical Services, Department of Social Services, P.O. Box 6500, Jefferson City, MO 65102.

Upon receipt of the completed forms, DOSS will review the application material and conduct an investigation of the applicant's professional background. Approval is dependent upon DOSS's acceptance of the provider's application.

Therapists serving more than one school district need a separate Medicaid provider number for each district. This requires the completion and submission of enrollment forms for each provider number needed. When enrolling, therapists must indicate the district (referred to as the "pay to") for which they work and to which Medicaid reimbursements are to be made. A provider's number is related to the "pay to " school district. Once approved, a provider has the responsibility to keep the Provider Enrollment Unit apprised of any change in status, including a change of employment which would affect the payment of claims.

All providers receive direct mailings from DMS. Among the first documents to be received by a provider is the Provider Manual. Section 2 of the Provider Manual refers to provider

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*Missouri Department of Elementary and Secondary Education, *Missouri Public School Medicaid Implementation Guidebook*, Version 1.0, Jefferson City, MO: Division of Special Education, October 1992, pp. 5-9.

conditions of eligibility and should be closely reviewed. It contains information relating to the State's right to terminate a relationship with a provider and to fraud and abuse.

Included in this section of the guidebook are copies of the provider enrollment forms along with instructions for completing the forms. There is a different set of enrollment forms for each type of provider. Persons may contact the Provider Enrollment Unit at 314-751-3571 to request enrollment forms.

When approving providers, the DMS assigns each an eight-digit number which must be included on all correspondence between the school or therapist and DMS and GTE, the fiscal intermediary. Mailing labels with the provider number printed on them are sent to the provider for use in mailing materials to DMS and GTE.

GTE, a company which serves as the fiscal agent for the Medicaid program, will send the provider a packet of various billing forms. With the exception of the claim forms, all other forms may be disregarded by school districts. Districts which plan to file claims via computer should discard claim forms received from GTE.

It is important that district administrators encourage therapists who are enrolled as providers to communicate with them whenever they receive correspondence from DMS or GTE and not to correspond with DMS or GTE without consulting with district administrators. Doing so may prevent confusion among DMS, GTE, therapists, and district administrators.

B. Provider Enrollment Forms and Instructions to Complete

The provider enrollment packet consists of several forms which are to be completed by a provider seeking approval to provide Medicaid services. When completing the forms, the following should be noted.

-Forms are specific to provider type. Check upper left hand corner to ensure use of correct form.

-Read the entire packet carefully prior to completing forms.

-All forms are to be original. Copies are not acceptable.

-Name and signature of the provider must be exactly as it appears on their certificate or license. If a name change has occurred and the license or certificate does not reflect the change, a copy of the legal document changing the name (marriage license, divorce decree, et.) should accompany the application.

-The telephone number and address of the school district should be used when phone number and address are requested.

-All questions must be answered.

The first form in the packet is the Missouri Medicaid Provider Questionnaire (MO 886-2802). The purpose of this form is to obtain information about the applying therapist, to determine the district to which the Medicaid reimbursement check will be made payable, and the address to which it should be sent. Instructions for completing requested information have been inserted on the form which follows this narrative.

The second form to be completed is the Title XIX Participation Agreement for Physical Therapy (or speech therapy or occupational therapy) Services (MO 886-2802). This form is printed on the backside of the Missouri Medicaid Provider Questionnaire form. By signing this form, the provider agrees to adhere to the rules and regulations which govern their participation in the Medicaid program. Specific instructions for completion are filled in the appropriate spaces on the form which follows the Missouri Medicaid Provider Questionnaire.

The third page in the enrollment packet (which follows the Title XIX Participation Agreement for Physical Therapy) is not a form but an agreement statement. Each provider completing the enrollment packet should read the Title XIX Non-Discrimination Agreement (MO 886-2802) carefully.

Note: If the district uses the ASAP billing system processing Medicaid claims, a provider will be required to sign an assurance form which contains some of the same compliance requirements found in the provider enrollment packet. It is suggested that this form be completed and signed at the time of enrollment.

The form which follows the Title XIX Non-Discrimination Agreement is the Medicaid-Provider Enrollment Application - State of Missouri. This form asks specific information regarding the provider and can only be completed by the provider. However, the business telephone and address requested on this form should be that of the school district.

The Remittance Advice on Tape and Turn-Around Claims form follows the Medicaid-Provider Enrollment Application form and refers to the receipt of follow-up claims reports. The Remittance Advice is a report which shows the payment or denial of claims filed. It is not necessary to complete the Remittance Advice section of the form since a paper copy of the report is sent to the district. The Turn-Around Claims form is a report which accompanies the Remittance Advice and shows what was entered on the original claim form and any errors. Some corrections can be made on the Turn-Around Claims form without resubmitting the claim.

The last form is the Civil Rights Transmittal form (MO 886-0965) which provides the Department of Social Services with a means of ensuring compliance by an agency with various laws and regulations on accessibility and discrimination. Instructions for completion are inserted on the form which follows the Remittance Advice on Tape and Turn Around Claims form. The Civil Rights Transmittal form is also included in this section of the manual and follows the Remittance Advice on Tape and Turn Around Claim Form.

School districts will receive a follow-up form to the Civil Rights Transmittal form. This form is titled Self Evaluation for Compliance with Section 504 Regulations, The Americans with Disabilities Act of 1990, Title VI, and the Civil Rights Act of 1964 and a copy of it is in the Appendix. The purpose of the form is to assist in determining a school's status of compliance with the above named regulations and laws. Upon completion, it is to be returned to the Department of Social Services, Division of Legal Services, Office of Civil Rights, P.O. Box 1527, Jefferson City, MO 65102-1527.

EFF:

KEYED:

TAC: RA:

Department of Social Services
DIVISION OF MEDICAL SERVICES

MISSOURI MEDICAID PROVIDER QUESTIONNAIRE

PLEASE TYPE OR PRINT)

I. ALL PROVIDERS

1. PROVIDER NAME | 2. BUSINESS TELEPHONE NO. | 3. YOUR PRESENT MEDICAID PROVIDER NUMBER(S)

4. PROVIDER ADDRESS | 5. CITY | 6. COUNTY | 7. STATE | 8. ZIP CO

PAYMENT INFORMATION (If different from above)

9. PAY TO NAME

10. PAY TO ADDRESS | 11. CITY | 12. STATE | 13. ZIP C

14. YOUR MEDICARE PROVIDER NO. (ATTACH COPY OF MEDICARE LETTER OR SCMS) | 15. MEDICARE CARRIER | 16. SOCIAL SECURITY OR EMPLOYER I.D. NO. (CHECK ONE) C C Number | 17. STATE LICENSE NO.

18. TYPE OF PRACTICE (CHECK ONE) Individual Practice C Partnership C Hospital-Based Physician C
Corporation C Charitable C City, Municipal, County, Dist., State-Owned C Sanatory Owned C

19. PROVIDER TYPE (ENTER NO. FROM ATTACHED 48

II. PROVIDERS PARTICIPATING IN A GROUP OR CLINIC (List all Groups and Clinics that are paid directly by Medicaid for your services — if applic

20. 1) NAME OF CLINIC OR GROUP PRACTICE | 21. ADDRESS | 22. CITY | 23. STATE | 24. ZIP CO

25. 2) NAME OF CLINIC OR GROUP PRACTICE | 26. ADDRESS | 27. CITY | 28. STATE | 29. ZIP CO

30. 3) NAME OF CLINIC OR GROUP PRACTICE | 31. ADDRESS | 32. CITY | 33. STATE | 34. ZIP C

III. PHY

35. DO YOU EMPLOY

NAME OF FROM A Code

1.
2.
3.

A

35. NA

41. NA

NA

44. NA

NA

VI. PHA

45.

NA

VII. PHA

47.

VIII. HOME HEALTH ONLY

48. NA

INSTRUCTIONS FOR COMPLETION

1. Name of individual applying for approval as a Medicaid provider. Name to appear as it is on license, registration or certificate.
2. Telephone number of district.
3. If any, list Medicaid provider numbers.
4. Address of district.
5. City of district.
6. County of district.
7. MO
8. Zip code of district.
9. Correct full name of district.
10. Address of district.
11. City of district.
12. MO
13. Zip code of district.
14. NA
15. NA
16. District's employer I.D. No.
17. Number from the license of the individual filling out form.
18. Check appropriate type of practice of the applying individual.
20.-34 If applicable.

PLEASE COMPLETE AND SIGN REVERSE SIDE

RETURN TO: DIVISION OF MEDICAL SERVICES
PROVIDER ENROLLMENT UNIT
615 Howerton Court P.O. Box 6500
Jefferson City, Missouri 65102
Telephone: (314) 751-2517

ALL ENROLLMENT FORMS MUST BE ORIGINAL (No photocopies acceptec

MO 886-2202 (7-91)

Appendix G:
Missouri's Provider Activities and Forms*

III. THERAPIST ACTIVITIES

Upon enrolling as Medicaid providers, therapists must agree to adhere to rules, regulations, documentation requirements, etc., set forth by Division of Medical Services (DMS). Also, if a district elects to file claims by computer media, its therapists are required to sign and have notarized a form entitled "Missouri Medicaid Provider Agreement with the Department of Social Services for Participation in Accelerated Submission and Processing of Medicaid Claims—ASAP". This agreement sets out certain responsibilities and activities of the therapist. However, some of the responsibilities and activities may not pertain to the therapist. The school district may have designated other staff members to conduct certain functions, e.g., file claims, maintain necessary Medicaid records, etc. If a therapist is not responsible for the performance of all activities in the ASAP agreement, a school district may need to enter into an agreement directly with the therapist assuring him/her of the district's responsibility for various activities. A sample agreement is included in Section I of this document. Therapists must sign the ASAP agreement before claims can be submitted and processed. The DMS Provider Enrollment Unit will notify the provider in writing when the ASAP agreement is approved.

The following critical activities may remain the responsibility of the therapist and should be validated by district administrators periodically:

-The maintenance of a logging form of services provided to Medicaid-eligible students. It is recommended there be one form per student. The logging form will be the document from which claims for reimbursement will be made. Therefore, all information must be complete and accurate. Information on the form should include, but not necessarily be limited to:

a. month of services,
b. school,
c. provider name,
d. provider Medicaid number,
e. student name,
f. student Medicaid number,
g. date,
h. begin time,
i. procedure code,

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*Missouri Department of Elementary and Secondary Education, Missouri Public School Medicaid Implementation Guidebook, Version 1.0, Jefferson City, MO, Division of Special Education, October 1992, pp. 33-34.

j. end time,
k. number of units,
l. description of activities and exercise performed and equipment used, and,
m. a signature line for the therapist.

The logging form should be maintained in an easily accessible file. A sample logging form is included.

-The recording of periodic progress notes on each Medicaid-eligible student receiving Medicaid services. The progress notes should be maintained in an easily accessible file.

-The acquisition of the doctor's referral or prescription which is renewed annually. The prescriptions and referrals should be maintained in an easily accessible file.

The Appendices contain the portion of the State regulation which pertains to documentation. All records which document the provision of Medicaid services and the billing for those services must be maintained for a period of five years.

SAMPLE

THERAPIST LOGGING FORM

Month of Service_____ School _____

Therapist Name _____

Therapist Medicaid # _____Type of Therapist _____

Student Name _____

Student Medicaid # _____Diagnosis Code _____

Date of Service	Procedure Code	Begin Time	End Time	# of Units	Comments*

_____

Signature of Therapist

*Include record of activities and exercises performed as well as equipment used.

Appendix H:
Missouri's ACM Methodology Development Outline*

Appendix B
Sample Administrative Case Management Methodology

(Agency Name)
EPSDT Administration Time Study and Cost Allocation/Claims Procedures

Introduction

Definitions

I. Agency Description

II. Time Study Procedure

A. Cost Pool Group

B. Frequency and Intensity of Time Study Samples

C. Staff Training on Time Study Procedures

D. Data Accumulation and Maintenance

III. Determination of Allowable Cost

A. Direct Cost Pool Expenses

B. Indirect Costs

IV. Claims Process

A. Reimbursement Claim

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*Missouri Department of Social Services, *Medicaid EPSDT Administrative Case Management: Procedures for Missouri Schools*, Jefferson City, MO, Division of Medical Services, August 1993, p. 28.

B. Appeal and Resolution Process for Disallowances

C. Certification of Non-Federal Match

Attachments

A. Child Health Services Administration Time Study
B. Child Health Services Administration Time Study Logsheet

Appendix I:
Missouri's Time Study and Log Sheet*

Attachment A
Child Health Services Administration Time Study

CODE A: General Administration and Overhead

Examples: lunch, breaks, any form of leave, faculty or staff meetings, external relations, staff/teacher supervision, reviewing district rules/procedures

CODE B: Non-Health Related Activities

Use of educational and service activities which are not health related.

Examples: classroom instruction, lesson plans including supplies, correcting papers, course scheduling, field trips, educational testing, discipline activities, playground/lunchroom supervision, child care, report cards/conferences, school safety) fire drills, etc.)

CODE C: Medicaid Eligibility

Use this when helping a child and family to establish Medicaid eligibility.

Examples: collecting information for the Medicaid application, helping the parent complete the necessary forms for the Medicaid application, updating any forms when the child's circumstances change

CODE D: Outreach to Children and Families to Access EPSDT

Use this code when performing specific activities to inform eligible children under the age of 21 and their parents about EPSDT benefits and how to access it. Information includes a combination of oral and written methods which describe the range of services available through EPSDT, their cost (if any) location, how to obtain them, and the benefits of preventive health care.

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*Missouri Department of Social Services, *Medicaid EPSDT Administrative Case Management: Procedures for Missouri Schools*, Jefferson City, MO, Division of Medical Services, August 1993, pp. 36-42.

Examples of activities which are considered as part of EPSDT outreach are:

informing all Medicaid eligible families in the school district about the EPSDT program;

informing foster care providers of foster children residing within school district boundaries about the EPSDT program;

informing Medicaid eligible pregnant students about the availability of EPSDT services for children under the age of 21 (including children who are eligible as newborns);

developing and presenting materials to explain EPSDT and health services which are available to Medicaid eligible children in the districts;

interpreting materials about EPSDT to persons who are illiterate, blind, deaf, or who cannot understand the English language with children within the school district boundaries;
informing eligible clients and their families of the availability of necessary transportation and providing scheduling assistance;

completing the paperwork necessary to perform the above activities;

traveling related to the above activities.

CODE E: Coordination of Screening, Examinations, Assessments and Evaluations

Use this code when making referrals for and coordinating the delivery of child health screening, examinations, and evaluations including all the required EPSDT screens and evaluations.

Examples of activities which are considered to be part of this function include:

informing the parent or guardian of immunizations that are required to be completed for school age children in accordance with state law;

making referrals for and/or scheduling the complete EPSDT screen, interperiodic screens and appropriate immunizations;

ensuring that the screens and immunizations are provided in accordance with the Periodicity Schedule;

arranging for the child's transportation to these screens, immunizations, examinations or evaluations as necessary;

arranging for any diagnostic or treatment services which may be required as the result of a condition identified during the child's screen or initial health examination;

gathering any information that may be required in advance of these evaluations (medical, social, health history, and records);

assisting parents with the completion of any paperwork that may be required by the child's health care provider.

CODE F: Immunizations

Examples:

notifying parents of immunization requirements;

scheduling immunizations;

arranging for transportation of the child to the EPSDT provider;

recruiting providers to do immunizations;

completing any paper work that is necessary to the immunization;

traveling related to the above activities.

CODE G: Case Planning and Coordination

Use this when planning, coordinating, and monitoring health-related case plans that are developed for children with health related needs, including those with IEP's.

Examples include:

scheduling and coordinating the meetings of an interdisciplinary team to develop or review the case plan.

identifying the kind, frequency, and duration of medically necessary speech therapy, occupational therapy, physical therapy, and/or psychological services to be provided for conditions identified in the client's Individual Educational Plan (IEP) or (Individual Family Service Plan (IFSP);

identifying, arranging, or scheduling any medically necessary services required as the result of any regular, interperiodic, or partial EPSDT screens;

arranging for a child's transportation to any medically necessary services;

providing follow-up contact to ensure that the child received the service identified in the treatment plan (IEP, IFSP, or plan developed by the student support team) and to determine whether further treatment is required;

contacting providers to determine if the eligible child needs to continue services;

coordinating the completion of the case plan, the close of the case, and the referral of the client to other related services which may be required to provide continuity of care;

updating and disseminating the paperwork necessary to document the case plan;

traveling associated with the above activities, including transporting the client to medically necessary services or treatment.

CODE H: Prenatal Care Services

Examples:

arranging for prenatal, post-partum and newborn care;

coordinating health education for new mothers around infant health and development, accident and disease prevention;

coordinating prepregnancy risk prevention activities;

arranging for transportation of the recipient and her infant to medically necessary services;

assisting the recipient in the completion of paperwork that will assure access to services for herself and her infant;

traveling related to the above activities.

CODE I: Nutrition Services

Examples:

arranging for and coordinating nutrition education services;

arranging for and coordinating dietary counseling and special diets;

coordinating information and arranging for access to food assistance programs;

traveling related to the above activities;

assisting recipients in completing any paperwork that may be required in order to access nutrition services.

CODE J: Health Education

This code should be used whenever a staff member arranges for, coordinates, or provides follow-up around health education or anticipatory guidance activities.

Examples of activities which are part of health education include:

assisting parents to understand what to expect in terms of the child's age appropriate development;

arranging and scheduling the delivery of accident and disease prevention services to children;

scheduling the activities which educate children and their families about the benefits of healthy lifestyles and practices;

scheduling and coordinating of activities which educate children and their families about good nutrition, safety and sound health and mental health practices;

disseminating health education materials to children and their families, including the dissemination of materials to families who are illiterate, deaf, or unable to speak the English language;

traveling associated with the above activities, including transporting the child to medically necessary services or treatment.

CODE K: Interagency Coordination

Use this when working with other agencies to improve services, expand services and their utilization to specific target populations, to gather information about their functions, to improve early identification of health problems. Include paperwork that may be required to accomplish these activities and related travel.

Examples of activities which are included in interagency coordination include:

coordinating health, mental health and insurance abuse services for students through agencies providing services for children and families within the school district's boundaries;

assisting parents to access to develop methods for the early identification of children and adolescents needing health services;

following up on plans and arranging appointments for health services provided for a child served by more than one agency;

identifying for parents and students information about the services of agencies providing child health and mental health;

developing evaluation strategies for assessing the effectiveness of health outreach, education and follow along activity;

completing the paperwork necessary to perform these activities;

traveling associated with these activities.

CODE L: Screening, Care, Treatment, and Counseling

Use this when providing direct care, service, or treatment to a child to correct a condition.

Examples: primary health care, speech, occupational or physical therapy, screening like vision, hearing, EPSDT screening, immunizing, or counseling.

Attachment B

CHILD HEALTH SERVICES ADMINISTRATION TIME STUDY

Name:_____Position Title:_____School #_____Date:_____Work Hours:_____

Instructions: List the letter of one administrative code for each 15 minute segment of your regular work day. Use the code which describes what you were doing for the majority of that interval. The log should not include work that you do on your own time unless it is a staffing or IEP Conference that extends beyond your regular work hours.

7:00 - 7:15 a.m.	9:30 - 9:45	12:00 - 12:15	2:30 - 2:45
7:15 - 7:30	9:45 - 10:00	12:15 - 12:30	2:45 - 3:00
7:30 - 7:45	10:00 - 10:15	12:30 - 12:45	3:00 - 3:15
7:45 - 8:00	10:15 - 10:30	12:45 - 1:00	3:15 - 3:30
8:00 - 8:15	10:30 - 10:45	1:00 - 1:15	3:30 - 3:45
8:15 - 8:30	10:45 - 11:00	1:15 - 1:30	3:45 - 4:00
8:30 - 8:45	11:00 - 11:15	1:30 - 1:45	4:00 - 4:15
8:45 - 9:00	11:15 - 11:30	1:45 - 2:00	4:15 - 4:30
9:00 - 9:15	11:30 - 11:45	2:00 - 2:15	4:30 - 4:45
9:15 - 9:30	11:45 - 12:00	2:15 - 2:30	4:45 - 5:00

Code Codons:

A. General Administration and Overhead - lunch, breaks, leave, staff meetings, external relations, staff supervision, reviewing rules/procedures.

B. Non-Health Related Activities - classroom instruction, lesson plans, correcting papers, scheduling, field trips, testing, discipline activities, playground/lunchroom supervision, report cards/conferences.

C. Medicaid Eligibility - collecting information for Medicaid application, helping parent complete forms, updating forms.

D. Outreach to Children and Families to Access EPSDT - informing eligible families or foster care providers about EPSDT.

E. Coordination of Screening, Examinations, Assessments & Evaluations - informing of immunizations, referrals for or scheduling EPSDT screens, arranging transportation to these screens, treatment services, gathering information required for these evaluations, assisting parents with paperwork.

F. Immunizations - notifying of requirements, scheduling, arranging transportation, reminding providers, completing paper work, related travel.

G. Case Planning & Coordination - scheduling and coordinating meetings to develop or review the case plan; identifying the kind, frequency, and duration of speech therapy, occupational therapy, physical therapy; arrange transportation to medically necessary services; follow-up contact to ensure service received; updating and disseminating paperwork; associated travel.

H. Prenatal Care Services - arranging for prenatal, post-partum and newborn care.

I. Nutrition Services - arranging & coordinating nutrition education services, dietary counseling, special diets, access to food assistance programs, related traveling, assisting with paperwork.

J. Health Education - assisting parents to understand child's age appropriate development; arranging & scheduling delivery of accident and disease prevention services; scheduling activities which educate children and their families about healthy lifestyles, good nutrition, safety and sound health & mental health practices; disseminating health education materials, related travel.

K. Interagency Coordination - coordinating health, mental health and substance abuse services; assisting parents to access agencies; arranging appointments for health services; identify information about the services of agencies; assessing effectiveness of health outreach, education and follow-along activity; completing paperwork; related travel.

L. Screening, Care, Treatment & Counselling - providing direct primary health care, speech, occupational or physical therapy.

END NOTES

1. States are required to provide screening and any medically necessary follow-up or treatment service that is reimbursable under Medicaid, whether or not the service is included in its Medicaid plan. The EPSDT amendments in OBRA-89 "were intended to increase preventive care for all low-income children, and the expansion of treatment services was meant as a boon for chronically ill, developmentally disabled, and emotionally disturbed children, many of whom were not covered for special services such as mental health or physical therapy because of modest state Medicaid plans" (Koppelman, 1993: 5).

   The Medicaid program was established under Title XIX of the Social Security Act in the 1965 Amendments. Title XIX provides federal matching funds for states that choose to pay for health related care for low-income persons and families, primarily those low income persons who are, or are eligible to be, recipients of public assistance programs (AFDC or SSI) and certain other defined "medically-needy" groups. Eligibility for Medicaid was broadened in the Omnibus Budget Reconciliation Acts (OBRA) of 1986, 1987, and 1988 (Center for the Study of Social Policy, 1988: 7,9).

2. Mr. Gary Stangler was appointed director in 1989. The Missouri State Medicaid program is located in the Missouri Department of Social Services, Division of Medical Services.

3. Interview with Marva Lubker, Deputy Director for Medical Services (Missouri State Medicaid program), Missouri Department of Social Services, December 15, 1993.

4. The U.S. Department of Health and Human Services' Region VII Office of Health Care Financing Administration (HCFA) worked closely with Missouri's Medicaid program to make the service work within the confines of federal regulations.

5. J.M. Caccamo, J.M. *The Independence experience: Health care management through Missouri Medicaid Healthy Children and Youth Program.* (Unpublished paper. Independence, MO: School District, October, 1992), p. 13.

6. National Center for Educational Statistics, K-12, per pupil expenditures, 1990-1991.

7. This statement of philosophy is taken from Caccamo (1992: 1). This document contains a fuller statement of schools' roles:

   > "The Board believes that education should assist each student to achieve to the limits of their capacities and that each student realize their worth as an individual. The student's education should lead them toward becoming a productive member

of our society and help them live an effective and satisfying personal and social life.

There are many societal barriers impinging on the Board of Education realizing its goal for the children of Independence. Poverty, lack of adequate health care, growing violence in our society, rising unemployment, drug/alcohol abuse, and the need for high quality child care are only some examples of the societal barriers affecting school outcomes.

Many years ago, the Board of Education decided to begin to assist children in Independence to realize their potential by removing the effects from these societal barriers. If we can help young children and their families overcome the effects of societal barriers, then the student who comes to the school house door at age five will perform better. We believe that we are making a significant difference for our children and their families by insuring that all children will start school ready to learn.

The School District has recognized that we cannot serve the breadth and depth of the needs of our children and families if we provide only our "franchised" services of public education for children kindergarten through grade twelve. Our children's needs are much greater! For this reason, the School District has been working to meet the needs of our children and their families through an integrated system of programs and services".

8. U.S. Department of Health and Human Services, Health Care Financing Administration, Medicaid Bureau. *EPSDT: A guide for educational programs.* (Washington, DC: September, 1992), p. 9.

9. The State Medicaid program is now requiring new school districts which are beginning EPSDT/Medicaid programs to make a similar commitment, codified in the interagency agreement between the State and the School District.

10. The Assistant to the Superintendent for Special Programs devotes one-third time to the EPSDT/Medicaid program. These 2.33 FTE positions constitute the District's administrative staff for the program.

11. District staff made a commitment to the Board of Education that implementing these new services would not require the District to provide any additional tax-based local funds. Board and staff believed that establishment of this reserve fund would serve as protection.

12. U.S. Department of Health and Human Services, 1992: 12.

13. U.S. Department of Health and Human Services, 1992: 17-18.

14. For a discussion of school clinics/health centers, see: S. Garfield, *The answer is at school: Bringing health care to our students* (Washington, DC: Making the Grade, School-Based Adolescent Health Care Program, 1993); MATHTECH. *Healthy caring: A process evaluation of the Robert Wood Johnson Foundation's school-based adolescent health care program* (Princeton, NJ: 1993); T. Ooms and T. Owen. *Promoting adolescent health and well-being through school-linked, multi-service, family-friendly programs* (Wasington, DC: The Family Impact Seminar, 1991); State Health Notes. *School-based health centers: Taking services to the students* (October 4, 1993).

15. If a child is not in special education and does not have an IEP, a separate treatment plan is written on a computerized form identical to the IEP form. This plan becomes the authorization for treatment and is annually updated.

16. Technically, the Medicaid ACM invoice to the State certifies that the School District has "expended state and local general funds in an amount sufficient to provide the non-federal share of expenditures being claimed for federal financial participation (FFP)."

17. Currently, 52 percent of pre-school children are immunized.

18. Telephone interview with Marva Lubker, Deputy Director, Division of Medical Services, Missouri Department of Social Services, January 25, 1994. This requirement is now built into the revised Missouri interagency agreement (effective January 1, 1994): "Within 90 days of the signing of the agreement, a school district must develop and submit for approval an internal process for measuring the progress of the school in assisting district students..."

19. Telephone interview with Dr. Robert Watkins, the District's Superintendent of Schools, January 22, 1994.

20. *Ibid.*

21. In person interviews with Drs. Henley and Caccamo, December 15-16, 1993.

22. Missouri House of Representatives. *House Bill No. 564.* 87th General Assembly (Jefferson City, MO: 1993).

23. Missouri Department of Social Services. *EPSDT/HYC services in schools* (Jefferson City, MO: Division of Medical Services, July, 1993), pp. 5-8.

24. The process for establishing a health care agenda, developed by the Missouri Medicaid program, is contained in Appendix C (Missouri Department of Social Services, 1993: 5-8).

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TEN GROUND RULES FOR REINVENTING STATE EDUCATION AND HUMAN SERVICES

Highlights of the
Meeting of Legislative Chairs and Governors' Aides
of the Policymakers' Program

THE DANFORTH FOUNDATION

Co-Sponsored by
Education Commission of the States
National Conference of State Legislatures
National Governors' Association

San Diego, California
January 20-23, 1994

PREFACE

In January of this year, 101 state legislators, governors' aides, analysts, researchers, and association staff members made their way to San Diego at the invitation of the Danforth Foundation, the Education Commission of the States, the National Conference of State Legislatures, and the National Governors' Association.

Representing 19 states, they came from the East coast and the West, from the Gulf of Mexico and the Canadian border. They held one belief in common: State education and human service programs must be reinvented and coordinated if today's children and youth are to become tomorrow's healthy and productive citizens.

They arrived armed with the passion of their convictions and the power of their ideas. And they arrived prepared to act, ready to start designing an action plan for coordinated state change.

Participants in the meeting heard the case for dramatic system reform from nationally known state legislators, analysts, demographers, and educators. They listened to business leaders outline the revolution in school-to-work expectations. They spoke with elected and appointed state leaders about the value of the Policymakers' Program. They discussed one of the best known local collaborative efforts, San Diego's New Beginnings program, with the people who designed and implemented it.

Attendees challenged each other in formal sessions and brainstormed in team meetings. In hallways, at dining tables, and informal gatherings around the coffee pot, the question was always the same: How can we do a better job of preparing our people for the future?

From these participants, the Danforth Foundation's Policymakers' Program intends to invite 6-8 states to a Policymakers' Congress in May, at which state teams will

begin to formulate problem statements and state team-building strategies to address education and human service policy issues. These problem statements and plans will serve as an application to a five-day summer Policymakers' Institute for three states.

No report could do justice to the depth and quality of the presentations and discussions. This document tries to capture the main features of the conversation, to describe a new of thinking about state education and human service delivery systems, in ten ground rules:

1. Start with the Numbers: Define the Problem.
2. Acknowledge the System is Broke.
3. Crystallize a Vision.
4. Create a Critical Mass of People Who Care.
5. Change Expectations: Collaboration is not an Afterthought.
6. Build Boats, not Houses.
7. Understand that Education Reform and Welfare Reform Are the Same Thing.
8. Follow the Money.
9. Burrow into the Bureaucracy.
10. End with the Numbers: Insist on Results.

To those who were able to be with us, our thanks. To those who will join us in the future, we hope these highlights are a useful summary of the conversation so far.

Robert Koff
Program Associate
The Danforth Foundation

Ground Rule One:
Start with the Numbers: Define the Problem

"We politicians always have to worry about the numbers," said Wilhelmina Delco the first African-American woman elected to the Texas House of Representatives, "and when I look at them I get worried. I can get votes for prisons in seconds, but it takes long haggling to get votes for education and human services.

"But let's start with the numbers and what they mean. We need to define this problem so people understand why its important. We know that older Americans are growing faster than young people. If we don't do something about unwed mothers, we face a future of old people waiting for Social Security checks; younger people waiting for food stamps and public assistance; and people in the middle supporting both. That's not a recipe for economic growth."

In a fascinating *tour de force*, demographer Harold (Bud) Hodgkinson laid out the demographic challenges facing the nation and suggested that state officials could map these trends within their own borders.

Demography, said Hodgkinson, relies on simple, rigid, scientific rules: "If you weren't born, you don't count. Some people have more kids than others. Some people move more often. Some people live longer. Today's children will become tomorrow's adults. And, every decade, people get exactly ten years older."

Here's what the numbers tell us:

- 23% of today's children are born in poverty;
- 25% are born to unwed mothers, two-thirds of the mothers are teenagers;
- 50% of low-income children live with a single parent;
- for every "hyper-poor" inner-city child there is a "hyper-poor" rural child (defined as an income at half the poverty rate);

- minority children will be half of all America's children by 2025, half of all Americans by 2050.

While all of these changes are going on, said Hodgkinson, we are stagnating economically. "For every high-skill job we create, we also create nine low-skill jobs."

"We simply have to reinvent our service delivery systems," he said, "and understand that all of our institutions are dealing with the same customer."

Hodgkinson's advice: Focus on kids. "The chances of a high school dropout becoming a prisoner are greater than the chances of a smoker getting cancer." And he pointed to the success of Head Start graduates to make his point. At the age of 21, 59% of Head Start graduates are employed, versus 32% of non-Head Start students. High school graduation rates: 67% for Head Start, 49% for non-Head Start. College attendance: 38% for Head Start; 21% for non-Head Start. Arrested: 31% of Head Start students at the age of 21, 51% for those who never attended the program.

Finally, Hodgkinson noted that state officeholders could map these demographic trends in their own states very easily. "Get your hands on the publication *Kids Count*, published by the Annie Casey Foundation. It maps most major demographic trends on a state-by-state basis. You also need to look at within-state incidence of, for example, rates of poverty; that is a little harder, but it can still be done. The Bureau of the Census provides county data you can use to pinpoint families in the greatest trouble."

Ground Rule One: Start with the numbers to get a handle on the problem.

Ground Rule Two:
Acknowledge the System is Broke.

"Why can't we point to more progress in making sure that every child has a legitimate shot at achieving his or her full potential?" asked Bob Wehling, Vice President for Public Affairs, The Proctor and Gamble Company. The answer: We do not approach the problems of children in a comprehensive, "holistic," fashion.

But we have now reached the point, he said, where we are willing to consider comprehensive solutions. "We have learned in business that meaningful reform occurs only when the pain of *not* changing is worse than the pain of change." In education and human services, the pain of business as usual exceeds the trauma of reform.

We need to do better, said Jan Backus, Vermont's Senate Health and Welfare Chair. "We are all trying to solve the same problems with distinct, repetitive, badly coordinated programs. It is not working. Yet we spend two-thirds of our funds on education and human services."

"Acknowledge the system is broke," said Martin Gerry, Director of the Austin Project at the University of Texas . "It is structurally broke, and it is badly broke." According to Gerry, the system is failing in three key areas: Families are providing less time and nurturing for their children; neighborhoods are collapsing due to factors such as concentrations of poverty and the erosion of commercial tax bases, and government is "dysfunctional," providing an array of services, but no system of services. Fixing government is not enough. "Policymakers have to aim at all three problems."

"We need to start thinking in terms of *universal* services," said Gerry. "Now we operate *programs*. That is not good enough. The definition of a program is that someone

won't get the service! The definition of a pilot is that you won't get the service for very long. And the definition of an entitlement is that, as time passes, you'll get less and less."

"In the United States, we offer services based on an 'edge of the cliff' model. Either you qualify and receive the service, or you don't qualify and fall off the cliff." In Europe, services are universal, financed by a sliding fee scale, based on ability to pay.

The "second lunacy" of our current approach according to Gerry: "Failure is rewarded with more money. The more you succeed, the less you receive."

Gerry's Austin Project is a non-profit agency, overseen by a broadly based board involving parents, schools, health and nutrition agencies, mental health services, family courts and social services providers, Head Start, law enforcement agencies, substance abuse facilities, and local universities.

The project operates in two low-income neighborhoods (5,000 children) and incorporates four major components : (1) healthy child development; (2) neighborhood functioning; (3) economic development; and (4) career paths.

One of its key strategies puts three-member teams of visiting nurses, parents as teachers, and family advocates in place, all three universally available for every family in the target neighborhoods.

Concluded Gerry: "Our broken system puts the family on a train and shuttles it from station to station. At each station, a different professional examines the family. We are trying to fix the system by stabilizing the family in one station and putting the professionals on the train."

Ground rule two: Before you can fix the system, you have to acknowledge that what we have is not working. The system is broke.

Ground Rule Three:
Crystallize a Vision.

In a passionate statement near the end of the meeting, Representative Delco challenged the participants to be much sharper about what they wanted to accomplish. "I have to tell you my constituents will not understand all of this talk about collaboration and cooperation. And when you speak about integration, they're likely to think we were here to talk about school bussing.

"I am willing to commit my time and resources and whatever talent I have to this issue. Nothing is more important to our future. But I want us to crystallize this issue into a vision of what we are trying to accomplish, a vision that ordinary people can understand.

"How much time will this take? How much money are we talking about? How many warm bodies do we need to get it done? Let's move from generalities to specifics."

Recounting his state's experience in coordinating education and human services, Vermont's commissioner of Human Services Con Hogan, said the critical first step was developing a sold vision statement of what the state was trying to accomplish.

Vermont's Commissioner of Education Rick Mills agreed: "We started looking for people who wanted to take risks with us to realize a vision of reinventing state government. We did not know what the result would look like, except that we would focus on results, not turf."

"We left the Policymakers' Program with a vision of statewide coordination, starting with a Children's Congress convened by the Governor," said Pennsylvania's Ron Cowell, Chair of the House Education Committee. "Our aim—to create a new environment and the expectation that people will collaborate."

The vision is becoming real, said Hogan. Team meetings, community by community, have educated the Vermont public about what the state is trying to do. The team has pushed "local evaluations for local needs. The governor is pushing new relationships built around new education and human services partnerships. The media in Vermont is backing cooperation and the public has started demanding it."

"Understand that you have to work at it," said Jane Krentz, Vice Chair of Minnesota's Senate Education Committee, describing a statewide reform coalition she established by law. "Risk-taking behavior is not rewarded either in state legislatures or in schools. But if a freshman legislator such as myself can pull this off, just imagine what a powerful, entrenched incumbent can accomplish."

But, Krentz warned, "Dinosaurs are not extinct. They are not confined to Jurassic Park. They are alive and well and walking the halls of legislatures and schools every day of the year."

Ground rule three: Crystallize a vision and then work at it.

Ground Rule Four:
Create a Critical Mass of People Who Care.

Ground rule four: Create a critical mass of people who care.

"As Senate Education chairman," said Vermont's Jeb Spaulding, "I had always thought that I needed human services to meet educational needs. What we have learned is that we need to create common partnerships to meet human needs.

"If you are going to get into this," said Spaulding, "you need to understand that the most important thing for us was to create a critical mass of people who understood what we were trying to do. The composition of the state team was critical. We were lucky and came up with a great mix—chairs of legislative committees, the commissioner of education, the commissioner of human services and a variety of policy implementers.

"Because we had these people and went around the state talking about what we were trying to accomplish, the public understood what we were trying to do. When opponents accused us of trying to take over local functions, the general public understood that was not so—we respected local ownership, but we wanted local ownership of coherent services."

Ted Sanders, Ohio's Superintendent of Instruction, agreed. Ohio created the Governor's Education Management Council including major corporate leaders, educators, and leaders of the General Assembly.

Sanders' efforts were complemented by the Ohio Education Improvement Steering Committee, which Proctor and Gamble's Wehling described as a "marketing group" co-chaired by Sanders and himself, organized to mount a public awareness campaign about the need for education reform. Made up of disparate grass-roots organizations such as the AARP, The Farm Bureau, churches, The Business Roundtable,

the NAACP, and others, the steering committee worked with the membership of these organizations to help legislators "get the job done for young people."

"Let's look at this issue of involvement," said Texas's Delco. "To what extent are we willing to involve clients in designing services? Are we as legislators willing to give up some of our authority to make this happen? We have to look hard at these questions. You know we get a lot of opposition because people outside the power structure don't really understand what we're talking about and trying to accomplish. Involvement is a critical issue."

In Minnesota, according to Krentz, the Coalition for Education Reform she created is a 24-member coalition made up of legislators, school officials, teachers, and representatives of business, human services, country government, and higher education. Without a budget or staff, "right now we're powered by passion," says Krentz, but the group is already receiving significant press attention and editorial approval.

"You need to give a lot of thought to bringing as many of the right people as you can to the table as soon as possible," said Pennsylvania's Cowell. "The twelve people on our Danforth Team were not enough. You have to expand that group quickly."

"In a week at the Policymakers' Institute," said Vermont's Hogan, "you can build a hell of a team. You are going to need that team and then you will have to expand it when you get home. But with the right team you can get the job done."

Yet another ground rule: Create a hell of a team, then expand it into a critical mass of people who care.

Ground Rule Five:
Change Expectations: Collaboration is not an Afterthought.

Throughout the meeting, voiced in many different ways, was the sense that the biggest impediment to improving the life chances of children was the barrier of bureaucratic turf protection.

As Pennsylvania's Cowell put it: "Create the expectation that people will collaborate." That applies not only to state agencies but also to the executive branch, the legislature, and units of state and local government.

"But if you look in the dictionary," said Gary Stangler, Director of Missouri's Department of Social Services, "you find that people who collaborate should be shot. They are people who cooperate with an enemy invader of their country. By and large that's how our bureaucracies think of coordination."

Martin Gerry defined three styles of collaboration. The first starts with the question, 'What can you do for me?" Stangler redefined that style with the following aphorism: "The road to collaboration is paved with other people's money."

Style two asks, "What can I do for you?"

Neither style one nor two does the trick, said Gerry. We need to aim at style three: "What can we do for the child?" Bureaucracies, he said, "have to get past turf protection and way beyond cooperation. They have to worry about the comprehensive needs of the child and that means mounting *joint enterprises*."

"What we came up with," said Vermont's education commissioner Mills, "was the realization that both my department and the education department were looking at the same room, we just happened to be in different corners of it.

"All of us always preach cooperation and coordination. We're expected to. But until our state team began working on this issue with the Policymakers' Program, cooperation was somewhere between fifth and tenth on our list of priorities.

"What Con Hogan and I realized was that we had to make cooperation our top priority if either of us hoped to succeed."

Worrying that "a real skepticism exists about whether or not the system is capable of reforming itself," Proctor and Gamble's Wehling stressed a lesson from corporate America: Every organization is perfectly designed to obtain the results it gets. "We don't have a lot of bad teachers and ineffective social workers. What we have is a bad system that keeps teachers and social workers from cooperating to solve the problems of the same clients."

Jeanne Jehl, Co-Chair of San Diego's New Beginnings Council, came to the same conclusion but reached it from the client's perspective. "Families *know* there is no system. They know that nobody cares what happens to them *in toto*, that the bits and pieces of the system worry about the family in bits and pieces.

"Schools, for example, worry about attendance but they often intervene inappropriately because they have no knowledge of parental addiction or capacity to deal with child abuse. Yet the Department of Social Services spends $5.5 million annually on children enrolled at the Hamilton School. We decided that New Beginnings should be a program that dealt comprehensively with families and their needs, not simply with children as students."

Ground rule five: Collaboration cannot be skin deep. Expectations need to be changed so that collaboration is at the top of agency priorities.

Ground Rule Six:
Build Boats, not Houses.

"When most of us start thinking of building new institutional structures," said Martin Gerry, "we unconsciously think the way a home builder thinks, with separate functional structures for separate needs."

"But when you think about collaboration in human services," he continued, "you need to think about building boats, not houses. If you are building a house and leave a plank out, the house is basically all right. But if you leave a plank out of a boat, it sinks."

Picking up on a comment by Vermont's Jan Backus that "distinct, vertically integrated services" are not working, Ohio school superintendent Ted Sanders noted that his Governor's Education Management Council had recommended abolishing state and local school boards in favor of a single state body and a single local body responsible for all education and human services.

Although that proposal died, the state did create a cabinet council for human services. Serving on the council are the heads of all state units affecting children and families, with the understanding that principals only attend—substitutes or representatives are not allowed to participate.

Advocating a systematic education reform strategy, consultant David Hornbeck, former Maryland commissioner of education, said, "The real mistake we have consistently made is adopting a piecemeal, uncoordinated approach. Instead of a solid diet of reform, we have ended up with a menu of mush."

Missouri's Stangler also opted for coordinating efforts to try to make sure that no child or family slips through the cracks, that the boat does not sink.

"There are about 18,000 government entities in the U.S.," he observed. "We have added one to that total—the Family Investment Trust. It cuts across all units of state government and is designed to create similar entities at the local level and help fund them."

"All of us have a tendency," said Harold Hodgkinson, "to think that we need to do something—hit the target with dollars, 'enter the food chain' somewhere, award a planning grant, fund start-up costs, broker services. And all of these things are valuable.

"But it is at least as important to think consciously about what you are doing. Right now we have a vertical system in which separate units (for health, housing, education, corrections, and transportation) report to the 'boss' who presides over it all. That's the wrong model.

"What we need is a model that looks more like a wheel—with the 'family-at-risk' at the hub and all of these agencies revolving around families needs, interacting with each other as needed. Make the family the single customer and then watch the results."

New Beginnings' Jeanne Jehl agreed: "Let's quit funding the problem of the month. Let's agree to enact no more categorical programs. Seek bipartisan consensus on the importance of these problems and shift resources to prevention instead of fixing the problem after its grown big enough for us to notice it."

Ground rule six: When thinking collaboration, think of boats, not houses, and focus on the horizontal integration of services, at every level of government—services designed to meet the comprehensive needs of children and families in trouble.

Ground Rule Seven:
Understand that Education Reform and Welfare Reform Are the Same Thing.

Surprising things happen when people begin to think in unconventional ways about conventional topics. Perhaps the most surprising development in San Diego was the number of people who independently arrived at the same insight: Education reform and welfare reform are the same thing.

The first hint came from Harold Hodgkinson and his observation that Head Start graduates do much better in life than their counterparts without the benefit of Head Start and that nearly twice as many Head Start graduates are employed as those without Head Start.

The second was offered up by Wilhelmina Delco when she worried that unless something were done to lower the incidence of out-of-wedlock births the nation's future looked like one in which large numbers of young and old people depended on a diminishing number of working people to support them.

But hints pretty shortly gave way to outright assertions. "Two out of three kids in trouble in our communities are on welfare," said Missouri's Gary Stangler. "We know who the welfare kids are. We know where they live. We know where they go to school. I have convinced our governor that he cannot speak about education reform without talking about welfare reform, and vice versa."

"When you have a healthy system," said Maryland's Hornbeck, "you will have healthy children and youth. You will have fewer youngsters who become parents while in school, who abuse drugs and alcohol, become involved with the criminal justice system, and drop out of school for a life of dependence and unemployment."

San Diego's Jeanne Jehl demanded that legislators "connect school reform to human services reform. Quit pretending these are separate issues. They are the same thing."

"Let's not kid ourselves," said Ruth Massinga of the Casey Family Fund, "neither top-down nor bottom-up solutions, by themselves, will guarantee results. We need both. But we have a choice. We can pay now in the form of comprehensive services to young people, or we can pay later in the form of public assistance payments."

Whether in education or human services, said Martin Gerry, service reform should aim at nurturing five things in children:

- physical and emotional security and health;
- autonomy, creativity, and spirituality;
- the ability to choose when to be independent, interdependent, and participate socially;
- the capacity to form and maintain caring relationships with others; and
- the ability to live a productive, economically self-sufficient life.

Boiled down, these five goals restate what the other speakers were saying: Education reform and welfare reform amount to the same thing.

Ground Rule Eight:
Follow the Money.

Gary Stangler's third rule of effective collaboration: Remember the advice Deep Throat gave Bob Woodward during Watergate: "Follow the Money."

Promoting change, said Stangler, requires changing how systems are financed. "Turf is money. Money is Power. Therefore, turf is power. In government, nobody gives up power readily, and nobody gives up money easily, either.

In Ohio, reported Ted Sanders, "We have established a venture capital fund of $80 million to encourage systemic school reform—but only if local boards yield governance authority to local schools. Under those circumstances, we are willing to provide up to $25,000 a year to be used as the school sees fit.

"I also now have authority from the General Assembly to waive not only state regulations, but also state law. What all of this means is that we now have new resources for schools in low-income areas. For example, we can create family support centers, all-day, every day kindergarten programs; and programs for parents as teachers."

"Is more money necessary?" asked Ruth Massinga of the Casey Family Fund. More money is *absolutely* needed in health and pre-school programs including visiting nurses and home visits, she reported. It is needed especially to integrate human services as the New Beginnings program is doing.

But be prepared, she warned, for "a long gestational period before robust results appear. Don't deal with simplistic solutions in the hope that this will be easy and short."

"I cannot go back to my constituents and tell them things will be better in ten years," retorted Delco. "Money is important and legislators, in the current environment, can't spend it in the hope that things will improve sometime in the future.

"Most people are good people. But increasingly we have to worry about competing constituencies. Not everyone worries about poor kids. Not everyone lies awake at night thinking about service coordination. Many people believe in the old prayer:

> 'Dear Lord—
> Please bless me and my wife
> My son John and his wife
> Us four and no more.'

"It is hard to persuade people to worry about anything except 'us four and no more,'

"So if we want to follow the money and need more money, we have to be able to promise some long-term relief and guarantee some short-term success. We need some models that can work now."

Perhaps Gary Stangler had the best solution to this dilemma: "Don't try to solve these problems with more advisory boards," he said. "We don't need more advisory boards. If you need to create boards, establish them with some real authority over funds. Follow the money. "

Rule eight, follow the money, is hard. But compared to number nine, burrow into the bureaucracy, it is likely to be a piece of cake.

Ground Rule Nine:
Burrow into the Bureaucracy.

Quoting Machiavelli, Ohio's Sanders noted that nothing is more uncertain of success—drawing hostility from entrenched interests and only lukewarm support from friends—than the effort to reform existing institutions. New systems, said Sanders, probably have to improve services by a factor of ten before people will accept them.

One of the first questions you need to ask, said Gary Stangler, is "What is going on at the mid-management level?" In particular (back to ground rule eight) "what is going on at the mid-management level with the money?

Money is just one of the issues, according to Bud Hodgkinson reporting on an interview he had with a Philadelphia woman. She told him of 55 different interviews with social workers representing 30 different agencies, all demanding a separate case history which they refused to share with others because of concerns about confidentiality. "You know," the woman said, "in Philadelphia, you have to be smart to be poor."

The Philadelphia story was repeated on the West coast. San Diego's New Beginnings program had a "painful" time working out agreements on confidentiality, according to Jeanne Jehl. "We also had a very difficult time getting people to agree on common eligibility standards. We encountered huge resistance at the middle level of the bureaucracy.

"Originally, a consultant thought we could leave all of this 'stuff'—confidentiality, applications, eligibility standards—to the state because we wanted to get on with the business of serving kids and families. But we found we could not do that because this 'stuff' is the daily meat and potatoes of mid-level bureaucrats."

Sanders reported that Ohio's pilot program to coordinate services for children and families had adopted a training mechanism of quarterly meetings so that everyone, at every level of state and local government, understood what the Governor's Cabinet Council was trying to accomplish. And new legislation was in the offing to authorize "regulation free zones" for these pilot projects.

"We have some early results that indicate we may be on our way. First, we have developed a common set of regulations to govern most programs. Second, we have eliminated one 26-page application and replaced it with a one-page form."

As difficult as these efforts are, they are well worth the trouble, according to Jeanne Jehl.

New Beginnings, she said, began five years ago when Jake Jacobson of the social services department and school superintendent Tom Paysant got together and said, "We are serving the same youngsters, why don't we do it together?"

"Those two leaders could make the system respond. But both have since moved on. How did we keep it going? We survived because we had built relationships with people below the executive level, people in the middle. The result: when the leadership changed, there was no real thought to abandoning New Beginnings because the bureaucracy itself had a stake in our success."

The penultimate ground rule: If you want reform to work and last, burrow into the bureaucracy .

Ground Rule Ten:
End with the Numbers: Insist on Results.

"Our state team left the Policymakers' Institute in St. Louis last year committed to several things," said Pennsylvania's Cowell during a panel discussion. "One of the most important was an agreement that we had to create some indicators of progress so that we could measure what we were doing and report on our achievements to the public."

Cowell's comment identified one of the foundation themes of the meeting: the need to insist on results, assess progress, and be accountable to the public.

The framework developed to define the problem (ground rule one) may, in fact, serve as the framework for reporting on results. "You need to worry about accountability and rewards and sanctions," said David Hornbeck, describing a comprehensive approach to school and service reform he has helped implement in Kentucky, Washington, Missouri, and Ohio. In these states and a dozen others he got the process started with a "gap analysis" to measure the breach between needs and services. Tracking the "gap" is one way to measure results.

Julie Koppich, Deputy Director of PACE (Policy Analysis for California Education) on the Berkeley campus of the University of California, had a similar tale to tell. She described a major analysis of the needs of the state's children, *Conditions of Children in California*. Begun in 1984 as an annual report on education, it has recently expanded to cover an array of children's issues, ranging from family life, finances, and child care to physical and mental health, child abuse, and the juvenile justice system.

The most recent edition of the report generated major attention in the state around three issues: underservice of children, service fragmentation, and a *de facto* state policy of providing social services on a "triage" approach—like doctors on a battlefield, social

workers divide clients into three categories: those who are likely to get better by themselves, those for whom nothing can be done, and those who will receive attention.

Martin Gerry almost had the final word on the topic. "If collaboration is to work, you must have outcome measures," he said describing a comprehensive assessment strategy for Austin's ASCEND, a program designed to foster health child development. "Gather data on such things as fetal alcohol and drug addiction, infant and youth mortality, low-birth-weight babies, immunizations of 2-year-olds, access to appropriate child care, school readiness, educational achievement by age, and graduation rates of 7th and 8th graders.

"If you get into this," he warned, "realize that you need some principles for the government entities involved." Gerry cited five:

- outcome measures on status of children;
- self-evaluating delivery systems and on-going assessment;
- systematic and timely performance assessment;
- a reliable information system; and
- public information about children's welfare and system performance.

But Wilhelmina Delco put it all into perspective: "Information is critical. There is nothing worse than getting people all worked up about your issue and then finding that you got your facts wrong."

Ground rule ten: End with the numbers and insist on results.

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MOVING FROM PRINCIPLES TO PRACTICE:

Implementing a Family-Focused Approach in Schools and Community Services

by Judy Langford Carter

What is a Family-Focused Approach?

In the daily course of business for innovators in the human service and education fields, it is not uncommon to hear or read a set of words that by now have a meaning all their own. We recognize "comprehensive, collaborative, integrated, child-centered, family-focused community-based, school-linked, consumer-driven, flexible, responsive, empowering, preventive, and ..." as descriptors of an idealized human service and education system believed to be capable of producing better outcomes for children. In spite of our facile use of the words, each interrelated principle represents a complex challenge when it comes to implementing it in the real lives of families and communities and service providers. A "family-focused approach" in schools and community services—the subject of this paper—is one element of a larger system. We can define and illustrate it as though it stands alone, but we cannot fully implement it without simultaneously implementing the full litany of values from which it was extracted. A fully effective family-focused approach will ultimately require a surrounding system that is comprehensive, collaborative, and integrated. The discussion in this paper of a family-focused approach should be viewed in that context.

A family-focused approach grows from a logical sequence of beliefs: If better child outcomes are the shared goal of the community and its institutions, then we must use all the resources necessary to achieve those outcomes to their fullest potential. And if as research and common sense indicate, the family is the most important and effective resource available to any individual child, then we must make this resource the cornerstone of strategies to improve children's well-being. Finally, if the family's impact is to be fully realized, we must develop a partnership among all the resources that can make a difference in a child's life—families, schools, and services. A family-focused approach, then, acknowledges the central role families play in their children's well-being, shifts the traditional roles of other institutions that service children to reflect this new understanding, and creates (or expands, or redeploys) community supports to assist families in carrying out their roles.

In this context, a family-focused approach for schools and community services is not just an issue of frontline practice—that is of how teachers, social workers, health practitioners, and others interact directly with families. Incorporating a family-focused approach throughout the daily life of schools and community services requires these institutions to fundamentally change the way they view their missions as well as their relationships with families and with each other, as part of a whole community system supporting healthy development for children.

In the traditional system, families are rarely visible: institutions serve individual children or individual adults, and the other people in "clients'" lives are important only when they pose specific and identified problems to the primary recipient of service. In the system we envision, families and child-serving institutions together become full partners in the enterprise of achieving better outcomes for children. Getting from here to there is the hard part.

"A fully effective family-focused approach will ultimately require a surrounding system that is comprehensive, collaborative, and integrated."

Implementing a Family-Focused Approach

Implementing a family-focused approach is a developmental process which takes time, as each of the partners—families, school, service providers, and community institutions—renegotiates its role and accommodates the others in a new collaborative partnership. Like any other developmental process, implementation can move quickly when conditions are right but can be significantly delayed or obstructed by problems. Implementation involves changes in policy and practice, redefining roles for frontline workers (such as teachers) and managers (such as principals), extensive effort to gain parent participation in the whole process, and changes in policies at the school and community-service level and beyond that are impeding the process. Local, county, and state government policies and

practices often block a family-focused approach and can sometimes take a long time to change. A strong, well-planned, fully-supported neighborhood effort can make a good case for the necessary changes; and involvement of key policymakers at these levels early in the process can build useful relationships and understandings for later work.

The path of moving from talk to action in a local community is not mysterious: engagement and trust-building to ensure participation come first; then analyzing, planning and working out specific issues both within agencies and across agency boundaries; and finally reflecting on, refining, and building an ongoing partnership from successful beginnings. This process parallels a family-support approach to working with individual families and resembles the ways service providers develop collaborations. The elements are not exclusive or one-time events; they are interdependent and continue to circle back and repeat themselves over time as the process develops.

Gaining Participation

Experience in communities where a family-focused approach has taken hold shows that very little happens unless school leadership is committed to the process. Community service agencies can work closely with other partners and can approach their work from a family-focused perspective, but their impact is usually limited to their specific service area and to the relatively small number of families they serve. Parents are rarely in a position to come knocking on the doors of schools and service agencies demanding a response, unless they are organized because of concern over a single issue which does not always translate into a different overall approach. Occasionally, a charismatic service provider with strong backing from parents takes the first step toward a family-focused approach, but eventually, the school's involvement is essential to making such an approach work. The school is the connection to all the children in a community, and its leadership in reaching out to families and other agencies is critical.

We must stress that looking to schools for leadership on a new approach does not diminish the schools primary function as educators of children, nor does it burden schools with the full range of issues that families might bring to it. A truly functional partnership among families, schools, and communities should enable families and the other community institutions and agencies serving them to work together effectively to meet the "non-school" needs of children. When this occurs, schools are able to fill their educational role more effectively.

It is most common for an effort to engage parents in a school-family-community partnership to be led by an active and progressive school principal who takes the initiative with families of children in his/her school. The goal may be increasing parent involvement in school activities, getting input for planning a new program, increasing school attendance through parents' help, or simply finding out more about the barriers children face to succeed in school. Trust-building starts with reaching out to families, a sometimes difficult task especially when families are accustomed to an adversarial relationship with schools or community services.

Principal Mattie Tyson personally visited every family whose child attended her school on Chicago's west side, listening carefully to what each one had to say about the school, their children, and the issues and problems they faced. It took a year to complete the first round of visits. And the visits were just the first step in a larger process that included involving teachers in establishing and maintaining relationships with parents, reaching out to community service providers whose assistance was needed to serve the school's families, establishing easy ways for teachers and other school staff to connect with service providers, making connections with local businesses which then contributed in many ways to the school, and most important, continually responding in concrete ways to families' expressed needs. One concrete response was the school's acquisition and installation of sewing machines for parents to use to make the required school uniforms for their children. Over time, as an increasing number of parents felt needed, wanted, and comfortable coming to the school, they worked together with teachers and school personnel on community issues such as drugs. Teachers felt supported in their jobs, service providers responded when called; and children began to accomplish more in school—the goal everyone wanted in the first place. The principal's visible, committed leadership in gaining parents' trust was key to starting and maintaining a process that went far beyond simply getting a few parents to be more involved in their children's school.

While input and participation from families is vital to implementing a family-focused approach, buy-in from frontline staff and administrators is equally important. There must be shared accountability; without support from one another, families, schools, and other institutions will have a hard time succeeding at the job of producing a healthy, educated child.

Most front-line staff know the need for a collaborative partnership better than anyone else; they experience the frustration of working without it every day. Their enthusiasm to work hard toward implementing new and sometimes difficult ideas, such as a family-focused approach, will be limited by a lack of knowledge and skill, a lack of time and energy, and a healthy skepticism about the value of the end result. Leadership for change with people whose jobs are directly affected by it has to include not only provisions for skill-building and time to absorb a new perspective, but new expectations and new support for job performance in a new system.

NO-COOK COOKBOOK

Children are notorious for coming home after school HUNGRY. Why not have your parent group collect recipes that don't require cooking and publish a brochure for kids? Examples of easy, no-cook snacks include: no-bake peanut butter cookies, unique kebobs (like marshmallow, banana, strawberry, and apple or cubes of ham, cheese, cucumber, cherry tomato, and pickle), and cracker sandwiches (cream cheese and jelly, cheese spread and olive).

Identifying Issues: Solving Problems

Once partners are on board and willing to work together, the analysis and continuous work on needed changes in policy and practice can begin. Each agency or institution has its own analysis

to do, and the partners together have common issues to resolve. In real communities, this aspect of work toward a family-focused system usually grows most easily from a specific case or a specific issue that involves several stakeholders. The impetus may be a funding source's mandate for a family-focused approach to an issue such as substance-abuse prevention or child-abuse prevention, school restructuring efforts that acknowledge the need for a family-focused approach, or another highly visible problem that has created a public demand for solution.

A Chicago case illustrates an urgent need for problem-solving across agencies: A brother and sister attempted to enroll in a Chicago high school when school opened in the fall. They were sent home with a note from the school nurse stating that they could not enroll until they had documentation of immunizations. After several weeks, they returned with the right documentation, but were told by the attendance clerk that their mother was required to appear in person to reinstate them in school. The children explained that their mother had some problems with drugs and that most of the time, they lived with their grandmother, who could come to reinstate them. Because the grandmother was not the legal guardian as required by school policy, they were not allowed to enroll. No one knows where they went.

None of the policies involved here were intended to keep children out of school; they were made to ensure the safety and well-being of children and the participation of parents. None of the people involved failed to do their jobs; they did exactly what they were supposed to do. But a family-focused approach, across agencies, could have prevented this all-too-common occurrence. The school, the health system, and the substance abuse treatment agency must work together, as well as in their own systems, to unravel the problem and prevent it from happening again. Each of them must also work on policymaking levels to alter the policies and practices that created an insurmountable barrier for these children to attend school.

Many communities already have experienced a family-focused approach to problem-solving across agencies. Teen parent problems, programs for children with special needs, and maternal and child health initiatives have all required more than one agency to work together around a whole-family agenda. In some instances, the agencies have established ongoing mechanisms to regularly identify and resolve issues. In the Kentucky Integrated Delivery System (KIDS), schools regularly convene all the service providers involved with students for case presentations, ensuring that coordination and problem-solving happens in a timely way. Over time, the trusting relationships developed among service providers, combined with systematic attention to issues emerging from case presentations, have led beyond improved services for specific children, to policies and practices among all the agencies that are more family-focused and collaborative.

"Trust-building starts with reaching out to families, a sometimes difficult task especially when families are accustomed to an adversarial relationship with schools or community services."

Building a Working Partnership that Lasts

Moving from problem-solving to establishing a family and systems partnership that lasts over time is the third aspect of implementing a family-focused approach. An ongoing partnership goes beyond linkages and agreements made by individual parts of the system. It develops a mechanism for establishing desired outcomes for the whole system and accepts a shared accountability for them. The longterm goal of the ideal partnership is a full complement of resources easily accessible to every child in a neighborhood as needed, beginning with a family adequately supported to do its job as chief nurturer and advocate.

A Normative System that Supports Families

A family-focused partnership requires planning and analysis that goes beyond the scope of its members and into the larger community. Over time, a successful partnership needs to continuously assess and develop the whole system of community support—both formal and informal—available to families so that they are able to be the best possible resource for their children. Families must have many opportunities to participate directly in the assessment and identification of needs. Families usually DO know best what they need to assist their children, but well-meaning schools and community services rarely ask them.

Planners seldom go beyond surveying traditional provider agencies or analyzing demographic data to find out how well families are being supported in the larger community. A lasting partnership cannot accomplish its goal without assessing how well its community is supporting families with accessible health care, economic opportunities, childcare, adequate safety, affordable housing, recreation, education and information about child development, and opportunities for the development of social networks for all families. These essential elements of a normative system—the resources that have to be there for ALL families to survive and thrive—are often overlooked. Most planning is done on the basis of traditional numerical "needs" and counting government services, which are only available when families have "failed" in some identifiable, eligibility-producing way. Successful child development and the improved child outcomes we are seeking require a workable, nurturing normative system. Monitoring its status and the gaps that need filling—and developing resources to fill the gaps from ALL available sources—is a primary function of a family-focused partnership.

Specialized Services

A second primary function is ensuring that the specialized services—which only some families need—work well together and fit comfortably into the larger community system. Child welfare,

juvenile justice, public aid, and services to children with special needs offer specific resources when families are having difficulty. A family-focused approach in these systems is critical to harnessing all available resources toward improving the capacities of these families to adequately care for their children. Close and timely cooperation among schools, special services, and other community resources can identify and support families in need of assistance before their small problems grow into large ones.

Hawaii's Healthy Start program, which contacts all mothers at the time their babies are born, offers voluntary, supportive home-visiting to families identified as being at risk of later problems. The home visits provide coordinated access to the full range of services—both formal and informal—available to families in their communities, and a long-term relationship aimed at supporting and enhancing the family's own capacity.

Implementation Challenges

No community has yet fully implemented a family-focused approach, although an increasing number of neighborhoods and localities have put many of the elements in place. The tunnel vision with which schools and community services have sometimes operated, focusing on a single child or a single service, has been broadened to accommodate the vital role of the child's family and the impact of the child's larger community in achieving the best outcomes. Every linkage made, every problem solved, every parent involved, is one more step in the direction of building the partnerships necessary to sustain a system that is "comprehensive, collaborative, integrated, child-centered, family-focused, community-based, school-linked, consumer-driven, flexible, responsive, empowering, preventive, and..." At the same time, to give the new system a chance, we need to define more fully the concepts of 'family support' and 'family focus.' We must also address potential barriers to implementation." Among the questions to be answered:

What is the full scope of changes in policy and practice needed to create institutions that are truly family-focused and family-friendly?

Incremental changes are helping schools and agencies to become more nurturing and supportive entities. Yet, one part of an organization may change and another continue with contradictory practices. A school may operate a morning program for preschool-age children and their parents, yet have a sign on the front door that says to parents of schoolage children: "If you are picking your child up after school, please wait outside the building." An agency may encourage workers to talk with parents about child-development programs, yet have a waiting room without toys or activities for children. What are the essential elements that reflect a family-friendly and family-focused institution? How can an institution assess the extent to which it is fully manifesting a family-focused approach? How can the necessary changes be put into place? How can potentially competing needs be balanced for example, allowing community access to the school building and preserving the safety of students?

How can local communities and institutions gain the flexibility and discretion needed to implement a family-focused approach?

The most important characteristic of an effective family-focused approach is its adaptation to its community. Moreover, the extent to which local administrators have authority to institute a more family-focused approach in their schools and agencies will dramatically influence the speed and scope of implementation. How can state and local governments ensure high-quality standards for programs and practice, but at the same time allow flexibility and responsiveness at the community level and family level? What policies need to be changed to facilitate local control and adaptation? What policies and practices need to be changed to allow individual administrators to improve their agency's or school's perspective? How would the role and accountability of individual administrators change in a more decentralized system?

What new skills, tools, and technologies are needed in communities in order to implement and support a family-focused approach?

New skills, perspectives, and tools will be essential to fully implement an ongoing family-focused, participatory, cross-systems partnership at the community level. Yet, the technology needed to change from a traditional system to a family-focused one is in the embryonic stage. What needs to be done to strengthen internal and collective planning capacities of existing institutions? What needs to be done to enable families to participate fully in the process? What is needed in the way of family-focused job descriptions and job performance standards, cross-agency training, adequate family assessment methods, and evaluation criteria for programs? What other tools would help? How can state and local governments help? How can we disseminate adaptable tools as they are developed in local communities?

What new or additional training and staff development is needed to help partners assume new roles and institutionalize a family-focused approach?

Teachers, social workers, and others on the front-line working with children and families are key to implementing a new approach. Without adequate training and team-building across agencies, their jobs may be harder instead of easier. Who will be responsible for developing a training strategy, funding it, and including it in the staff-development activities of each partner? What will the curriculum content include? What training is needed for families to enable them to participate fully in setting priorities for a family-focused system, designing programs, and overseeing the results?

How can schools and human-service agencies create the time necessary for teachers, social service workers and other staff to incorporate a family-focused approach day-to-day?

Responding well to family issues and needs, rather than just to an individual child, requires time—time to listen to the family's issues, time to understand family relationships, time to enter into the collegial partnership that allows a family to trust a professional, and time to collaborate with other community partners. Yet time is the scarcest commodity in both the education and human-services systems. How can schools and human-service providers arrange schedules, shift workloads, or redefine responsibilities so that time is available for a family-focused approach?

This paper was prepared for a meeting in Clearwater Beach, Florida, November 10-12, 1993 on "Improving Outcomes for Children" sponsored by The Center for the Study of Social Policy, the Council of Chief State School Officers and the Danforth Foundation.

Judy Langford Carter is executive director of the Family Resource Coalition.

A FRAMEWORK FOR IMPROVING OUTCOMES FOR CHILDREN AND FAMILIES

by Frank Farrow, Sara Watson, and Lisbeth Schorr

The Improved Outcomes for Children Project (IOCP)* is a multi-year effort designed to help communities improve life outcomes for families and children. It is the "community services and supports" partner of a major national school reform effort, the National Alliance for Restructuring Education. The Alliance is a consortium of organizations funded by the New American Schools Development Corporation (NASDC) and the Pew Charitable Trusts. As part of the Alliance, we (the authors, together with David Hornbeck of the National Center on Education and the Economy and the Business Roundtable) are working with four states and four cities to bring together education and social service staff and to create an environment in which children arrive at school, every day, ready to learn.

Our work is based on the conviction that both school reform and human service reform will be most effective if communities focus clearly on improving measurable outcomes that reflect the wellbeing of children and families. We believe that the performance of both agencies and systems can best be measured by results, and that an outcomes orientation can create a climate of accountability in schools, human services, and the broader community. In addition to our outcomes orientation, our work is informed by the following principles:

- Effective programs and systems focus on children in the context of their families, and on families in the context of their communities.
- Effective community services are comprehensive, high quality, flexible, and responsive: they are available when and where families need them, and are rendered respectfully and collaboratively.
- Primary supports (libraries, parks, parent groups) should be encouraged, since they are usually where families turn for help first.
- Instead of top-down controls, there must be a commitment to a strong local ownership and control over service delivery strategies.
- The services, supports, and institutions must be responsive to and inclusive of ethnic, racial, and cultural diversity in all aspects of the design, delivery, and governance.

In our work with states and communities we build on what is known about developing effective services, supports, and systems, drawing on the experience to date of many communities and states. In doing so, we are mindful that ultimately, each community will and must develop its own unique programs, policies, and systems.

In this article, we briefly describe the five components of our work:

- Shifting to an outcomes orientation
- Developing a comprehensive system of services and supports that accomplish the desired outcomes
- Conducting the professional training necessary for professionals to work effectively in the reformed system
- Pursuing financial strategies that support comprehensive reform
- Creating a governing system that supports ongoing reform.

Each of these components is enormously complex, and the brief overview in this article only skims the surface of the long and demanding process of reform. (A more comprehensive paper, on which this article is based, covers these ideas in more detail.)

Shifting to an Outcomes Orientation

An outcomes orientation means creating, delivering and evaluating services based not on process rules, but on their effects on outcomes for children and families.[1] Instead of designing services to meet agency needs, and evaluating them based on process inputs (such as number of forms filled out), services are designed and evaluated for their effect on the recipients of the service. Shifting to an outcomes orientation is the foundation for change because it drives so many other elements of reform. Outcome accountability can replace—or at least diminish the need for—top-down, centralized micromanagement, which holds programs responsible for adhering to rules that are so detailed that they interfere with a program's or institution's ability to respond to families' needs. In this orientation, the question asked of professionals at the front-lines shifts from "Did you do what they told you to do?" to "Did it work?" A different organizational climate results, in which well-trained professionals use their judgment and experience to respond to the needs of children and families, rather than being constrained by pressures which primarily reflect the narrow

*The IOCP is itself a collaborative of the Center for the Study of Social Policy, the Harvard Project on Effective Services, and the National Center on Education and the Economy. In addition to funding through the Alliance, the IOCP also receives support from the Lilly Endowment, the Carnegie Corporation and the Danforth Foundation.

system so they are used more effectively. Redeployment ensures that existing funds are well-spent before new resource allocation decisions are made. Specific redeployment opportunities will vary according to each state and locality, but opportunities include the redeployment of staff, such as by outstationing, as well as the redeployment of dollars, such as by shifting residential care funds to support less intensive, preventive services.

3. Refinance and reinvest dollars

Refinancing is the process by which federal funds are used to pay for services previously financed with state or local funding. This process frees up an amount of state and local money equivalent to the new federal funding, and allows this freed-up money to be reinvested into improved services for families and children. Three titles of the federal Social Security Act provide states the most significant opportunities for refinancing services to families and children:

1. Title IV-E can be used to pay for some preventive and case management costs incurred in the child welfare and juvenile justice systems.

2. Title IV-A (AFDC) can be used for such services as family preservation, protective services, shelter care, and other community responses to emergencies.

3. Title XIX (Medicaid) can be used to claim reimbursement for social and rehabilitative services. EPSDT provisions of Medicaid create considerable opportunity for funding school-based health efforts.

The resources freed-up through refinancing are often regarded as general revenues to be used for any purpose on the state or local agenda. We recommend that states and communities participating in this effort make every attempt to ensure that funds gained through refinancing are reinvested to strengthen children and family services and thus to achieve each community's defined outcomes. Once a reinvestment commitment is made, it must be monitored closely.

Developing Governing Entities

To achieve improved outcomes for children and carry out the other essential components of reform, states and communities are likely to require new forms of community governance at the local level.[5]

The current organization for most services delivered to families and children is top-down, categorical and process-oriented. Each of these characteristics, among others, has thwarted attempts to improve the lives of families and children. Adopting an outcomes orientation leads inexorably to the conclusion that new governing entities are necessary. These new entities must be bottom-up—responsibility for achieving outcomes and delivering services must rest at the most local level. They must exercise responsibility for agencies that are working together toward common goals that cut across agency boundaries to help either an individual family or to advance a broader community policy.

The purpose of these new governance entities is to facilitate community agreement on problems, focus attention on the need for cross-cutting approaches, and create more effective methods of achieving desired outcomes for families and children through improved and more comprehensive strategies of services and supports. This goal requires the development of many new capacities at the local level.

Governance bodies vary in terms of scope, structure, and activities; but there are five basic functions that a governance entity usually must carry out, regardless of its specific substantive focus:

1. Agree on a defined set of outcomes sought by the community for children and families.

2. Identify needs and developing community-wide strategies in response to priority problems confronting children and families.

3. Promote innovative community services in order to ensure the earlier, more accessible, and more responsive service delivery that families want and that schools need to accomplish their education mission.

4. Coordinate fiscal strategies to promote more comprehensive services.

5. Assess and monitor outcomes for children and families so that local service systems create and maintain a "climate of accountability."

The collaborative's role does not replace the responsibility of individual agencies to be accountable. However, the collaborative must reach beyond single agency accountability and determine if the sum total of agency efforts is producing the expected results. In a sense, the collaborative becomes the accountability agent for the service *system*, with each agency continuing to track its own performance within that broader framework.

Any one of these responsibilities is difficult, and all five together represent a major challenge. For that reason, many collaborative governing entities have recognized the need to move toward these responsibilities gradually over time.

Conclusion

This article has discussed elements and strategies that communities can use as they move toward more effective service systems to improve outcomes for children. Within this framework, states and communities must make their own choices, set their own priorities, and determine which strategies work best for them. This framework is advanced now in order to be used, revised, and adapted for each community.

Notes

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interests of the bureaucracies within which they work.

Agreement on desired outcomes also facilitates cross-systems collaboration and systems change, fosters greater attention to children and families, and helps to minimize expenditures that don't contribute to improved outcomes. The shared commitment to improve specific outcomes for children can make service integration efforts fall into place—not as an end, but as an essential means of collaborating to achieve improved outcomes.

While the shift toward outcome-based accountability brings many clear advantages, it is not an unmixed blessing. In fact, it carries real risks, which must be reduced through careful design and thoughtful implementation. Demands for documenting outcomes must not be allowed to drive programs to engage in creaming or to distort activities to emphasize only those that result in outcomes that are easy to measure. And some elements of process regulation must remain in place, to safeguard quality and guard against racial and other discrimination.

Developing a System of Comprehensive Services and Supports

Once a community has agreed on a set of outcomes, it must then address the question of what is known about how these outcomes are most likely to be achieved and how communities can utilize this knowledge to achieve the desired outcomes. Communities are likely to find that they need to modify, expand, or create new services and supports, as well as to develop linkages among existing services. One way to identify the needed supports is to undertake the following process.

The first step in using agreed-upon outcomes to shape the analysis and action around needed services and supports is to break the outcomes down into their component parts—for example, increasing healthy births is a result of many other factors, such as reduced school-age pregnancy and improved prenatal care. Second, communities need to determine the services and supports needed to achieve—or make progress toward—each of the agreed-upon outcomes (and outcome components). The third step is to identify which services and supports already exist in the community, and to determine how effective or ineffective they are in improving outcomes. Effective services share a number of common attributes, such as being comprehensive, flexible, family-focused, tailored to individual communities, and responsive over time.[3] The fourth step is to undertake a "gap analysis" to determine which needed services and supports are missing, and which are available, but must be restructured or otherwise modified to make them effective. The final, and by far the most difficult, step is to identify and take action needed to put missing services and supports in place, to make all services and supports maximally effective in improving outcomes, and to institutionalize change.

Staff Development and Training

The changes described in this paper require skilled, motivated people to carry them out. Improving outcomes for children can only be done through a well-trained workforce, knowledgeable about their own responsibilities as well as how they fit within the broader service system. For this reason, another component of reform is staff development and training to ensure appropriate skills, attitudes, and commitment among frontline personnel. Such training must emphasize:

- Respectful relationships with children, youth, and families and respect for family diversity
- The importance of involving families in their children's healthy development
- More flexible, comprehensive, and non-bureaucratic responses to children and families.

Training content would include material in the following areas:

- A family-centered approach: Understanding children in the context of their families, and families in the context of their community settings. Enabling families to develop skills that promote their own use of community resources
- A developmental approach: Understanding children in the context of their developmental stage
- Working collaboratively with other agencies, systems, and community resources
- Enhanced ability to work in reformed services and systems: Professionals equipped with a problem-solving, persevering mindset and problem-solving skills

Any efforts at new forms of cross-systems, inter-disciplinary training must be sustained by the organizations involved. Therefore, managers and supervisors must also be participants in these professional development activities, so that they will be fully supportive of the new forms of practice.

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Building a Stable Financial Basis for a Reformed System

Current fiscal realities demand that communities use every possible creative approach to expand resources available for services and supports.[4] The fiscal strategy we recommend has three parts:

1. Establish an overall joint program and fiscal strategy that links funding plans to clear program priorities.

Program priorities should determine fiscal strategies, not the reverse. To ensure that this occurs, we urge sites to link their program and fiscal agendas through development of an explicit "joint program and fiscal strategy" that identifies priority program goals and the fund sources used to finance them.

2. Redeploy existing resources

While state and local officials often look first to new funding, there are important opportunities to move resources around within the current

Key Issues in Developing School-linked, Integrated Services

Sidney L. Gardner

Abstract

This article identifies several nuts-and-bolts issues involved in planning and implementing school-linked services. Effective planning must include discussion of implementation details and is possible only if a policy-minded team of coequals works toward the same goals. No one agency should "own" the process. In addition to education, health, and social services agency leaders, the team should include representatives of community and neighborhood groups, line workers, and parents. This team must carefully address questions of targeting, governance, financing, evaluation, and information sharing. In addition, team members must consider operational issues such as ensuring line worker buy-in and establishing an effective case management staffing plan that is acceptable to existing staff. The article discusses different strategies that community teams can use to address each of these issues.

The development of school-linked services has progressed to a point where we can begin to distill the most effective approaches to planning and implementing these programs. In this journal issue the article by Levy and Shepardson discusses key elements of these programs. This article identifies some of the nuts-and-bolts issues that must be addressed when establishing school-linked service programs. These include planning, targeting, governance, information systems, and staffing.

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Planning

Perhaps the most obvious lesson to date from the experience of communities that have embarked on school-linked service efforts is that no one model fits all settings and works well in all cases. In fact, those who advocate one "franchise" model to fit all sites quickly confront skepticism from those who must adapt the model to local realities.

Successful programs must be shaped by the history and current needs of the community, the politics of agency relationships and government entities, and the unique energies and talents of particular program leaders. To accomplish this requires good planning. In fact, planning is a key operational issue and perhaps the most important phase of any program.

Schools and communities cannot cut short planning in their rush to open the doors of a new program.

Planning Is Implementation

Good planning is good implementation. Quality planning is the best insurance for quality implementation. The best implementation literature from the late 1960s to the present repeatedly stresses the need for a blurring of the lines that some planners draw between planning and implementation.[1] In fact, carrying out effective school-linked service programs demands implementation planning, in which the distinction almost completely disappears.

For example, when planners target a single group of children and families to be served in a newly opened school-based program, the planning for serving that target group needs to include in-depth discussion of implementation issues. If children under age 5 are to be served, planning must specify the ways to perform outreach to these young children; it will not be enough just to mention outreach in the design and leave the details for staff to work out later, when the center opens. Or, if children who are two grade levels behind are targeted for services, planning must specify the appropriate links to the testing staff, the need for special arrangements for multilingual testing in diverse schools, and the funding for the testing.

Quality planning is the best insurance for quality implementation.

There is a further paradox of implementation planning, however. It is that the better the job the planning staff does in considering implementation issues, the more likely it is that a form of "projectitis" takes over. Projectitis occurs when the operational details of the project itself have obscured the policy reasons for undertaking the project. Operations drives out policy as more immediate concerns take priority over long-term goals. In such cases, the original goals of institutional change may no longer seem to have priority because of the constant pressures of responding to the daily details of getting a project off the ground. The more complex the project, the more its implementation details threaten to swamp policy goals. And school-linked services are invariably complex, because they are interagency efforts that require multiple approvals.

When projectitis takes over planning, the project is likely to become merely additive. Additive projects cannot change institutions, because they operate as new activities grafted on top of the existing system. School-linked services are especially at risk of becoming additive, since they often develop out of a perceived need to address the problems of "at-risk youth." This label, however, may become part of the problem, since it sometimes signals a mistaken belief that fixing children is more important than *fixing the institutions that we fund to help children*. Perhaps we have at-risk schools, at-risk health agencies, and at-risk United Way agencies as often as we have at-risk children.

Children are at risk when they are likely not to live up to their full potential as parents, citizens, and workers. Institutions, in contrast, are at risk when they are likely to fail at doing what they receive public money for doing: providing services and support to children and families so that they can transcend the risk factors in their lives and become successful parents, citizens, and workers.

Planners need to bear both sets of needs in mind in preparing interagency approaches to the problems of students who are in fact at risk of not fulfilling their potential. Project planning that leaves out these institutional dimensions will leave these institutions intact in a comfortable but inadequate status quo.

The solution to projectitis, if there is one, is to staff the team with policy-minded planners (a topic this article will discuss) and at the same time ensure that policy review by senior officials takes place often enough to provide a periodic injection of the "policy" perspective. Also, employing outside consultants may be a means of keeping the policy goals in view during planning, as the following discussion will describe.

Planning Staff Characteristics

One of the basic questions faced by any school district or interagency consortium as it moves toward school-linked services is Who should do the planning? Larger districts and agencies may have full-time

planning staffs, and in such cases the tendency is to vest planning responsibilities in such staffs because planning is what they do all the time.

The problem is that agency planners are usually most familiar with planning projects, not institutional reforms. And here the lesson is clear: It takes senior staff with several basic characteristics to do the kind of in-depth, strategic planning demanded for school-linked services. Those characteristics include:

- Experience at both line and supervisory levels, so that the staff members understand the delivery point and the points in the organization where decisions are made
- Full access to the senior executive officials of the agency
- Adequate time—at least one quarter of the business day—to devote to the planning effort
- Diplomatic and "intercultural" skills in working across agency and disciplinary lines with professionals in other fields
- A natural curiosity and willingness to learn new things

Without these characteristics, planners will plan, but they are likely to end up producing just another set of isolated projects—projects unreviewed by senior officials, cautiously designed to fit within the status quo, and protective of all existing arenas of power.

A second issue that arises in forming the planning team is balance. As Jehl and Kirst discuss in their article in this journal issue, no one agency can be allowed to "own" the process to the point that the other agencies just withdraw and leave it up to the "owner." The planning team must be just that—a team. If its captains are too much in charge, other team members will gradually fade away, since they are all likely to have busy tasks to return to in their own agencies.

When the team functions well, it becomes a part of the implementation process, since it is involved in its own cross-training. In 1989 in San Jose, California, an interagency team that was based at a local elementary school gave a progress report to a meeting of senior county officials. One of the workers said enthusiastically, "We didn't have any formal training program, so we just went ahead and trained each other!" Such informal cross-training, when tackled with this kind of energetic support from line workers, can accomplish more than an elaborate staff development program handed down from a training office or a university.

Cross-training means, in part, learning "the glossary function." This training decodes each agency's alphabet soup—IEP, 99-457, JTPA, Chapter I, WIC, ADA, DRG—and carefully explains it to the full team. A spirit of "no questions are dumb questions" has to pervade the process. After a few meetings, the glossary begins to fall into place, and what one law enforcement official describes as the "Peggy Lee effect" occurs: Participants ask, "Is that all there is?" meaning, Is that all there is

to the jargon and acronyms you've been using?

One example illustrates the importance of the glossary function particularly well. A team in a city that had spent many months developing a nationally recognized model of school-linked services was having difficulty communicating with child protective services staff members who were to be part of school-based case management. What team members finally realized was that the problem was the way they were using the term *preventive services*. To the child protective services staff, *preventive services* had a specific meaning: any services designed to prevent placement in out-of-home foster care. In contrast, most school staff members used the term more loosely to mean any programs that try to anticipate and prevent school failure. Once the planners realized that they were using a precise term imprecisely, they were able to communicate more clearly.

Those who are most often left out—and most often needed in planning—are first, professional workers at the line level and second, parents.

Some interagency experts talk about the need to learn to speak "CSL: coordination as a second language." What is required is not mastery of every other agency's special terms and funding sources, but an openness to ask questions, to clarify the differences, and to work through the best ways of making dissimilar systems work for children.

Consultants

Another tendency for some districts and consortia is to rely too much on outside consultants. Consultants are at their most effective in three roles: (1) questioning the basic policy assumptions of the process or pushing and helping the local team to make those policy assumptions clear if they have not yet been stated, (2) networking with project planners in other communities and states to give local planners a comparative sense of how another site handled the same issue, and (3) providing actual expertise with particular school-linked service efforts in which the consultant may have personal skills and knowledge. Such expertise might be in the areas of information systems, federal reimbursements, or foundation funding. Beyond these roles, consultants who are relied upon to do the planning will in most cases walk out of town with most of the planning process left in their heads. This can cost the local team a great deal of time figuring out "Now, why did she do it that way?"

Community and Neighborhood Groups

Another issue in planning is which local "outsiders" to invite into the planning team. For example:

> Should we invite the United Way?
>
> Should we invite the local neighborhood, ethnic, and self-help groups?
>
> Should we invite community organizations that have been critical of the service delivery system in the past?
>
> What about the PTA or the local school site councils?
>
> What about corporate groups that have been working with the schools or that have plants and offices in the neighborhoods where we are planning school-linked services?

Decisions about involving each of these groups should be made explicitly, recognizing the trade-offs among the overall size of the planning team, the benefits the group can bring to the table, and the costs of omitting the group from the initial planning effort. For some of these groups, an early chance to react to the initial proposal will be more useful than being at the actual planning table from the start. But what is crucial is to ensure that no influential group feels it was not consulted at all before the public announcement of the adoption of the new system.

Those who are most often left out—and most often needed in planning—are first, professional workers at the line level and second, parents. Both, in obvious ways, can make the implementation of a school-linked service system easier—or much harder. Because of the potential of line-level professionals to introduce resistance, workers whose daily practice will be affected by a new system of services must be involved in its design. This set of planning issues will be discussed in a following section.

The role of parents in implementing the program is obvious: Without their support at home, the interventions at school and in the agencies will lack indispensable

reinforcement. In planning, parents can become members of focus groups, join advisory councils formed before the program opens its doors, help build cultural understanding on the part of new workers, serve as paraprofessional aides, and even take part in the initial training for school-linked service staff. In all these ways and others, parents are critical partners in school-linked programs.

Health and Social Services Agencies

Determining which health and social services agencies will participate in the planning and implementation of school-linked services requires sensitivity to whether agencies are interested and ready to do so. Communities cannot follow a formula in making this determination. They must examine organization health and readiness, perhaps bearing in mind an old saying: Never try to teach a pig to sing. It won't work, and it will only irritate the pig.

Organizations have life cycles, cultures, and insecurities just like humans.

There are some agencies that are quite like pigs being taught to sing—they are just not interested. This may be due to their current leadership, their history, their professional culture, or their budget. Some organizations, however, are just not interested or are incapable of becoming interested. Planners need to know that integrated services does not necessarily mean integrating *everybody*, and that the perfect is often the enemy of the good.

It is also helpful to realize that organizations have life cycles, cultures, and insecurities just like humans. Some agencies have recent "life experiences" that make them as profoundly insecure in discussing interagency negotiations as some people can be in discussing marriage or other long-term partnerships. Planners with a psychological perspective may view these agencies as not having resolved their own Eriksonian crisis stage, uncertain of their own identity, unable to deal with the demands of autonomy, or even frightened of it because of a history of "abuse" from legislators, the media, or their clients.

An insecure agency is probably not as effective a service integration partner as a secure one. Planners need, therefore, to learn to size up an unfamiliar agency and not assume that all agencies will come to the table with the same readiness to develop new partnerships by bargaining as equals. The experience of acting as equals in marriage is difficult for some people who have lacked that history in their own family of origin. So, perhaps, is the experience of co-equal partnership for agencies whose history suggests either that they were always in control or that they were never in control. In either case, they will bring that history to the process of negotiating service integration, and planners should recognize its impact.

Planners may be able to defuse the problem by acknowledging that an agency has experienced recent budget cuts, or that its caseloads are unusually high, or that its leadership just turned over and staff members are uncertain of their directions. Negotiations in planning should be tailored to these realities, rather than treating all potential interagency partners as equally equipped to enter into the partnership.

Fiscal climate also affects planning for integrated services. On the one hand, there is an inevitable response to budget crisis; agency planners say, "We can't do anything new now. This is no time for demonstration projects." On the other hand, times of budget crisis are sometimes the best possible periods to try new ideas. The time may be ripe for relocating staff in combined offices, working as a team of generalists instead of as isolated specialists, and setting priorities among clients instead of assuming that all those who are referred to the agency can be served equally well. In a kickoff for a new school-based service planning effort in a small California city, one leader summed up this view particularly well: "We've got to try this new approach because we've got nothing to lose now and we know that doing things the old way won't work any more."

Targeting

Schools and communities must face a basic question early on: Will their school-linked service efforts be universal, providing some level of service for all children, or will efforts be targeted, focusing on a particular age or subgroup of children, such as those who are poor? For some agencies and school districts, this decision is the single most difficult issue they have to confront.

At one California site, the decision makers resolutely avoided addressing this issue for the better part of a year. They assumed that their target would be the entire school population and that there was no need to single out any one group within a very needy elementary school student body. Finally, they agreed on a numerical target but still resisted designating any explicit criteria that would define which one group of students would "go to the head of the line" for services.

The phrase makes clear, perhaps, why we are reluctant to target in specific terms. "Going to the head of the line" has a ring of unfairness to it. "First come, first served" is a more prevalent principle of social services priority setting than many agencies would like to admit. Crisis management—the kind of atmosphere we so often operate in today, with funding reductions and growing human needs—means taking whomever shows up and not waiting to do some formal assessment of who might need help most.

But every school in America has a pyramid of needs, in which a small number of students are severely at risk, in physical danger, or have serious health disorders. These students, at the top of the pyramid, are high-cost, high-needs cases, likely to be referred out to other agencies that handle clients with intensive needs. Then there is a larger, less seriously impacted group. And below them is a group of students who may come from poor families in dangerous neighborhoods but who have personal qualities of resilience or family support that will enable them to make it—no matter what schools or social agencies do to or for them.

Every school in America has a pyramid of needs, in which a small number of students are severely at risk . . .

Where to provide services on that pyramid is the first and most basic targeting question. It may be answered in advance by categorical funding services that dictate, for example, that services can only be provided to Chapter 1 students or to those whose English-language skills are limited or to those who are Medicaid eligible. But without such categorical restrictions—which could stigmatize at-risk students—the targeting question remains, and planners must address it explicitly. They should do so knowing that there will be substantial political resistance to saying that one group is more in need than another.

Sandra Small

Governance Issues

One of the most important issues that emerges when planning a school-linked service program is Who should run it? The issue of governance is unavoidable, even if the school system is fully in the lead. Initially, in fact, it is often the schools that propose to take the lead. As a result, an "educentric" governance system can emerge in the first stage of planning. Three powerful reasons underlie this focus: (1) Schools have more access to children than the other, far-more-fragmented social service systems that serve children; (2) schools have better data on children; and (3) schools realize more quickly than other agencies the need for interagency cooperation. School personnel often recognize that they cannot accomplish education reform for the most at-risk students without help from the other agencies that are serving the same children and their families.

Yet, for several reasons, it has proven difficult for a school-dominated governance system to operate successful school-linked services. The primary reasons for this include (1) the difficulty of attracting other agencies' funds if schools are seen to be in charge; (2) the difficulty of structuring the hierarchy so staff members from other agencies report only to school personnel; (3) the possibility that only one or two agencies will come under school management, rather than the broad array that can be attracted to a system of genuine partnership; (4) the need for space that many cramped urban schools face, which means that school-linked programs must use agencies' facilities as bases of operations; and (5) the enormous challenges faced by schools in responding to the tasks for which they are most directly responsible—reforming the education system and raising levels of academic achievement.

There is also a more subtle problem that planners need to take into account: If school leadership—or any one agency—steps forward to "own" an interagency partnership, the partnership is likely to step back and let that agency take the lead. The other agencies will continue to staff the program but not with senior people, and they will describe the system as "that school project" rather than as a partnership. When governance is really in the hands of one dominant agency, some planners talk about the system as having yielded to the "Sinatra syndrome": An agency says it wants to collaborate, but it has to do it "My Way." This message is not hard for other agencies to pick up. When this happens, a system that needs to be co-equal in mobilizing resources from many agencies becomes merely unilateral.

The governance choices often come down to three broad options: (1) Let an existing public agency, typically the schools, run the new school-linked services; (2) set up a new nonprofit agency,

It has proven difficult for a school-dominated governance system to operate successful school-linked services.

such as the collaboratives created in three of the New Futures cities funded by the Annie E. Casey Foundation; or (3) work with a consortium of agencies to establish an operation that is co-equal, more or less.

A co-equal system can be more difficult to plan and operate than a unilateral system. But recent literature on corporate and public-sector management suggests that the management systems of the twenty-first century will be far less hierarchical than those of the twentieth century.[2] These writers stress that, increasingly, management will be about horizontal partnerships among agencies and firms that do not control, but depend upon, each other. To again cite the point noted by Jehl and Kirst in their article in this journal issue, no one agency can own the planning process.

Governance Issues and Funding

Many governance issues become finance issues, for obvious reasons. The agency that contributes the most funding wants and perhaps needs to maintain control. Planners need to understand how much the sources and duration of funding will affect their decisions. If funding is restricted to short-term, nonrecurring funds, funding issues will come up each year and may threaten the stability of the whole effort. As noted in the article by Farrow and Joe in this journal issue, institutionalized funding, such as Medicaid, child-welfare services, or Average Daily Attendance funding, is far more stable than one-time grants. Grants may be necessary to start operations, but as soon as possible

longer-term funding commitments should replace or supplement them.

Governance Issues and Evaluation

Governance issues also relate to evaluation and its effect on funding decisions. To convince legislators or other elected officials to buy in to the sponsorship of an integrated service program requires an early clarification of what would justify the buy-in. This then becomes an issue of evaluation, in which the most powerful question is What would it take to prove to you (a potential funder) that this is worth funding on a long-term basis? The task is then to organize the information systems and evaluations to produce that data. The elected officials must be involved in this process. If the outcomes of the project are positive but no elected official knew that these were the intended outcomes, the buy-in may be more difficult than if the elected officials helped to decide what outcomes would convince them the project was worth funding.

Well-intentioned confidentiality requirements have been developed separately by state and federal agencies and imposed piecemeal in a way that often results in inconsistency.

One of the clearest examples of this is the negotiation over the past few years between the Mental Health Department in Ventura County, California, and the state legislature regarding a program offering comprehensive services to a targeted group of children at risk of institutional placement. In the early stages of program development, planners asked legislators what it would take to convince them to fund the project. The planners devoted resources to establishing the information system that could produce what the legislators asked for. The system involved tracking clients and dollars in much more depth than is usually the case. This evaluation is described in Appendix B, under the heading "Ventura County Children's Demonstration Project."

Information Systems

Each school-linked service system inevitably confronts issues of information systems and confidentiality when trying to work across agency lines with students who are in more than one agency's caseload. In his powerful monograph, *The Same Client*, Bud Hodgkinson shows how often the same children and families may be served by schools and other agencies.[3] Yet, documenting this fact and organizing systems around this reality is a very difficult part of planning new networks of services for students.

At the outset, planners must inventory current information systems. They are often amazed to find how inadequate some large public agencies' data systems really are. Agencies that have no files on repeat clients, agencies that have all their files on 3 by 5 cards in totally nonretrievable form, agencies that cannot allocate any costs to client services—these are common realities in the recent history of planning school-linked service programs.

Also common is the frequency with which someone says, usually quite early in the planning, "We can't give you that information because of confidentiality requirements." Well-intentioned confidentiality requirements have been developed separately by state and federal agencies and imposed piecemeal in a way that often results in inconsistency. Therefore, confidentiality can be a tangled thicket for planners to negotiate. (See Appendix A for a discussion of confidentiality issues.)

The thicket is not impenetrable, however. Some careful studies of this issue are currently under way, and they provide hope for those who want to remove barriers to sharing information in an interagency context while protecting confidentiality. In addressing confidentiality problems, planners must keep uppermost in mind the central principle of *informed consent*. Many schools have designed parent-consent forms for use in developing multiagency intake and assessment processes.

There are definitely some cases in which agencies are simply using confidentiality to duck accountability. Clearly, an interagency system that follows clients from one agency to another can evaluate what services, if any, those clients receive. This follow-up is an unaccustomed form of accountability for some agencies, and initially it can be quite threatening for an agency unsure of its performance. Although technical issues are often important in information systems, planners need to look behind these "presenting issues"

to determine whether more basic political issues of accountability are really at stake.

Other Operational Considerations

When planning school-linked services, the people who will be directly involved in implementing changes in the delivery of services to clients play a very important role. Several issues emerge in the efforts to build a staff that functions as a team.

Line Worker Buy-in

In his recent book, *The Predictable Failure of Educational Reform*, Seymour Sarason established the fact that teachers are frequently omitted from the planning of education reform.[1] The same scenario applies throughout much of the history of human services reform as well. The very people whose daily work with clients is being changed by a "reform" proposal are not involved in the planning and implementation of these changes until the late stages. The result is completely predictable, either open opposition or "wait-out" responses, in which workers' organizations assume that top-down policy initiatives will fade away as the policymakers leave to go on to new jobs.

Ensuring line workers' involvement in the early stages of planning can demand a great deal of time. Yet, in general, doing so results in a net savings of time . . .

Ensuring line workers' involvement in the early stages of planning can demand a great deal of time. Yet, in general, doing so results in a net savings of time because workers who are in on the early stages of planning are able to identify problems that will arise later, in implementation. Once such problems are identified, the team can jointly develop alternative responses in the planning stage, rather than after implementation has begun.

Some school-linked service planning teams have used worker focus groups to get a "bottom-up" view of how today's school-agency interactions really work. Others have encouraged unions and workers' organizations to design their own orientation programs, with staff time set aside for developing in-service training. Such planning can tap into those colleges and universities that have been involved with school-linked services, using their continuing education programs and in-service programs. Planners may also want to participate in the growing discussions about how to build collaboration skills into undergraduate and graduate programs.

Worker reassignment or relocation, often an element of school-linked service proposals, raises major personnel issues. Planners must involve the staff in the personnel department at an early stage, even though the staff may at times be skeptical. As protectors of the organization's credentialing process, the personnel staff may overstate the uniqueness of personnel needs, but knowing in advance what credentialing issues will be raised during implementation is helpful. For example, in one school system existing counselors refused to work with outside "case managers" whose credentialing and pay was different from theirs. Knowing this in advance is far preferable to finding it out on the first day a team is scheduled to handle family cases on referrals.

Case Management: The Staffing Plan for Integrated Services

Issues of line worker buy-in tie directly into the staffing plan developed by school-linked service planners. A common direction for such planning is to describe a form of case management in which a team of workers from different agencies assesess, treats, or refers students to a variety of services and then tracks the referrals and outcomes.

Case management, however, is another of those terms that means many different things to different agencies and disciplines. Case management, like integrated services as a whole, is at risk of degenerating into "just another program," in which the case management staff operates parallel to existing staff without changing the system at all. Case managers then may be perceived as isolated new staff members who are sometimes paid more than other staff members. The consequences are obvious. In one California city, a headline reading "Super-Counselors to Treat At-risk Youth" understandably upset existing counselors. They saw the new staff members as glorified counselors, called case managers, who had smaller caseloads and higher pay.

Other issues of case management that have proved difficult for planners are those related to governance. Case management that deteriorates into just another program usually does so because it merely performs a referral function, sending students out to receive services but without any assurances that the services will in fact be there. What planners need to focus on is the source of clout—the power to get things done for students in the receiving agency. Clout can come from different sources; it can be as a result of personal relationships, a carefully negotiated interagency agreement, a "line of credit" for a certain number of referrals, or the power of the elected official who is sponsoring the project. But whatever the source, clout is essential to making case management more than a lot of paper without any new services or changed outcomes for children.

Community Controversy and School-linked Services

Planners should not assume that community reaction to their work will be low-key and technical. The basic role of schools in delivering social services is an issue of great controversy in communities where a vocal minority believes schools should never address issues that are the exclusive province of the family. This controversy becomes most acute over the issue of providing reproductive information in school-based health clinics serving adolescents; it also arises in regard to health education at the elementary school level. Planners need to know that the responses to their proposals will not always be rational and that some groups are extremely well-organized. Some are capable of opposing proposals on a national level, using emotion rather than facts as their primary ammunition.

Conclusions

Those planning school-linked services face some issues that are technical; other issues are political or policy-oriented. Of these, the political and policy issues are most important in seeking partnerships among independent agencies within a complicated, intergovernmental setting. To prevent projectitis from taking over planning, the technical issues must be addressed in the larger context of policy goals for children and families. Designing an interagency system is challenging. Planners should allow the outcomes for children and families to serve as the guideposts for planning and implementing school-linked services.

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A Look at Current School-linked Service Efforts

Janet E. Levy
William Shepardson

Abstract

The authors of this article contend that there is no single model for school-linked services. Rather, they conclude that lessons from existing efforts indicate that such services must be shaped according to the needs of the community and of the students being served. Six current school-linked service efforts are described in terms of the goals of the effort, who is served, what services are offered, where services are located, and who is responsible for providing services. A fundamental concern to those involved in initiating school-linked services is that these services become part of a truly integrated system that produces more successful outcomes for children and families. The authors identify a number of integrating elements that are key to effecting the kind of systemic reform needed to make school-linked services more than a passing fad.

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Millions of America's children and families face a combination of circumstances that not only threaten their immediate well-being, but put them at risk of long-term disadvantage. Of the children entering school this year, one in five is living in poverty, many in households with an income far below the official poverty level. Half a million in the incoming class were born to teenage mothers, often at low birth weight, with attendant risks to physical and intellectual development. A significant number were exposed to drugs in utero or carry HIV infection. More than half of these new students are expected at some point during their childhood to live with only one parent, usually the mother, in households that are particularly prone to poverty and stress.

Traditionally, education has been viewed as the means of escape from poverty and disadvantage. Yet today, when a high school education is barely sufficient to secure work that can provide economic stability, one of every four youngsters entering ninth grade will not graduate. In urban areas and areas of concentrated poverty, the outlook is even more dismal.

Although poverty and the other cited conditions cannot always be equated with school failure—many of those "at risk" do succeed—

research increasingly points to a demonstrable and fundamentally troubling correlation between low educational achievement and serious problems outside the classroom. For example, Hahn and Danzberger reported that students from poor families are three times more likely to drop out than those from more advantaged homes.[1] Wehlage and Rutter reported that four national longitudinal studies "confirm that a family background characterized by low socioeconomic status is strongly associated with dropping out."[2] Forty percent of girls who drop out do so for reasons related to pregnancy,[3] placing themselves and their babies at especially high risk of poverty; over half of the mothers receiving Aid to Families with Dependent Children had their first child as a teen.

That these correlations have dramatic implications for the nation as a whole, as well as for the affected individuals, becomes clear when one understands the dimensions of the problem. Henry Levin of Stanford University estimated that almost one third of the nation's schoolchildren are educationally disadvantaged, lacking "the home and community resources to fully benefit from conventional schooling practices," and the proportion is steadily increasing.[4] With declining birthrates making it likely that every able-bodied adult will be needed in the future work force, the possibility that so many will lack the skills they need to be acceptable workers is a far-reaching concern.

Systems Reform and Cross-Sector Linkages

Policymakers, administrators, and staff throughout the education and human services systems, who daily confront the grim reality represented by these statistics, are well aware of the gap between what is needed to address the problems and what the systems, as presently configured, can do to help. As a result, fundamental reform addressing philosophy, policy, and practice is under way in virtually all sectors.

A notable aspect of these movements to reform individual systems is their emphasis on the formation of partnerships with other institutions serving children and families. In part, this represents a growing awareness of the interrelated nature of the problems with which different systems and their clientele are struggling and a belief that coordination of services can, in Lisbeth Schorr's term, "break the cycle of disadvantage" by providing comprehensive, flexible, and continuous support to prevent or alleviate problems.[5]

The problems faced by children and families are simply too large and too complex to be taken on alone by any one system.

But an even more important motivation for the creation of linkages is the recognition that, although each system is committing itself to successful outcomes for the people it serves, the resources

available to any individual system are insufficient to fulfill this commitment. The problems faced by children and families are simply too large and too complex to be taken on alone by any one system.

Why School-linked Services?

Within the swirl of interest in better connections among the institutions serving children and families, the school is rapidly becoming a central focus. Fundamental to this focus is the continuing popular belief, challenged as it may be by the statistics cited previously, that education is an escape route from whatever problems a child or family may confront. In the domain of social policy, where broad-reaching consensus is rarely found, there is virtually undisputed agreement that education is a good thing, indeed an irreplaceable element in achieving success in the current and future marketplace. A not illogical leap leads to the conclusion that, if supportive services can help ensure educational success and self-sufficiency, then the institution responsible for education should have a part in the provision of those services.

This philosophical basis of interest in school-linked services is complemented by a number of practical reasons. The most important and obvious is that the school is where children can be found and, in fact, is the only institution with which virtually every child and family has contact. The school also offers a cadre of skilled staff that regularly comes into contact with children and families. The quality of these relationships and the extent to which these interactions are fully exploited as opportunities to identify and respond to need are potentially of great significance in constructing an effective system of support. Finally, the school building is an easily accessible physical plant—often one of the few reasonably maintained facilities in a hard-pressed community—that can be used as a center of positive community activity.

A Cautionary Word About Models

The growing interest in cross-sector collaboration as a strategy to secure successful outcomes for children and families, and the specific interest in schools as a focal point in that collaboration, is manifesting itself in a rich base of experimentation with school-linked services.

As more communities begin exploring the idea of a school-linked service strategy, they understandably are eager to extract from this experimentation "models" that can be replicated. Yet, from our perspective, a distillation and promotion of models seems premature. The very diversity of efforts in itself defies categorization into a limited number of structures and approaches. Moreover, because the movement is still so young, there is a lack of hard evidence that what is being tried is indeed effective. Drew Altman, president of the Henry Kaiser Family Foundation and creator of the New Jersey School-Based Youth Service Program when he was that state's human services commissioner, has observed that he hopes "someday soon what we know will catch up with what we believe." With a longer history and the structured evaluation of efforts that is now beginning, in time that should be the case. At this point, however, measures of effect on which to base a solid judgment of "best practice" and "model" are rarely to be found.

A final concern with respect to the idea of models is that, even when the experience and knowledge base is more mature, it is unlikely that there will ever be one or two models that could or should be reproduced "cookie-cutter" style throughout the country. To succeed, a community must develop an approach and tailor program design to capitalize on its particular strengths and opportunities and to respond to its citizens' unique combination of needs and expectations.

Some Current Efforts at School-linked Services

Nonetheless, communities clearly can learn a great deal from one another, and those who have yet to develop their own school-linked service strategy can benefit from the experience of early leaders on this agenda. In the following sections, we describe some promising and informative early efforts, with a particular eye to how they have addressed key elements that go into a school-linked service strategy, such as what the goals of the effort are, who is served, what services are offered, where services are located, and who is responsible for actual service provision.

Reaching Youth at the School Site: The School-Based Youth Services Program—New Jersey

The idea of bringing nonacademic services to the school site is not a new one. The school-based health clinic movement, for example, began in 1970, when the first comprehensive health center offering a range of health and social services was opened on a Dallas campus. But today's widespread activity really dates from 1987, when the New Jersey School-Based Youth Services Program (SBYSP) was enacted. This was the first substantial effort by a state to link schools and social services to help ensure youngsters' success.

Seeking to assist New Jersey's youth in making the often difficult transition from adolescence to adulthood, the New Jersey Department of Human Services (DHS) initiated this program to place comprehensive services in or very near high schools. There are 30 program sites, at least one in each county and most in low-income urban or rural areas. Managing agencies of local sites include schools, hospitals, social services agencies, and community-based organizations.[6]

The state does not impose a single statewide design, but requires each of the sites to offer at least a core set of services and to operate not only during school hours, but also after school, on weekends, and during vacations. Core services include mental health and family counseling, primary and preventive health services (on-site or by referral), substance-abuse counseling, employment counseling, summer and part-time job development, academic counseling, and referral to other health and social services not available on-site. Recreation is offered by the sites as a way to attract youngsters. Some sites also offer other services, such as day care, services for teen parents, special vocational programs, family planning, transportation, and hotlines.

It is unlikely that there will ever be one or two models that could or should be reproduced "cookie-cutter" style throughout the country.

Primary funding for SBYSP is through an annual $6 million state appropriation.

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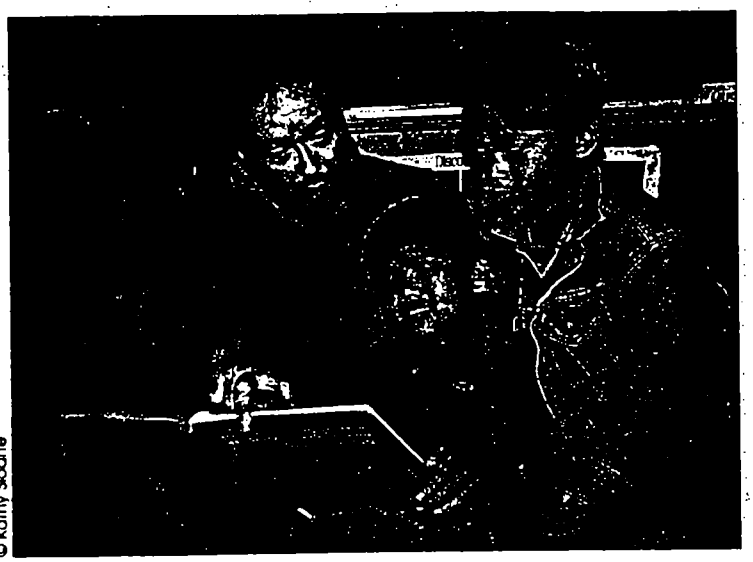
Average site grants are $200,000, an amount which is supplemented by a financial or in-kind contribution of 25% of site costs from the host community. In addition to financial support, DHS provides sites with technical assistance and helps them make use of existing service programs. For example, if health services are to be provided, the department will seek to certify the school-based program as a Medicaid provider so that it can claim reimbursement for services to Medicaid-eligible students.

SBYSP is one of the few school-linked service programs that is open to any student in a participating school. There are no limiting eligibility criteria, nor does a student have to have an identified problem. This open approach is intended to avoid stigma and encourage students to use the center before small concerns become big problems; the high volume of student participation in the centers suggests that this strategy is working. Parental consent is required for all SBYSP services and some family services are available, but generally speaking the target for services is the youngster, not the family.

Preventing "Risk" From Becoming Reality: Project Pride—Illinois

The objective of Illinois's Project Pride was similar to that of New Jersey's SBYSP—to provide school-based support to high school students to keep them on a successful track. In Illinois, however, both the target population and services provided were narrower in scope. This program, which began in 1986 as a federal demonstration project, closed at the end of the 1990-91 school year because funding was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no longer available. Its reported results and its truly preventive orientation are notable enough, however, that the program merits continued attention.

Project Pride, located in Joliet West High School, sought to improve future prospects for girls whose families were receiving Aid to Families with Dependent Children (AFDC). Program participants had not necessarily manifested any problems, but research suggests that family circumstances such as theirs put them at risk for too-early childbearing and future welfare dependency. Many of the participants came from families who had been welfare recipients for several generations; Project Pride aimed to break the "cycle of dependence" by helping these girls gain the skills, knowledge, and personal confidence to achieve economic self-sufficiency as adults.

In its first year, with $150,000 in federal funds and $60,000 in state funds, Project Pride enrolled 59 students; additional students were added each year. After the federal demonstration period ended, funding was provided entirely by the Illinois Department of Public Aid and the school in which the program was housed.

The program focused on enhancing the participants' employability, educational achievement, and personal relationships. Staff located in the school provided individualized case management, as needed. Tutoring, homework assistance, and advice on study skills and test taking helped participants maintain or improve their grades. Through group and individual counseling, Project Pride students learned to develop and sustain mutually supportive relationships with boyfriends, family members, and friends. Volunteer mentors from the business community taught participants the qualities employers value and what is expected in the work world; coached them in interview techniques; and, in some instances, helped them find part-time jobs.

The program reported an 80% high school graduation rate among participants, a remarkable achievement among this high-risk population when compared with the overall national graduation rate of 70% in the same period. Further, the reported number of pregnancies among Project Pride participants has been about half that of Joliet's city-wide average for adolescents since 1986.

Making Connections for Families: Probtsfield Elementary School—Moorhead, Minnesota

At the middle school and high school levels, youngsters are old enough to seek and receive services themselves, although many would argue that the family continues to be important and should be a part of any intervention if at all possible. But at the elementary school level, the family's role and responsibility is undeniably central, and service efforts for children at this age must actively engage the family. Serving the family also means that siblings of a child experiencing difficulties may be reached before they themselves begin to experience problems. The value of a family focus is clearly recognized by teachers and school administrators at Probtsfield Elementary School, who are seeking to help their students by helping the families.

At the elementary school level, the family's role and responsibility is undeniably central, and service efforts . . . must actively engage the family.

Among Probtsfield's students are youngsters from two nearby housing projects. School personnel were concerned that many of these children were performing poorly on schoolwork, that they and their families had needs that were not being met, and that there was little trust between the families and the school. School officials reasoned that trust could be built and the children's achievement

improved if parents saw the school as a source of help in solving problems.

In contrast to the New Jersey and Illinois programs, Probtsfield tackled this objective by developing an effective information and referral capacity in the school, rather than by bringing services to the school site itself. The school began by asking all the human services agencies in the community to contribute information about their services to a resource manual for teachers. A copy of the manual was given to each teacher—making it much easier to use than if there were a copy in the library only—and teachers received in-service training in how to identify problems and make referrals. With the help of the manual and training, teachers now are expected to explore family needs in parent-teacher conferences and to make referrals as appropriate.

To increase the likelihood that the referrals will result in a connection between the family and an agency that can help, agencies have representatives in the school building on the days parent-teacher conferences are held. Even though services beyond the initial conversation are provided off-site, through this arrangement a parent need only walk across the hall, rather than travel across town, to take the first step to act on the teacher's suggestion. Although no formal evaluation has been conducted, members of the school staff believe that many of the concerns that underlie this initiative are now being addressed and that the circumstances of the children who were of priority interest are improving.

Keeping Children on Track Through Early Intervention: Youth At Risk Program—Cortland, New York

Families are also an important element in the Youth At Risk Program of Cortland, New York. The program combines school- and community-based service components.

Realizing that existing efforts to help at-risk youth and their families did little more than react to crisis, in the fall of 1988, the Cortland City School District and county Department of Social Services (DSS) joined forces to shift the focus of Cortland's Youth At Risk Program to early intervention and prevention. As a first step, they formed a Community Advisory Council to help devise ways to identify at-risk youth as early as possible, make school and community services more accessible, and provide special support to at-risk youth.

As recommended by the Advisory Council, multidisciplinary Youth Intervention Teams (YITs) were formed in each of Cortland's schools to bring a range of professional expertise to bear on the problems of youth and their families. YITs meet weekly to consider referrals from teachers and counselors. Recommendations of the YITs are implemented by youth and family counselors—social workers hired by DSS but stationed in the schools—who serve as case managers to facilitate the provision of suggested services. In addition to weekly meetings at the school sites, YITs meet monthly with the deputy commissioner of social services and the school district's director of pupil personnel services to review complex cases.

The Great Kids Program is another part of Cortland's attempt to keep serious problems from developing. Designed to help children make a successful transition from elementary school to junior high, this intensive summer program targets students who are performing poorly in school, exhibit a lack of self-esteem, or display frequent behavior problems. Students strengthen their academic and social skills and learn practical skills such as budgeting money. The Great Kids Program also reaches out to parents. Youth and family counselors make home visits to obtain parental permission for student participation in the program and to learn more about the family situation. During the summer program itself, parents are asked to attend weekly meetings where they receive an update on their child's progress and are offered support in planning for their child's future. Students and families in need of ongoing services are referred to the YITs for follow-up, and school counselors meet with student participants throughout junior high to provide continued support and guidance.

The budget for Cortland's overall Youth At Risk Program is approximately $440,000; first-year costs were $144,000 for Youth Intervention Teams in the district's four schools and $14,000 for the Great Kids Program, with 20 youngsters participating. Major funding sources include a state Youth At Risk grant, prevention money available to the Department of Social Services, and federal and state substance-abuse resources.

The changes in Cortland's Youth At Risk Program already appear to be making a difference. Whereas the statistically expected dropout rate among the city's seventh and eighth graders is over 10%, no Great Kids participant has left school, and improvements have been seen in completion of school assignments and overall attitude toward school. In a rare example of cross-sector accountability, Cortland is also measuring non–school-related outcomes attributable to school-linked services. Fewer children needing out-of-home placement are being placed in juvenile facilities and other institutions, and more of those who are placed are in community-based programs. DSS staff credits these positive trends to the availability of intensive case management and better-coordinated services.

Revitalizing a Community: The Walbridge Caring Communities Program—St. Louis

The preceding examples distinguished between school-linked programs that target only students and those programs that reach beyond the school building to serve the students' families as well. The Walbridge Caring Communities Program (WCCP) goes even further, to address the needs of the community surrounding Walbridge School in St. Louis, where the program is based. Most community residents have low incomes, and the neighborhood is struggling with drug dealing, unemployment, and crime. WCCP is guided by an African proverb—"It takes a village to rear a child"—and seeks to re-create in this extremely challenged community a "village" that can nurture its children and help them succeed.

Caring Communities is a pilot project of four Missouri state agencies—the Departments of Elementary and Secondary Education, Mental Health, Health, and Social Services—and the Danforth Foundation. Its objectives are to keep high-risk children performing successfully in school; to help those children and their families avoid family dysfunction and separation; and to help the children stay out of trouble with the law.

WCCP is co-located with Walbridge School (preschool through grade 5) and a "community school" offering adult education and after-school programs for neighborhood youth. The school principal and the directors of the two co-located programs work as a team to operate a facility that is open more than 15 hours a day.

Referrals to WCCP come mostly from school personnel, although some families living in the community are referred by the courts and the Division of Family Services. WCCP services are both school- and home-based. They include case management, an intensive crisis-intervention program for families at risk of having children removed from their homes, a daytime in-school treatment program for troubled youth who need individual and group therapy, before- and after-school child care, substance-abuse counseling, school nursing services, pre-employment training and job placement for parents, academic tutoring, and a food bank. Classroom presentations using an Afrocentric curriculum reinforce students' self-esteem as a way to prevent drug abuse, and monthly parent meetings keep families posted on what their children are learning.

Community empowerment is as important a part of WCCP's mission as service delivery. The Substance Abuse Task Force, for example, is organizing anti–drug-dealing marches in which parents, students, and police participate. Empowering the community also means giving the residents a say in how best to use the resources of the participating state agencies in that community. Most of WCCP's $570,000 budget comes from redirected state agency dollars that would have been spent serving children and families in the area. The Advisory Council—drawn in equal parts from parents, community representatives, agency representatives, and school personnel—guides WCCP in deciding how those funds should be used and the services the program should offer.

Outcome data are limited at this point, pending completion of a formal evaluation now under way, but there already is evidence of improved school attendance and achievement and a reduction in problem behavior.

Rethinking How a City Serves Its Youth: New Beginnings—San Diego

Like WCCP, New Beginnings reaches well beyond the boundaries of a school building and its students. In fact, this initiative did not begin with a school focus; school-linked services are only one component in a multifaceted, citywide effort to ensure the well-being of children and families.

A partnership that spans jurisdictional as well as sector lines and includes both

political and professional leadership, New Beginnings involves top executives from the county Departments of Social Services and Health and Probation, the San Diego City Schools, the Community College District, and the city Housing Commission, Parks and Recreation Department, library system, and police force. The county's chief administrative officer and the city manager participate as well.

In mid 1988 these officials began a series of informal but penetrating conversations about the condition of and outlook for San Diego's children and families. As unmet needs and fragmentation of services became focal points of discussion among the executives, they turned to school-linked services as a key strategy in an overall effort to improve the way the city deals with concerns such as the growing number of children in poverty.

For New Beginnings, the concept of school-linked services has already taken multiple forms. A parent-school communication curriculum has been included in the training provided to San Diego welfare recipients participating in California's welfare-reform effort, Greater Avenues to Independence (GAIN). Special procedures have been adopted so that school nurses and the Department of Social Services, working together, can expedite access to benefits and services for pregnant and parenting teens, to help them fulfill the dual roles of student and parent. The Department of Social Services was also an active participant with the school system in designing a new middle school, where the staff now includes a family advocate at the school site to counsel students and staff and coordinate with other agencies.

To explore the potential of using the school site as a locus of more comprehensive service delivery, New Beginnings recently opened a demonstration center at Hamilton Elementary School. Like Walbridge School, Hamilton is in an extremely challenged community. Families in the community and staff in the school and service agencies participated in determining the kind of services the center would provide. Initially, the center has been charged with serving Hamilton's 1,300 students, grades K–5, and their families; future plans include expansion to preschool-age children. In an innovative twist that helps introduce all families to the center and its resources, basic registration for school now takes place at the center


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rather than in the school's administrative offices. The center offers parent education classes, adult education classes, and health care services such as immunizations and basic physicals. A team of family services advocates provides service planning, counseling, and some direct services. Complementing the school-based staff is an "extended team." Team members remain in their own agencies but are trained and ready to take referrals from the Hamilton center.

The center opened in the fall of 1991; as yet there are no outcome data available. However, because the New Beginnings leadership itself regards the center as an experiment from which they intend to draw lessons for wider implementation of school-linked services, this endeavor may well eventually provide some of the most useful data about the efficacy of this strategy.

Questions to Ask in Designing a School-linked Service Strategy

In his article in this journal issue, Sid Gardner observes that successful planning and implementation of a school-linked service strategy depends on the willingness of planners to make clear and thoughtful choices about key design elements. The preceding section described various programs and initiatives that illustrate well what those elements are and how diverse the choices can be. To review, those who are planning a school-linked service strategy must answer a set of interrelated questions:

1. *What is the primary purpose or objective of the strategy?*

Traditionally, most program interventions have been intended to accomplish one or a combination of three purposes: (1) *remediation,* to alleviate or correct a problem; (2) *early intervention,* to respond to warning signs that a problem is emerging rather than waiting until it is fully developed; (3) and/or *prevention* of a problem by addressing those factors that are known or believed to be causes or contributors. The spectrum of possible purposes has been widened recently to focus on the strengths of families and children, rather than only their problems, and to provide general *support* (such as information and training) to enhance their abilities to cope with the normal questions and stresses of life. The earliest school-linked service efforts tended to be remedial in nature, directed in particular to students on the verge of dropping out or to adolescent parents. Today, as the cited examples demonstrate, there is much more activity in the areas of early intervention and prevention. Support as a purpose of school-linked services, as of services in general, is still rare but of growing interest.

. . . a vision can be set for future efforts, and short-term compromise need not become long-term complacency . . .

Absent any constraining factors, most would choose to act at an earlier rather than a later stage, to prevent—if not provide support—rather than wait until remediation is necessary. But other factors are rarely neutral and the choice of purpose must usually reflect what resources and consensus will allow. This often means responding to compelling problems that cry out for attention. Though this choice may be an uncomfortable one, if it is at least made consciously and in the context of the broader range of possible purposes, a vision can be set for future efforts, and short-term compromise need not become long-term complacency, with "Band-Aid" approaches. A clear and conscious choice of purpose is also key to setting outcome goals for which one can reasonably be held accountable and, if achieved, rewarded.

2. *Who is to be served?*

Related to the question of purpose is that of who will be served by the school-linked service effort. For example, will the effort target a particular subgroup of the population, such as those manifesting a problem of special concern, or will it be open to anyone? "Universal" coverage, like that in the New Jersey program, reduces the potential stigma attached to seeking services and facilitates intervention at early stages. Moreover, per-child or per-family program costs may be less in universal programs because earlier forms of intervention are less expensive than remediation, although this may be offset by a larger number of people seeking services. In addition, Heather Weiss cautions that high-risk families most in need may not avail themselves of universally available services without special outreach.[7] Other aspects of the "who" question illustrated by the cited examples include whether the effort will be primarily family-centered or child/youth-centered and whether it will focus on the children and families served by the school, as does San Diego's New Beginnings effort, or whether it will focus on the whole community in which the school is located, as the Walbridge Caring Community project does for at least some of its services.

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3. *What services will be offered?*

Answers to the why and who questions will set the basic parameters for deciding what is to be offered, although the choice may also be affected by the availability of resources and services. Generally speaking, with the growing recognition that many high-risk children and families need multiple, well-integrated, and readily accessible services, there is a strong desire to strive for comprehensiveness or the inclusion of as many of the services a youngster or family might need as can be accommodated. That is the objective of the New Jersey program and of the many proposals to set up "one-stop shopping" centers on school grounds. Often, though, resource limitations mean that planners must settle on a smaller selection of services, especially if the target is families or children whose circumstances will require intensive—and therefore expensive—intervention. Project Pride's results show that a limited range of services can still lead to successful outcomes, if the services selected are well suited to the goals and are of sufficient scope to address at least the major factors affecting the outcome. An important rule of thumb, particularly when comprehensiveness is not possible, is to include the potential recipients of services and line-level staff in making choices about what will be offered, as Walbridge and New Beginnings have done.

4. *Where will services be located?*

The theme of this journal issue is school-*linked* rather than school-*based* services, an important distinction that allows for variation in where actual service delivery may take place. The idea of housing all services in a facility that is readily accessible to virtually all communities and that is set up to serve children is inherently attractive. But the question of location has both policy and pragmatic implications. Foremost is the issue of whether or not, in a given community, the school is viewed as a friendly institution to which families and children will readily turn for help and support. This can be a function both of how the school operates and of the parents' own educational experience. In St. Louis, the Walbridge School was seen by the community as a positive force; in one of the New Jersey sites, the nearby Police Athletic League building was more inviting to the students and therefore became the locus of most program services. Robert Chaskin and Harold Richman's article in this journal issue offers some cautions about using schools as a service base. Sometimes, of course, basing services in the school can be a way to change perceptions. For example, Missouri's Parent and Child Education program puts adult literacy classes and early childhood activities in an elementary school so that the parents can become familiar and comfortable with the school their children will enter.

Questions to Ask in Designing a School-linked Service Strategy

1. What is the primary purpose or objective of the strategy?
2. Who is to be served?
3. What services will be offered?
4. Where will services be located?
5. Who will be responsible for service delivery?

Even if the school is deemed to be a desirable center, the choice about service location may be affected by practical considerations, such as insufficient space or service agency inability to place staff at the school or to otherwise relocate services. When services are provided off-site, an effective "bridge" to span the distance, like that developed at the Probtsfield Elementary School, is key. As discussed previously, at this school teachers received comprehensive information about services available for their students and families in the community. In addition, these community agencies have representatives at the school on parent-teacher conference days.

5. *Who will be responsible for service delivery?*

Most effective planners of school-linked services readily agree that, although instructional staff must have a role in developing the effort and in helping to connect students and their families to available services, they should not be expected to be service providers themselves. The lament of school personnel that schools cannot do everything is well-founded and, indeed, one of the attractions of today's school-linked service movement is that it creates an explicit capacity to respond to nonacademic needs, rather than leaving that role de facto to an ill-equipped and overburdened school staff. Services may be provided by existing

agency staff members who are already performing the desired activities or who are reassigned to the new effort, or staff may be hired for a newly created program. As Gardner points out, a choice must also be made about governance—whether the school or an outside entity will be "in charge" of the service program or perhaps, as in San Diego, whether responsibility will be shared. It is extremely rare to find a school-linked service effort that is under the exclusive direction of school authorities, and many observers—such as Richman and Chaskin—question whether that would be desirable. At the same time, some linkage to school governance is probably necessary if the school-linked service effort is ever to be well integrated with the regular operations of the school itself.

Systemic Change to Improve Long-term Prospects for Children and Families

Whatever the specific design choices, the issue of how school-linked services relate to basic operations gets at a matter of fundamental concern. Will school-linked service programs remain occasional and isolated appendages to regular school and service operations, with little effect on or connection to those operations? Or will school-linked services become part of a well-integrated system of more effective supports for children and families? How these questions are answered in the long term will likely decide whether this movement becomes one more fad that failed or a sustained innovation that truly contributes to more successful outcomes for children and families.

Systemic change in and among large bureaucratic organizations does not happen overnight.

Thus far, although we have few data on "people outcomes," the school-linked efforts described in this article and the hundreds of efforts throughout the country have made advances that hold promise for greater effectiveness. Many schools and human services agencies are adopting policies and practices that reach beyond their traditional activities and reflect a more holistic vision of what children and adults need to succeed. Through approaches such as cross-training, better referral techniques, and more convenient location of services, ways are being found to ensure that people who need a service are aware of and have ready access to that service. New services are being developed to fill identified gaps, and a base of mutual understanding and trust among the various systems working with children and families is being built.

To move from these positive beginnings to true systemic reform, however, specific programmatic initiatives will have to be complemented by deep-reaching changes in the basic ways people-serving systems operate and interact with one another. Those who seek to re-create and support nurturing communities must turn to elements that can help weave together school-linked services, an array of other special efforts to help children and families, and the core systems themselves into a functioning whole. Among such integrating elements might be:

- Ongoing processes and structures for joint planning that create an interagency framework of shared goals, that ensure systematic identification of current and emerging needs of children and families, and that facilitate joint decision making in responding to those needs
- Budgets and funding streams structured so that people can be served in the most appropriate manner and place, without threatening any system's financial stability and ability to carry out its basic mission
- Policies that, while respecting legitimate privacy rights, allow for joint data collection and the exchange of relevant information to support coordinated action
- Designated persons, with responsibility and authority that span systems, who can help individuals and families develop problem-solving skills and use multiple services effectively
- Pre-service and in-service training that help staff members understand the communities in which they are working and the full array of resources that are available to help children and families
- Job descriptions and reconfigured caseload and classroom assignments that encourage and allow staff members flexi-

bility in responding to those with whom they are working

- Accountability and reward structures that emphasize the achievement of positive outcomes rather than dictate specific inputs

Systemic change in and among large bureaucratic organizations does not happen overnight. Yet, this change must occur if we are to use effectively the limited resources available, achieve comprehensiveness in spite of necessary specialization, address the crises that prevent learning, and ensure the learning that avoids dependency.

Conclusions

Admittedly, the experience to date with school-linked services is limited in scope and in scale, but it is nonetheless rich and exciting, for it affirms that institutions can work together in creative and effective ways and it represents a first, important step toward these broader changes. It is the start of a foundation on which to build a system of systems, an integrated structure of support that can help ensure the well-being and success of children, families, and the communities in which they live

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6. In 1991 New Jersey began experimenting with adapting the School-Based Youth Services Program to serve middle school and elementary school students. The program is being piloted at seven sites in middle schools and elementary schools.
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Overview of Service Delivery to Children

William A. Morrill

Abstract

The human services delivery system contains three components: education, health, and social services. The organization of each component differs and each has its own financial and programmatic relationships to federal, state, and local governments. Each component addresses different problems and serves different subsets of children through a variety of programs. A major shortcoming in this tripartite system is its inability to deal with children with multiple problems in an effective, coordinated way. The fragmentation, specialization, and complexity of the current system prevent effective service delivery. One solution is to reorganize the current system by linking or integrating health, education, and social services. This approach emphasizes prevention, attempts to deal with children and families holistically and promptly, and is designed to meet multiple needs across professional and program categories. Service integration using this approach has been part of recent collaborations that often involve the school system and sometimes use school facilities as a base for delivering health and social services. In the past, reformers outside the human services system were usually the ones to propose collaboration and school involvement. Today, in contrast, the impetus comes increasingly from providers within this system, who operate as equal partners.

The United States is focusing anew on the content, quality, and delivery of human services for children. Led by concern about the apparent inadequacies of the current education system, particularly for at-risk children, there is increased interest in linking health and social services to education to ensure that children receive the full array of services they need. Proponents of this approach urge that there should be more emphasis on prevention and early intervention and a focus that extends to the needs of the entire family unit, not just the child. Among education, health, and social services providers, this interest has led to a growing number of collaborations to integrate service delivery.

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There are important antecedents in the American experience for linking health and social services to education. David Tyack describes early efforts in his article in this journal issue. His article deals not only with the character of these efforts, but also with the motivation behind them. Attempts at integrating health, social, and education services at

the state and federal levels were made as recently as the early 1970s, but they faded in the face of professional and political opposition.[1] It is reasonable to ask, therefore, whether the recent interest in school-linked services presents anything new or different. Or is it one more round of faddism stimulated by many of the same forces as earlier attempts and proposing roughly the same solutions? To answer these questions, it is important to have an understanding of the current human services system for children and the problems of the system.

The Human Services Delivery System

Children require a variety of human services as they mature. In this article, *human services* includes education, health, and social services. Some children have special needs in each of these areas; some require special education, ongoing medical attention, or a variety of more intensive social services, such as child protective services.

Western democracies, and particularly the United States, have historically relied on the family unit to be the initial provider or primary manager of human services for children. Families have secured these services through public, community, and religious institutions when providing the services is beyond the competence or capability of the family itself or in circumstances where societal standards are considered important (in the provision of education and health services, for example). These institutions and specialists constitute a network of services and support that families have been able to use as they deem necessary.

This traditional model of reliance on the family, a model in place throughout this century, has been eroded by two interactive trends in society—one trend is professional; the other, demographic. First, in the twentieth century, the trend toward professionalism and specialization in the delivery of human services to children has continued unabated, creating new complexities for families who must use these services. Second, this trend has been accompanied by a growing demand for extrafamilial assistance that has been fueled by an increase in the number of working women in two-parent families and the number of single-parent households. From 1970 through 1988, married women in the labor force increased by 38%,[2] and the number of female-headed families rose by 95% over the 1970 through 1989 period.[3]

New technical and scientific knowledge about services, new family needs, and the declining capacity of established institutions to cope with these new demands have spawned a complex array of programs, specialists, and processes. This array is beyond the easy comprehension and management of today's families, who are trying to cope with increasing disorganization and time pressures. This system costs hundreds of billions of dollars in public and private expenditures. Despite these expenditures, in the United States little effort has been made to maintain a comprehensive human services delivery system that can meet the spectrum of individual and family needs. Instead, the penchant, at least through the mid 1970s, was to create new programs for each new social problem, an approach that only further fragmented the service systems.

As stated previously, the present human services delivery system can, with considerable oversimplification, be grouped into three major categories: education, health, and social services. The education system provides primarily instructional services to children in public and private schools. The health category encompasses nutrition, medical, and mental health services; the social services

category includes not only traditional social services (such as child welfare, day care, and counseling), but also income maintenance, housing, and training. The delivery systems for these services are somewhat different, and a brief description of them will be helpful in understanding the nature of current problems.

Education

The education system in the United States is highly decentralized. Although most legal authority rests at the state level, decision making for operational matters lies primarily with the more than 15,000 local school districts across the country. In the 1988–89 school year, approximately $179 billion of public funds was spent to educate approximately 40 million children in the public schools,[4] and another $15 billion was spent for the education of the 5 million children in private schools.[5] In the public schools, 50.2% of the funding was provided by the states, 44.7% by local governments, and 5.1% by the federal government.[5] This 1988–89 funding represented an increase of $83 billion or 86% from aggregate funding levels in 1979–80 (in 1989 dollars), with little change in total enrollment.[5]

The public is increasingly concerned about the outcome of this investment in education. While the National Assessment of Educational Progress suggests that it is possible, with concerted effort, to close some performance differences between black and white students, the higher expenditures on public education in recent years has not resulted in general improvement of student performance.[6]

The problems of today's education system are not necessarily new, but their consequence and importance to society have increased. For example, although general dropout rates have declined over the past decades, they still remain high. (See Child Indicators in this journal issue.) More important, their consequences are more severe. The U.S. economy of several decades ago could absorb large numbers of individuals with few or limited reading, number, and problem-solving skills. These individuals could work in agricultural, manufacturing, construction, or unskilled service jobs. The number of such jobs in the U.S. economy is shrinking, however. The need for a higher success rate in elementary and secondary education is therefore greater than ever.[7]

Certainly, some responsibility for inadequate student performance rests with the quality of instruction and school programs. Budgetary problems, issues of pay adequacy, and the obvious special problems present in poor communities may also provide some explanation for unsatisfactory outcomes. However, human services professionals and the literature readily acknowledge that the physical and mental condition of the children, and their out-of-school experiences and behaviors are powerful influences on their in-school performances.

The shortcomings of the current education system have given impetus to renewed consideration of system change. This change does not necessarily require that schools assume more direct responsibility for all noneducation needs. It does require, however, that schools work with others to ensure that the nonschool issues that affect the performance of educational institutions are addressed.

This recognition of the importance of noneducation needs has also been stimulated in part by school reform initiatives. For example, experimentation with site-based management has often included consideration of service integration, because such management reform usually also involves examination of all obstacles to learning. These obstacles include students' noneducation service needs, which —if unmet—can diminish student performance. Collaborations to integrate services can and do exist without an accompanying school reform, but school reform usually forces some consideration of the delivery of nontraditional services, such as health and mental health services, day care for parenting teens, and family interventions for schoolchildren whose performance is poor.

Recognition of the importance of noneducation needs has also been stimulated in part by school reform initiatives.

Health

Although the American education system is largely decentralized, public, and dominated by state and local governments, the American health system is quite different. Health services providers are largely private

and nonprofit, rather than public, with most health services financed through employer-based and other third-party plans. Low-income and other vulnerable populations are primarily served through third-party public programs (Medicaid and Medicare) dominated by federal and state governments. Nutrition supplementation is dominated by the federal food stamp and school lunch programs. Some directly financed health services in the areas of nutrition, preventive and clinical services, and mental health include local as well as state delivery and financing.

The nation spent on the order of $600 billion for health services in 1989.[8] The portion of this amount that was expended through private sources for health services to children is uncertain until new data become available. Approximately $21.8 billion in federal and state funds was spent in fiscal year 1989 on health and nutrition services for children, although this figure almost certainly undercounts expenditures in mental health and locally funded health services.[4] In regard to payment for health services, approximately 87% of 64 million children under 18 were covered by insurance and 13% had no insurance in 1990.[9]

Like the education system, the health system faces a new set of challenges brought on by many societal changes. Despite new medical knowledge and technology, the prospective major improvement in the health of the American public is more likely to occur because of better access to services and reduction of risky behavior rather than through further advancement in knowledge and technology.

Access to health care has become a significant problem for many American children. Less than 60% of children who are eligible for Medicaid on the basis of family income receive Medicaid services.[10] Health services costs continue to rise at a rate faster than inflation and are putting new pressure on health insurance programs. This new pressure, combined with current recessionary conditions, has led to a rise in the number of families and children with no health coverage. Since the late 1970s the number of families without health insurance rose by almost 30%.[11] At the same time, these recessionary factors are also leading to cutbacks in direct public funding of health services at the state level, further blocking low-income families from health care. Whether there is presently a net decrease in funds for children's health care in the aggregate is a complex, difficult question. Although the new expansions in Medicaid-mandated services may lead to some increased spending (see the article by Farrow and Joe in this journal issue), other factors have often led to reductions in public spending. Overall, for disadvantaged and stressed communities already thinly served, access to health care continues to be a major problem.

The growing realization of the importance of behavior to health is also putting new pressures on the health services delivery system. Reducing risky behaviors to improve health conditions calls for the skills of psychologists and social workers, who function in settings and with techniques different from those in the traditional approach, which treated individual patients who needed acute-care services. For example, providing ongoing health services to adolescents with drug abuse problems is very different than dealing with appendicitis.

These factors—rising costs, restricted access, and the need to reduce high-risk behaviors—are forcing new examination of the health delivery system, particularly in the fields of pediatrics and adolescent medicine. This interest is further driven by increasing concern about the mental and emotional health of the younger population.

Like educators, health professionals have been cautious in moving beyond their own professional boundaries to restructure the delivery of health services.

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Although during this century a variety of new structures and practices (capitation and group practice, for example) have emerged for the delivery of health care, these typically have not extended beyond the more traditional medical services.

Since 1980 the interest in school-based services has increased with the creation of programs to provide comprehensive primary care and/or specialized services directed at high-risk behavior. Such behavior includes drug abuse, sexual activity, and pregnancy among teens. Most of these recent efforts have been directed to the adolescent population, although the newest undertakings are beginning to target elementary- and middle-school children and families as well. These school-based or school-linked health services are usually organized and delivered by a wide range of external health providers—public, nonprofit, and private—rather than by the school system itself.

Social Services

The social services delivery system is even more diffuse and fragmented than the education and health systems. As this article has discussed, the social services system attempts to address a wide range of needs, including income support, child welfare, housing, and child care. Social services are financed by all levels of government—federal, state, and local. In addition, social services are purchased directly by consumers from a large number of service providers with a relatively narrow focus. Because services are delivered by an array of state and local governments and nonprofit and for-profit private agencies, consistent information about the quantity of services provided and their recipients is simply not available on a nationwide basis.

In 1989, approximately $26.8 billion of federal, state, and local funds were expended on income maintenance (such as Social Security and Aid to Families with Dependent Children) for children; most of the funds were federal.[4] For the same year expenditures for more traditional social services for children (foster care, child welfare, day care, and the like) accounted for another $5.4 billion.[4] Even these figures do not give the whole picture, because they exclude a variety of state and local government expenditures and all nonprofit and privately financed services. Federal training and housing expenditures for children amount to another $6.6 billion, but this amount does not include any state or local funds.[4] All told, funding for readily countable social services amounts to at least $38.8 billion, with significant expenditures left uncounted.[4]

There are several indications that the social services system is falling short. Child poverty is high. Today, one in five children lives in a family whose income is below the federal poverty level.[12] The current system fails to protect large numbers of children from child abuse and to provide them with child care and adequate housing. For example, the number of child-abuse reports rose 259% from 1976 to 1989, and the number of children in foster care increased in the mid- to late 1980s after significant decreases in the previous years.[13] Evidence suggests that at least 100,000 children are homeless on any given day.[14] Despite the numerous federal and state funding streams for subsidized child care, shortages exist, especially in infant care, after-school care, and child care for children with special needs.[15]

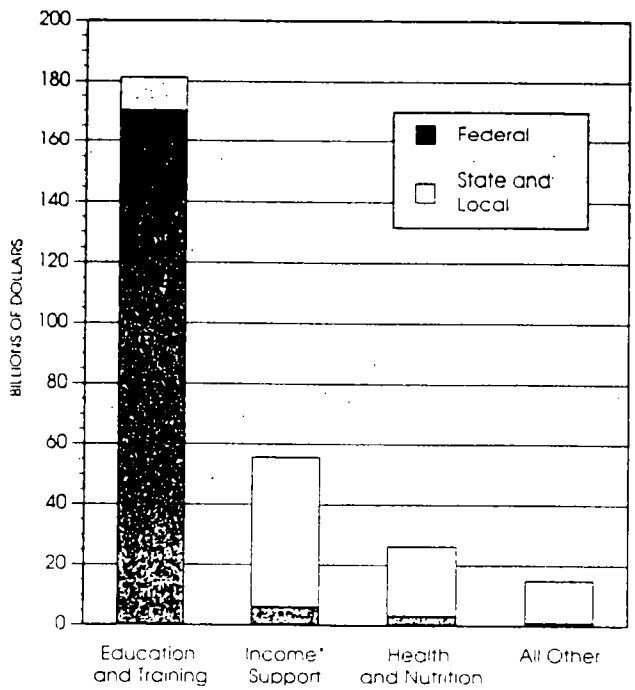
The social services system faces the same pressures—scarce resources and changing demands from the society—that plague the education and health systems. Because of the fragmentation of organizations and the diverse characteristics of professionals, social services organizations have often shown a willingness to collaborate and innovate, but their capacity to lead such innovations remains shaky in many cases.[16]

Summary

In summary, this picture of the human services delivery system for children shows a system of significant size, substantial diversity in regard to sponsorship and delivery characteristics across and within its broad categories, and a system full of professional insularity. Although close collaboration is not unknown, it is not common.

The human services system for children is an expensive system. For 1989, countable human services expenditures on behalf of children totaled $239.8 billion in federal, state, and local funds plus another $38.6 billion in tax expenditures—a total of $278.4 billion.[4] (Tax expenditures consist of favorable treatment in the tax code for certain expenditures, such as the dependent care credit.) Even this very large number leaves out considerable state, local, and private spending. (See the figure on the facing page.)

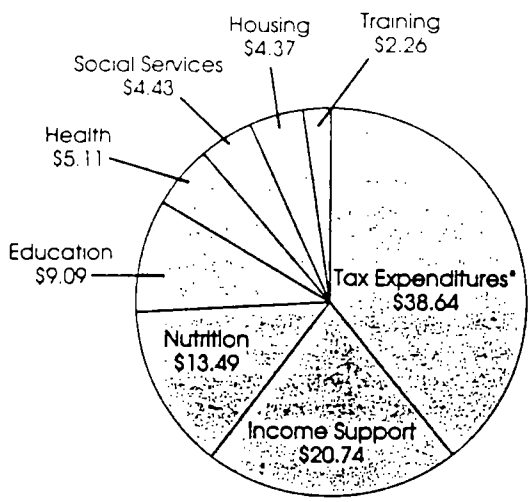
Estimated Expenditures on Children for Fiscal Year 1989



Combined Federal, State, and Local Expenditures on Children (estimated) Fiscal Year 1989

TOTAL: $278.4 BILLION

*Figure used represents combined outlay equivalents of expenditures such as AFDC, Social Security, dependent exemption, and food stamp and housing benefits, to name several.



Estimated Federal Expenditures on Children Fiscal Year 1989 ($ billions)

TOTAL: $98.13 BILLION

*Outlay equivalents for dependent exemption, earned income credit, and various tax exclusions or benefits such as disability benefits, employer health insurance, etc.

Source: Based on Table 11-1, Estimated Public Expenditures on Children, Fiscal Year 1989, in *Beyond Rhetoric, A New American Agenda for Children and Families*, The National Commission on Children, Washington, D.C., 1991, p. 315.

The system for children is also a system that is failing in many ways. Although there can be substantial debate about whether the total amount expended is enough, there is little question that the delivery system is not producing appropriate or desired results for many of the children it serves. Indeed, improved results may be the most effective route to more resources.

Problems with the Current System

The problems with the current system that contribute to poor outcomes arise from its fragmentation, specialization, and complexity. As previously discussed, the American penchant for starting one new program after another has produced a bewildering array of human services that are spread across all levels of the governmental structure and into the nonprofit and private sectors—an array that is full of gaps and inconsistencies. Although middle-income and higher-income families with a modest set of problems may make the system work well for them, problems in access and receipt of services increase in this system as income falls, family structure deteriorates, multiple problems appear, and community resources diminish. Ironically, the current system operates most poorly for those who need it most. The worse the set of problems to be dealt with and the more limited the family's personal and financial resources, the more likely it is that the system available to these families will be underfunded and disorganized.[17] This is just the opposite of how one would design a system to operate.

Further, in each of the health, education, and social services sectors, the current system is strongly skewed toward remediation rather than prevention. In health care, for example, those children whose families are poor and lack health insurance are more likely not to get preventive care and end up with serious problems in emergency rooms.[18] Problems must become acute before services are brought to bear. This, too is the reverse of the desired sequence from the standpoint of either effectiveness or cost.

Children and Families with Multiple Problems

Perhaps the greatest failure of the current system is its ineffectiveness in serving children and families with multiple problems. If the likelihood of children and families with multiple problems was low or highly concentrated, there would be less reason for concern with the present system. We do not have reliable national data about the number of children who suffer from multiple problems and what services they receive, but providers' experiences suggest that the incidence of such children is neither low nor highly concentrated. Although all children clearly do not have multiple problems on a continuing basis, the odds are significant that children will at least periodically experience problems that span the education, health, or social categories and require professional attention. The large number of these children and the frequency of multicategorical problems cause concern about the weakness of the current services delivery system to meet their needs. Further, it is evident to most practitioners and clinicians that, for these children, their parents' problems will exacerbate the children's problems. Thus, the parents' problems require attention as well.

Only a modest imagination is needed to grasp an illustrative situation of two children with school attendance and performance problems who are nutritionally deficient, medically underserved, and depressed in a single-parent family in which the mother works two jobs in a neighborhood beset with drug problems. Failure to address—preferably early—all dimensions of these problems could well result in school failure or dropping out, diminished life chances, and high societal costs for those two children.

Access Problems

Access is the first difficulty multiproblem children and their families face in obtaining the receipt of appropriate services. The barriers are both technical and physical. Each human services program has rules about whom it will serve and under what circumstances. Unfortunately, although these rules are often appropriate to a particular program, they are not consistent from one to the other in terms of who is eligible (individual, family, or household) and in what situations (in regard to income and household composition, for example). However meritorious, these eligibility rules—administered by different organizations in different locations—can constitute an enormous access problem for children and families with multiple problems and limited means.

But varying eligibility rules are only part of the problem. Access is also impeded in a family where parental time may be severely limited, transportation is a problem, or neighborhoods are unsafe and children simply cannot get to the needed services. The child without transportation may well decide not to chance a ten-block walk through a gang-dominated area to keep an appointment for special services.

Specialized Case Management

Children's access to the array of services they may need is further impeded by the current practice of specialized case management. This specialized system often means that a child receives help for his or her original presenting problem only. Services are determined by which human services port the child entered. For example, a boy with an acting-out problem who enters the juvenile justice system may get all the services the court is able to deliver, but these may meet only a small part of his overall needs. Securing a positive outcome for the child and his family may require the provider to assess needs beyond the provider's own special competence and link the child and family with other providers who can supply the needed services. Although this does occur occasionally, most providers focus only on those needs and services with which they are most familiar.

Poor Follow-up

Even if the intake and assessment are well done, the present system of follow-up is often weak or nonexistent. Outreach to ensure return visits may or may not be part of the provider's system. Follow-up on referrals, particularly those to providers beyond the normal scope of the referring provider, may be perfunctory or nonexistent; in many cases, no one ensures that the child receives the needed comprehensive services. Today, even when case management includes this outreach function, follow-up is usually oriented to a specialized particular discipline rather than to all of the needs of the child. The system assumes that the child or the child's family can find the means and the way to the other needed services. This works where the family copes well, but fails where the family does not.

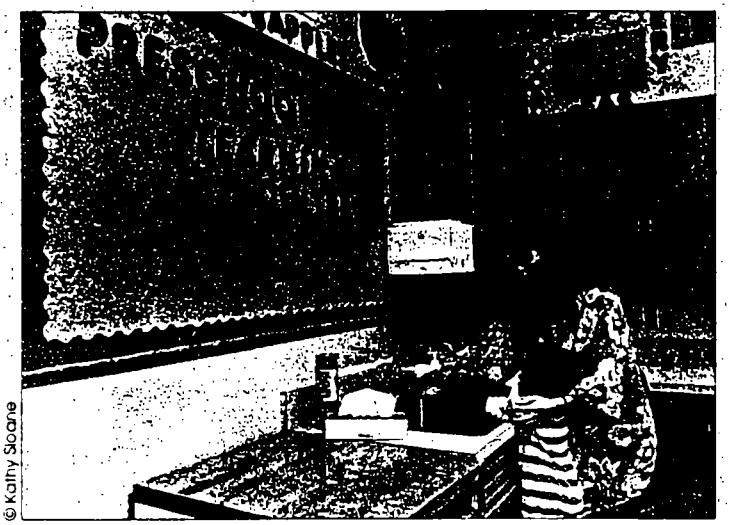
Other System Problems

The current system creates other barriers for multiproblem children and families whose needs cut across traditional institutional and professional lines. These barriers include bureaucratic rules, restrictions on information sharing, requirements of professional credentialing, and the limitations of professional cultures. Large programs, particularly public ones, often create rigid rules regarding what services are provided; who can provide them; and when, where, and how they will be provided. This occurs not only for administrative ease, but because of a desire to achieve equity by ensuring that all who apply for services are treated in the same way. Although uniformity serves some laudable objectives, it can frustrate innovations intended to improve service delivery to meet individualized needs, particularly in multiproblem cases.

Bureaucratic Rules Examples of rigid rules frustrating innovation are common and varied. School facilities cannot be used for noneducational or nonstandard purposes. Noneducational organizations cannot be located in schools to deliver noneducational services. Public funding agencies limit their grants to other public bodies and thus discourage or complicate collaborations that include nonprofit groups or other private providers. The list could go on, but suffice it to say that rule making and bureaucratic behavior in the traditional system have worked to discourage innovation to improve services for children and families with multiple problems.

Restrictions on Information Sharing With programs and their providers defined in narrow categorical terms, information sharing among related providers can become a serious problem. Confidentiality requirements can make sharing appropriate data about children among schools, health providers, and social services agencies impossible or very difficult. It is important to understand that there are confidentiality values to protect and enforce on behalf of service consumers; however, confidentiality beyond that needed to protect consumer privacy can and does become a problem when it prevents recognition of broad client needs early enough to permit sensible collaboration. For further discussion of confidentiality issues, see the article by Gardner, and Appendix A in this journal issue.

Professional Credentialing Requirements In the current fragmented system, required credentials and professional cultures can hamper or at least raise the cost of delivering effective human services to children and families with multiple needs.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Staffing patterns are often so rigidly specified that bringing services together across broad functional categories is very difficult or expensive. For example, health service centers on school campuses may face considerable difficulty getting certified for reimbursement from public or private health insurance programs because the centers cannot meet the programs' strict staffing requirements. These same credentialing requirements can also narrow professional knowledge and experience to a particular specialty and impede the program's effectiveness.

Professional Culture Limitations Finally, professional cultures, including professional language, is likely to impede integration of services to consumers with multiple needs. This situation is worsened by negative, stereotypical attitudes that some professionals have about those in other parts of the human services delivery system. The results can be deadly, whether dealing with a child in need or the initiation of a collaboration to improve and integrate service delivery (when someone says, for example, "Let's get together and fix the schools!").

Possible Solutions Through Integrated Services

In response to the rising alarm about the education and life-readiness outcomes of children and the problems of the current system in serving children with multiple needs, the number of options is limited. Three broad approaches are theoretically possible. One approach is to radically restructure human services legislation at the federal and state levels so that organization and funding are wholly reformed and consolidated. However, the size and political difficulty of reform on this scale would deter all but a few from the strategy. Even for the few attracted to this approach, the lack of evidence that it will succeed or improve upon the current system makes this approach difficult to sell even on the merits.

Second, existing categorical and targeted programs can be expanded without attention to their interrelationship. This is a popular strategy, even though there is not much evidence that the components of the current system are performing well enough to merit expansion, despite considerable effort over the past two decades to build on them. The overall goal of the current system—that children, particularly children at risk, grow to adulthood able to cope effectively and productively with the world around them—remains elusive. Since this disappointing performance is often attributed to system failure in dealing with children with multiple needs, simply expanding on the current system is not an appealing strategy.

The third approach lies in reorganizing the current tripartite system through a strategy of linking or integrating health, education, and social services. The goals of this approach are to address the weaknesses of the existing system and develop a capacity (1) to emphasize prevention,

Simply expanding on the current system is not an appealing strategy.

(2) to deal with children and families holistically and promptly, and (3) to manage effectively children with multiple needs that cross professional and programmatic categories. This strategy seeks to reform rather than replace the existing system. It is a more practical, but no less fundamental or far-reaching approach to achieve change. It could well lead at a later time to legislative restructuring and more resources, but more likely on an incremental basis predicated on demonstrated needs and improvements.

Redefining Service Integration

It is this third approach that is receiving the most attention today. Understanding the approach is easier when key terms such as *service integration* and *collaboration* are defined. In this approach, *service integration*

means far more than a consumer information and referral function provided by one human service provider about the kind and location of other human services. There is not much evidence that this level of intervention, though no doubt useful for some, has had a significant impact on outcomes or services received for at-risk populations. Service integration today implies a more intensive intervention in the assessment of a student's needs and actual provision or management of services.

Further, the term *service integration*, as used in this approach, does not imply a specific model of service delivery (see the articles by Gardner, by Jehl and Kirst, and by Levy and Shepardson in this journal issue). The variety of models now being undertaken vary in the composition of education, health, and social services delivered; the intensity of services and mode of delivery; the skill and quantity of staff; and the definition of the target group. Considerable empirical research is still needed to determine whether there is a single or, more likely, a collection of service integration models that can provide improved or effective delivery of human services.

Finally, in this third approach, the term *collaboration* is used to describe efforts that go beyond mere conversation or information sharing; the term encompasses concerted action among committed partners. Collaboration requires the blending of provider disciplines and usually involves several organizations working together in a unified structure. These collaborations provide information and referral services; they provide an integrated collection of primary human services to both child and family in a way that addresses the whole family and its multiple problems and needs. The collaborations seek to strengthen or, where needed, supplement the family's ability to assess and meet the education, health, and social services needs of their child.

There has been strong interest in this linking, or integration, strategy at the national, state, and local levels (see the discussion by Gerry and Certo in this journal issue). Although state and federal authorities can and should play critical roles in exploration or implementation of the strategy, the decentralized nature of the current system will also require local initiative for tangible experimentation with this strategy. Such local experimentation has been occurring (see the Levy and Shepardson article in this journal issue).

Schools as an Important Link

The collaborations that have emerged in recent times usually, but not always, involve the school system and are often, but not always, school-based in location. Health and/or social services providers may be involved to varying degrees, but school districts are almost always involved. This fact raises special questions about school involvement and leads to a debate about whether school participation in collaborations to integrate services is appropriate and needed or is, rather, an inappropriate diversion of school energies and resources from the primary educational mission.

If the goal of the service collaboration is to include in the target group school-age children with multiple needs, the case for some school involvement becomes strong if not overwhelming on several grounds. The importance of nonschool problems to educational success (as well as the importance of educational success to improved life chances) underscores the need for some school involvement in the collaboration. Further, the schools are where the children are in a community, and there may be few, if any, alternative places central to a community where sufficient space or community trust is available. Finally, the schools often provide a much needed outreach network to the community to be served which cannot be matched by other institutions.

If the goal of the service collaboration is to include in the target group school-age children with multiple needs, the case for some school involvement becomes strong if not overwhelming . . .

Nonetheless, collaborations involving schools may raise controversy. On the one hand, involvement in a collaboration will require effort and energy by school administrators and faculty to participate and become knowledgeable about the services to be offered and how the educational component can be strengthened by collaboration. These are true costs to the education system. On the other hand, the schools are already affected by the consequences of noneducation problems among students

and their families, and they often find themselves forced to deal with noneducation problems with few resources and little expertise. The potential educational benefits from a collaboration that deals effectively with students' noneducation problems are often seen as large. This issue continues to be discussed in policy circles, though school personnel in many communities with substantial numbers of at-risk children and families see strong merit in effective programs to provide comprehensive services.[19]

Current Efforts and Historical Precedents

Today's efforts at integrated services through the schools differ from past efforts in several ways. The persons who are advocating this approach, the motivations that seem to be at work, and the kind of collaborations being planned or undertaken are arguably different from those of the past.

Earlier reforms came from outside the human services system. They grew out of professional and sometimes societal convictions that the school system should add increments of health and social services to school offerings to fill unmet deficits among disadvantaged populations, often new immigrants. Today, the institutions and leadership expressing interest in collaborations to integrate services are more diverse. Political leaders at all levels of government, particularly the governors, have called for exploration or adoption of human services collaborations. The statement about education improvement and reform goals issued by the President and the governors in the fall of 1989 is a case in point.[20] The employer community, alarmed about the quality of new entrants to the work force and the potential societal cost of the ill prepared and left out, also urges collaboration and integration.

Perhaps more important, the current impetus for collaborations comes increasingly from inside the system—from the professional human services providers who are responsible for mainline education, health, and social services.[16] Rather than resist new approaches to integrated service delivery—a stance that was common in the past—some frontline professionals and leaders of institutions in the provider community have become the instigators and advocates.[16] The importance of this support is hard to overestimate. It appears to come as much from a fundamental conviction that the present system is failing as it does from the conviction that service-integrating collaborations are an innovative, promising alternative.

The motivations that underlie the interest in school-linked services have shifted from the earlier focus, which involved adding increments of services to functioning school institutions to plug perceived deficits for disadvantaged or newly arrived citizens. Today, the primary goal cited is restructuring the delivery of education, health, and social services to make institutions better at producing a productive and independent citizenry in an environment of substantial societal change and increasingly demanding economic competition. The rhetoric for change refers to the perceived failures of the present human services delivery system to intervene early and broadly enough to ensure that children overcome deteriorating or stressed families and communities and reach adulthood with a capacity to meet rising workplace and societal demands. Different rationales support today's collaborations: the adverse effects of noneducation problems on academic performance, the adverse impact of poor education performance on individual and national economic success, and the high cost of delayed interventions and public dependency resulting from education, health, or social deficits.

Another important difference between some past efforts and current school-linked services efforts lies in the character of the new collaborations. The more recent collaborations do not seek to ask schools to assume managerial and full budgetary authority for a growing list of noneducation services. Rather, the new approaches attempt to draw schools in as equal partners with health and social services agencies that bring their own resources to the table. No less demanding or difficult to achieve, the new collaborations do not seek to persuade schools to become involved in health and social services issues or to lure them with short-term discretionary funds.

The current impetus for collaborations comes increasingly from inside the system . . .

Conclusions

The historic tripartite human services delivery system with its dependence upon effective family functioning for successful utilization of needed services no longer meets the needs of an increasing number of children and families. Changed demographics, growing poverty, more people with multiple problems, and a rising demand for competence to survive or cope in society bring pressure for accommodation in the historic delivery system. Neither more of the same nor wholesale restructuring of the system are strategies that can meet existing political or financial constraints. School-linked service integration represents an available if difficult strategy which provides a promising alternative worthy of careful and thorough exploration.

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Learning from Denver Family Resource Schools:

The Model and the Process

by Lucy Trujillo

The Model

The seven Denver Family Resource Schools (FRS) operate from the premise that children are likelier to succeed in school with a strong family and community supporting them. Unfortunately, many families and communities, particularly in urban areas, cannot by themselves provide the essential foundation for effective schooling. For this reason, Denver's Family Resource Schools focus on building the relationship between schools and communities and on strengthening the capacity of families and communities to support children's learning.

The Family Resource Schools provide the traditional, student-focused, academic support programs and non-traditional family-focused programs—like employment workshops, adult education, parenting classes, peer support groups and tutoring programs that involve parent participation. They aim to increase students' academic achievement through enriching the academic program and removing noneducational barriers to learning.

All Family Resource Schools have expanded their hours of operation, have developed summer programs, and have increased parent and community involvement. They also offer childcare.

Each school has a Collaborative Decision Making team (CDM) that makes all programming decisions. Each CDM includes representatives from the school (teachers, office, custodial, food service, principal), families, neighborhood, and businesses. They reach all decisions by consensus.

Although each CDM decides on its school's final program, the CDMs from all seven Family Resource Schools (FRS) have agreed to concentrate on the following five program areas in order to achieve their mission:

1. Student achievement and growth
2. Adult education and skill-building
3. Parent education
4. Family support services
5. Staff development and training

Actual programs and activities vary from school to school. One school coordinates family nights at the Denver Art Museum and Colorado Symphony; another implements a Family Math program; and yet another has cleared a piece of school land for a community garden. Each school feels pride in its accomplishments! And families are involved at every level from planning to execution of each activity.

Each school has an FRS site coordinator who works under the direct supervision of the principal. The site-coordinator implements and manages FRS programs and coordinates school, parent, and community outreach. The site coordinator functions as case manager, fundraiser, translator, instructor, clerk, financial manager, broker of resources, appointment scheduler, chauffeur, volunteer coordinator, and much, much more!

Project Development

Planning for the Family Resource Schools project began in the fall of 1989. It relied on both research ("Schools of the 21st Century" by Dr. Edward Ziegler, Yale University) and a successful school project already underway in Denver where one elementary school had been experimenting with site-based management and community partnerships for the delivery of services.

Representatives from the Denver Public Schools, the Mayor's Office, community organizations, and foundations worked together on the project planning team. In addition to drafting the concept paper and establishing the proposal process, the planning team borrowed a local corporate executive to develop fundraising strategies. They sent the request for proposals to all Denver public elementary school principals. Elementary schools were the focus for two reasons: first, all available research indicates that early efforts to improve children's lives pay greater dividends; second, elementary schools have close ties to neighborhoods and are within walking distance of the homes of most neighborhood residents. Thus community building efforts based at elementary schools are likelier to succeed.

The Denver planning team offered each school:

- Technical assistance to develop a plan to become a Family Resource School
- Assistance in negotiating collaborations with other agencies to bring additional services into the school
- Assistance in securing outside funding for new activities.

Copy the Process, Not the Model

Patricia Carpio, FRS Project Director, warns educators in other cities: "Don't take a program that has already been designed and just plop it down in front of staff and community. They might say "OK". But they won't have internalized the commitment it takes to make the program work. And that program might not be what they need." Instead, Carpio says," Copy the process.

"Start by creating a climate that is free of blame." Carpio suggests. "Too often, when children aren't learning what they need to learn, principals blame teachers, teachers blame parents, parents blame the school. Rather than look for someone to blame, they all need to prepare to make

changes—even drastic changes—that will improve the children's education. To work together, principals, teachers, and parents must assume each other's commitment to their common goal."

"Get a commitment to change from a group, even if it is a small group. The group needs to be representative of the community so its actions can have a ripple effect. It also needs to set its own direction so it has an investment in the process."

"Then design the programs, the means of change. Remember it requires no blame and a lot of determination."

The Role of the Principal

The principal of a school is a key person in the effort to bring a family-focused program to the school. Only minimal progress will be made unless the principal commits his/her support to the program. *Ultimately*, within the school system, the principal still is accountable for the safety and academic progress of the children. In addition, the principal continues to evaluate staff and meet with parents when conflicts arise.

The new program's planning and decisionmaking process requires that the principal share power with teachers and with parents. As a result, the principal's role becomes more problematic. Teachers or parents may challenge some of the principal's functions and the principal may feel threatened by some of their suggestions. All parties need to understand that the program cannot succeed unless the principal feels comfortable with it. A Family Resource School does not have to implement every new idea, but it must listen to new voices and new ideas.

The principal also serves a vital role in freeing up teachers to participate in meetings, training sessions, and special events while ensuring that the children do not suffer from the teachers' frequent classroom absences. On the other hand, as resources for a school are leveraged and children have many more opportunities to participate in many more excursions and special activities during the regular school day, teachers' classroom goals and objectives may suffer. The principal must create the proper balance for both staff and children.

The principal is also key in getting staff "buy-in." A Family Resource School experiences more nontraditional teacher-parent interaction (many parents drop in as casual classroom observers or volunteers) and increased work for office and custodial staff (busier phones, increased number of parents seeking assistance, more evening events requiring late night cleaning shifts). If these work demands irritate staff members and evoke a hostile response from them, the school environment will not be family-friendly. The principal can help prepare the staff for the changes and identify ways to handle the increased workload.

Parent Outreach

Parents also play a key role in implementation. If they don't participate, "family" is missing from the Family Resource School. When asked how she gets parents to participate in school functions, FRS site coordinator Tep Falcon says, "I remember back to my campaigning days. I was told a voter must see or hear the name of a candidate 28 times before they will remember it. It's the same with our activities: you can't just send a flyer home with a child two weeks before the event and expect family participation. You have to send the flyers, but you must also make phone calls, send reminders, make personal visits, get the children interested to let them know you want them there. That they are special. That they will be missed if they can't attend. There also has to be time for socializing and celebrating successes. All work and no play will definitely keep parents away."

Project Implementation

Successful implementation has a bottom line. No matter how good or how poor the model, key people have to want it to work and they have to be willing to put in a lot of 16-hour days.

Every person in the Family Resource School is vital to its success. It comes down to people: people who share a vision and are willing to put in the time, people who have high expectations but recognize the importance of celebrating small successes, and people willing to work *together* as a team to make a difference for children.

For more information, contact Lucy Trujillo, project coordinator, Family Resource Schools, 975 Grant Street, Denver, CO, 80203 303/764-3587.

Core Components of the Family Resource Schools

Student Achievement and Growth:
Before-and after-school programs including:

- Community study halls with volunteer tutors
- Family read-alongs and family math classes
- Swimming lessons
- Guitar classes
- Community garden
- Cultural activities with the Denver Art Museum

Adult Education and Skill Building:
- Adult Basic Education (ABE)
- General Equivalency Diploma (GED)
- English as a Second Language (ESL)
- Spanish as a Second Language
- Conflict management
- Employment workshops
- Housing workshops for first-time buyers
- Weight Wise—health and nutrition programs

Parent Education:
- MELD program (Peer support group for young mothers)
- Weekly parent training programs
- Positive discipline workshops
- Sex education workshops
- Gang prevention workshops

Family Support Services:
- On-site case management
- Alcohol and drug prevention programs
- Before- and after-school childcare
- Childcare for all school programs and activities
- Baby-sitting co-ops
- Food and clothing banks
- Mental health services
- Women's support groups

Staff Development and Training:
- FRS orientation concept and philosophy
- The school community
- Parental involvement
- The culture of poverty
- Building teams
- Community resources
- Making referrals

EVALUATION FORM
Danforth Policymakers' Program
Legislative Staff Seminar
January 19-22, 1995

Please help the cosponsoring organizations evaluate this forum by completing this evaluation form. By all means feel free to use additional sheets of paper in responding. Thanks for your help.

1. **Meeting Objectives.** To what extent do you think the meeting achieved its objectives? Please circle the number which best expresses your opinion. (1 = Excellent, 2 = Good, 3 = Average, 4 = Only Fair, 5 = Very Poor)

Overall Objective	**Rating**				
a. To help policymakers design state policy that will ensure that all children and youth succeed as healthy, productive citizens and learners - in school and beyond.	1	2	3	4	5
Specific Objectives	**Rating**				
a. To stimulate dialogue between education and human service policymakers and governors about changing systems that serve children.	1	2	3	4	5
b. To move our discussion from exploring the need for collaboration, to a discussion about using collaboration for systems change.	1	2	3	4	5
c. To explore new developments in the research and practice of comprehensive services to support all children.	1	2	3	4	5
d. To bring together governors/governors' staff and state legislators chairing education and human service committees to discuss their roles in implementing a statewide strategy for improved results for all children.	1	2	3	4	5
e. To provide opportunities for states to share experiences, difficulties, and accomplishments in implementing system reform.	1	2	3	4	5

2. **Issues.** To what extent were the issues addressed in the meeting timely and important?

_____

_____

_____

_____

3. **Issues.** What issues did we miss that were equally or more important than those addressed?

_____

_____

_____

_____

(Over)

4. **Utility**. What are you leaving the forum with in terms of new ideas, connections, motivations, plans, etc.? What do you expect to do back home as a result of this experience?

5. **Additional Considerations**. What do you think we should do differently for future meetings "of this type"? What other suggestions do you have to help the sponsors plan future meetings?

6. **The Policymakers' Program**. What changes, if any, would you recommend be made in the way the program has been designed?

7. **Overall Evaluation of the Forum**. Please circle the number which best expresses your opinion. (1 = Excellent, 2 = Good, 3 = Average, 4 = Only Fair, 5 = Very Poor)

Forum Elements	**Rating**				
a. Forum Planning	1	2	3	4	5
b. Forum objectives met	1	2	3	4	5
c. Value of information presented/discussed	1	2	3	4	5
d. Overall meeting logistics	1	2	3	4	5
e. Balance of meeting process (discussions, presentations, etc.)	1	2	3	4	5
f. Opportunity to participate in discussion	1	2	3	4	5
g. Overall forum rating	1	2	3	4	5

8. **Other Comments**.