System Implementation
Issue Brief #2 Lessons from Successful Systems

Sharon Hodges, Ph.D., Nathaniel Israel, Ph.D., Kathleen Ferreira, M.S.E., & Jessica Mazza, B.A.

February 2007

Critical Factors in System of Care Implementation

There is not a checklist of interagency agreements, governance structures, funding mechanisms, or service modalities that will dependably yield a system of care—even when these strategies are put into place with commitment and care. Family and youth engagement and cultural competence will support and help sustain system implementation, but do not guarantee it. As a field, we know that systems of care positively affect the structure, organization, and availability of services (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Rosenblatt, 1998; Stroul, 1993), but there is still much to learn about what factors are critical in bringing about system change and how these factors interact to establish well-functioning systems. Because systems of care are not implemented with inevitability, predictability, and consistency, it is important that we understand what factors are critical in their planning, implementation, and sustainability (Hernandez & Hodges, 2003).

Systems of care are distinguished by their ability to provide access and availability of appropriate services and supports as well as effective practices in keeping with values and principles that embrace individualized, culturally competent, family-driven care in the least restrictive setting (Hodges, Ferreira, Israel, & Mazza, 2007). Findings from *Case Studies of System Implementation* provide insight into critical factors in system implementation from the perspectives of local system stakeholders. Systems participating in *Case Studies of System Implementation* include the following systems of care: the State of Hawaii (HI); Placer County, CA (PC); Region 3 Behavioral Health Services, NE (R3); and Santa Cruz County, CA (SC).

This issue brief will present cross-site patterns of system implementation. These patterns emerged from the analysis of locally identified implementation factors that stakeholders considered critical to system of care development. In each of the four participating systems, local implementation factors were identified and defined by a small group of key system stakeholders and validated by a broader group of system stakeholders. A total of 41 implementation factors were identified, and the research team grouped these factors into four categories according to their primary role in leveraging system change: Values and Beliefs Factors, Goals Factors, Structures Factors, and Information Factors. This cross-site analysis of factors is grounded in literature related to complexity theory (Capra, 2002; Holland, 1995) and system development (Checkland, 1993; Meadows, 1999). In particular, concepts related to leveraging system change were informed by Meadows (1999, n.d.). A complete list of locally identified system implementation factors and definitions is available at http://rtckids.fmhi.usf.edu/cssi/.

Lessons Learned from Established Systems of Care

Lesson 1
VB →
Values and Beliefs Shift the Mindset of the System

Findings from this study indicate that a critical feature of system implementation involves establishing a shared stakeholder understanding from which the system is developed. Key stakeholders used implementation strategies related to Values and Beliefs (VB) to leverage change in the philosophy and the fundamental beliefs of other system stakeholders. Cross-system analysis indicates that factors related to the values and beliefs of system stakeholders incorporate three important characteristics:

1. Shared stakeholder values and beliefs that aligning service planning and delivery strategies with system of care principles will result in benefit to children and their families.

Study 2

Case Studies of System Implementation is a five-year national study of strategies that local communities undertake to implement community-based systems of care. The purpose of the study is to understand how factors affecting system implementation contribute to the development of local systems of care for children with serious emotional disturbance and their families.

Methods

This study uses a multi-site embedded case study design. Participating systems were identified through a national nomination process and were selected on the basis of having: (1) an identified local population(s) of youth with serious emotional disturbance; (2) clearly identified goals for this population that are consistent with system-of-care values and principles; (3) active implementation of strategies to achieve these goals; (4) outcome information demonstrating progress toward these goals; and (5) demonstrated sustainability over time.

Data collection includes semi-structured key informant interviews, document review, site-based observation, and documented aggregate outcome data related to system implementation in communities with established service systems. Analysis uses an intensive and iterative team-based approach. The study will include a total of eight cases.

NiDRR

USF UNIVERSITY OF SOUTH FLORIDA

Research & Training Center for Children's Mental Health

Sharon Hodges, Ph.D., M.B.A. • hodges@fmhi.usf.edu
Department of Child & Family Studies • Louis de la Parte Florida Mental Health Institute
University of South Florida • 13301 Bruce B. Downs Blvd. • Tampa • Florida • 33612-3807

2. Shared stakeholder values and beliefs that trust, commitment, and shared responsibility across system stakeholders is critical to system functioning.

3. Shared stakeholder belief that change is possible and that responsiveness and commitment to change makes it possible to transcend the initial fragmented conditions of service delivery.

Interview and observation data indicate that shared values and beliefs extend beyond the mental health service system to child welfare, juvenile probation, and education service sectors. In addition, commitment to system of care values and principles has permeated community-based organizations and private providers. Implementation factors associated with Values and Beliefs have great power for change because they have the potential to guide all other actions taken within the system. Cross-site data indicate that system implementers were strategic in their early and consistent emphasis on creating wide exposure to the values and beliefs of their system of care. The data indicate that the emphasis on values and beliefs factors provided a significant anchor for sustaining the difficult and complex work of system development.

"Core system principles keep system participants moving in a coherent direction while allowing creativity of action in the pursuit of broad goals."
—(HI)

Lesson 2
G → A
Goals Enable Action

System Goals (G) make stakeholder values and beliefs concrete, and they orient system activity toward specific **actions** (A) directly related to system implementation. Cross-site analyses indicate that as system of care values and beliefs begin to permeate the system, stakeholders set in motion the use of goals-related factors to establish shared expectations and intended outcomes for system change.

Data indicate that shared broad-level system goals serve to focus system partners on shared actions. Participating systems had in common three types of goals related to system implementation: (1) outcome goals such as the reduction of out-of-home placement; (2) process goals such as increasing culturally competent and individualized care; and (3) planning goals related to strategic action. These broad-level system goals were intended to bring systems under the influence of a single plan grounded in system of care values and principles and were used to set agreed-upon targets for action across system partners. Stakeholder use of goal-related factors also supports changes in how systems respond or adapt to their environment. For example, factors such as Santa Cruz's Cross-System Expertise and Region 3's focus on Collaboration both support the creation of innovative services and supports and interagency case management that are able to directly respond to community need.

The goal of collaboration is that partners will "leverage, share and maximize resources and also share responsibility and accountability."
—(R3)

Finally, goal-related implementation factors enable action by helping system stakeholders define a system's scope and boundaries. For example, Hawaii's articulation of *Core System Practices* provides both explicit and implicit rules about interagency boundaries and appropriate day-to-day action. This is not to say that the scope and boundaries

of systems are fixed over time. Each of the participating systems showed evidence that their goals were allowed to evolve over time and within the broad framework provided by system values and beliefs. This was considered critical because it allows for both system adaptation in response to changing community needs and system expansion to meet the needs of broader populations of children and families as stakeholders develop the system over time.

Lesson 3
→ Sc
Collaborative Structures Support Local System of Care Implementation

Structural changes are those related to specified roles, responsibilities, and authorities that enable a system to perform its functions. Data confirm that all participating sites developed local **Collaborative Structures** (Sc) to support system implementation. These included:

1. changes in the physical arrangement of services such as the co-location of cross-agency staff;

2. changes in the structures and budgetary authorities that facilitate interagency decision making regarding service eligibility and placement;

3. creation of infrastructure that facilitates transition across service environments such as home and school as well as transitions to varying levels of services.

Structural change is difficult because of territorial thinking, language, fears of incompetence, fear of change, fear of loss of identity (professional identity)… it "has taken a long time, but great progress has been made."
—(PC)

Data indicate that collaborative structures were used by stakeholders to moderate the impact of existing rules and regulations so that the system response was more aligned with system of care values and principles. An important finding regarding structural change is that it supports system implementation only to the degree that these changes are anchored in widely held values and beliefs. All indications are that structural change must have strong local grounding in the vision and mission of systems of care in order to facilitate or sustain the positive impact that system implementers intend.

Lesson 4
System Information
Information Facilitates System Responsiveness

System Information includes the content, structure, and flow of system feedback and uses both formal and informal information mechanisms to accomplish system change. Providing structure and flow of system information across stakeholder groups reinforces system values and beliefs and expands the knowledge of system participants. In addition, the content of system feedback must be both timely and relevant to issues of system performance in order to support the flexibility and responsiveness of stakeholder decision making.

Cross-site data indicate that the structure and availability of information were strategically designed to support system development and reach specific agreed-upon goals. The form and format of information exchanged included the formal review of system information at regular meetings, everyday conversations arising from co-location, and team-based clinical work involving partners from multiple systems. It is important to note that these systems worked to facilitate direct contact between line workers, supervisors, and senior administrators. This flat-

tened the communication hierarchy and allowed stakeholders to make rapid decisions about how to allocate resources and how to act strategically to reach system goals regarding services and supports for children and families.

Across systems, stakeholders were clear on the intent of their system activities and used information about system performance to shape the direction of system development. For each system, the structure and availability of system information created an informed responsiveness to local conditions. This allowed stakeholders to take action in response to local need and to make system adaptations as local conditions or concerns changed.

"Good evaluation staff with vision for how [evaluation] fits into the system of care."
—(NE)

Local System Implementation

Taken individually, the lessons learned describe critical strategies used in system of care implementation. It is important to consider how these strategies fit together in the process of system implementation. The concept of a system suggests that a set of elements can come together to form a whole that has different properties that those of the individual component parts (Checkland, 1999; Meadows, 1999). In the process of system implementation, Values and Beliefs (VB) are essential to initiating the process of system change and impact the development of Goals (G). Shared values and goals, however, are insufficient to implement or sustain system change. Stakeholder Action (A) is pivotal to system change because it is only when system partners take action that values and goals become meaningful. Otherwise, the system of care exists only as an expression of intent.

Study participants report that in each system there was a point in time when local stakeholders recognized that the traditional system structures were inadequate for achieving the goals of family-driven, culturally competent, community-based care. This recognition took shape differently across communities. In Hawaii, this played out in the form of a court-ordered mandate to implement systems of care; in Placer County, a Juvenile Court judge brought agencies together; participation in the development of statewide system of care legislation brought Santa Cruz stakeholders together; and in Region 3, reading the original system of care monograph (Stroul & Friedman, 1986) inspired change. In each system, stakeholders decided not to accept the traditional system structure as given. They took action anchored in their values to intervene strategically in the structure, processes and relationships of the traditional system and modify its impact.

A key finding across these systems is that collaborative structures (S_C) were created as a way of institutionalizing and supporting the value-based system activity (Figure 1). Some of these structures, such as state and county agreements for co-location of staff and interagency agreements to share the burden of budget cuts, were newly generated. Others, such as Medicaid waivers and mechanisms for flexible funding, were modifications of existing structures. These collaborative structures were in direct support of system of care values and beliefs. System information, both formal and informal, became the key mechanism for facilitating system implementation activities related to values and beliefs, goals, and structures (VB, G, and S_C). Each was undertaken in response to local context, and each interceded differently in the traditional structure-

driven system. Factors related to system information enabled system change by monitoring system performance and providing feedback that let stakeholders know how well system values and beliefs were being translated into meaningful action.

Figure 1
Local System Implementation
Values and Beliefs Support Collaborative Structures
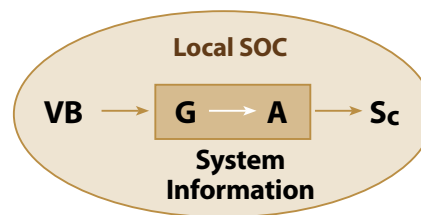

Figure 1 illustrates the relationship among factors that stimulate the process of local system implementation. Values and beliefs (VB) are essential to shifting the mindset of system stakeholders and redirecting their goals and associated actions toward system of care development. Collaborative structures (S_C) emerge from this process to support the developing system of care. The flow of system information allows stakeholders to respond knowledgably as the system evolves.

Results of System Implementation: The Structures–Values Shift

How does system implementation moderate traditional service delivery outcomes? Stakeholders described their initial system conditions as driven by federal and state regulatory structures. They described the traditional outcomes as prescribed and enforced by criteria that restrict eligibility, range of services, and funding. The values and goals implicit in the traditional structures were rarely explicit but often rewarded service rationing, restrictive placements, and professional-driven care over family-driven, culturally competent and community-based care. In each system, stakeholders began system development with actions designed to interrupt the traditional system functioning that led to high rates of out-of-community placements in restrictive settings.

The net effect of system of care implementation was a shift away from the traditional structure-driven outcomes to outcomes that were directed by explicit values and beliefs. Over time and in response to system feedback, stakeholders were able to produce outcomes more in keeping with expressed system of care values (O_{SOC}) such as individualized, family-driven, culturally competent care (Figure 2). Examples of this shift to value-based system outcomes abound. Placer County stakeholders strategically interrupted their cycle of group home placements by providing home-based and wraparound care. Savings from the reduction of more restrictive placements enabled the expansion of day reporting and other community-based services for troubled youth. Hawaii stakeholders interrupted the cycle of out-of-state placements and redirected resources to the development of community-based care by building local case management services and evidence-based practices. Region 3 Behavioral Health Services in Nebraska created the Professional Partner Program, an intensive therapeutic care management program that uses the wraparound approach in coordination with family teams. Outcomes demon-

demonstrated in included a reduction in out-of-home placements and juvenile crime as well as improvement in school performance and attendance. It also reduced the number of children and youth who were being made state wards simply to gain access to services. Santa Cruz stakeholders interrupted the cycle of office-based services by moving most of their service delivery time into the community. This shift has supported the growth of a community-based system that extends beyond agency partners to engage families and community-based providers.
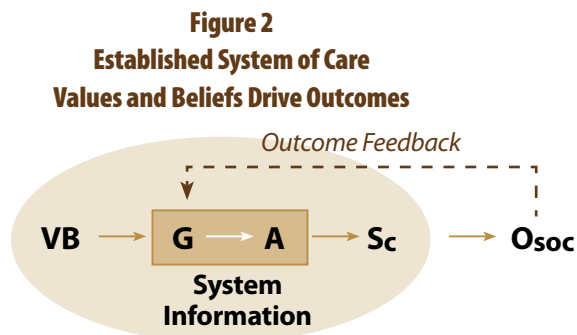
Figure 2
Established System of Care
Values and Beliefs Drive Outcomes

Outcome Feedback

VB → G → A → S$_c$ → O$_{SOC}$

System Information

Figure 2 illustrates the relationship between system of care outcomes (O$_{SOC}$) and the system's stated goals (G). The availability of outcome information provides ongoing feedback to system stakeholders and supports their ability to adjust system goals (G) and actions (A).

The real world experience of value-driven outcomes was not as neat or bounded as Figure 2 suggests. Value-based actions taken by stakeholders varied according to local need and local context. In each system, implementation activities were uneven rather than stepwise and took shape as opportunity was seized. The critical common thread, however, is that these actions were planned and carried out collaboratively, rather than initiated and implemented by a single agency. Data from this study indicate that the power of this collaborative action created a significant shift in how the systems produced outcomes and what outcomes were produced.

Conclusion

The systems of care described in this study were not implemented in a predictable, step-wise approach. Even so, the core components of system implementation that were considered critical by local stakeholders were remarkably similar across sites, as was the move from values, to goals and actions, and to the creation of collaborative structures that addressed issues and challenges of local system context. Given inherent differences in local contexts across the United States, how can system planners and implementers use these lessons learned to maximize the results of system change? The stakeholders' use of critical implementation factors suggests the following broad guidelines:

1. Create an early and consistent focus on values and beliefs. The emphasis on Values and Beliefs factors provides a significant anchor for system development regardless of the challenges faced.

2. Translate shared beliefs into shared responsibility and shared action. Most importantly, share a commitment that things really can be done differently and that local stakeholders can be empowered to make change.

3. Recognize that opportunities for action are not linear. Take advantage of opportunities to leverage system change when and where they occur.

4. Know that being concrete does not mean being static. Being concrete about values and strategic about action allows stakeholders to be flexible in system response and proactive in system development.

5. Be aware that structural change, without a solid anchor in values and beliefs, rarely has the sustained positive impact that system of care implementers seek.

6. Remember that the system emerges from the choices and actions of stakeholders throughout the system, including family members, front-line staff, and community partners.

References

Capra, F. (2002). *The hidden connections: Integrating the biological, cognitive, and social dimensions of life into a science of sustainability.* New York: Doubleday.

Checkland, P. (1993). *Systems thinking, systems practice.* Chichester: John Wiley & Sons, LTD.

Hernandez, M. & Hodges, S. (2003). Building Upon Theory of Change for Systems of Care. *Journal of Emotional and Behavioral Disorders, 11*(1), 19-26.

Hoagwood, K., Burns, B., Kiser, L., Ringeisen, H., & Schoenwald, S. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52*(9), 1179-1184.

Hodges, S., Ferreira, K., Israel, N., & Mazza, J. (2007). *System implementation issue brief #1—Lessons from successful systems: System of care definition.* Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Holland, J. H. (1995). *Hidden order: How adaptation builds complexity.* Reading, MA: Helix Books.

Meadows, D. (1999). *Leverage points: Places to intervene in a system.* Retrieved February 21, 2007, from http://www.sustainability-institute.org/pubs/Leverage_Points.pdf

Meadows, D. (n.d.). *Dancing with systems.* Retrieved February 21, 2007, from http://www.sustainabilityinstitute.org/pubs/Dancing.html

Rosenblatt, A. (1998). Assessing the child and family outcomes of systems of care for youth with serious emotional disturbance. In M. Epstein, K. Kutash & A. Duchnowski (Eds.), *Outcomes for children and youth with behavioral and emotional disorders and their families* (pp. 329-362). Austin, TX: PRO-ED.

Stroul, B. A. (1993). *Systems of care for children and adolescents with severe emotional disturbances: What are the results?* Washington, DC: Georgetown University Child Development Center.

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