



Maine Department of Health and Human Services

Office of Child and Family Services

Children's Behavioral Health Services Assessment Internal Operations Final Report

December 18, 2018

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I. PROJECT OVERVIEW

The Maine Department of Health and Human Services (DHHS) contracted with Public Consulting Group (PCG) to conduct an assessment of Children's Behavioral Health Services (CBHS) in Maine, which is overseen by the Office of Child and Family Services (OCFS). This assessment includes examination of the Office's internal operations including staff roles, responsibilities and business processes.

"Maine Children's Behavioral Health Services (CBHS) focuses on behavioral health treatment and services for children from birth up to their 21st birthday. Services include providing information and assistance with referrals for children and youth with developmental disabilities/delays, intellectual disability, Autism Spectrum Disorders and mental health disorders."

- Maine DHHS OCFS Children's Behavioral Health Services

As noted above, Maine's OCFS website indicates that the purpose of their Children's Behavioral Health Services is to **provide information and assistance with referrals**. Long-tenured CBHS staff who are well-known and embedded in the community have grown their roles to include **clinical consultation, child assessment** and **supportive counseling** with families, providers and case managers about **behavioral health systems and services**.

The purpose of this operational analysis was to understand *how* the staff within the CBHS team support the mission and vision of the Department and to make recommendations to improve operations. PCG utilized a variety of information gathering techniques including:

- **CBHS Stakeholder Interviews.** PCG met individually with CBHS staff to understand their role, workload, and job satisfaction.
- **Collateral Stakeholder Interviews.** PCG met with child welfare staff and supervisors, as well as staff at Spring Harbor and Acadia Hospitals to understand how CBHS staff support other stakeholders and how external entities perceive the challenges and strengths of the department. PCG also discussed the OCFS role during interviews with over 100 individuals, including current and former providers, families, and guardian ad litem, for the larger assessment of the children's behavioral health system of care.
- **Observational Shadowing.** PCG spent half-days shadowing both a Program Coordinator and a Resource Coordinator during their active work day, allowing PCG to observe how work is prioritized and the types of tasks undertaken by each coordinator. PCG also attended a Behavioral Health Program Coordinator (BHPC) team meeting.
- **Site Visits.** PCG visited district offices in Portland, Augusta, and Bangor and observed workspaces used by various CBHS staff who work in those offices.
- **Information Review.** PCG reviewed job descriptions, the CBHS organizational chart, and documentation specific to individual staff (e.g., the application used by providers and given to the Resource Coordinators).
- **Survey.** PCG analyzed staff responses in the DHHS employee survey to understand how staff perceive the strengths and challenges of the CBHS team and the service array.

II. BACKGROUND INFORMATION

CBHS Roles At-a-Glance

The following descriptions provide an overview of the roles within the CBHS team based on the *defined job description* for each title, as well as what PCG identified through stakeholder interviews, observations, and survey responses. PCG will discuss how the job descriptions reviewed align with practice in the Findings and Recommendations section of this report.

It is important to note that while charts below describe current responsibilities, job duties tend to vary based on the priorities of the existing Administration and state leadership. While there are tasks indicated below that are dictated in job descriptions and remain fairly constant, some of the responsibilities indicated here reflect work that was observed happening at the current point in time and are not set in stone.

It is also understood that while some positions are stated to serve a specific function (e.g., Clinical Care Specialists are responsible for developing and administering training) the extent to which everyone executes that function may vary on capacity and even geography.

An updated organizational chart for OCFS and the CBHS team can be found in Appendix A.

CBHS Management

CBHS Management Titles	Responsibilities
Behavioral Health Director	<ul style="list-style-type: none"> • Create a strategic vision for CBHS • Develop and implement statewide policies and procedures • Conduct program planning, evaluation, budgeting, and provide oversight and management of state and grant funds • Serve as a member of the OCFS senior management team • Supervise CBHS teams and managers • Oversee work through reviewing, analyzing and monitoring case information and records
Policy Coordinator (currently vacant) ¹	<ul style="list-style-type: none"> • Provide Evidence-Based Practice (EBP) Oversight <ul style="list-style-type: none"> ○ Coordinate meetings with EBP programs (i.e. Multi-systemic Therapy (MST)) • Attend provider meetings to present on policy updates - currently suspended, but there is discussion about resuming them at a later, undefined time • Behavioral Health Professional (BHP) Contract and oversight <ul style="list-style-type: none"> ○ Expansion and integration of BHP into other services, e.g., residential and school-based ○ Contract amendment needed - not sure of status • Behavioral Health Home (BHH) program oversight <ul style="list-style-type: none"> ○ Rule revision ○ Bi-monthly provider meetings • Youth Outcomes Questionnaire (YOQ) contract oversight

¹ The Policy Coordinator position has recently been moved under the Communication & Compliance Manager at OCFS. The impact that this will have on the CBHS team will be discussed more in the Findings and Recommendations sections of this report.

CBHS Management Titles	Responsibilities
	<ul style="list-style-type: none"> • Child and Adolescent Needs and Strengths (CANS) contract and program oversight <ul style="list-style-type: none"> ○ Provider trainings in fall - 4 days ○ Ramp up for Home and Community Based Treatment (HCT) providers ○ System integration of CANS ○ Movement of CANS into Atrezzo (KEPRO database) system ○ Development of outcomes measurement system • Maine Enhanced Parenting Project (MEPP) program oversight <ul style="list-style-type: none"> ○ Program point person ○ Oversight of Triple P (Positive Parenting Program) and Matrix contracts and practice • Rules <ul style="list-style-type: none"> ○ Section 28 - Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (RCS) ○ School-based policy ○ HCT/MST/Functional Family Therapy (FFT) ○ Clinician only HCT ○ Psychiatric Residential Treatment Facility (PRTF) ○ Targeted Case Management (TCM) ○ Write policy with Office of MaineCare Services (OMS) for use of Triple P, Parent Child Interaction Therapy (PCIT) and the Incredible Years (IY) in attention deficit/hyperactivity disorder (ADHD) and conduct disorder - new policy development • Contracts <ul style="list-style-type: none"> ○ Good Will-Hinkley (GWH) contract ○ In process of taking on Deaf contract - writing Request for Proposals (RFP) to meet statute expectations ○ Update contract riders for all CBHS services and develop OCFS/OMS process • CASE Initiative <ul style="list-style-type: none"> ○ Training providers in adoption competency with online training – will be completed this fall in conjunction with staff from child welfare
<p>Clinical and Community Resource Team Leader</p>	<ul style="list-style-type: none"> • Oversight and supervision of team of 9 staff, including Nurse Consultants, Resource Coordinators, Long Creek Social Workers, Reportable Events Coordinator, Residential Services Coordinator and Program Support Coordinator • Act as Children’s Residential Lead for OCFS and responsible for creating new residential policies in conjunction with the Commissioners’ Office and the Office of Maine Care • Work with KEPRO regarding out-of-state authorization, referral management and residential authorizations

CBHS Management Titles	Responsibilities
	<ul style="list-style-type: none"> Provide support to team to ensure staff provide oversight and support of clinical treatment
Program Coordination Team Leader	<ul style="list-style-type: none"> Oversight and supervision of Program Coordinator staff Serve as the Case Coordination Unit (CCU) Leader Provide support to team to ensure staff actively assist families and their teams to find the most effective treatment in the least restrictive environment in a timely manner; deal with challenging children who are in higher levels of care than needed and are ready for discharge with no safe post-discharge placement Provide support to the team to ensure that staff have appropriately assessed the child in person, clearly understand the child’s needs and are working with teams to explore all discharge options and move the discharge process along Facilitate Statewide/District transition with OADS, ensuring transition age youth with developmental disabilities are referred and transition smoothly Work with KEPRO regarding out-of-state authorization, referral management and residential authorizations
Child and Family Program Specialist	<ul style="list-style-type: none"> Oversight and supervision of CBHS Family Information Specialist position Responsible for writing, oversight and management of the Mental Health Block Grant (MHBG), and associated funding, that supports Family and Youth Support in Maine including all contracted providers Provide oversight and management of Maine’s CBHS Respite Program; and program aspects of the Autism of Maine contract Attend monthly Quality Improvement Council and lead the quarterly Maine Alliance of Family Organizations meeting Behavioral Health Home (BHH) and Peer Support Curriculum work²

CBHS Program Coordination Staff

The following staff are supervised by the Program Coordination Team Leader.

Title	# of Staff	Responsibilities
Program Coordinator	10 ³	<p><i>OCFS currently defines this role as responsible for: providing care coordination and system navigation to community providers, OCFS district staff, and families on behalf of children with behavioral health care needs.</i></p> <p>Tasks across all staff include:</p>

² This was previously done by the Policy Coordinator, but the role has been absorbed by the Child and Family Program Specialist since the role is vacant – an example of the fluid nature of staff responsibilities.

³ Note that while there are 10 Program Coordinator positions, one of the lines is currently allocated to the Care Coordination Unit (CCU), so there are 9 people serving the role in the capacity described.

		<ul style="list-style-type: none"> • Family contact and support: to include consultation and program support; team meetings with other providers or community stakeholders; case reviews and case summary documentation; monitoring transition aged youth; and relationship development • Emergency Department and psychiatric hospitalization monitoring • Waitlist follow-up after 120 days • Provider coordination: hospital, juvenile corrections, community stakeholder & residential (quarterly reviews of children in residential and discharge plans) • Child welfare case coordination • Child welfare adoption transfer support • Community stakeholder involvement • Transitional Services review • Referral and coordination • Constituent complaints • Community board representation <p>Specialized tasks for some staff include:</p> <ul style="list-style-type: none"> • Department of Corrections liaisons • Management of out-of-state services
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Clinical and Community Resource Staff

The following roles are supervised by the Clinical and Community Resource Team Leader. Of these roles, several have new titles (Program Support Coordinator, Reportable Events Coordinator, Residential Coordinator and Nurse Consultants) that were previously more broadly termed “Clinical Care Specialists” based on staff qualifications. Throughout the remainder of the report, if a task is completed by Clinical Care Specialists it means that one of these staff support the responsibility.

Title	# of Staff	Responsibilities
Program Support Coordinator	1	<p><i>Assists in coordinating training and support for Children’s Behavioral Health Service Programs, including developing and providing training and technical assistance for providers and child welfare staff.</i></p> <ul style="list-style-type: none"> • Residential program record reviews • Training and needs assessment, including training for child welfare staff about CBHS services and trainings (by special request) and for community providers • Provide program support to providers if needed • Child welfare clinical consultation⁴ • Follow up on reports of concern, as needed

⁴ While this is not a direct function of the Program Support Coordinator position, Child Welfare staff will often consult with the Program Support Coordinator because it is known that the role is clinically based and is currently co-located with child welfare staff. This function could be served by any of the clinical positions.

Title	# of Staff	Responsibilities
Reportable Events Coordinator	1	<p><i>Screens all reportable events for Children’s Behavioral Health Services and follows up on specific reportable events. This position also monitors patterns and trends; and supports providers in data quality and organizing agency feedback regarding reportable events to ensure safety of children and monitoring of services.</i></p> <ul style="list-style-type: none"> • Reportable events screenings: reviewing all reportable events, flagging events that require further assessment or engagement with provider and escalating based on trends or significant concern • Reports of concern • Program reviews, as there is an identified need • Training and needs assessment, including training for child welfare staff about CBHS services and trainings by special request • Child welfare clinical consultation
Nurse Consultant	2	<p><i>Provides medical consultation within Children’s Behavioral Health Services and Child Welfare to ensure that the medical and behavioral health needs of children coming into state custody are addressed. The Nurse Consultants also support initiatives around medical issues, such as reducing the use of psychotropic medications for children in state custody.</i></p> <ul style="list-style-type: none"> • Trainings, including training for child welfare staff about CBHS services and trainings by special request, psychotropic medication trainings, and training for community providers • Supporting the tracking of 10-day medical reviews, ensuring compliance with state statute, and following up on any recommendations • Quarterly psychotropic medication review • Program reviews as there is an identified need • Child welfare clinical consultation
Residential Coordinator	1	<p><i>Provides oversight of residential providers when there are concerns presented, supports resource development and training for providers and conducts reviews when determined necessary by the Team Lead.</i></p> <ul style="list-style-type: none"> • Residential program record reviews • Reportable events screenings: reviewing all reportable events, flagging events that require further assessment or engagement with provider and escalating based on trends or significant concern (backup for Reportable Events Coordinator) • Family contact and support • Supporting provider enrollment and recruitment • Training and needs assessment, including training for child welfare staff about CBHS services; and trainings by special request for community providers • Follow up on reports of concern for residential providers

Title	# of Staff	Responsibilities
Long Creek Clinical Social Worker ⁵	2	<ul style="list-style-type: none"> • Child welfare clinical consultation <p><i>Work in Long Creek with the detained population, providing initial mental health assessments, care management in the facility and discharge planning. These staff provide crisis supports and safety planning in the facility, as well as short-term treatment focused on managing stressors in detention.</i></p> <ul style="list-style-type: none"> • Individual treatment and support • Family contact and support • Referral and coordination
Resource Coordinator	3 ⁶	<p><i>Responsible for developing and maintaining a comprehensive array of behavioral health resources for children with autism, intellectual disabilities and mental health problems as well as reviewing and approving new agencies and programs. They are the primary contact for agencies seeking to provide behavioral health services for children, including outreach to connect children in need with services, and for agencies seeking information and/or technical assistance from the Department.</i></p> <ul style="list-style-type: none"> • Provider enrollment and recruitment - reviewing applications, contacting existing providers to expand service offerings and providing explanation of MaineCare requirements • Provider coordination with community stakeholders - serving as a liaison between DHHS, the community and providers to answer questions about services or availability • Community board representation • Referral and coordination • Program record reviews (residential and other CBHS programs) • Follow up on reports of concern from community members or agency workers • Develop and distribute corrective action plans when necessary • Monitor waitlist: includes but is not limited to: identifying outliers in underserved areas with long waits, reviewing and contacting families on the Family Choice waitlists and answering any questions about status

⁵ These staff are located at Long Creek Youth Development Center (LCYDC) but supervised by the Clinical and Community Resource Team Leader at OCFS who does not have authority within the facility.

⁶ Note that while there are 3 Resource Coordinator positions, one of the lines is currently allocated to the Care Coordination Unit (CCU), so there are 2 people serving the role in the capacity described.

Child and Family Program Staff

The following roles are supervised by the Child and Family Program Specialist Team Leader.

Title	# of Staff	Responsibilities
Family Information Specialist	1	<p><i>Acts as the statewide first point of contact for families and provides peer support to families of children with behavioral health needs.</i></p> <ul style="list-style-type: none"> • Systems navigation, including the MaineCare Katie Beckett Application Guide and supporting families in meeting basic needs (food, oil, etc.) • Coordinating with Targeted Case Managers (TCMs) for transition needs, accessing individual planning funds (IPF), and more • Transitional services review • Waitlist follow-up • Grievances • Managing Howard Espa Trust funds in Aroostook County • Reviewing IPF requests for completeness

CBHS Staff Tasks

The following tables show how each position within the CBHS team offers support to key stakeholders: children and families, providers, DHHS and the larger community. While there are some tasks, described above, that are unique to individual CBHS staff roles, there are also some tasks that are shared among CBHS staff. When more than one position is responsible for providing support, this does not necessarily indicate duplicative efforts, but rather the close-knit team approach that includes “no wrong door” and capitalizes on the experience of current CBHS staff. These tables highlight the need for careful coordination among CBHS staff and the necessary distribution of responsibility.

Child and Family Support					
	Program Coordinator	Resource Coordinator	Long Creek Clinical Social Worker	Family Information Specialist	Nurse Consultant
Family Contact & Support	X	X	X	X	
Hospitalization Monitoring	X				
Waitlist Follow-Up	X			X	
Community Stakeholder Involvement	X	X			
Juvenile Justice Coordination	X		X		

Child and Family Support					
	Program Coordinator	Resource Coordinator	Long Creek Clinical Social Worker	Family Information Specialist	Nurse Consultant
Systems Navigation	X			X	
Transitional Services Review	X			X	
Grievances				X	
Quarterly Psychotropic Medication Review					X
Manage IPF & Howard Espa Trust Accounts		X		X	
Individual Treatment & Support			X	X	
Referrals & Coordination	X	X	X	X	

Provider Support					
	Program Coordinator	Resource Coordinator	Reportable Events Coordinator	Residential Coordinator	Nurse Consultant
Provider Coordination: Hospitals	X				
Provider Coordination: Juvenile Corrections	X ⁷				
Provider Coordination: Community Stakeholders	X	X			
Provider Coordination: Residential	X	X	X	X	
Management of Out-of-State Services ⁸	X				
Reportable Events Screenings			X	X	
Reports of Concern	X	X	X		

⁷ This task is specific to the five Program Coordinators that serve as DOC liaisons.

⁸ This is currently supported by one Program Coordinator. CBHS is working to transition this process so that Program Coordinators follow youth from their region, even if they are out-of-state.

Provider Support					
	Program Coordinator	Resource Coordinator	Reportable Events Coordinator	Residential Coordinator	Nurse Consultant
Provider Program Record Reviews		X	X	X	X
Provider Enrollment & Recruitment		X		X	
Monitor Waitlists	X	X			

OCFS/DHHS and General Community Support						
	Program Coordinator	Resource Coordinator	Residential Coordinator	Reportable Events Coordinator	Program Support Coordinator	Nurse Consultant
Child Welfare (CW) Case Coordination	X	X ⁹				
CW Clinical Consultation			X	X	X	X
CW Adoption Transfer Support	X					
Training & Needs Assessment			X	X	X	X
10-Day Medical Review						X
Constituent Complaints	X					
Community Board Representation	X	X				

Out-of-State Hospitalization On-Call Duty

At times, there is the need to complete an out-of-state service authorization during non-business hours to step a child out of the emergency room to an out-of-state psychiatric hospital placement. To meet this need, OCFS has developed an out-of-state hospitalization on-call process. Staff choose if they will opt into on-call duty. Currently, between 10 and 12 staff are supporting the function. The group rotates responsibility,

⁹ While this is not an explicitly stated job function of the Resource Coordinator, because they are co-located with child welfare staff, staff will often answer questions and provide assistance.

serving as the on-call contact for one week every 10 to 12 weeks. This responsibility is not listed in the job descriptions because it is performed on a voluntary basis.

As-Is Process Examples

OCFS’ Children’s Behavioral Health Services team receives work from a variety of sources. Each question, crisis or request for assistance results in a response that could range from a single phone call to months- or years-long engagement with a family to coordinate services or oversee transitions.

OCFS employs a “no wrong door” policy for CBHS services, meaning that no matter who a stakeholder contacts, each CBHS employee can either provide an answer or refer the stakeholder to the person who can help them. While this ensures that families have their needs quickly identified and addressed, it also results in a complex flow of work that is challenging to map linearly.

Figure 1 below depicts an array of incoming requests for help and a selection of the tasks that a Behavioral Health Program Coordinator manages as a regular part of the job. This is one instance of a CBHS position that handles incoming requests for information or coordination from a variety of sources, resulting in an array of task outputs.

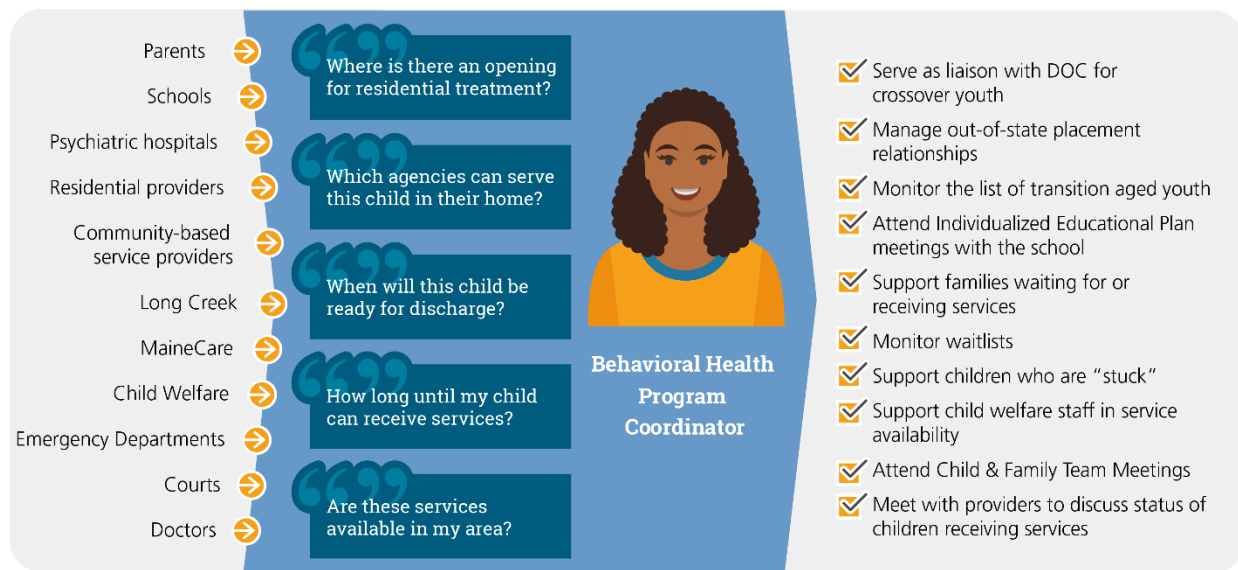


Figure 1. Example Program Coordinator Process

While no stakeholder experiences the same process moving through the CBHS service array, the following process flows provide individual examples of what a potential path might look like and the CBHS staff involved in the process. Figure 2 shows the process from the perspective of a family with a child receiving children’s behavioral health services, starting from the initial diagnosis and moving through their interactions with CBHS staff throughout the child’s case.¹⁰ Figure 3 shows the process from the perspective of a

¹⁰ While this graphic depicts a family member working with the Family Information Specialist at the beginning of their experience with OCFS, the “no wrong door” policy means that this contact could start with any member of the CBHS team.

behavioral health services provider working with OCFS to provide care, starting with the application process and moving through the corrective action plan process.

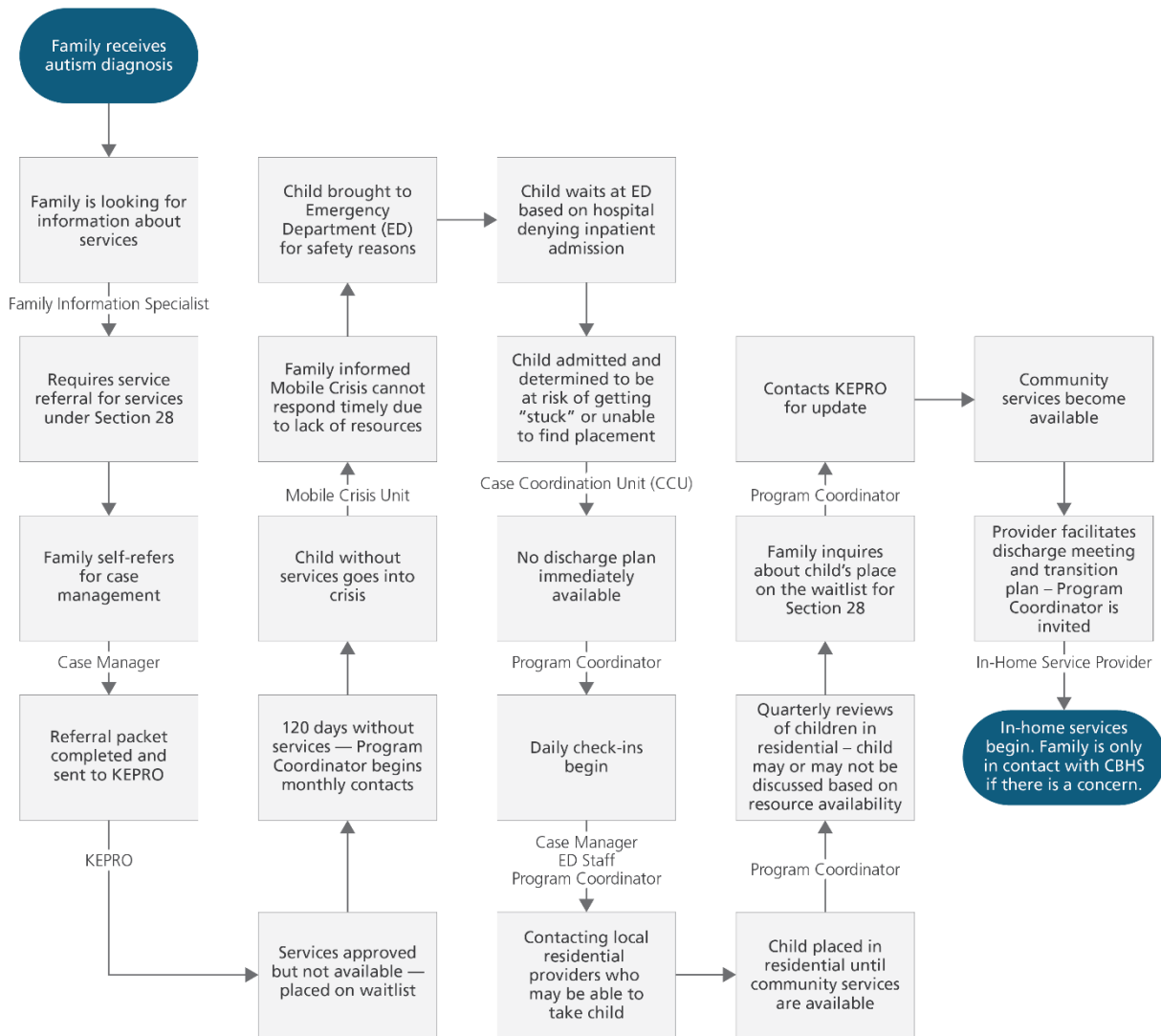


Figure 2: Example Family Process Flow

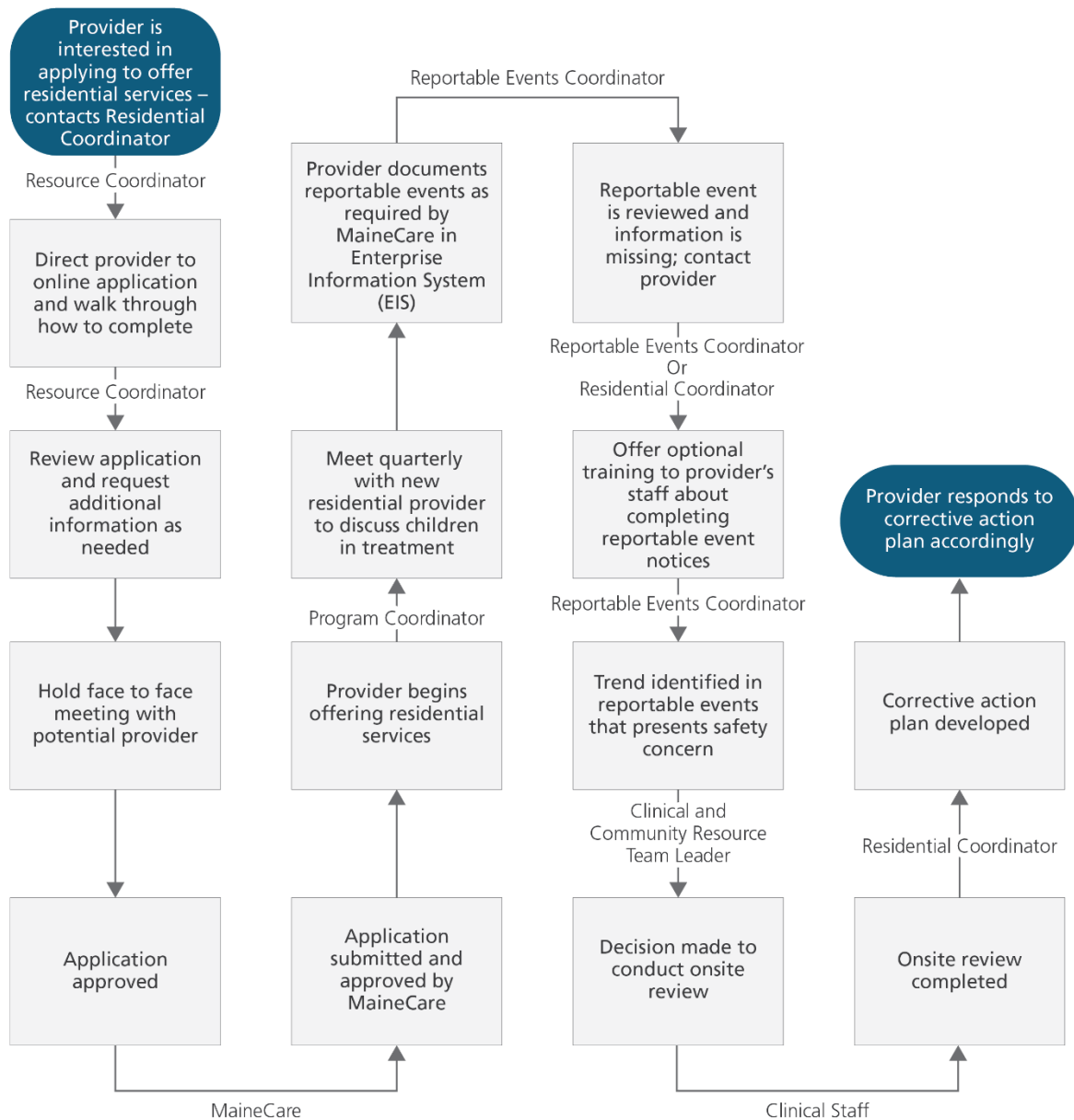


Figure 3. Example Provider Process Flow

Systems

Systems play an important role in the day to day activities of staff. CBHS staff currently use several electronic documentation systems, as well as their own hard drives and the shared drive to track and document work. Primarily, CBHS staff cited using Enterprise Information System (EIS) but they are also responsible for collecting information from the Maine Child Welfare Information System (MACWIS) and Atrezzo, and reporting in SharePoint. Additional detail about each of these systems and the functions they serve in capturing CBHS work are documented in the table below.

System	How staff uses system
<p>Enterprise Information System (EIS) – Secure, HIPAA-compliant application geared toward treatment data collection to manage the data for the Mental Health, Developmental Services and Children’s Behavioral Health Services clients of the department.</p>	<ul style="list-style-type: none"> • Includes demographics, Developmental Services member specific rates, progress notes and waitlist information • Monitor status of children during CBHS involvement • Enter case contacts for each child (Program Coordinators) • Enter notes about transition reviews (Family Information Specialist) • Review notes from other agencies (while this is minimal, TCMs may enter referrals for Office of Aging and Disability Services for transition preparation) • Track information on children who have been waiting for services over 120 days • Management of reportable events
<p>SharePoint – Site used to communicate with the MaineCare Care Coordination Unit (CCU) and the Commissioner’s Office</p>	<ul style="list-style-type: none"> • Enter notes about child progress with hospitalization, discharge and transition • Download notes entered by CCU and merge them into EIS • Upload case summaries for children who are “stuck” in the ED or a psychiatric hospital
<p>MACWIS – OCFS Child Welfare case management database</p>	<ul style="list-style-type: none"> • Access information about a case to complete CBHS case summaries • Tracking of 10-day medical appointments
<p>Atrezzo – KEPRO database that tracks applications and authorizations for behavioral health services</p>	<ul style="list-style-type: none"> • Access information about a case to complete CBHS case summaries and to check the status of Intensive Temporary Residential Treatment (ITRT) or other service authorizations
<p>Shared Drive – Shared drive on CBHS staff computers</p>	<ul style="list-style-type: none"> • Manage various Word documents and Excel spreadsheets to track information regarding daily work and share with other staff. Includes all CBHS provider approvals, Corrective Action Plans, and more.
<p>QNXT – MaineCare database</p>	<ul style="list-style-type: none"> • Provides the Family Information Specialist with updated parent information. Specifically used when communicating with families regarding transition services.

III. FINDINGS

Organizational Strengths

1. Dedicated Professionals

Throughout this assessment PCG interviewed and received feedback from providers, stakeholders and other DHHS staff who shared that there are many dedicated professionals within the CBHS team at OCFS. Some general comments about CBHS staff from stakeholders outside of OCFS included:

Staff overall are invested and passionate about their work.

The staff are hard workers dedicated to their clients.

It was not uncommon to speak to staff in the CBHS team who have decades of experience working in the children's behavioral health field and with this experience comes many strengths including:

- There is a strong sense of camaraderie among peers within the CBHS team. This camaraderie and teamwork is apparent to stakeholders outside of OCFS as well, with one stakeholder noting that they were "*Working as a team to problem solve given limited resources throughout parts of the state.*"
- Staff reported feeling supported by direct supervisors.
- Staff are knowledgeable and experienced. They have long tenures, are clinically experienced and understand the supports needed to parent children with special needs.
- CBHS staff have built good relationships with external stakeholders. There is a positive perception of CBHS staff from providers, state child welfare staff, and community stakeholders. As one stakeholder noted, "*The staff is always willing to try to help. They are very responsive and always follow up with the families I refer to them.*"

2. Initial Investment in Evidence-Based Practices (EBPs)

OCFS established the Program Enhancement Project (PEP), which is a team of clinicians focused on learning about and advising OCFS in the implementation of EBPs, including the development of trainings and resources. This team also develops technical assistance documents and other avenues to address quality treatment provision and is well supported by OCFS Management and Leadership.

General Findings

1. A need to provide clarity about roles and responsibilities.

Over the past ten years, the CBHS team has undergone several organizational transformations. First, the team was transitioned from the Department of Behavioral and Developmental Services to OCFS, joining early intervention and child welfare programs so that children's services could be centrally managed and coordinated. Several years following this transition, the CBHS team was reduced by more than half due to budget reductions and staff were laid off or transitioned to other roles in DHHS. **Following these changes, staff have become unclear about their specific responsibilities and there are not always clear delineations between staff roles.**

We observed this role confusion manifest in several ways. *First, there appears to be some duplicative efforts between the Resource Team and the Program Coordination Team, who both work directly with*

providers. Staff from both teams may be contacting providers and seeking similar information from them, but the CBHS staff do not have a practice for communicating this between each other. Staff reported feeling uncertain about their responsibilities and reported conflicting explanations of their roles across identical positions. Staff reported that their roles are constantly shifting based on changes in the priorities of leadership and the administration. This role confusion may also be the result of the transitions that the CBHS team has undergone, the need for staff to “wear multiple hats” in response to a smaller team, and/or that staff with a long tenure have held onto responsibilities from previous positions because they have the institutional knowledge or skills and continue those activities even if they don't fit well with current responsibilities.

This role confusion spills over to community members and service providers who are unsure of who to contact for questions or information. For example, Resource Coordinators reported receiving inquiries from families about accessing services and providers may ask questions of Program Coordinators who they have been working with on individual cases. While the CBHS team does follow a “no wrong door policy”, as described earlier, there are distinct differences in the staff's area of expertise, and this seems unclear to those outside of OCFS. The actual position titles given to OCFS staff may be contributing somewhat to this confusion from stakeholders, with generic titles given to entire teams without any definition to how their role varies. For example, a Program Coordinator is always a Program Coordinator, but some serve as Department of Corrections (DOC) liaisons, working most closely with crossover youth, and others support all out-of-state placements, but all report being contacted for information that would typically fall outside of the purview of their typical job duties. While it's certainly helpful for all OCFS staff to be knowledgeable about how to support providers and families, there may be a loss in efficiency when staff are trying to be responsive to one stakeholder and it takes them away from other responsibilities. While this is the nature of most jobs, the inefficiency is exacerbated by not giving providers and family members clear points of contact throughout their journey with children's behavioral health.

CBHS leadership has worked to respond to **staff reductions** by developing positions that have combined multiple functions under a single role, to bridge services previously provided by now vacant positions. *The multi-functional nature of these roles exacerbates the challenge of defining what each position is responsible for.* For example, staff formally referred to as the Clinical Care Specialists were given individual titles under a previous OCFS Director, resulting in what is now the Reportable Events Coordinator, Residential Coordinator, Program Support Coordinator and the Nurse Consultants. These positions were designed with specific functions in mind. For example, the Residential Coordinator was intended to be responsible for monitoring the admission and discharge of children from residential treatment, but it was felt by other state agencies that this was going to be a duplicative function of existing units so OCFS was tasked with redefining the new positions. When the OCFS Director changed without defining these roles clearly, the functions of these staff organically manifested. This has resulted in a group that largely manages similar tasks across roles, not too different than was seen when they were the Clinical Care Specialists, just with more complex and nuanced titles.

The challenges associated with the **geography** of the state have also resulted in staff with the same titles serving multiple purposes depending on where they are located and the resources that are available. *The CBHS team is dispersed throughout the state, and for good reason, to make their services available to families and providers where they live and operate.* However, because of the smaller team, the staff must cover larger geographic areas. The result is that, for better or worse, CBHS staff operate very independently in the field. This independence allows staff to be flexible and responsive to local needs, but can also result in more role confusion as they assume increasing responsibilities across roles to cover the needs in their area.

2. CBHS position titles are unclear or unfilled.

The CBHS team is led by a *Behavioral Health Manager* (previously called the Behavioral Health Director), whereas other parallel leadership positions on the Organizational Chart within OCFS are *Associate Directors* (see Appendix A). The Behavioral Health now reports directly to the OCFS Director, as the Associate Directors do, however the position title gives the impression that CBHS is somehow separated from other major units at OCFS and that its leader has less authority.¹¹

Position titles within the CBHS team may also lead to confusion, particularly with providers and those outside of OCFS. The title names are all very similar and not always descriptive of their responsibilities. OCFS reported that some of the position title names were the result of reorganization.

The role of the CBHS Policy Coordinator (currently vacant) has been moved out to serve all program areas across OCFS. While the policy tasks are considered a component of the Policy Coordinator's responsibilities within CBHS, there had also been a significant degree of program planning and oversight that occurred. Currently, the CBHS leadership team does not have the capacity to assume all of these responsibilities with their current workload.

As also noted in the larger report on the children's behavioral health system of care, the OCFS Medical Director is currently a part-time position, located in Massachusetts. The Medical Director is responsible for consultation and support across OCFS program areas including child welfare. CBHS staff report not having sufficient access to the Medical Director and that there is a lack of knowledge and relationships that existed under previous full-time, onsite Medical Directors.

3. Workload may be inefficient or unmanageable.

Because of the reorganization and reductions in the CBHS team, staff have assumed more responsibilities and are expected to travel farther to serve larger areas of the state, resulting in lost productivity. Staff have shifted from being proactive to being more reactive. In the PCG survey, half of the CBHS staff who responded felt their workload was manageable, and half felt it was not. In comments, CBHS staff noted that they could be doing more if they had more resources. For example, staff described,

At a minimum, I can manage it; if we are to really address concerns and system issues (residential and community providers) we would benefit from more resources/people.

At this moment, [priority work] is manageable but we could be doing a lot more. [We] have to prioritize what we are doing [and some work is put on hold].

According to staff, prioritized work includes crises (e.g., client hospitalizations), monitoring constituent complaints, providing monthly follow-up calls to families waiting more than 120 days for services and responding to calls from new families.

Staff report not enough time to do unprioritized (non-crisis) work, including:

- Attending child and family team meetings with child welfare
- Attending meetings with schools
- Attending meetings that are open to the provider community to ask questions and share information

¹¹ Note that under the new OCFS organizational chart the CBHS Director now reports directly to the OCFS Director, although the title is not equivalent to others in the same level.

- Conducting proactive and ongoing family engagement activities
- Monitoring and supporting youth transitioning to adult services
- Proactive quality service reviews
- Participating on community boards

Staff described that the role of the CBHS team has shifted away from direct, supportive services to be more administrative. They described that some of these administrative tasks are not an effective use of time. For example, maintaining contact with families on the waitlist each month and coordinating the Case Coordination Unit (CCU).

These concerns are further exacerbated by a limited staff capacity. Resource Coordinators and Residential Coordinators wish they could more sufficiently engage with providers to increase services, recruit new providers and monitor providers. However, with only two Resource Coordinator positions to cover the whole state and fulfill responsibilities, it can be challenging to support any provider to the extent needed. Staff report they do not have enough time to engage proactively in provider recruitment, instead they are only able to reach out to discuss expanding service array with providers in regions with long waitlists for services. The Resource Coordinators cite having been strained when there were three people in the role, but after having a colleague transferred to the CCU, they are now not only managing their own workloads, but that of another person as well.

To the extent that reportable events are reported and flagged, programs may be reviewed reactively, with the trend in urgency being largely focused on residential programs, but all providers, including HCT and Section 28 services, are not reviewed unless an urgent concern is raised. Staff described concern that some agencies may be underreporting their reportable events to avoid these reviews altogether. The elimination of the Quality Assurance team has resulted in the need to pull staff away from their other tasks to perform reviews. Additionally, processes that are outsourced to KEPRO still require a lot of management by OCFS staff because the quality of data is poor, the authorization process is cumbersome or unclear for families and providers and KEPRO lacks a nuanced understanding of the child's needs and provider capacity.

The two Nurse Consultants are also increasingly busy with responsibility for the 10-day medical review for children in child welfare custody as the number of children in foster care increases.

The precise volume of work for CBHS staff is unknown because the frequency of incoming and outgoing contacts (families, providers, community) and time spent coordinating cases, conducting research and collecting information is not tracked. For example, Behavioral Health Program Coordinators utilize EIS to document their work, but staff described that the volume is relatively unpredictable and fluctuates based on time of year, availability of providers and the typical ebb and flow of families' needs. However, without consistent tracking of the progress with children receiving services, it is hard to anticipate when crises will arise, requiring extra time and effort for support and coordination, or when staff have under-utilized capacity that could be dedicated to other work. Without data available across CBHS services, it is difficult to measure the impact that CBHS staff have on the lives of the children and families they serve and difficult to determine if the workload is inefficient or unmanageable as was described by many staff.

4. No standard process for engagement and referral.

To the extent that CBHS staff's role is to consult with providers and families about appropriate services, the intensity of services and level of care, CBHS Program Coordinators do not have a specific, measurable process by which to do this. Program Coordinators currently engage with families in an ad hoc manner, adapting their engagement to the structure of the primary service location (hospital, provider, family), rather

than having a formal meeting model for CBHS cases, such as the family team meeting structure utilized by OCFS' child welfare unit. CBHS staff attend meetings between the provider and the family when they have the time available. They follow the lead of the case manager or the other primary service provider. Depending on who is leading and what the child's circumstances are, there are different timeframes for meeting and follow-up frequency, and documentation expectations. The inherent obligation of OCFS to adapt to multiple styles of case management makes it challenging for CBHS staff to keep track of a child's progress over time as there isn't a clearly defined role for CBHS staff in these meetings, specifically Program Coordinators, and they are receiving a different quality and depth of information about a child depending on the provider(s).

Like the frustration felt by Program Coordinators, those on the Resource Team cite that *"nothing is routine and everything is specialized."* When there is a report from the community about a concern with specific services, there is no process for the response that requires calls to different stakeholders (e.g., Division of Licensing or MaineCare) depending on the situation and those involved, although there is no procedure that dictates at what point to involve someone outside of OCFS, relying instead on the discretion of the Resource Coordinator about the best path forward. This lack of a clear process results in ad hoc responses to concerns that can be time consuming, as there is the need to identify a creative solution in every situation.

5. A desire to be included in organizational change efforts.

Staff feel supported by their team but feel that leadership does not understand what they do or appreciate their role and expertise. They do not feel included in the strategic planning or problem solving such as how to address issues of care coordination and provider oversight. The purpose and value of new initiatives are not fully explained to staff, but rather handed down as directives and therefore initiatives do not always realize their value in practice. As one survey respondent suggested, OCFS needs to

Ensure that CBHS staff truly understand the "why" of what they are being asked to do and when a shift needs to occur, to have it clearly articulated and provide them with effective tools to do the work. Encourage and provide support to CBHS staff. Build a culture of respect, trust and empowerment of staff.

A specific example of leadership being out of step with CBHS staff was a two-day mandatory training. Staff described that leadership did not understand or respect staff backgrounds as the training seemed to target entry-level behavioral health workers, not the seasoned CBHS staff.

6. Limited resources to make a difference for families.

In interviews with CBHS staff, they reported frustration that their work with families is less impactful than previously. Staff described that while they used to help families, they now feel like they have nothing to offer them in terms of resources or solutions. This frustration is directly linked to the challenges in overall access and quality of services detailed in the PCG report on the CBHS service array. A specific frustration is the 120-day waitlist follow-up process: Program Coordinators and the Family Information Specialist are required to contact families whose child has been on a waitlist for over 120 days, but they do not have any resources to offer to these families – most have already waited long enough to have tried all the creative solutions and are still struggling and CBHS staff feel like they are wasting the family's time.

Due to the stresses on CBHS staff workload, Program Coordinators cannot participate in child and family team meetings, attend meetings with school staff or even be as actively engaged with providers as they were able to do previously, and they feel less effective as part of the child's team. The CBHS staff and the

treatment team only interact when there is a crisis, which results in an inconsistent relationship and inability to provide comprehensive oversight or consultation.

CBHS staff also noted that they lack the ability to track and measure individual child progress and outcomes. In part because information is not collected, but also because data is siloed. For example, EIS only contains information manually updated by CBHS staff or case managers. It is not integrated with other systems, such as Atrezzo, and therefore information on children may be out of date.

The Family Information Specialist and a Resource Coordinator are responsible for the oversight and approval for Individual Planning Funds (IPF) and Howard Espa Trust funds. However, staff and providers reported these funds are difficult for families to access because they must first be denied by MaineCare for the item, which must be tied to the existing service plan. CBHS staff used to have flexibility to be creative with helping clients with unmet needs using flex funds, but as the availability of these funds has decreased, so has staff's ability to leverage the resource.

7. Engagement with providers is more reactive than proactive.

Previously the CBHS team had staff focused on conducting routine quality assurance with providers, however their monitoring is now more reactive (primarily limited to Reportable Events) than routine. While there are desk-level procedures around reportable events, the number of avenues by which information is brought to CBHS and where that information is directed has resulted in a number of siloed and specialized ways to respond.

Program Coordinators, Resource Coordinators, and the Residential Coordinator may see concerning patterns of residential provider issues based on reports of concern from the community. Staff discuss these with the Clinical and Community Resource Team Leader to determine if a program site review is warranted. There is not enough time for a feedback loop between staff who are reviewing providers and the Reportable Events Coordinator. Therefore, small to moderate issues go unaddressed, and sometimes unreported.

The Residential Coordinator, Nurse Consultants, Reportable Events Coordinator, and Program Support Specialist, also known as Clinical Care Specialists, share the responsibility to follow-up on Reportable Events of concern and conduct onsite reviews when determined necessary by the Team Lead. Due to geographical constraints, some staff are more able to travel and assist than others. The focus of these reviews is on residential programs right now due to concerns raised from reportable events and licensing investigations and complaints, but the team spoke often of their desire to provide more oversight to community services like Section 28 and HCT due to frequent concerns about quality. This effort is currently unmanageable because of limited staff capacity.

The Reportable Events Coordinator and Residential Coordinator provide trainings to providers on Reportable Events including client rights and how to document these events. One goal of these trainings is to keep providers, who have high turnover, up to date on the reporting requirements and reduce reporting errors. Not only do these trainings provide OCFS with better data about reportable events, but they save both the CBHS team and providers time in following-up and accurately completing an event, which are communication-heavy tasks. These trainings are not mandatory for providers, so the impact of training cannot be accurately measured across the service array. While there are Corrective Action Plans issued to providers in response to onsite reviews, the CBHS team does not have the capacity at this time to provide training related to quality or service delivery to support these corrective action plans.

New provider recruitment efforts are mostly passive. The only active outreach is conducted by the Resource Coordinators and Residential Coordinator with agencies in underserved areas to encourage additional

service provision. Resource Coordinators also used to hold regular, public provider meetings with providers to share information and respond to inquiries, but these have been discontinued.

8. Desire to strengthen partnerships with other stakeholders.

These concerns, also noted in the larger assessment of the children's behavioral health system of care, stem from changes in CBHS staff roles and reductions in the CBHS team. For example, while three Program Coordinators were previously co-located with juvenile justice programs, staff now split their time between DOC and OCFS offices. Time spent in each office can be limited as Program Coordinators are often tasked with traveling. As a result, there is less communication between the CBHS team and juvenile justice and the Program Coordinators are utilized less frequently by DOC.

Staff also cited a decrease in participation in community activities, including on community boards, in IEP meetings, at Child and Family Team Meetings, community provider meetings and in pre-adoption meetings; largely the result of limited capacity, and resulting in less engagement in community groups where knowledge sharing occurs.

Staff cite some of the benefits of their engagement with child welfare, as it plays out in their day to day work. For example, it was heard from a Program Coordinator that, *"(We meet kids in the ER who are in crisis.) If I had been able to go to the Family Team Meeting, case managers could have pulled me in ahead of time to get to know the child and connect the family with interventions before the situation escalated."* The same Program Coordinator noted that although there is not the time to proactively attend these meetings, case managers have also stopped inviting the CBHS team because there is no confidence in their ability to connect the family to a service due to the lack of availability.

Staff and providers cited the quarterly provider meetings as a once valuable platform for providers to ask questions and network with the CBHS team, without which it is a challenge to provider engagement. This was an area where OCFS could push information to providers about what is needed, where there are concentrated pockets of children not receiving a service, and providers could collaboratively work to identify how that need could be met. Without this platform for regular relationship development, communication is more ad hoc and sporadic.

IV. RECOMMENDATIONS

The recommendations below focus on how the processes and systems within OCFS related to CBHS can be improved.

1. Develop a strategic plan that clearly and concisely documents the CBHS team's purpose, responsibilities, and goals.

The capacity of the CBHS team has changed, with external providers and contractors beginning to absorb functions that were previously held by the department, such as the service approval process now owned by KEPRO. CBHS should consider the impact this change has on CBHS' responsibilities within the larger children's behavioral health landscape, and within the Office of Child and Family Services (OCFS). As discussed in the findings this has resulted in an unclear understanding of what CBHS and CBHS staff responsibilities are, and what the remaining responsibilities are of providers, other state agencies, families, or community members.

It is our recommendation that before the department embarks on the implementation of any substantial recommendation provided by PCG, either from the internal Memorandum of Understanding or the external report, OCFS should undertake a significant strategic planning process. (See PCG report on the Children's Behavioral Health Services' system of care for additional information on this recommendation.) A strategic planning process would allow: 1) OCFS leadership to clearly define the purpose of CBHS, and particularly that purpose within a much larger network of stakeholders to achieve the CBHS mission; 2) establish realistic goals and objectives that are consistent with the CBHS mission and a clear, outcome-driven vision; 3) create a defined timeframe within CBHS's capacity for implementation; 4) develop a sense of collective ownership of the work towards achieving that vision. It may be beneficial for this process to be undertaken with the support of an outside, independent entity that is not involved in the day to day operations of CBHS but has expertise in the strategic planning process.

While PCG recognizes that CBHS leadership have already begun conversations around the development of a robust strategic plan, it is imperative that the strategic planning process be thorough and include all levels of CBHS staff. PCG recommends first establishing a leadership committee to serve as the CBHS principals for the development of the strategic plan. These leaders should represent a healthy mix of those with the authority to make decisions, as well as those who are frequently immersed in the direct service components of the work (both at CBHS and provider agencies) and the children and families who are impacted by the CBHS system. This coupled with a balance of long- and short-tenured staff will create a committee with a wide variety of perspectives on CBHS, both historically and presently, as well as the potential for an idealistic future.

The following steps provide a description of a typical strategic planning process that we may recommend, as well as some possible action items or guiding questions within each step.

Phase 1: Internal	
1. Discuss and decide on key values for CBHS team	Make sure the guiding values are explicit and can be questioned, decided upon by the group and referred to for the full strategic planning process. This step should answer the question: <i>What is driving the priorities outlined in the strategic plan?</i>

	<p>As specific goals for the strategic plan are being identified, ensure that they tie back to the key values agreed upon in this beginning step of the planning process.</p>
<p>2. Understand the current work of CBHS team</p>	<p>The path from the current state to a future state cannot be established without a clear understanding of the current state. Establish a shared understanding of how things work now, so that decisions can be made about what changes are needed to reach the desired vision. Review the mission, vision and key values of the CBHS team that were solidified in Step 1 and ask the question, <i>How far away is the agency from practicing this way?</i></p> <p>This should include a commitment from all levels of staff within the CBHS team up through DHHS leadership to commit a deep understanding of the daily work conducted. This may include “Listen and Learn” site visits by leadership to district offices.</p>
<p>3. Review past strategic plans, successes and shortcomings</p>	<p>This step is intended to allow reflection on past accomplishments as well as past challenges. Hold a working session to review the history of CBHS and how it has adapted to changes in service array and leadership. Analyze strengths, weaknesses and opportunities for improvement.</p> <p>Ask questions, such as: <i>What has previously worked well for CBHS, providers, families or children? Why did these things work well? What were the environmental factors that forced CBHS’ adaptation over time? Were there external forces that were outside of the control of the Department?</i></p> <p>Set the stage for effective change management, building trust and consensus among staff by seeking feedback about how the implementation of changes has historically impacted CBHS staff, families and providers. Ask questions about how change could be delivered more effectively.</p>
<p>4. Review and discuss current trends in data (e.g., data on the service population, waitlists or expenditures).</p>	<p>Similar to Step 2, this step focuses on establishing a clear, shared understanding of the current nature of children’s behavioral health services in the state of Maine, with this step focusing on some of the more quantitative components of the current state.</p> <p>One of the barriers that OCFS may face in Step 4 is the lack of robust data that is available about services.</p>
<p>Phase 1 Outcomes</p>	<ul style="list-style-type: none"> ✓ Concrete outline for vision/mission and purpose/responsibilities of OCFS at all levels of CBHS staff. ✓ Communication strategy for the implementation of changes, including a structure of how decisions are made, the timeline for change planning, and the feedback loop for staff involvement in testing and modifying new processes when issues are discovered.

Phase 2: Internal and External	
1. Identify specific constraints or requirements (e.g., legislative mandates, existing grants or contracts that have requirements)	<p>This is an appropriate time to document any foreseen changes that may be coming to the CBHS team, or any areas of unforeseen change that may arise (e.g., a change in the priorities of an administration) so that constraints are explicit to everyone involved in the planning process. Discuss how to best prepare for mitigating these constraints and how the committee will approach addressing any possible concerns should they arise. This could be through consideration of quarterly strategic discussions with a stakeholder group to ensure that the implementation of the strategic plan is on track, or through another mechanism identified by the planning committee as being appropriate.</p>
2. Conduct an environmental scan and discuss key trends, opportunities, strengths and challenges	<p>The nature of CBHS within the children’s behavioral health landscape in the state of Maine is complex. There are many stakeholders involved in the larger picture, including providers, community members, families, children and advocates, just to name a few, and all are impacted by the strategic roadmap for services in the state. In planning for the strategic plan, it is important to consider who these stakeholders are, what function they serve in the service array and how any discussion on change might impact their place in the children’s behavioral health world. This discussion should be staff-driven and may even take the form of a presentation of the “current state of needs and service availability” delivered by those who know the environment intimately.</p> <p>Stakeholder engagement allows for stakeholders to feel as though their voices were heard and their opinions and feedback are valued. It also allows for OCFS and DHHS leadership to get an understanding of the perspective that external stakeholders might have about the vision, recommendations and ideas about the future of CBHS. Engage stakeholders who may not be a part of the core planning group with safe ways to discuss tough issues and taboo topics with the breadth of children’s behavioral health stakeholders (families, youth, providers, advocacy groups and DHHS staff).</p>
3. Review and finesse key values and mission of CBHS	<p>Test that guiding values are clear and account for any gaps in the wider system of care. Reaffirm that these key values are clearly documented in the strategic plan as they can then serve as the key values adopted by all children’s behavioral health stakeholders engaged in the strategic planning process (e.g., providers and families).</p>
Phase 2 Outcomes	<ul style="list-style-type: none"> ✓ Documentation of the current state of need and service array within the population ✓ Final version of CBHS vision/mission and purpose/responsibilities, including the roles and responsibilities of stakeholders and providers.

It is important to remember that strategic plans for objectives and strategies should be concrete, but they should also be flexible, as the goals of the administration and leadership are fluid based on the changing nature of government services and limited control of agency staff.

After the planning process has been completed, the development of a formal strategic plan by which all stakeholders agree with the general direction may begin to be developed. We recommend the following key elements for the development of a strategic document.

- **Vision.** What do leadership and other stakeholders want children's behavioral health services to look like, in concrete terms?
- **Mission.** What is CBHS contributing to this vision? The mission and vision can be realigned if that feels more appropriate once developed.
- **Objectives.** What will CBHS do to move the Department closer to alignment with the previously agreed upon mission and vision? Specific objectives should be quantifiable and measurable, either qualitatively or quantitatively.
- **Strategies.** Specific steps identified to address each objective, with details on the sequence of activities and the thoughtful consideration to the various processes and stakeholders involved in achieving and measuring each objective.
- **Timeframe.** Development of a roadmap for implementation of individual steps and activities within the plan as well as a timeframe for the longevity of the entire plan.
- **Communication Plan.** Identifying a process by which the strategic plan will be shared with stakeholders and what the intended engagement level of all stakeholders will be in the implementation process. *This will require consideration and strategy of a very delicate balance of ensuring that the process coincides with what is in the best interest of the Department and also with the expectations of external stakeholders.*
- **Ongoing Fidelity.** Details for how the plan will be monitored, discussed and shared with new staff and how leadership will uphold the objectives throughout the life of the full plan.

Benefits and Impact

The development of a strategic plan will allow OCFS to succinctly communicate its CBHS goals and objectives to all stakeholders, align their focus and priorities along with the larger children's behavioral health community and clearly articulate their role among all other providers and stakeholders. The documentation of vision, responsibilities and priorities also provides the Department with a base for the present state by which progress, and change can be measured.

Risks and Dependencies

While PCG does not foresee any risks to a thorough strategic planning process, the success of the venture is dependent on the readiness and willingness of leadership within OCFS and stakeholders from across children's behavioral health to review and define the strategic direction of CBHS. The process is also dependent on the agency's flexibility toward meeting the needs of the entire system, including a commitment of time and energy on the process itself as well as OCFS leadership's investment in developing a clear, concise plan that supports a strong, dedicated team.

2. Clarify existing roles and consider any new roles needed to support the newly defined CBHS mission and responsibilities.

Many CBHS staff have responsibilities that expand beyond their original position in the organization, or even their job description. As cuts to staffing have been made and resources for CBHS have been constrained, remaining staff have absorbed functions considered critical to supporting the existing CBHS mission and purpose.

PCG recommends that OCFS conduct a formal review of the existing CBHS staffing structure, with the goal of clarifying existing roles and consider any new roles that may be needed to best support the Department in their work. PCG proposes the following steps to completing this review:

2A. Perform a time study and/or a random moment survey to understand the time that each part of the work done by existing staff takes and to monitor fluctuations in that workload over different periods of time.

PCG recommends that OCFS undertake a time study and/or a random moment survey to monitor the CBHS workload of existing staff. Time studies are an effective method for gathering quantitative data that would support a request for additional fulltime equivalent (FTE) staff. A random moment study is a strong supplement to a time study, as it can capture and measure task specific information allowing OCFS to see not only what tasks staff are completing but how long each of those tasks are taking. This will allow for a system-wide understanding of any duplication or gaps in service that haven't been identified by this assessment, while also information OCFS in the determining if existing staff have the capacity to fill gaps (e.g., transitional services) and what activities may require staff hiring to address.

2B. Shadow CBHS staff to better understand each current role and the way that role varies across employee. Engage actively in conversations about what works well and what is challenging.

PCG recommends that OCFS leadership invest time in understanding the tasks conducted by CBHS staff through observational shadowing. Allowing adequate time for engaging directly with staff, through opportunities such as observing their workday, will support leadership in answering the following key questions:

- *How does the work that is being completed in the field align with the strategic objectives that were identified in the strategic planning process?*
- *Where are the gaps in the current array of job duties that need to be filled for CBHS's strategic objectives to be achieved?*
- *What is the capacity of existing staff to fill those gaps?*

This process will help to repair the sense of disconnect between OCFS leadership and frontline staff, enlighten leadership about the day-to-day activities of the CBHS team, identify potential opportunities for improvement and improve employee trust and morale.

2C. Conduct a review of existing job duties and update responsibilities and titles as is appropriate based on current processes.

As needs across the CBHS team are identified, staff have absorbed functions that are in addition to or unique to their regular job description. For example, one Program Coordinator has become the gatekeeper for out-of-state placements and serves only some of the other Program Coordinator functions, yet still has the same title. Many Program Coordinators are specialized in this way and all non-specialized Program Coordinators manage many tasks.

This process may appear to work effectively while the CBHS team has experienced a low turnover rate, but under the current structure of titles and job descriptions, any new staff being onboarded may not inherently fit into these undefined specializations, due primarily to lack of institutional knowledge but also lack of role definition. External stakeholders, such as providers and families, may also have a hard time understanding the subtle distinction between these roles.

OCFS should review existing job descriptions and compare them to how staff describe their roles and responsibilities. This should form the basis of how jobs are redefined. This should be a collaborative process that leadership engages with front line staff on to ensure that there is agreement in what is needed from each role and an understanding of how that role aligns with the purpose of the department as defined in the strategic plan. It was apparent that there were at times misunderstandings regarding the role of other CBHS positions internally, with some staff reporting that they were the only position that interacted directly with providers, which was inaccurate. Reviewing positions and expectations across positions will support staff in better understanding what their colleagues' roles are in supporting CBHS work. This will also support staff in their ability to direct inquiries to the correct CBHS employee, rather than handling individual constituent comments themselves and further widening the scope of responsibility held by each position.

This review of job titles and responsibilities may result in new titles that better align with the role; for example, Residential Coordinator, who was intended to monitor admissions and discharges from residential services but performs other job functions. Similarly, the Program Coordinator title is uniform, whereas their responsibilities are not. A review of these functions may result in new titles for specialized positions, for example, staff responsible for managing all out-of-state placements or a liaison to a specific hospital.

2D. Identify staffing and responsibility gaps and develop strategies to address those gaps to support achieving the objectives outlined in the strategic plan.

With an understanding of the functions of the CBHS team as well as the capacity of those staff to absorb additional job duties, CBHS leadership will be positioned to critically consider what is needed to support the objectives outlined in the strategic plan. This will require careful consideration of existing processes and the development of efficient practices for achieving goals (e.g., developing a standard practice for youth who are stuck in the emergency room) and streamlining any areas of duplication (e.g., identifying a key resource to serve as the point of family contact).

Two common themes were apparent when completing this internal assessment. The first is that staff capacity is limited. The CBHS team has been trimmed to support only the bare minimum staff and operates focused more on crises than proactive oversight. The second is that because of these constraints in staff resources, staff duties have become blurred. Staff do their best to support the specialized populations served by CBHS, but have limited capacity to do so, and other priorities often shift the focus away from the monitoring of these more specific groups.

OCFS should consider developing specialized positions, including, but not limited to:

- **Education Specialist:** Someone(s) responsible for maintaining the relationship between CBHS and educators and monitoring the integration of education with a child's behavioral health services.
- **Juvenile Specialist:** Like the DOC liaisons, this position(s) would be responsible for managing the relationship with DOC and any youth who are involved in both corrections and receiving behavioral health services. This may be the DOC liaisons, but the role should clearly own the responsibility of supporting the relationship with DOC without over-burdening remaining Program Coordinators with more traditional Program Coordinator tasks.
- **Substance Abuse Specialist:** An apparent gap in the service array in Maine is the ability to treat youth with substance abuse disorders. Having a Substance Abuse Specialist would make adequate treatment, close to a youth and family's community, a priority in CBHS.
- **Out-of-State Specialist:** As the number of children out-of-state continues to increase, it becomes increasingly important that the CBHS team has the capacity to monitor those youth and oversee

their services. This is currently being supported by one Program Coordinator with additional responsibilities. If it is not the function of every Program Coordinator to "own" their cases wherever they might be, then it should be a clearly established role for one staff person.

- **Transition Specialist:** While this is currently a function of the Program Coordinator, it is important that OCFS prioritize this vulnerable population with the development of a dedicated Transition Specialist. This person(s) would follow all youth beginning at an age that allows for adequate preparation (typically 14 or 16 years old) and would work with children and families on what to expect and the steps that are needed to ensure that the transition between programs is seamless when the time comes. This might include transition of medical insurance, connecting children and families with contacts within the Office of Aging and Disability Services (OADS) and supporting the transition of case management services. (See PCG report on Children's Behavioral Health Services' system of care for additional information on this recommendation.)

These specialist positions are comparable to the level of responsibility of the Program Coordinators, appointed as a lead for each of the major agencies serving overlapping populations. This distinction would provide specialists in given areas while also reducing some of the burden on Program Coordinators and make it clear where responsibilities lie. While some of these (i.e. the Transition Specialist), would likely require a full FTE, others could potentially become specializations of different staff. If OCFS were to go with the latter, titles should clearly reflect any specialization.

In addition to specialized positions designed to focus on some of the more complex cases, there are functional gaps that exist in the broader CBHS context as well. Other positions to consider should include:

- **Policy Coordinator.** There are implications for the recent move of this position from under CBHS team to OCFS at-large. Policy as it relates to child services is complex, and there will likely be significant challenges in identifying a resource that could supply the necessary subject matter expertise across subject areas. This challenge, coupled with the increased burden on existing CBHS leadership associated with repurposing this line, leaves CBHS at significant risk for gaps in policy, evidence-based practices, and contract related tasks. OCFS should maintain a position that supports policy and program development specific to CBHS.
- **Nurse Consultants.** OCFS should review the Nurse Consultant role and identify how their clinical expertise can best support CBHS, as they are currently being utilized heavily by child welfare. Based on time study results, OCFS should determine if additional Nurse Consultants are needed to support CBHS tasks or if their responsibilities should be re-balanced across OCFS.
- **Medical Director.** For all OCFS departments to be supported as needed, the Medical Director should be full-time and onsite in Augusta. Staff cited that there were challenges with access to the Medical Director because of time and location, resulting in a lack of ability for the Medicaid Director to distribute equal time across OCFS departments. Providers noted that they feel as though they do not have a relationship with the current Medical Director, who does not have connections within the state the way that someone in-state would. PCG observed Team Leaders making notes of topics that the larger CBHS team had considered that required further conversation with the Medical Director, so that the questions could be covered when there was a management meeting because he is inaccessible to staff normally. A full-time Medical Director onsite combined with oversight from leadership about the allocation of that Medical

Director's time throughout OCFS would result in increased clinical support and supervision. (See PCG report on Children's Behavioral Health Services' system of care for additional information on this recommendation.)

- **Quality Assurance Team.** The elimination of the Quality Assurance Team has led to limited oversight of providers, which has resulted in significant variances in quality and safety across providers in the state. OCFS should consider what role the organization should have in monitoring quality and build a team to support that vision. When developing what a Quality Assurance Team might look like, consider other mechanisms for maintaining quality, including performance-based contracting, which increases provider accountability. (See PCG report on Children's Behavioral Health Services' system of care for additional information on this recommendation.)

2E. Invest time for community networking through board membership.

As CBHS team resources have been constrained, priorities have shifted away from relationship development and more toward managing critical situations. Staff described that they used to have the opportunity to regularly engage with the community and that their work suffers as without this engagement. OCFS leadership should try to ensure that this community relationship is a priority for staff by encouraging participation in community meetings and holding positions on boards.

Prioritizing a public face for CBHS not only allows providers and the community to feel more connected to CBHS, but it also allows CBHS staff the opportunity to create and leverage relationships that can be used to provide services. Many staff mentioned times when they would regularly attend provider meetings where they could discuss what the highest need children were missing and could work collaboratively with providers to find a solution. Without prioritization of that relationship, CBHS staff are less likely to know what is available in the community to support children and families.

Benefits and Impact

A time study will allow OCFS leadership to understand what the capacity of their existing workforce is, and it may also benefit the disconnect that seems to exist between leadership and staff regarding the scope of work being supported by the CBHS team. This process will clarify existing roles and help OCFS to identify where there are gaps in their current staffing array that are needed to meet the goals and objectives outlined in their strategic plan. With these gaps defined, OCFS can make a case for what the impact of additional lines might mean on the ability to maintain a high quality of system of care and ensure that families and children feel optimally supported in their journey through the children's behavioral health system. Finally, with a renewed emphasis on community engagement, staff can feel more supported in their ability to do their job and do it well, having a network to leverage to best support children and families.

Risks and Dependencies

While there are no major risks in reviewing roles and responsibilities of staff, the success of this activity does have dependencies. Implementing this recommendation is dependent on buy-in across DHHS including any costs associated with new positions and managing union requirements. Without support from DHHS, it is likely that OCFS will find themselves with a hopeful strategic plan, but without the resources to implement that vision. To mitigate this risk, it is important to make it clear why additional resources are needed, if applicable, and what the return on the investment to DHHS will be. A fully staffed CBHS team will allow CBHS to focus not just on putting out fires, but rather on maintaining the safety and quality of the

children's behavioral health system while simultaneously nurturing the relationships that ensure the success of the system of care.

3. Develop clear and efficient procedures, policies and practices using organizational and change management methodologies

3A. Invest in robust technology that supports the array of CBHS stakeholders, streamlines data collection and improves OCFS' ability to measure and track data.

PCG recommends moving away from the existing case summary tool and employ dynamic technologies to support modernized communication and data reporting capabilities at the desk or in the field.

An interoperable case management system would allow for a central repository of information for CBHS staff to access when they are engaged with a family or child at various stages throughout the system of care (whether that be accessing information for the first time, the amount of time they've waited for services or the length of time that a child has been in residential). Much of this data is currently inaccessible to CBHS staff unless they have experience working directly with that family as it is maintained by private providers, leaving a gap in staff's ability to best support a child or family with support needs, service planning, etc. A system that supports data exchange would allow OCFS to send and receive, as well as store data.

An interoperable case management system might include some or all the following functions:

- Supports not only CBHS, but is also accessible to providers, through either provider access to the system or through data exchanges that support information sharing.
- Allows for communication and messaging capabilities to notify staff about provider updates.
- Includes access to live data around provider availability, performance and capacity.
- Supports the development of a family portal, where families could access information about their child's care, access frequently asked questions and correspond with providers and CBHS staff when necessary.
- Interoperates with systems used by other stakeholders throughout the service array, including hospitals, community providers, corrections, schools, child welfare, and the Commissioner's office.
- Supports the authorization and service referral process for all aspects of the CBHS service array, including integrated mobile crisis response.
- Allows for active management, which includes the ability to manage waitlists and track service access by area, as well as robust reporting functionality, allowing OCFS to query data for ongoing monitoring.

This would require a transformation across all facets of children's behavioral health services throughout the state. However, the investment would support OCFS in providing optimum service to children and families, ensuring that data is not lost as a child or family moves through the system of care. With buy-in and commitment from all stakeholders, an interoperable form of case management would address concerns raised about the continuity of services and support the "no wrong door" approach. It would allow OCFS to be confident in the data being used to measure outcomes and track process and a tool for stakeholders to remain engaged in a child's services, even if they aren't their primary point of contact.

Many state human services agencies and child-serving agencies are moving toward the development of interoperable systems, and they are each approached differently. Pennsylvania, a state that serves an oversight capacity and contracts services out to private providers, chose to not develop a case management system but rather just a data store, that allows the state to access, monitor, and report on the specific data

needed to best oversee services. As child welfare agencies respond to the Comprehensive Child Welfare Information System (CCWIS) regulations, as prescribed by the Administration of Children and Families (ACF), many states are developing solutions that align with the CCWIS goals around data quality, data sharing, and federal reporting.¹²

It is important to note that OCFS is currently planning for a significant transformation of their MACWIS system in an effort to become CCWIS compliant. OCFS should consider coordination in any system development, as it allows for economy of scale and also coordination of care.

3B. Institutionalize knowledge-sharing through the development of procedures for each role.

One of the strongest assets of the CBHS team is the level of institutional knowledge of its staff. Much of the current work is done through the expert knowledge of existing staff who have worked with and formed long-term relationships with agencies, organizations and individuals in the community. Losing those staff would be irreplaceable in the short-term, requiring the commitment of time and resources to rebuild capacity. If OCFS experiences sudden or significant turnover, it would be challenging, time-consuming and potentially impossible to transition that knowledge to new staff, given the current structure. PCG proposes prioritizing the recording of this information through the development of process procedures. This knowledge documentation should be owned by the individuals who do the work. Procedures for how the work is done, including the people and resources needed to do it, should be documented in detail. At a leadership level, OCFS should create a plan and schedule for the sharing of new knowledge on an ongoing basis to ensure that nothing critical to the mission and vision of CBHS is lost with a departing staff member and the procedures are regularly reviewed and updated as needed.

OCFS can consider the development of cross-functional process flows, which are intended to assign specific steps in a process to different stakeholders. This will help with alleviating role confusion and make it clear who (OCFS, provider, case manager) is responsible for specific tasks throughout a child's movement through the behavioral health system. Once OCFS has developed high level cross-functional process flows, more detailed desk-level procedures that further describe the nuance behind each step in the process can be developed. For example, PCG was able to review the process and procedure for the 10-day medical reviews conducted by the Nurse Consultants. This is a strong example of how a process flow should support a more detailed procedure that can be used to train and guide staff on questions to ask and steps to take to sufficiently complete a job duty.

Process and procedure development should be thoughtful and collaborative. Leadership should begin by working with CBHS staff to establish an understanding of current practices. To identify what could be more efficient with a clear procedure, consider asking, *What are the key tasks your role is responsible for? And If there were someone new starting tomorrow, what would the most challenging responsibilities to explain?*

When developing process procedures, encourage staff to start with the path most frequently traveled and map this process out in its entirety and ideal state. Once the foundational process has been mapped, begin to walk through what unique circumstances might arise and develop secondary paths to support the process. For example, when a Reportable Event is screened, it can either be cleared, flagged for assessment or raise immediate concern, warranting a referral to the Division of Licensing for further review. When mapping the process for the reporting of Reportable Events and developing the corresponding procedural process, it is critical to flush out each of these paths in detail.

¹² 46 states, the District of Columbia, and Puerto Rico have all declared CCWIS. The capacity in which they choose to comply with the regulation varies. Each states approach can be found here: <https://www.acf.hhs.gov/cb/resource/ccwis-status>.

OCFS should not shy away from questioning the status quo. If there is a step in a process that doesn't make sense or there is a duplication across roles, use this mapping process as a time to streamline. The result will be formal documentation used to train and onboard new staff, introduce a practice to new leadership and help existing staff adapt. It should represent best practice. If there a specific process that no longer aligns with the new strategic direction of the CBHS team, this is the time to change it.

OCFS should also be mindful of policy implications. Questions to ask include: *Is there a piece of the process that is mandated by policy? Is there something that is not currently mandated by policy, but should be to help standardize practice?* OCFS should involve DHHS and MaineCare as needed to ensure that policy is being considered and to also begin discussions on how to implement change if it is needed.

Based on PCG's observations, it is recommended that OCFS consider developing detailed processes and procedures for the processes listed below. This is not an all-inclusive list but should serve as a foundation for beginning the process.

- 1) Develop a method for staff to communicate with leadership to provide feedback, including ideas and concerns. Currently, staff cite that they feel very supported by their immediate supervisors but have challenges with connecting above that when it is thought to be needed. Identify methods and processes to allow for a continuous feedback loop that allows staff to feel as though they have access to leadership when they feel it is important. Recognizing that email is not always the most effective way of getting attention, as emails can be difficult to prioritize, this might require a more thoughtful approach. This might be the establishment of a regularly occurring meeting that is attended by leadership where the focus is these types of conversations or the development of regularly scheduled "office hours," where leadership has time that is dedicated to addressing CBHS staff concerns.
- 2) Standardize the process for OCFS involvement when children are considered to be "stuck." Create procedures for what OCFS involvement should be when children are in either an emergency department or a psychiatric hospital waiting for a placement or discharge. Clarify: *What classifies a child as being "stuck"? How quickly does that child need to be seen? Who needs to be actively engaged in that child's placement?*
- 3) Define reportable events to include what warrants the escalation of Reportable Events. Clarify: *What are the different paths that a Reportable Event might take once it has been reported? What are the specific decision points around escalation and how does that escalation vary based on the decision that is made?* Streamline what warrants being dismissed, flagged for assessment, or escalated to OCFS management, the Division of Licensing or Office of MaineCare Services.

3C. Create a change team to develop updated procedures based on changes in purpose and tasks.

The development of updated formalized processes, procedures and policy will benefit from change management techniques throughout implementation. Change management is relevant for implementations ranging from as large as a full-scale technology implementation to as small as revised steps in a longstanding, existing practice. Both large- and small-scale change is most successful if staff on the front lines are as invested in changing their practice as leadership is. Encourage the meaningful participation of staff from the start. Their insights, talent and wisdom will help ensure that solutions are practical and supported by those responsible for carrying it out. Ideally, these staff will become "ambassadors of change" during implementation, generating support from their peers and increasing the likelihood of lasting, sustainable improvement. Sustainable change techniques include:

Get Feedback

1

OCFS' most valuable asset will be incorporating feedback from staff about the effectiveness of process changes. It is important for staff to feel heard and valued in the process, developing a cross-role commitment to change. Cultivate OCFS "ambassadors of change" by developing a team charged with engaging in the development and implementation of changes. This Change Team can be a focused, consistent and empowered cohort of agency staff that identify roadblocks and support a continuous improvement model with a cycle of review and revision to ensure processes support the intent of the change. The Change Team will feel ownership over processes and procedures if they are engaged in their development and brought in to consult on the impact of new solutions.

Use Language and Practices that are Familiar

2

Change is hard. Include staff on discussions about the shifts in CBHS purpose and staff roles from the beginning, from development of the strategic plan and into implementation planning. Especially for a team as small as CBHS, transparency creates a sense of mutual respect and trust. Provide frequent updates and detailed explanations to support each decision because understanding the reason behind change makes it more palatable. Framing change in a way that gives staff a role in the improvement process will both set expectations and provide OCFS leadership with a wealth of knowledge and feedback from those on the front lines as they implement change. Consider how responsibilities fit into staff's day to day work and keep lines of communication open, through the Change Team, to discuss workload management as well as impact and outcomes to children, families and providers

Provide Ongoing Support

3

When formalizing processes and procedures, it is important to listen, providing a regular venue for staff to report issues or concerns as they adapt current workstyles to the new process. This should occur outside of and in addition to the Change Team. Continue to offer opportunities for involvement to provide feedback, ask questions and clarify uncertainties to make sure staff and leadership remain on the same page.

Benefits and Impact

Clear processes and procedures set a more streamlined and predictable process both for staff and external stakeholders. For example, providers will know what to expect from OCFS when a child is stuck in the emergency room, including their specific role (and limitations). This consistency will reduce the pressure on the CBHS team to be all things to all people, making staff more efficient in the way that they perform their work by not overextending themselves. Rather than recreating the wheel each time that there is a crisis, there will be an internal toolbox to guide staff through the questions to ask, the stakeholders to involve and the typical service options available.

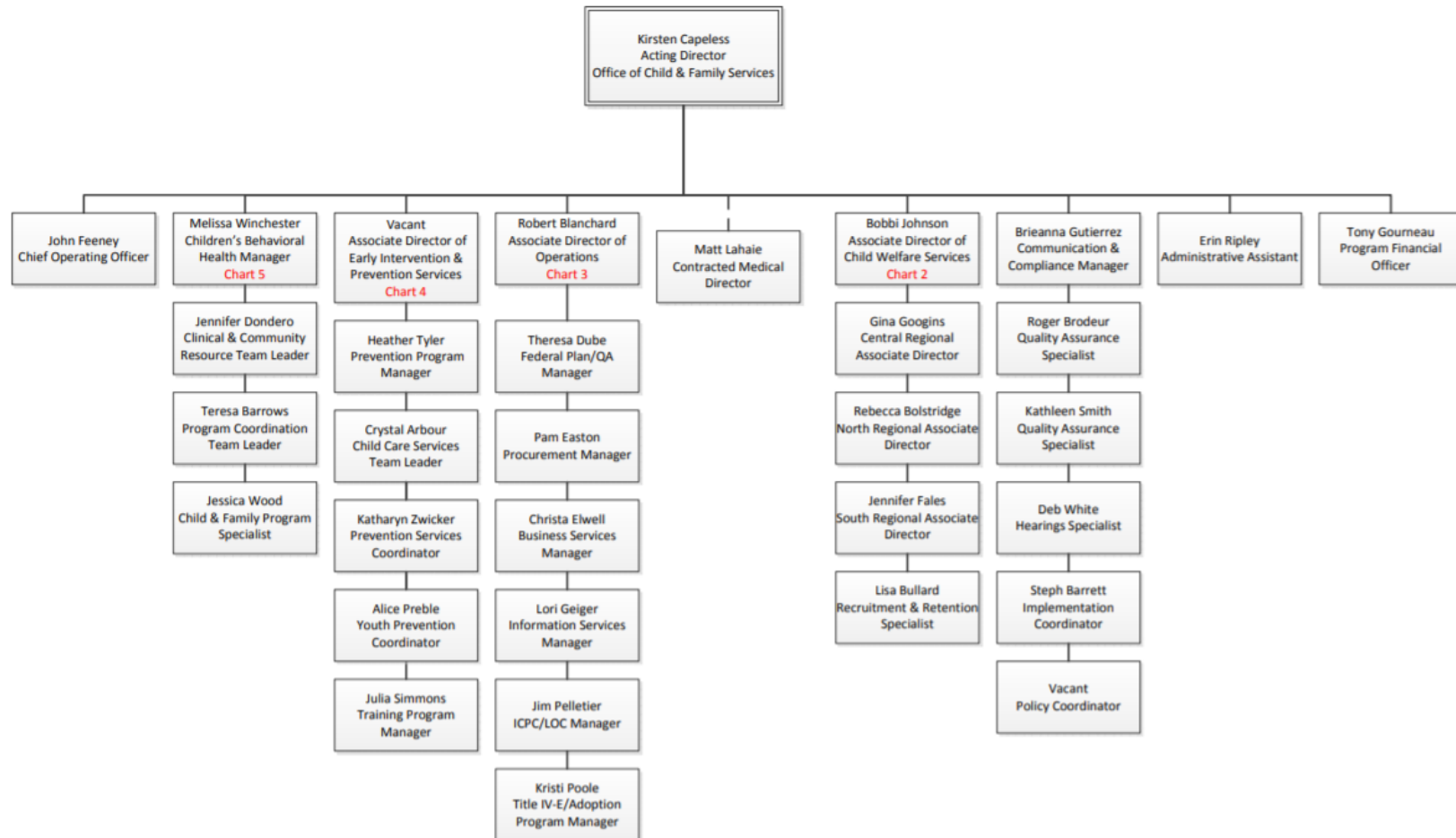
Internally, this will also formalize responsibilities across staff. Not only will staff be clearer about their own role, but they will more confidently be able to hold others – providers and other DHHS staff – accountable to their respective roles as well. A clearer understanding by staff of CBHS responsibilities and limitations will better position OCFS to oversee that system of care; not only providing information and referrals, but setting expectations within coordination that holds others accountable for their role.

Risks and Dependencies

The risk of process and procedure development comes from the significant need for buy-in from staff and stakeholders. Many CBHS staff are accustomed to working independently and appreciate the flexibility to respond differently, based on the child or family, provider and even region in the state. While this may not be an element that changes significantly under the strategic plan, it will be important to consider the degree to which it impacts staff job satisfaction. Supporting staff buy-in through these types of growing pains depends on the extent to which change management practices are included, reducing risk and increasing success in change implementation.

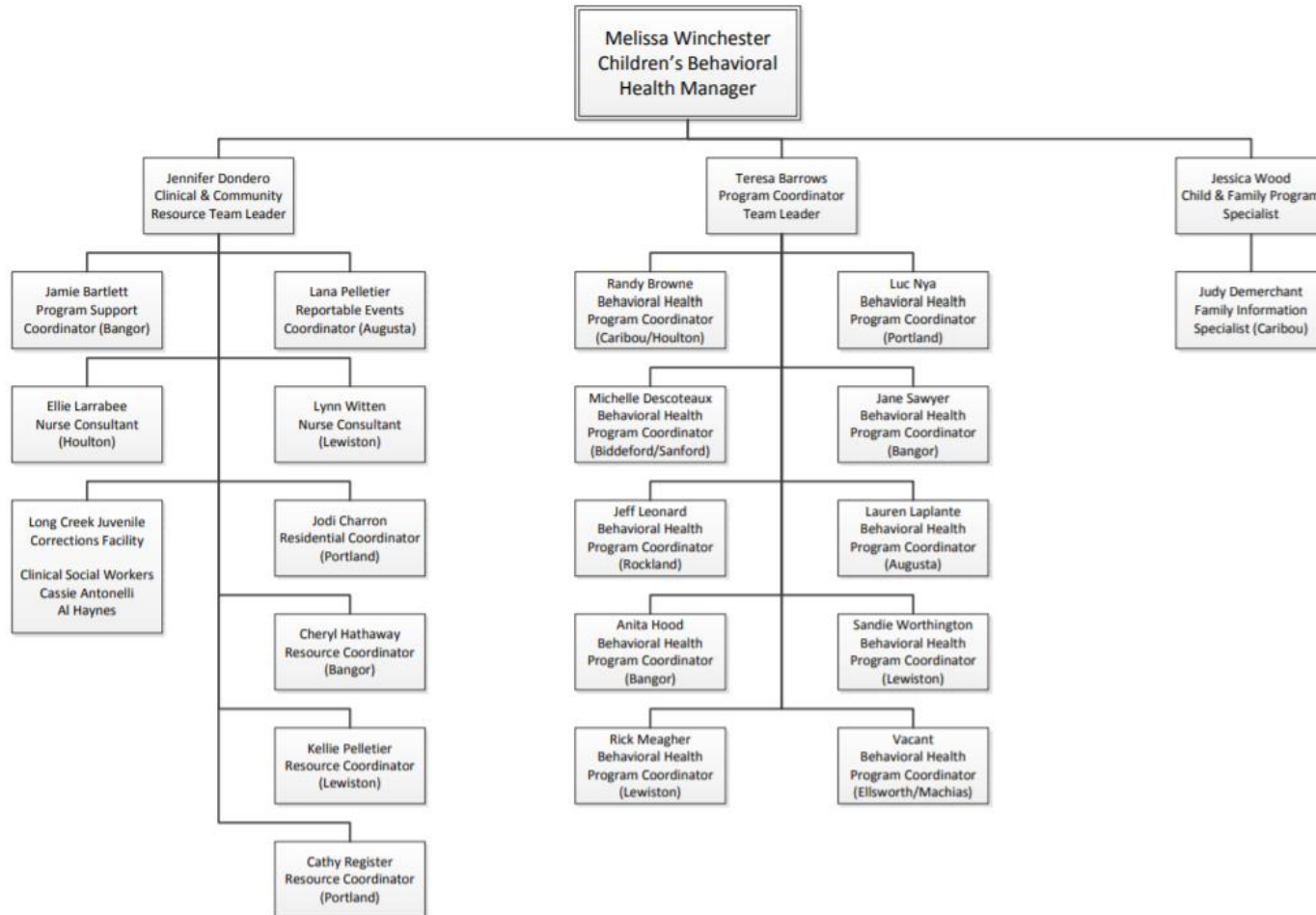
APPENDIX A: OCFS ORGANIZATIONAL CHARTS

Office of Child & Family Services



Children’s Behavioral Health Services Team

Two lines in the CBHS Team, one Resource Coordinator and one Behavioral Health Program Coordinator, have been moved to the Case Coordination Unit (CCU), and are not included in this organizational chart.





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