

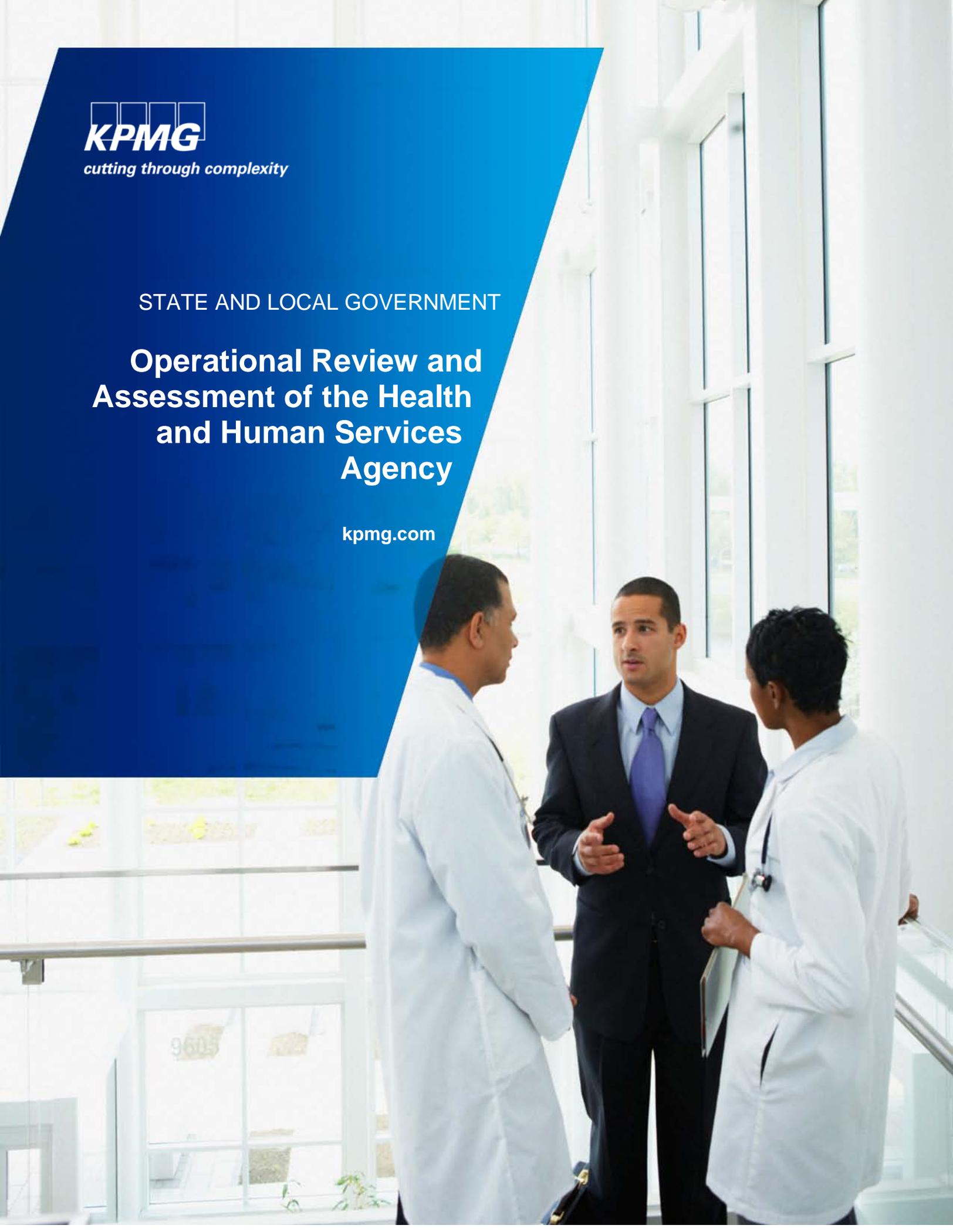


cutting through complexity

STATE AND LOCAL GOVERNMENT

Operational Review and Assessment of the Health and Human Services Agency

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1 Executive Summary

1.1 Project Background and Purpose

In 2008, Fulton County implemented a new health and human service initiative focused on service integration, community involvement, and a holistic delivery approach to address health inequities and disparities throughout the County. The County's initiative - Common Ground, defines strategies for positively influencing health and human service outcomes and improving overall client care for County citizens. Furthermore, Common Ground established the foundation for the County's Integrated Care Service Delivery (ICSD) model. The Common Ground initiative consists of three overarching themes impacting enhanced HHS service delivery to citizens:

- Enhance the integration of service delivery
- Enhance community involvement and awareness
- Develop public policy that enables improving client care

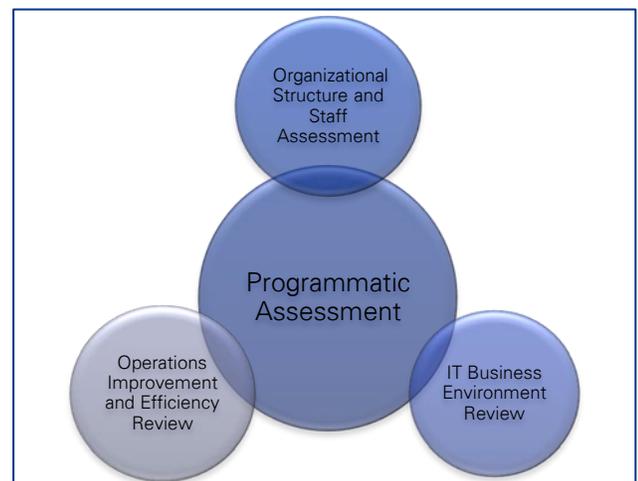
Fulton County engaged KPMG to assess the County's Health and Human Services Agency comparing current state health and human service operations to objectives and goals developed in the 2008 Common Ground initiative. KPMG's project objectives include:

- Compare current HHS operations to Common Ground/ICSD objectives
- Identify progress achieved towards Common Ground/ICSD objectives
- Identify remaining gaps towards Common Ground/ICSD objectives
- Develop a roadmap for achieving future Common Ground/ICSD objectives

1.2 Scope/Approach

The Operational Review and Assessment of the Health and Human Services Agency scope included four primary work streams:

- **Assess Organizational Structure and Staff** – review the Agency's organizational structure to assess specific operations within the Agency, within Fulton County government, and externally to other organizations and individuals.
- **Perform Programmatic Assessment** – review programmatic service delivery focusing on integration of client services and other Common Ground goals.
- **Conduct Operations Improvement and Efficiency Review** – review specific Agency support functions focusing on processes, inputs/outputs, policies and procedures.
- **Conduct IT Business Environment Review** – review the Agency's current use of technology to understand how technology supports programmatic and business results.



KPMG's approach to the project included a broad analysis of administrative, organizational, operational, technological, and programmatic areas of the Health and Human Services Agency. Specific project tasks within each of the four work streams are detailed below. Although each work stream contained distinct

tasks, there are significant interrelationships among each functional work stream impacting the ability for the County to achieve Common Ground objectives.

1.2.1 Organizational Structure and Staff Assessment

- Reviewed existing organization charts and other relevant documentation
- Reviewed existing County measurement and outcome tools
- Conducted interviews with County management and staff
- Conducted and distributed an electronic survey (Job Activity Questionnaire) to County personnel for the purpose of obtaining feedback about current operations, job functions, and staff knowledge of Common Ground initiatives
- Documented and assessed current state organizational structure and staff functionality
- Identified potential opportunities for improvement and leading practices

1.2.2 Programmatic Assessment

- Reviewed Program, Common Ground, and Integrated Care Service Delivery Documentation (including overviews, measurements, status reports, etc.)
- Identified measureable action items from the initial Common Ground document
- Conducted interview with County management and staff
- Gained an understanding of program service delivery
- Conducted gap analysis of documented ICSD initiatives, and measures to current operations
- Worked with the County to determine a program sample to further assess program delivery models and outputs

The exhibit below shows the 22 programs selected for more detailed assessments. The 22 programs selected are a representative sample of HHS services offered to County citizens within Health Services, Behavioral Health, Human Services and Housing and Community Development.

Exhibit 1.1

HHS Program Sample (22 Programs)		
• Adolescent Health and Youth Development	• Jail Diversion/ Court Services	• Fresh Grants
• Babies Can't Wait	• Community Health Education	• Dental Health
• Children First	• Emergency and Transitional Housing	• Women's Health
• Children's Medical Service	• Workforce Development	• Primary Care Clinic (Grady Medical)
• Child and Adult Immunization	• Housing and Community Development	• Child, Adolescent and Family Services
• WIC	• Adult Day Care	• Adult Behavioral Health
• Transforming Lives of Children (TLC)	• Senior Multipurpose	
• Teen Dads	• Primary Care Screening*	

*At the time of the programmatic review, the Primary Care Screening Program was administered by Health and Wellness. Since that time, administration of the program was transferred to West End Medical centers.

- Reviewed coordination and collaboration between programs or departments
- Conducted customer satisfaction survey at two service delivery centers
- Compared current state to leading practices
- Identified potential opportunities for improvement and leading practices

1.2.3 Operations Improvement and Efficiency Review

- Reviewed the following HHS workflows:
 - Hiring
 - Purchasing
 - Grants Management
 - Patient/Client Intake
 - Referral
 - Service Assessment
 - Case Management
 - Patient/Client Records
- Reviewed existing workflow documentation (process flows, Key Performance Indicators, Policies and Procedures, etc)
- Conducted interviews with County management and staff
- Gained an understanding of current workflows
- Identified potential opportunities for improvement and leading practices

1.2.4 IT Business Environment Review

- Reviewed IT documentation (Annual Plans, Architecture, etc.)
- Conducted interviews with County management and staff
- Reviewed and documented current IT usage and environment
- Assessed and documented IT current state
 - Identified duplication of effort or systems within HHS and the County
 - Gained an understanding of IT security and disaster recovery
 - Identified IT support roles and skills
 - Identified HHS business needs
- Gained an understanding of future short term and long term IT needs and priorities
- Identified potential opportunities for improvement and leading practices

1.3 Common Ground Initiative Overview

In 2008, the Georgia Department of Community Health released a report titled *Health Disparities 2008: A County-Level Look at Health Outcomes for Minorities in Georgia*. The report assesses health outcomes for each of the 159 counties within the State. The report indicates significant health disparities across the State, including Fulton County. In response, the Fulton County Board of Commissioners implemented a new initiative focused on service integration, community involvement, and a holistic approach to providing health and human services. The County's Health and Human Services cluster (the Department of Health and Wellness, the Department of Behavioral Health and Developmental Disabilities, the Department of Human Services, Atlanta-Fulton Library System, the Cooperative Extension, and the Department of Arts and Culture) published *Common Ground: Creating Equity through Public Policy and Community Engagement* in late 2008, outlining the County's philosophy for addressing health inequities and disparities and improving overall client care.

The new philosophy of Integrated Care Service Delivery seeks to fundamentally change the way Fulton County citizens receive services by increasing access to health and human services. The Common Ground initiative consists of three overarching themes impacting enhanced HHS service delivery to citizens:

- Enhancing the integration of service delivery
- Enhancing community involvement and awareness
- Developing public policy that enables improving client care

The themes above, along with increasing administrative efficiency, establish the foundation for the County's Common Ground initiative. This initiative supports HHS's commitment to healthy and equitable communities.

Fulton County was proactive and innovative in creating a strategic vision for positively influencing health and human service outcomes for its citizens. Common Ground, with its focus on Integrated Care Service Delivery, is a leading practice among public health and human service organizations.

1.4 Common Ground Goals/Objectives

The overarching objective of Common Ground is improving health outcomes for Fulton County residents and address health disparities in the community. The 2008 Common Ground report identified several goals to support its overarching objective including:

- Increasing access to health care in under-served communities
- Increasing awareness of health disparities and social determinants of health within the community
- Providing programs and prevention strategies to needy and at-risk populations to enhance the quality of life
- Improving overall health outcomes for clients served

Service integration and service availability is critical to Common Ground's success. HHS designed a service model for delivery of integrated and comprehensive health and human services at County health centers, known as Integrated Care Service Delivery. The current HHS ICSD model contains the following components, as outlined in the *2010 Common Ground Mid-Year Update* report:

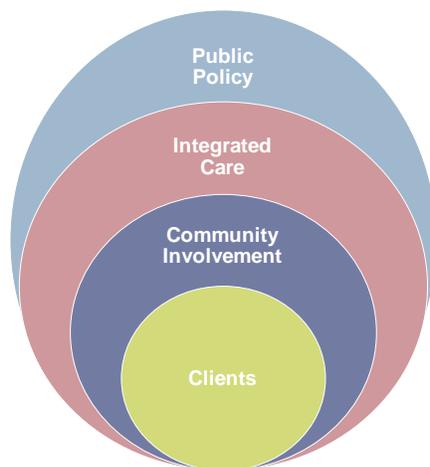
1. Integration of Service Provision
2. Individualized Needs Assessment
3. Standard Clinical Services
4. Needs-Based Services
5. Case Management
6. Trained Staff
7. Partnerships
8. Community Outreach/Engagement
9. Capital Improvements
10. Program Evaluation

The 10-component model listed above is the framework for which HHS implements the Common Ground philosophy. The result is several "one-stop shop" facilities that offer multiple services at a single location. Common Ground initially focused on program delivery and has since evolved into an Integrated Care Service Delivery philosophy.

1.5 Looking Forward

The alignment of Common Ground's core elements – ICSD philosophy – is essential for implementing an effective care system for County residents. The exhibit below illustrates the relationship and interdependency of elements that lead to a successful care system. The four bands: Clients, Community Involvement, Integrated Care, and Public Policy are dependent upon one another for overall success and increased positive health outcomes for citizens.

Exhibit 1.2



The expected outcome of the Common Ground initiative goes beyond improving health outcomes today. The Common Ground initiative's focus on ICSD helps to prevent future health disparities through proactive and holistic client care. Common Ground is an investment in the community that can improve overall client health and reduce County costs. The Center for Disease Control claims that preventing disease is the best buy in the health sector. CDC research shows that for every \$1 spent on childhood vaccinations, there is \$10 return on investment and prevents about 20 million cases of disease nationally, per year. Additionally, a one percent reduction in weight, blood pressure, glucose, and cholesterol risk factors would save \$83 to \$103 annually in medical costs per person.¹ The Common Ground initiative and its focus on Integrated Care Service Delivery is a critical step towards improving the quality of care for Fulton County citizens and reducing health disparities in the community.

1.6 Common Ground Key Milestones and Observations

Fulton County has made significant strides in realizing its vision for Common Ground. The County successfully established multiple integrated service centers. The service centers serve as "one-stop shops" for clients and are one of the hallmarks of the County's vision. Integrated service centers such as Neighborhood Union and North Fulton offer primary care, behavioral health, oral health, workforce development and other services in a single location - enabling a holistic approach to client care. Further progress towards establishing integrated service centers is critical to supporting the continued success of Common Ground and ICSD. Fulton County is in the process of renovating and opening several new service centers such as the Oak Hill Child, Adolescent and Family Center, the South Fulton Service Center, and the Adamsville Service Center.

¹ National Prevention Council, *National Prevention Strategy*, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.

Fulton County also made progress towards realizing its goal of integrated service provision through internal administrative and organizational realignments. In 2009, the Health and Human Services Agency was formed, realigning the Departments of Health and Wellness, Housing and Human Services, the Atlanta-Fulton Library System, Cooperative Extension, and Arts and Culture. The County also realigned HHS support functions under a single division. The Division of Administrative Services (DAS) provides centralized support to HHS departments and programs.

The future potential success of ICSD is highly dependent on innovative and effective information technology strategies. Common Ground's ICSD objectives cannot be achieved without proper information systems to track, maintain, share, measure, and analyze client information. Capturing and sharing client information throughout HHS is vital to enabling providers to fully and accurately provide clients with the health and human services needed to improve life situations and health outcomes. For HHS to be a leader in Integrated Care Service Delivery, HHS requires a technology foundation that supports holistic and strategic client care.

Although HHS programs provide services to similar clients, they operate out of aged disparate systems designed for different purposes. Many HHS service providers maintain client information that is limited to the individual programs they support. Presently, HHS information systems do not enable comprehensive tracking and sharing of client case history across HHS departments or programs. HHS's existing client information environment includes:

- Multiple information systems to track client information
- Inconsistent client information among multiple technology systems
- Lack of a single method to access client information from disparate information systems
- Numerous paper-based processes

The County made significant progress towards Common Ground goals by co-locating services to single locations. Co-locating services is a step towards integration of client care, but integrated assessment, planning, and service delivery require client information to be shared consistently across service providers. HHS does not have a single information system or portal to access a holistic account of client service history among the multiple programs offered at the single location.

HHS must align its overall business goals with Fulton County's future IT strategy. Fulton County defined specific business goals and strategies through the Common Ground initiative. The County needs to further define and implement technology requirements to support Common Ground. In addition, the County needs to ensure future technology endeavors align to federal and state guidelines as well as data sharing and security requirements. Technology is imperative to Common Ground's success and will drive improved and automated processes that increase the agility and effectiveness of HHS services.

1.6.1 Observations Summary

The following exhibit is a high level summary of key observations contained throughout the report. Details supporting the recommendations and for implementing the recommendations are contained in Section 7 of this report. The report should be read in its entirety to gain a full understanding of the context for the observations and recommendations.

Exhibit 1.3

	Current State	Recommendations	Outcome	Common Ground Goals Supported
Organization				
A	There is limited consistent and clear governance of ICSD objectives and execution across HHS personnel.	Implement a Common Ground Governance Model	Daily focus on driving Common Ground initiatives to implementation	<ul style="list-style-type: none"> Community Engagement Public Policy Advocacy Integrated Care Service Delivery
B	A strategic coordinated approach is needed to transition the staff/organization, community partners, stakeholders, and clients to the ICSD approach from the current state.	Create and Execute a Change Management Strategy	Coordinated and holistic method for driving Common Ground operational changes consistently throughout all HHS programs	<ul style="list-style-type: none"> Community Engagement Public Policy Advocacy Integrated Care Service Delivery
C	There is currently a limited focus on reviewing and developing Public Policy that aligns with ICSD.	Review and Develop Public Policies that Impact Social Determinants of Health	Improved Social Determinants of Health through alignment of public policy and Common Ground initiatives	<ul style="list-style-type: none"> Public Policy Advocacy
Operations				
D	The County hiring process offers little flexibility and DAS has limited input and control throughout the process.	Enhance the Hiring Process	More accurately meet hiring needs in a timely manner	<ul style="list-style-type: none"> Overall effectiveness
E	DAS lacks clear, enforceable, and consistent procedures for requisitions. Current processes are not uniformly applied across all HHS departments and require numerous approvals which may result in process delays.	Streamline HHS internal Purchasing Process	Reduced administrative burden and costs, allowing employees to focus more on client service delivery	<ul style="list-style-type: none"> Overall effectiveness
F	There is not a defined grants management function for HHS. Grant management responsibilities are primarily decentralized and executed at the program level.	Create and Define Agency-wide Policies and Procedures for Grants Management	Reduced risk around grant non-compliance	<ul style="list-style-type: none"> Overall effectiveness
Technology				
G	DAS IT processes and initiatives do not consistently align to DoIT's operating model or the County's overall IT strategy. There is limited coordination between HHS technology efforts and DoIT technology efforts.	Redesign HHS IT Support to Better Align to Established Countywide IT Policies and Procedures	Improved service delivery and more consistent IT support processes	<ul style="list-style-type: none"> Overall effectiveness

	Current State	Recommendations	Outcome	Common Ground Goals Supported
H	HHS client information management systems do not currently provide an integrated, holistic client record. Business processes for client service management are not consistent across HHS departments.	Integrate Client Service Information Management Applications and Supporting Business Processes	Established technology foundation necessary for integrated service delivery	<ul style="list-style-type: none"> Overall effectiveness
Programmatic Assessment				
I	There does not appear to be a systematic approach for comprehensive case management across HHS.	Identify and Implement Models for Integrated Case Management for Target Populations	Decreased burden on the client to identify service needs and eligibility	<ul style="list-style-type: none"> Integrated Care Service Delivery
J	A consistent and ongoing method for standard business processes, and uniform branding is not currently in place across service centers.	Develop Common Practices for Service Delivery that are Consistent with Common Ground's Philosophy	Increased awareness and delivery of Common Ground goals	<ul style="list-style-type: none"> Integrated Care Service Delivery
K	Service centers have multiple client intake entry points resulting in inconsistent client processes.	Develop a Common Intake and Screening Process at Each Common Ground Delivery Site	Enablement of the County to more accurately match services offered to client needs	<ul style="list-style-type: none"> Integrated Care Service Delivery
L	The lack of a single integrated referral process limits client access to other programs.	Develop a Standardized Referral Process with Required Follow-up Actions	Increased positive client outcomes by guiding clients through standard referral process	<ul style="list-style-type: none"> Integrated Care Service Delivery
M	HHS maintains multiple client data systems resulting in duplication of data entry efforts and limited client data sharing.	Develop a Process and Supporting Infrastructure for Sharing Client Data Across Programs	Established technology foundation necessary for integrated service delivery	<ul style="list-style-type: none"> Integrated Care Service Delivery
N	There is not a coordinated effort to engage and develop community partnerships. Most partnerships are developed at the program level.	Create and Execute a Community Engagement Strategy	Amplified ability to impact community health factors	<ul style="list-style-type: none"> Community Engagement
O	There does not appear to be consistent or standardized categorization of key performance indicators and outcome measures across HHS departments. Methods to track evidence based outcomes are inconsistent across HHS.	Clarify Outcomes for Each Service	Readily available relevant data to make service delivery decisions	<ul style="list-style-type: none"> Integrated Care Service Delivery
P	There is little historical data to comprehensively evaluate Common Ground and the implementation of ICSD across HHS programs over multiple years.	Implement Ongoing and Comprehensive Program Evaluation	Readily available relevant data to make management decisions regarding health and human service provision in the County	<ul style="list-style-type: none"> Integrated Care Service Delivery

1.6.2 Observations Implementation

The following exhibit represents a visual summary of estimated timelines, complexity and costs for each recommendation. The following definitions apply:

- **Short-term** – Implementation period of less than 12 months
- **Long-term** – Implementation period of greater than 12 months
- **Estimated Complexity** – Defined as high, medium, or low effort for implementation. High complexity requires substantial commitment of staff effort, financial resources, and coordination among multiple stakeholders both internal and external to HHS and the County. Medium complexity requires moderate staff effort, financial resources, and coordination among stakeholders. Low complexity requires minimal disruption to day-to-day staff responsibilities, limited financial commitments, and is not dependent on multiple stakeholders
- **Estimated Cost** – Defined as high, medium, or low cost for implementation. High estimated cost requires a financial investment of \$500,000 or more. Medium estimated cost requires a financial investment of between \$100,000 and \$500,000. Low estimated cost requires a financial investment of less than \$100,000

Exhibit 1.4

Recommendation	Short Term 0-12 months	Long Term 13 – 36 months	Estimated Complexity	Estimated Cost
Organization				
A. Implement a Common Ground Governance Model			Medium	Medium
B. Create and Execute a Change Management Strategy			Medium	Medium
C. Review and Develop Public Policies that Impact Social Determinants of Health			Medium	Low
Operations				
D. Enhance the Hiring Process			Medium	Low
E. Streamline HHS Internal Purchasing Process			Medium	Low
F. Create and Define Agency-wide Policies and Procedures for Grants Management			Medium	Medium
Technology				
G. Redesign HHS IT Support to Better Align to Established Countywide IT Policies and Processes			Medium	Low
H. Integrate Client Service Information Management Applications and Supporting Business Processes			High	High

Recommendation	Short Term 0-12 months	Long Term 13 – 36 months	Estimated Complexity	Estimated Cost	
Programmatic Assessment					
I. Identify and Implement Models for Integrated Case Management for Target Populations	→			High	High
J. Develop Common Practices for Service Delivery that are Consistent with Common Ground's Philosophy	→			Medium	Medium
K. Develop a Common Intake and Screening Process at Each Common Ground Delivery Site	→			Low	Medium
L. Develop a Standardized Referral Process with Required Follow-up Actions	→			Medium	Medium
M. Develop a Process and Supporting Infrastructure for Sharing Client Data Across Programs	→			Medium	High
N. Create and Execute a Community Engagement Strategy	→			Low	Low
O. Clarify Outcomes for Each Service	→			Medium	Medium
P. Implement Ongoing and Comprehensive Program Evaluation	→			High	Medium



2 Project Overview

2.1 Project Background and Objectives

In 2008, Fulton County implemented a new health and human service initiative focused on service integration, community involvement, and a holistic delivery approach to address health inequities and disparities throughout the County. The County's initiative - Common Ground, defines strategies for positively influencing health and human service outcomes and improving overall client care for County citizens. The Common Ground initiative consists of three overarching themes impacting enhanced HHS service delivery to citizens:

- Enhance the integration of service delivery
- Enhance community involvement and awareness
- Develop public policy that enables improving client care

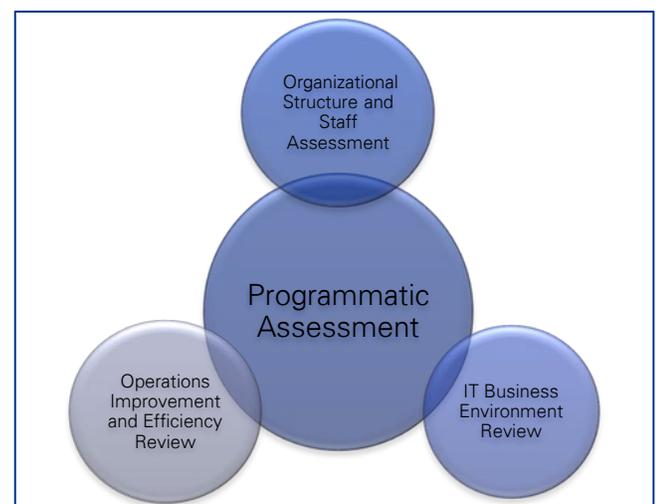
In January 2012, Fulton County engaged KPMG to assess the County's Health and Human Services Agency comparing current state health and human service operations to objectives and goals developed in the 2008 Common Ground initiative. KPMG's project objectives include:

- Comparing current HHS operations to Common Ground/ICSD objectives
- Identifying progress achieved towards Common Ground/ICSD objectives
- Identifying remaining gaps towards Common Ground/ICSD objectives
- Developing a roadmap for achieving future Common Ground/ICSD objectives

2.2 Project Scope

The Operational Review and Assessment of the Health and Human Services Agency scope included four primary work streams:

- **Assess Organizational and Staff Structure** – review the Agency's organizational structure to assess specific operations within the Agency, within Fulton County government, and externally to other organizations and individuals.
- **Perform Programmatic Assessment** – review programmatic service delivery focusing on integration of client services and other Common Ground goals.
- **Conduct Operations Improvement and Efficiency Review** – review specific Agency support functions focusing on processes, inputs/outputs, policies and procedures.
- **Conduct IT Business Environment Review** – review the Agency's current use of technology to understand how technology supports programmatic and business results.



2.3 Project Approach

KPMG’s approach to the project included a broad analysis of administrative, organizational, operational, technological, and programmatic areas of the Health and Human Services Agency. Specific project tasks within each of the four work streams are detailed below. Although each work stream contained distinct tasks, there are significant interrelationships among each functional work stream impacting the ability for the County to achieve Common Ground/ICSD objectives.

2.3.1 Organizational Structure and Staff Assessment

- Reviewed existing organization charts and other relevant documentation
- Reviewed existing County measurement and outcome tools
- Conducted interviews with County management and staff
- Conducted and Distributed Job Activity Questionnaire (JAQ) to County personnel. The purpose of the JAQ was to obtain feedback from the broader employee population in a non-disruptive manner to better understand current operations, job functions, and knowledge of Common Ground initiatives. The JAQ was sent directly to a randomly selected HHS employee population and also was made available to any HHS employee that desired to participate
- Documented and assessed current organizational structure and staff functionality
- Identified potential opportunities for improvement and leading practices

2.3.2 Programmatic Assessment

- Reviewed Program, Common Ground, and Integrated Care Service Delivery Documentation (including overviews, measurements, status reports, etc.)
- Identified measureable action items from Common Ground
- Conducted interview with County management and staff
- Gained an understanding of program service delivery
- Conducted analysis of gaps between the documented Common Ground/ICSD initiatives and current operations
- Worked with the County to determine a program sample to further assess program delivery models and outputs. The exhibit below shows the 22 programs selected for more detailed assessments. The 22 programs selected are a representative sample of HHS services offered to County citizens within Health Services, Behavioral Health, Human Services and Housing and Community Development

Exhibit 2.1

HHS Program Sample (22 Programs)		
• Adolescent Health and Youth Development	• Jail Diversion/ Court Services	• Fresh Grants
• Babies Can’t Wait	• Community Health Education	• Dental Health
• Children First	• Emergency and Transitional Housing	• Women’s Health
• Children’s Medical Service	• Workforce Development	• Primary Care Clinic (Grady Medical)
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• WIC	• Adult Day Care	• Adult Behavioral Health
• Transforming Lives of Children (TLC)	• Senior Multipurpose	
• Teen Dads	• Primary Care Screening*	

*At the time of the programmatic review, the Primary Care Screening Program was administered by Health and Wellness. Since that time, administration of the program was transferred to West End Medical centers.

- Reviewed coordination and collaboration between programs or departments
- Conducted customer satisfaction survey at two service delivery centers
- Compared current state to leading practices
- Identified potential opportunities for improvement and leading practices

2.3.3 Operations Improvement and Efficiency Review

- Reviewed the following HHS workflows:
 - Hiring
 - Purchasing
 - Grants Management
 - Patient/Client Intake
 - Referral
 - Service Assessment
 - Case Management
 - Patient/Client Records
- Reviewed existing workflow documentation (process flows, KPI's, Policies and Procedures, etc)
- Conducted interviews with County management and staff
- Gained an understanding of current workflows
- Identified potential opportunities for improvement and leading practices

2.3.4 IT Business Environment Review

- Reviewed IT documentation (Annual Plans, Architecture, etc.)
- Conducted interviews with County management and staff
- Reviewed and documented current IT usage and environment
- Assessed and documented IT current state
 - Identified duplication of effort or systems within HHS and the County
 - Gained an understanding of IT security and disaster recovery
 - Identified IT support roles and skills
 - Identified HHS business needs
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3 Common Ground Initiative Overview

In 2008, the Georgia Department of Community Health released a report titled *Health Disparities 2008: A County-Level Look at Health Outcomes for Minorities in Georgia*. The report assesses health outcomes for each of the 159 counties within the State. The report indicates significant health disparities across the State, including Fulton County (County). In response, the Fulton County Board of Commissioners (Board) implemented a new initiative focused on service integration, community involvement, and a holistic approach to providing health and human services. The County's Health and Human Services cluster (the Department of Health and Wellness, the Department of Behavioral Health and Developmental Disabilities, the Department of Human Services, the Atlanta-Fulton Library System, Cooperative Extension, and the Department of Arts and Culture) published *Common Ground: Creating Equity through Public Policy and Community Engagement* in late 2008, outlining the County's philosophy for addressing health inequities and disparities and improving overall client care.

Common Ground, with its focus on ICSD seeks to fundamentally change the way Fulton County citizens receive services by increasing access to health and human services. The Common Ground initiative consists of three overarching themes impacting enhanced HHS service delivery to citizens:

- Enhancing the integration of service delivery
- Enhancing community involvement and awareness
- Developing public policy that enables improving client care

The themes above along with increasing administrative efficiency, establish the foundation for the County's Common Ground initiative. This initiative supports HHS's commitment to healthy and equitable communities.

Fulton County was proactive and innovative in creating a strategic vision for positively influencing health and human service outcomes for its citizens. The Common Ground vision, with its focus on ICSD is a leading practice among public health and human service organizations.

3.1 Common Ground Goals/Objectives

The overarching objective of Common Ground is improving health outcomes for Fulton County residents and address health disparities in the community. The 2008 Common Ground report identified several goals to support its overarching objective including:

- Increasing access to health care in under-served communities
- Increasing awareness of health disparities and social determinants of health within the community
- Providing programs and prevention strategies to needy and at-risk populations to enhance the quality of life
- Improving overall health outcomes for clients served

The Common Ground initiative began with six "Targeted Opportunities" designed to address health disparities by targeting at-risk populations within the County. The following list identifies the six intended Common Ground opportunities:

- Implement Services To At-Risk Teens (START) to create a continuum for youth and coordinate and target funds and programs for at-risk youth and their families
- Renovate Oak Hill Mental Health Treatment to serve as the foundation for a county-wide system of care and coordinate comprehensive services to include support and prevention, early intervention, focused intervention, and crisis intervention

- Renovate North Fulton Service Center to provide a spectrum of services that residents can access in a single location
- Renovate South Fulton Service Center to provide a spectrum of services that residents can access in a single location
- Build Neighborhood Union Primary Care Partnership to serve as a foundation for integrating traditional services such as public health, mental health, and human services with primary care services
- Establish Intergenerational Communities to provide quality childcare support services for older adults, including counseling services, educational opportunities, Temporary Assistance for Needy Families (TANF) assistance, Medicaid services, and access to the Women, Infants and Children (WIC) program

Service integration and service availability is critical to Common Ground's success. HHS designed a service model for delivery of integrated and comprehensive health and human services at County health centers, known as Integrated Care Service Delivery. The current HHS ICSD model contains the following components, as outlined in the 2010 *Common Ground Mid-Year Update* report:

1. Integration of Service Provision
2. Individualized Needs Assessment
3. Standard Clinical Services
4. Needs-Based Services
5. Case Management
6. Trained Staff
7. Partnerships
8. Community Outreach/Engagement
9. Capital Improvements
10. Program Evaluation

The 10-component model listed above is the framework for which HHS implements Common Ground philosophy. The result is several "one-stop shop" facilities that offer multiple services at a single location.

Today, Common Ground maintains a focus on improving service delivery to clients, strengthening interdepartmental collaborations, and enhancing external partnerships to improve health outcomes throughout the County. Section 6: ICSD Programmatic Assessment of this report details KPMG's review of the 10-component model of Common Ground.

3.2 Common Ground Key Milestones

Fulton County has made significant strides in realizing its vision for Common Ground. The County successfully established multiple integrated service centers. The service centers serve as "one-stop shops" for clients and are one of the hallmarks of the County's vision. Integrated service centers such as Neighborhood Union and North Fulton offer primary care, behavioral health, oral health, workforce development and other services in a single location, enabling a holistic approach to client care. Further progress towards establishing integrated service centers is critical to supporting the continued success of Common Ground. Fulton County is in the process of renovating and opening additional new service centers such as the Oak Hill Child, Adolescent and Family Center, the South Fulton Service Center, and the Adamsville Service Center.

Fulton County also made progress towards realizing its goal of integrated service provision through internal administrative and organizational realignments. In 2009, the Health and Human Services Agency was formed, re-aligning the Department of Health and Wellness, the Housing and Human Services Departments, the Atlanta-Fulton Library System, Cooperative Extension, and the Department of Arts and Culture. The County also realigned HHS administrative support functions under a single division – the Division of Administrative Services.

Further information regarding the County's milestones and progress regarding the Integrated Care Service Delivery model is discussed in Sections 4-6 of this report.

The future potential success of ICSD is highly dependent on innovative and effective information technology strategies. Common Ground objectives cannot be achieved without proper information systems to track, maintain, share, measure, and analyze client information. Capturing and sharing client information throughout HHS is vital to enabling providers to fully and accurately provide clients with the health and human services needed to improve life situations and health outcomes. For HHS to be a leader in Integrated Care Service Delivery, HHS requires a technology foundation that supports holistic and strategic client care.

Although HHS programs provide services to similar clients, they operate out of aged disparate systems designed for different purposes. Many HHS service providers maintain client information that is limited to the individual programs they support. Presently, HHS information systems do not enable comprehensive tracking and sharing of client case history across HHS departments or programs. HHS's existing client information environment includes:

- Multiple information systems to track client information
- Inconsistent client information among multiple technology systems
- Lack of a single method to access client information from disparate information systems
- Numerous paper-based processes

The County made significant progress towards Common Ground goals by co-locating services to single locations. Co-locating services is a step towards integration of client care, but integrated assessment, planning, and service delivery require client information to be shared consistently across service providers. HHS does not have a single information system or portal to access a holistic account of client service history among the multiple programs offered at the single location.

HHS must align its overall business goals with Fulton County's future IT strategy. Fulton County defined specific business goals and strategies through the Common Ground initiative. The County needs to further define and implement technology requirements to support ICSD. In addition, the County needs to ensure future technology endeavors align to federal and state guidelines as well as data sharing and security requirements. Technology is imperative to Common Ground's success and will drive improved and automated processes that increase the agility and effectiveness of HHS services.

4 Organization Structure/Staffing Assessment

KPMG assessed the HHS organizational structure including Agency-wide communication, employee performance management, interdepartmental relationships, and roles and responsibilities within the Agency pertaining to Common Ground initiatives.

4.1 Organization Structure and Staffing

In 2009, the County realigned the services of Health Services (which includes Health and Wellness and Behavioral Health and Developmental Disabilities), Housing and Human Services, and the Atlanta-Fulton Library System, Cooperative Extension and the Department of Arts and Culture (Quality of Life Services) to create an organizational structure that better supports Common Ground initiatives for integrated care service delivery. The new Agency, known as the Health and Human Services Agency also realigned HHS administrative support functions under the Division of Administrative services to support services such as finance, human resources, procurement, and information technology. The reorganization resulted in a single Agency with four Directors, who currently report directly to the County Manager. The scope of this report does not include additional discussion related to the Atlanta-Fulton Library System, Cooperative Extension or the Department of Arts and Culture.



HHS has more than 1,050 employees supporting more than 100 programs across numerous geographic locations in Fulton County. HHS distributes various communications to HHS staff such as electronic newsletters or emails and staff meetings. However, HHS does not have standardized procedures for distributing information across the Agency or a strategy for communicating to all employees at the same time.

KPMG identified specific action items derived from the 2008 Common Ground report and the 2010 draft Mid-Year Update reports. Key HHS stakeholders were interviewed to provide insight on the progress, relevance, and impact of the action items to current Common Ground initiatives and HHS operations. Fulton County has successfully executed several of the action items from the initial Common Ground Report. Roles and responsibilities were not consistently developed to support Common Ground actionable items. The actionable items should be updated to help ensure applicability with the County's evolving ICSD strategy. Currently there is not a person or persons responsible for ensuring accountability and consistent execution of Common Ground initiatives. A lack of defined responsibilities and

governance for continuously implementing Common Ground initiatives may hinder or slow future progress towards achieving Common Ground goals.

HHS has made positive progress towards meeting Common Ground themes. However, there does not appear to be a current defined role within the Agency focusing on public policy. Public policy development is one of the three main themes identified within the Common Ground report. There appears to be limited analysis supporting and establishing public policy with integrated care and Common Ground outcomes. As Common Ground initiatives continue to move forward, the County will need to create and align public policy to further support and enable Common Ground goals.

4.1.1 Contributing Factors to Common Ground Implementation

As part of the Common Ground initiative, HHS physically relocated certain Agency programs to increase physical proximity of related services. While it is important to note that physical proximity is only one of many factors that support integrated care service delivery, the relocations appear to assist with increased collaboration across programs and better enable the County to meet the holistic needs of clients.

4.1.2 Preventing Factors to Common Ground Implementation

Clear, consistent communication is critical to achieving Agency initiatives as HHS has more than 1,050 HHS employees supporting more than 100 programs. HHS employees explained communication is often inconsistent and unclear, including messaging around Common Ground objectives.

Communications from HHS top level management are often not provided directly to front-line HHS staff. Communications often pass through multiple layers and position levels before front-line staff receive HHS top level management thoughts which often results in misinterpretations or mixed messages. Primarily due to inconsistent communications, there is inconsistent understanding of the Common Ground philosophy and initiatives by frontline HHS staff.

In addition to limited Common Ground communication from management, there does not appear to be clear lines of Common Ground communication from employees, program managers and management. As a result, goals and expectations are not clearly communicated among staff.

While HHS appears to have effectively merged some support service functions such as finance and recruitment, several support functions such as procurement, grant management and employee training, continue to have processes fragmented across departments within the Agency. HHS employees have received limited training to increase knowledge of other programs/services available and appropriate contacts outside their specific department.

Clear management structures and lines of accountability do not exist within the Common Ground framework. Currently there is not a person or persons responsible for ensuring accountability and consistent execution of Common Ground initiatives. It will be difficult to fully realize Common Ground goals without a position or group continuously focused on implementing Common Ground initiatives on a daily basis.

Achieving Common Ground initiatives requires support and effort from every HHS employee. Yet, individual employee performance expectations are not driven by measurable goals that align to Common Ground initiatives. HHS does not provide employees with standardized processes for individual goal setting and performance feedback. In addition, direct supervisors do not have consistent, formal opportunities to incentivize good behavior or outstanding employee performance.

4.1.3 Other Efficiency Observations

HHS does not maintain a master organization chart that is regularly updated to reflect all Agency employees and reporting structures. Lack of a defined organization structure limits the Agency's ability to understand and improve communication channels, program relationships, and employee roles.

Employees may not be fully aware of other programs or services offered by other divisions or programs. For example, many HHS employees do not have a clear understanding of who to contact outside of their program to gain information regarding HHS programs and services. This limited program awareness hinders HHS employee integration efforts and impedes their ability to connect clients with other service offerings in the County.

5 Operations and Information Technology Assessment

KPMG assessed the following operational focus areas within HHS:

- Hiring
- Purchasing
- Grants Management
- Information Technology

As part of the assessment, KPMG assessed key work flows and distributed a JAQ to HHS employees. KPMG reviewed the people, process and technology supporting each focus area identified above. KPMG analyzed potential bottlenecks, duplication of employee and system efforts, and functional relevancy. KPMG discussed operations with HHS program personnel, HHS DAS personnel and other County personnel outside of HHS to gain an understanding and insight into the support services within scope.

5.1 Hiring

The HHS Human Resources (HR) division is located within the Division of Administrative Services and functions as the hiring agent for HHS programs. KPMG's scope for this engagement included a review of the hiring function within HR. KPMG reviewed the hiring function as it relates to external recruiting through extending an offer to a candidate. KPMG discussed the hiring process with HHS staff and Fulton County Central Personnel Office (CPO) employees. Five HHS HR employees support approximately 1,050 HHS personnel and 34 Fulton County HR employees support approximately 6,000 countywide personnel. HHS HR employees are responsible for communicating and serving as a liaison between HHS programs and Fulton County CPO.

HHS redesigned the organizational structure in an effort to centralize support services, including Human Resources in 2009. The HR division is not directly involved in the hiring process for the Library Services and Cooperative Extension, but may provide assistance if requested.

At the time of this report, a Countywide hiring freeze has been in place for approximately three years, requiring HHS HR to review the program justification forms to fill most positions. Temporary positions funded through grants do not require a justification. A freeze waiver requires three manual approvals coordinated by HHS HR.

Departments can fill positions with internal candidates and may do so without additional assistance and approvals from the CPO. When departments fill positions with external candidates, they must get assistance and approvals from HHS HR and the CPO. The CPO is responsible for advertising positions and identifying an initial pool of applicants. HHS HR is responsible for coordinating the interview process on behalf of the departments, making sure that interviews are conducted with consistency and are in accordance with Fulton County policies. Departments supply HHS HR with three personnel to sit on the interview panel. Candidate selection is ultimately the department's responsibility.

5.1.1 Contributing Factors to Common Ground Implementation

HHS HR coordinates recruiting and administrative efforts to allow departments to focus on Common Ground program execution. HHS HR hiring processes are dependent on department input and approval. For example, department representatives serve on candidate selection panels to help identify qualified candidates supporting programmatic initiatives. Program panel representation allows programs to ensure selected candidates possess the necessary skills to support the Common Ground philosophy and Integrated Care Service Delivery.

5.1.2 Preventing Factors to Common Ground Implementation

HHS processes are driven by policy and procedures determined by Fulton County CPO. For example, position descriptions are created by Fulton County and HHS HR cannot easily modify position descriptions to include specific medical skill sets. This can often result in a misalignment between positions advertised and specific HHS departmental needs resulting in under-qualified applicants unaware of the true roles and responsibilities for the position. Common Ground's focus on Health Disparities requires flexibility in recruitment to obtain the best talent to support initiatives.

5.1.3 Other Efficiency Observations

The CPO is responsible for several steps in the recruiting cycle which limits HHS HR's control over process time. HHS HR sometimes experiences a lag of four to seven weeks from the time a requisition is submitted before a list of eligible applicants is provided by CPO. As a result, HHS HR has limited insight into the recruiting process once the personnel request is submitted to CPO. Further fragmentation of HHS's hiring process may result from continued limited insight into CPO processes.

To promote a fair and equitable recruitment process, HHS HR requires the interview panel to contain the same members throughout interviews for a position. However, this can create scheduling challenges and process delays. HHS HR's manual processes for obtaining multiple approvals are also contributing to lengthy process time.

5.2 Purchasing

DAS helps coordinate purchasing activities for departments. KPMG reviewed the DAS processes for purchasing goods and services. DAS documented standard operating procedures for purchases less than \$2,500, purchases between \$2,500 and \$49,999, and purchases greater than \$50,000. The requisition process consists of both electronic and manual work steps, each with several layers of approval. The County does not have established approval thresholds for purchasing with the exception that board approval is required for purchases exceeding \$50,000.

Several HHS departments use the HHS Orders, a DAS Access database, system to track requisitions submitted by the departments to DAS. However, the Housing and Human Services Department does not use HHS Orders. Instead, the Housing and Human Services Department contacts an assigned employee in Administrative Services to track requisitions. DAS also maintains a separate Excel database outside of HHS Orders to help ensure requisitions are accounted and properly tracked.

HHS may use a purchase card (P-Card) for procurement of items under \$2,500. The assigned purchaser in DAS determines the use the P-Card versus a purchase order. As a result, the process may differ depending on the department submitting the requisition and the employee assigned to purchase the good or service. DAS then either purchases items on departments' behalf or alternatively, Behavioral Health may sign out the P-Card. The process for procuring items under \$2,500 can require up to eight touch points with HHS personnel.

5.2.1 Preventing Factors to Common Ground Implementation

There are a high number of approvals, reviews and touch points in the purchasing process. Some steps lack a review function and act as a pass through to another phase in the approval process. The process may result in duplication of efforts, as the multiple review and approval steps are often examining the same criteria. In addition, there is minimal variation in approvals and reviews for purchases of different dollar values. A \$100 purchase requires the same number of approvals as a \$10,000 purchase.

5.2.2 Other Efficiency Observations

HHS purchasing processes are highly manual. While some purchasing activities occur electronically, purchasing records are maintained manually and stored in hard copy. HHS does not have electronic signature or workflow enabled for purchasing activities.

DAS exists to help centralize purchasing activities for HHS. However, scenarios remain where process steps vary, such as requisition tracking, approvals, routing and P-Card use depending on the department submitting the request.

5.3 Grants Management

Grant management responsibilities are performed by HHS programs receiving grant funding and DAS. KPMG discussed the grants management process with HHS staff and Fulton County Grants Management Office (GM) employees. HHS has informal and decentralized management and monitoring processes. Additionally, many grant management processes are dependent upon grantor (federal, state, or other organization) requirements and countywide policies and procedures.

Grant program managers within HHS departments have primary responsibility for day to day management of grant financial and programmatic activities. DAS performs some application assistance and fiscal review upon request from HHS programs. DAS also performs financial drawdowns for non-federal HHS grant programs and often serves as a liaison between grant program managers, the GM office, and the grantor (federal, state, or other organization). The GM office performs an additional layer of assistance and review of grant applications as well as financial drawdowns for federal HHS grant programs.

5.3.1 Preventing Factors to Common Ground Implementation

HHS and the County perform limited monitoring of grant administration by program level employees. HHS, as an agency, does not consistently perform programmatic or grant audits to help ensure daily grant administration aligns to grantor (federal, state, or other organization) requirements. Also, grant monitoring is decentralized at the programmatic level. The lack of a defined business process owner increases the risk of grant mismanagement and non-compliance with federal, state, and other regulations. Limited monitoring increases financial and programmatic risks that may undermine Common Ground initiatives. HHS does not perform regular program audits.

5.3.2 Other Efficiency Observations

HHS and GM are performing duplicative review of grant applications and approval processes. The review function performed by DAS occurs simultaneously with the review steps at both the Department and the GM level.

5.4 Information Technology

HHS receives technology support from three functional groups within the County: Fulton County Department of Information Technology (DoIT), the HHS Division of Administrative Services (DAS IT), and additional technology staff within the Department of Housing and Human Services (DHHS). KPMG's assessment included a review of DAS IT operations. An IT assessment of DoIT was not in scope for this engagement; however, KPMG interviewed the Fulton County CIO and other staff to gain further context of HHS IT operations and roles and responsibilities of DoIT and DAS IT.

DoIT supports County agencies by defining Countywide IT strategy, policies, and processes and providing resources to meet technology needs of the County. This includes, but is not limited to, help desk support, procurement assistance, server maintenance, application hosting, and network administration.

DAS IT is comprised of three employees and supports the Department of Health Services by providing the following technology services:

- HHS subject matter assistance for applicable DoIT activities
- First-line technology support
- Liaison between end users and DoIT for second-line technology support
- Application functional/ "business facing" support (for HHS systems, primarily M&M and not DHHS systems)
- Application development and management for M&M
- Physical equipment and facility support such as telephony, wireless devices, printing, and laptops

Two program employees with a technology focus within the Department of Housing and Human Services support the department only by providing application functional/ "business facing" support (for DHHS systems, primarily Serve Tracker and AIMS). These two employees report directly to DHHS management, not DAS IT or DoIT.

5.4.1 Contributing Factors to Common Ground Implementation

HHS end-users communicated through interviews that DAS IT technology support generally provides a sense of personalized service. Many end-users at the service centers responded positively during KPMG interviews, saying most of technology issues were addressed with a simple phone call or email to DAS IT, because, through experience, they knew who to call.

5.4.2 Preventing Factors to Common Ground Implementation

DAS IT exists to supplement DoIT technology support, however, DAS IT processes and initiatives do not consistently align to DoIT's operating model or the County's overall IT strategy. There is also limited coordination between HHS technology efforts and DoIT technology efforts. Most HHS end-users contact HHS technology staff for their "first-line of defense" towards technology issues. DAS IT staff then work to resolve the issue, generally through informal processes, or forward the issue to DoIT for resolution. However, DAS IT often takes initiative to provide support, such as service management, vendor management, incident/problem management, or change/release management, which may be handled more efficiently by established processes and roles within DoIT.

The following examples indicate the lack of alignment and coordination between HHS technology support and DoIT technology support.

- **Nonalignment of Service Management** – HHS maintains a system inventory with system descriptions and mapping to specific program areas, but the inventory does not appear to align to an IT service management strategy within DoIT. Without a comprehensive understanding of what systems exist, whether they are considered critical, and defined responsibilities for system management, HHS faces higher risks around managing system availability, disaster recovery, capacity management, incident/problem management, and change/release management
- **Inadequate Vendor Management** – DAS IT was unable to demonstrate an ample understanding of vendor contracts and Service Level Agreements (SLAs) associated with HHS systems, limiting HHS’s ability to enforce SLAs and manage vendor performance. Without clear roles for vendor management, HHS may not be realizing the full value of vendor services articulated in the vendor contracts
- **Manual Project Management** – DAS IT project management activities are highly manual and spreadsheet driven. DAS IT does not appear to leverage any standardized process frameworks or methodologies that may exist within DoIT
- **Inconsistent Change/Release Management** – DAS IT is not consistently informed of change/release activities affecting HHS systems unless there is an issue. This creates a higher risk of implementation delays, inconsistent communication to end-users, missed SLAs, and service delivery interruptions to clients
- **Inadequate Incident/Problem Management Follow-up** – DAS IT does not consistently follow DoIT processes for incident management, such as assigning tickets numbers and tracking issue status in DoIT’s BMC Service Express, an incident management system. The lack of electronic incident tracking limits the department’s ability to identify, track, measure, and resolve trends in technology issues. It also limits DAS IT and DoIT’s ability to strategically implement preventative controls to better manage future incidents from becoming repetitive problems

HHS client service management processes and systems (e.g. M&M, AIMS, and Pathways) do not provide an integrated, holistic client record. Some HHS systems were implemented over 15 years ago and may not currently meet agency, state, or federal needs. The M&M system is a client records management system used by the Divisions of Public Health, and Behavioral Health and Developmental Disabilities; the AIMS system is a client management system utilized by HHS Aging programs, and the Pathways system is another client management system utilized by one of the housing facilities. Each system contains basic client demographic data and limited elements of patient history. Additionally, business processes, such as data gathering and reporting, for client service management are not consistent across HHS departments. The exhibit below identifies the three client management systems used throughout the Agency. Note: the table below is not exhaustive of each system within HHS.

Exhibit 5.1

System	User Department	Purpose
M&M	Division of Public Health; Division of Behavioral Health and Developmental Disabilities	<ul style="list-style-type: none"> • Maintains client record management system
AIMS	Aging	<ul style="list-style-type: none"> • Tracks client data such as services used and demographic information
Pathways	Housing Facility	<ul style="list-style-type: none"> • Tracks client information pertaining to services used within Jefferson Place; serves as the Homeless Management Information System (HMIS)

5.4.3 Other Efficiency Observations

There appears to be some duplication of functions for general technology support between DAS IT and DoIT. DAS IT exists to provide faster, more personalized service, yet evidence is not available to demonstrate DAS IT effectiveness or lack thereof. DAS IT processes for requesting technology support are unclear and do not consistently align to DoIT processes, thereby often creating unnecessary confusion to end-users. Further, HHS does not have clearly defined roles and responsibilities for technology staff. DAS IT does not have defined roles responsibilities for functional (business-facing) and technical (IT-facing) technology support causing staff to split responsibilities across many competing roles. During interviews, multiple end-users stated they were unclear about the processes to report technology issues, how their issues were being managed once reported, and what kind of services levels (i.e. time to resolve) to expect.

5.5 JAQ summary

KPMG distributed an online JAQ to HHS employees. The purpose of the JAQ was to learn more about responsibilities, strengths and opportunities for the County to continue to deliver integrated care services to clients. The JAQ enabled KPMG to obtain anonymous feedback from employees through a web based survey tool. The JAQ responses were analyzed to identify common themes to assist with issue identification and analysis.

JAQ Key Themes

The exhibit below shows the three most common themes identified in the JAQs.

Exhibit 5.2

Question	Summarized Themes from HHS Employee JAQ Responses
In terms of efficiency - What works well in your program?	<ul style="list-style-type: none"> • Providing quality services to clients
	<ul style="list-style-type: none"> • Addressing physical, behavioral, and social needs of clients (Common Ground Initiative)
	<ul style="list-style-type: none"> • Coordinating team and staff job responsibilities
In terms of efficiency - What does NOT work well in your program?	<ul style="list-style-type: none"> • Communication from management regarding implementation of Common Ground/ICSD initiatives
	<ul style="list-style-type: none"> • Adequate staffing for service demands
	<ul style="list-style-type: none"> • Adoption of IT systems and EHR capabilities
What should HHS keep doing?	<ul style="list-style-type: none"> • Integrate services within HHS
	<ul style="list-style-type: none"> • Offer quality services to their clients
	<ul style="list-style-type: none"> • Engage community and partner with external agencies
What should HHS start doing?	<ul style="list-style-type: none"> • Use updated technology and implement EHR capabilities
	<ul style="list-style-type: none"> • Refer clients between HHS programs effectively
	<ul style="list-style-type: none"> • Market the County's integrated services and capabilities
What should HHS stop doing?	<ul style="list-style-type: none"> • Assuming that Common Ground integrated services are working without a clear strategic plan
	<ul style="list-style-type: none"> • Rushing implementation of initiatives and outcome measurement

Question	Summarized Themes from HHS Employee JAQ Responses
	<ul style="list-style-type: none"> • Duplicating services
Additional comments.	<ul style="list-style-type: none"> • Better training and more formal processes need to be put in place to effectively implement the full integration of HHS services
	<ul style="list-style-type: none"> • Communication from management regarding implementation of initiatives needs to improve
	<ul style="list-style-type: none"> • Proper EHR capabilities are necessary to integrate programs under HHS

Source: Job Activity Questionnaires

JAQs indicate that employees perceive the Integrated Care Service Delivery model as a positive step toward comprehensively addressing the physical, behavioral, and social needs of the clients they serve. Furthermore, JAQs indicated that Common Ground/ICSD model is a good idea that aims at decreasing the health disparities within a community.

Another common theme identified in the JAQ responses is that HHS offers quality services to the clients and community members they serve. While many employees have varying comments on what activities HHS does and does not do well, many agree that HHS positively affects the community by offering quality services.

However, while JAQ comments regarding Common Ground reflect that employees believe the initiative is an important step to better client care, they also claim that the initiative lacks clear ownership, communication and procedural framework, preventing successful implementation.

There are three key themes throughout the JAQ responses in terms of preventing factors to the Common Ground/ICSD initiative: communication, implementation processes, and technology systems, including Electronic Health Records (EHR).

Analysis of the JAQ responses illustrates that employee's view inconsistent and informal communication within HHS as a barrier to service integration efforts. The responses addressing the communication issues within HHS can be broken down into two categories:

- Communication from management down to the front-line employees
- Communication between HHS programs

JAQ responses expressed that they receive minimal, clear, consistent messages regarding Common Ground's goals, message, benefits, and true definition through any form of regular communication from HHS management. This lack of consistent, regular communication on the initiative may lead to misunderstanding and lack of buy-in by the front-line employees who play a major role in the initiative's overall effectiveness.

JAQ responses indicated the absence of standard communication between HHS programs limits their knowledge on the other services that HHS offers to their clients. Employees expressed that to more effectively link their clients to other programs and services within HHS, they need to have a better understanding and knowledge of the various service offerings that HHS provides.

JAQ analysis also illustrated the respondent's common opinions toward HHS's current technology capabilities. When asked what HHS should start doing, many employees stated that HHS should start using Electronic Health Records. The topic of Electronic Health Records was also a common theme when employees were asked to describe any barriers to service integration. In general, employees commented that EHR technology and capability is essential to full service integration in that it allows necessary HHS programs to electronically sync to share client data and referrals.

Another theme found among the JAQ responses was that HHS does not appropriately address and provide the necessary processes to successfully implement the Common Ground initiative. Many employees commented that Common Ground was created and “implemented” without consistent processes and defined methods across HHS programs. According to the responses, this leads to miscommunication and confusion about how to effectively implement the initiative among HHS’s various programs and services.

JAQ responses saw the definitions of Common Ground and Integrated Care as interchangeable. When asked the two separate questions: what does Common Ground mean to you and what does integrated care service delivery mean to you, the most common answer to each question was that they meant a “one-stop-shop” for services. Employees further defined these “one-stop-shops” as a single location where HHS clients can receive the services they need.



6 ICSD Programmatic Assessment

KPMG's scope included a review of 22 HHS-related programs for the purpose of assessing progress toward an integrated service delivery model. KPMG conducted one-on-one and group interviews with program staff and conducted site visits at the following:

- Six service center site visits
- One homeless shelter
- Two multipurpose senior centers
- Fulton County administrative offices

KPMG examined program documentation, standard operating procedures, workflows, and business processes for each of the 22 programs. The following exhibit lists each of the 22 programs assessed, shows the associated HHS department, and briefly describes each program.

Exhibit 6.1

Fulton County HHS Programs Reviewed		
Program	HHS Department	Description
Health Services		
Adolescent Health and Youth Development	Health and Wellness	Programs target improved health outcomes for children ages 10-19 through provision of primary health services, such as physical exams, immunizations, vision and hearing screenings, and STD testing and counseling
Babies Can't Wait	Health and Wellness	Provides services for families with infants and/or toddlers, aged 0-3, who have development delays or disabilities. The range of services includes occupational and physical therapy, primary health care, and family and individual counseling
Children First	Health and Wellness	Supports early identification of medical, environmental, or social conditions that place children at risk for poor health outcomes. Services are provided to children aged 0-3
Children's Medical Service	Health and Wellness	Provides coordination of specialty health care for children ages 0-21 that chronic medical conditions and require ongoing care
Child and Adult Immunization	Health and Wellness	A variety of immunizations are available for low-income children and adults
WIC	Health and Wellness	A federal program administered by the U.S. Department of Agriculture that provides food, healthcare, nutritional counseling for low-income pregnant women, post-partum women, and infants and children up to 5 years of age who are deemed to be nutritionally at-risk

Fulton County HHS Programs Reviewed		
Program	HHS Department	Description
Dental Health	Health and Wellness	Provides dental and oral health care services for children starting at age 1 and continuing through the completion of 12th grade. Services are available at a reduced charge and include dental exams, cleanings, restorations, preventive services, and emergency treatment
Women's Health	Health and Wellness	Nursing services are provided for low-income women, including primary care, health screenings, pregnancy testing, gynecological exams, and referrals to more specific services
Primary Care Screening*	Health and Wellness	Primary care services are provided to adults aged 18 and up. Services include routine primary care, preventive care, lab tests, and screenings for diseases such as diabetes and hypertension
Primary Care Clinic (Grady Medical)	Health and Wellness	Provides primary care services at the Grady Medical Clinic located at the North Fulton Service Center in Sandy Springs
Child, Adolescent and Family Services	Behavioral Health and Developmental Disabilities	Operated out of the Oak Hill Child, Adolescent and Family Center, the County provides community-based behavioral health and addictive disease services for children, adolescents and their families. Services include diagnostic assessments and a variety of treatment programs such as individual, group, and family counseling, evening and summer therapeutic programs, and off-site community-based services including groups in the schools. Referrals to and coordination with the Fulton Family Care Network (FFCN) are also provided
Adult Behavioral Health	Behavioral Health and Developmental Disabilities	Provides an integrated and coordinated system of care to adults, including culturally competent screenings, assessments, and therapeutic services for citizens with mental health and substance abuse needs
Jail Diversion/ Court Services	Behavioral Health and Developmental Disabilities	Serves adults that are either incarcerated or diverted from incarceration by a Fulton County accountability court. In conjunction with a number of community agencies, the program provides case management, health and mental health services, substance abuse counseling, and reintegration into society
Supporting Services		
Community Health Education	Health and Wellness	Provides health education to community members and groups through health-related presentations, technical assistance in planning health-related events, training, and participation in community events

*At the time of the programmatic review, the Primary Care Screening Program was administered by Health and Wellness. Since that time, administration of the program was transferred to West End Medical centers.

Fulton County HHS Programs Reviewed		
Program	HHS Department	Description
Housing and Human Services		
Transforming Lives of Children (TLC)	Human Services	Designed to assist children in child care facilities that display mental health and developmental needs. Services include child behavioral observations, developmental screenings, therapeutic and educational referrals teacher training, and parent education workshops
Teen Dads	Human Services	Provides support services to teen fathers (ages 14 – 19) to ensure family stability. The overall goal is to strengthen families by providing young teen fathers with the skills, knowledge, and tools needed to successfully care for their child's financial and emotional needs
Fresh Grants	Human Services	Fulton Roundtable Expanded Services Headquarters (FRESH) provides grants to non-profits that provide services to children aged 0-21. Grants are targeted to at-risk youth and include services such as pregnancy prevention, youth leadership development, and after school programs
Emergency and Transitional Housing	Human Services	Emergency and transitional housing assistance is provided for homeless men, women, and children at a variety of facilities throughout the County. In addition to providing temporary shelter, programs offer various services including substance abuse treatment, counseling, and workforce development
Workforce Development	Human Services	The County offers numerous workforce development programs aimed at providing job search assistance, education, and training for unemployed and low-income adult residents. Specific programs provide workforce development assistance to teens
Housing and Community Development	Housing and Community Development	Several housing programs provide assistance for low and moderate-income residents with services such as rental assistance, affordable housing, down payment assistance, and housing rehabilitation opportunities
Aging		
Adult Day Care	Human Services	Offers services to adults aged 55 and over with functional impairments that prevent them from unsupervised living. Program aims to prevent premature institutionalization of seniors, maintain/improve senior functioning, and provide respite for senior caregivers
Senior Multipurpose	Human Services	The County's Harriett G. Darnell Senior Multipurpose Facility offers programs and services for seniors in numerous areas, including wellness, fitness, social activity, nutrition, and therapeutic services

KPMG reviewed leading practices for implementing ICSD by other jurisdictions in the United States and globally to compare Fulton County’s approach to integrated services. KPMG gathered information from numerous articles, reports, and websites as well as telephone interviews with seven individuals in five counties with ICSD experience in their respective jurisdictions. The seven individuals contacted and interviewed are identified below:

Exhibit 6.2

County	Contact
Los Angeles County, CA	<ul style="list-style-type: none"> Patricia Ploehn, Director, Services Integration Branch
Humboldt County, CA	<ul style="list-style-type: none"> Phillip Crandall, Director, Department of Health and Human Services Nancy Starck, Legislative Analyst
Hennepin County, MN	<ul style="list-style-type: none"> Stella Whitney West, CEO, NorthPoint Health and Wellness Center
Multnomah County, OR	<ul style="list-style-type: none"> Alice Galloway, Consultant, formerly Executive Director, Wraparound Oregon
Chester County, PA	<ul style="list-style-type: none"> James D. Bruce, Consultant, formerly Director, Department of Human Services Ruth Krantz-Carl, Director, Department of Human Services

In this section, KPMG defines ICSD, provides examples of leading practices, and compares leading practices to the HHS current state of services. The section ends with a summary of additional lessons learned and challenges pertaining to the implementation of ICSD.

Definition of Integrated Care Services Delivery

The field of human services recognizes the need for significant and fundamental changes in service delivery systems. Changes include the need for reforms that go beyond improving health and human services across multiple systems that serve essentially the same at-risk populations. Various leading practice initiatives are designed to solve the need for:

- A common intake with a standardized screening or client assessment
- Integrated care plans across programs
- Case management, often administered through multi-program teams
- Culturally relevant and inclusive practices
- Improved program efficiency
- Outcomes linked to individual, family, and community health

The effort to integrate human services began in the 1960s with the Economic Opportunity Act designed to improve the lives of the under resourced. The Federal government encouraged its agencies and counterparts at the state level to work towards more comprehensive systems, realizing that addressing poverty crossed over many human service agencies. Early in the 1970s the U.S. Department of Health, Education and Welfare (HEW) initiated several reforms that attempted to break down categorical barriers and integrate service delivery across program areas. In 1971 former HEW Secretary Elliot Richardson stated:

“Service integration refers primarily to ways of organizing the delivery of services to people at the local level. Service integration is not a new program superimposed over existing programs; rather, it is a process aimed at developing an integrated framework within which ongoing programs can be rationalized and enriched to do a better job of making services available within existing commitments and resources.”²

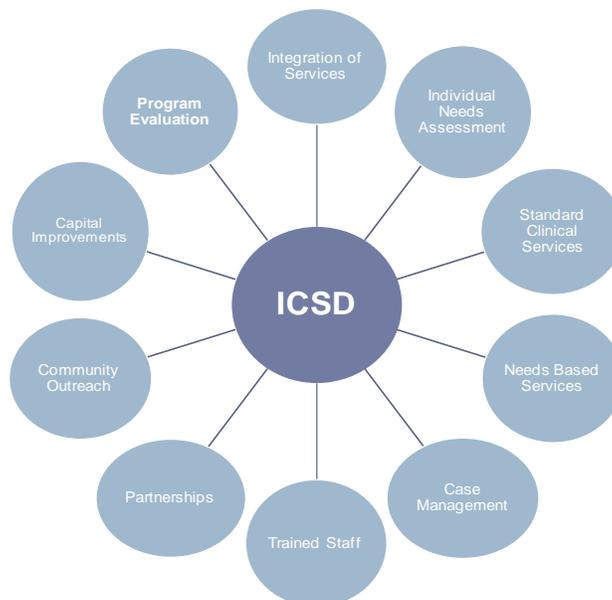
Over time, researchers have found it useful to think of ICSD as two types of strategies: administrative and operational:

- **Administrative Strategies** – Administrative strategies are behind the scenes changes such as reorganizing government agencies to consolidate program administration and functions; collaborating in planning, management, and oversight; integrating a wide range of service providers in local systems; and the blending of funding streams
 - **Operational Strategies** – Operational strategies directly affect client/worker processes such as co-locating staff from multiple programs and organizations; developing common client intake, assessment, and case management services; consolidating case plans and staff functions; and integrating staff from multiple agencies into a single team to address the client or family
- Administrative service integration strategies typically have more ambitious goals and are focused on reforming the delivery system. Operational strategies typically have more modest goals and are focused on linking clients to existing services and uniting various service providers, without altering the program budgeting or funding process, service Agency responsibility, or organizational structures

Fulton County’s Key Characteristics of Integrated Services

KPMG uses Fulton County’s 10 component model of services integration, as mentioned in the Common Ground Mid-Year Update report, for organizing the program assessments and leading practice discussion. For each component, KPMG describes the components and provides examples of leading practices, describes Fulton County current state related to the component, and identifies both contributing factors (processes in place to implement the ICSD) and preventing factors (areas where further implementation efforts are needed). The 10 components are identified in the exhibit below.

Exhibit 6.3



² Department of Health and Human Services of United States (DHHS). (1991). *Services Integration: A Twenty-year Retrospective*. Washington, DC: Office of Inspector General

6.1 Integration of Service Provision Assessment

Fulton County identified an Integrated Care Services Delivery (ICSD) Model as one of the primary goals of Common Ground. The core of this model is the coordination and integration of multiple services for a family or individual. Service integration is achieved, in part, through interdepartmental collaboration that coordinates the planning and delivery of services, and ideally, co-locates the services for convenient access for clients. Centralized intake and a standardized referral process are also important elements of ICSD. Such integration facilitates access to and enrollment in services that an individual or family might not otherwise know about or access. Fulton County envisions Common Ground to include interdepartmental collaboration that enables HHS to make continual progress and improvements toward integrated service delivery.

6.1.1 Leading Practices

The provision of integrated services presumes that staff assesses clients/families in a holistic manner and align identified needs to County services in an integrated care plan. Service delivery by multiple providers is then based on the common understanding of the overall circumstances and needs of the clients. As services are provided, the various service providers collaborate and coordinate, sharing information about progress, issues, and required service changes. An efficient mechanism and a common process for referring services across agencies provide both efficiencies and clarity for the clients and service providers. In an integrated service model, the case manager is the focal point for planning and service information exchange. The case manager has ownership of each case assigned to the individual, or the team, regarding a client care of services.

Multnomah County, Oregon emphasized the importance of using multi-disciplinary teams to conduct the initial assessments, make referrals, and assign case managers. No single program owns the case as the multi-disciplinary team approach enables individual workers to get out of silos and collaborate with others.

Multnomah County also stressed the need to assign facilitators to manage the multidisciplinary teams. Facilitators run meetings, maintain case notes, and help ensure tasks are accomplished. In Multnomah County, the teams meet each week until care plans are finalized. Because the family exists as part of the team from the beginning, the family is more likely to take responsibility for maintaining the care plan as well as a child safety plan, if needed.

Silos can develop at administrative levels and can impact the success of integrated service delivery. KPMG performed a review of Canada's Ministry of Health and Long-Term Care (MOHLTC) in 2008 and noted that the organizational structure of its Local Health Integration Networks (LHIN) led to the development of silos between the Performance, Contract and Allocation (PCA) teams and the Planning, Integration and Community Engagement (PICE) teams. The silos existed despite an overlap in staff skill-sets across the two teams. For example, the Aging at Home initiative, in which the PICE division was responsible for assembling proposals and identifying performance measures for each proposal, conducted its work without input from the PCA team. The PCA team has staff with performance indicator skills that could have provided an overview of all the indicators being used in the local health system³.

6.1.2 Fulton County Current State

Co-Location

Fulton County demonstrates integration primarily through co-location of services, which was evident in North Fulton and the Neighborhood Union service centers. Each location offers a variety of services, including primary care, dental, Adult Behavioral Health (ABH), workforce development, and housing.

³ KPMG. (2008). *MOHLTC-LHIN Effectiveness Review*. Ontario, Canada: Ministry of Health and Long Term Care.

These “one-stop shop” sites, can address a wide range of needs within a single facility, providing a more comprehensive set of services based on a holistic view of the clients and families served.

According to staff members interviewed during the program assessment, clients are pleased they can access multiple services at the integrated service centers. Many staff expressed a belief that the service center model has spurred greater client use of services than in the past. In addition, program staff indicated clients are more aware of the full complement of available services because of the program literature and signage located throughout the service centers. Staff also discussed that co-location of services supports collaboration among service providers. Staff from different programs within the service centers have greater ability to interact with one another, and as a result can discuss cases and client needs from a more holistic perspective.

Within the Health and Human Services industry, co-location by itself does not equate to fully integrated service delivery. Models of integrated service delivery involve planning a combination of services around a specific client and then managing that package of services in a unified fashion. This level of service integration is not yet fully in place in Fulton County.

The Referral Process

HHS referral processes vary by site. Across the County, referral methods range from formal referrals using a form to staff informally notifying clients about services and offering advice on how to access those services. In the North Fulton and Neighborhood Union service centers, a common form is used to refer clients among programs. Program staff at both North Fulton and Neighborhood Union reported that the referral form is completed by the client, by the care manager or jointly and then sent to a Care Manager. The Care Manager is a full-time staff member with sole responsibility to coordinate the referral process. The Care Manager works with clients to facilitate their access to other programs. Program staff further indicated that having a dedicated resource to manage the referral process enhances client access to services in multiple programs. Although the common referral process is useful, staff noted that the lack of an integrated referral system (for tracking and managing referrals) makes follow-up and monitoring of referrals a challenge.

Program staff also identified other referral processes that are in effect, but other referral processes are more informal and not in use by all programs. At North Fulton, staff in the primary care clinic and adult behavioral health services unit created what is known as a “hot referral,” where medical staff routinely assess clinic patients for potential behavioral health issues. If staff suspect issues, the on-site behavioral health counselor will immediately meet with that patient to determine if short-term or ongoing behavioral services are warranted.

Program staff at other service delivery locations identified less formal referral processes. At the College Park Regional Health Center, some staff stated that they may refer clients to other programs via an internal referral form (the Information Exchange Form). This did not appear to be a formal process, and staff could not identify any institutional mechanism or standard operating process for following up to determine whether the client actually received the service. Other staff members noted that they inform the client of services in other programs, but do not complete the internal referral form or help the client access the other services.

Current screening and referral processes are paper-based. Paper-based referral processes are cumbersome and preclude automatic tracking and follow-up functions that could help enhance the quality of services and likelihood that a client will follow-up on their referral. Lack of an automated system also inhibits the County from creating and reporting on metrics related to the referral process, such as referrals initiated, referrals accepted, and referrals engaged by the client.

Supportive Services

Supportive services available at the service centers provide additional resources for clients. The North Fulton site offers free childcare for parents meeting with their case workers. Free childcare eliminates the

client's burden of finding and (in some cases) paying for child care during their visit, thereby enhancing the likelihood the client will attend their scheduled appointments. The childcare service allows clients and program staff to work together without disruption enhancing the quality of the interaction. The service centers also have a resource room, staffed by the Atlanta-Fulton Public Library System, with book distribution and a program that encourages parents to read with their children. Finding ways to maximize the number and type of interventions during each contact with the client, contributes to the ability to address the holistic needs of each family served.

6.1.3 Contributing Factors to Common Ground Implementation

The implementation of the multi-service centers is a significant step toward implementation of ICSD in Fulton County. Where implemented, the centers provide an environmental context for ICSD and offer the potential to develop communications and procedures that support integrated services delivery. The following are key contributing factors:

- Fulton County demonstrates integration of services primarily through co-location
- "One-stop shop" sites, such as the North Fulton and Neighborhood Union Service Centers, provide a variety of services, including primary care, dental care, adult behavioral health, workforce development, and housing
- Clients are pleased that they can access multiple services at the integrated service centers
- Staff believes that the service center model has spurred greater client use of services
- Program staff indicated clients are more aware of the full complement of available services
- Co-location of services supports collaboration among service providers
- In the North Fulton and Neighborhood Union service centers, providers use the same Referral Form template to refer clients between programs within the same service center
- Dedicated resources to manage the referral process helps enhance client access to services in multiple programs
- At the College Park Regional Health Center, some staff stated they may refer clients to other programs via an internal referral form
- Supportive services available at the service centers, such as childcare, provide additional resources for clients and support the engagement in services by the clients

6.1.4 Preventing Factors to Common Ground Implementation

Based on KPMG's review of the current ICSD implementation, the following list identifies areas where future concentration will advance the implementation of ICSD in Fulton County:

- While services may be co-located, co-location by itself does not equate to fully integrated service delivery. Integrated services, as envisioned by Common Ground and as seen in other jurisdictions employing integrated services models, rely on centralized case management and/or multidisciplinary teams to assess, plan, and provide services
- Some staff members noted that they inform the client of services in other programs, but do not complete the internal referral form or help the client access other services
- In some centers, staff could not identify any institutional mechanism or standard operating process for following up to determine whether the client actually received the service
- Current screening and referral processes are paper-based
- Paper-based referral processes are cumbersome and preclude automatic tracking and follow-up functions

6.2 Individualized Needs Assessment

The Common Ground model envisions a centralized client intake process and an initial client individualized needs assessment. As a key component to an ICSD model, the Individualized Needs Assessment should begin at the point of initial client intake. Administrative staff such as an intake clerk or a receptionist typically conducts this process. In a typical integrated service model, the initial assessment process may begin with a simple screening tool, designed to identify client needs at a high-level, and document the client's potential eligibility to receive services addressing their needs. Integrated case managers or program providers then conduct more specialized assessments. A common core assessment and screening process, augmented by specialized assessments as needed, provide a basis for developing integrated service plans and coordinating the delivery of needed client services.

6.2.1 Leading Practices

The provision of integrated services presumes that staff assess clients/families in a holistic manner and address any needs and services identified in an integrated care plan. Multiple providers can then base service delivery on the common understanding of the overall circumstances and needs of the clients. As services are provided, the various service providers collaborate and coordinate, sharing information about progress, issues, and required service changes. In an integrated service model, the case manager is the focal point for planning and service information exchange.

The manner in which organizations incorporate individualized needs assessments in the overall integrated services approach was emphasized in our interview with Multnomah County, Oregon. They stressed the importance of using multi-disciplinary teams to conduct the initial assessments so that planning, referrals, and service delivery based on the initial assessment all emanate from a shared understanding of the client's needs. Implementation of ICSD type models depends on this collaborative perspective.

As noted to us by Oregon program staff, assigning clear facilitation responsibility is essential to the functioning of the multidisciplinary teams. Facilitators run the meetings, maintain the case notes, and help ensure that action items are complete. Centralized management of the multidisciplinary teams maintains a focus on the shared view of the client's needs and strengths and allows this common assessment to be the basis for all work providers perform. As discussed previously, the Canada Ministry of Health and Long-term Care (MOHLTC) found that, even with a multidisciplinary team approach, silos can develop at the administrative level and silos can adversely impact the success of integrated service delivery. Organizations need to help ensure administrative policies and procedures, as well as staff interaction across organizational units, are supportive of the overall integrated services approach.

6.2.2 Fulton County Current State

Integrated Services Questionnaire

The North Fulton and Neighborhood Union Service Centers have similar intake processes including an Integrated Services Questionnaire. The questionnaire lists the services available at the center and the client indicates the desired services. Program staff is also encouraged to review the questionnaire with the client and suggest services that may be appropriate. Once the questionnaire is complete, either the Care Manager or receptionist assists the client with scheduling appointments. This questionnaire is a useful tool that introduces clients to services they would not have known about otherwise. Combined with the common referral process, the questionnaire also provides a formal mechanism to help clients access additional services.

While only North Fulton and Neighborhood Union service centers use the questionnaire, all service centers/sites have the ability to use this process. In addition, the County can expand the Integrated Services Questionnaire to include all services provided by the County, even if those services are located at a different site. The County could redesign the questionnaire to provide information about where the additional services are offered.

Though the use of the Integrated Services Questionnaire is a positive step towards Integrated Care Service delivery, the process is manual and lacks the capability to share information across service centers. The County's current HHS information management systems are more than 15 years old and do not comprehensively support data integration. The implementation and use of an effective client information management system will enable the Integrated Services Questionnaire to fully realize the potential of a common assessment tool and promote fuller integration of client information and services used.

Program Specific Assessments

Several programs use specialized assessments that help document a client's needs, identify the appropriate services, and monitor a client's progress while receiving services. For example, the Fulton Family Care Network (FFCN) completes a Family Assessment Tool (FAT) that measures family stability factors. Programs complete the FAT at the onset of the client's engagement with FFCN and update the tool regularly to monitor the client's progress.

At the Jefferson Place Assessment Center, staff administer the Barriers to Housing Stability Assessment (BHSA) to each client. The BHSA identifies the factors preventing an individual from obtaining long-term secure housing, and collects information on family structure and functioning, physical and behavioral health, current and historical record of substance abuse, domestic violence incidents, and finances. The financial information section of the tool includes current and historical employment records, credit history, rental history, and criminal history.

Both the FAT and the BHSA are commendable tools and contribute to Integrated Care Service Delivery. However, in order for the County to fully realize the ICSD vision, it needs to consider expanding assessment tools similar to the FAT and BHSA to incorporate services across programs and centers. An effective client information management system will allow the County to standardized assessments across programs, ensure clients receive or are aware of each service applicable to them, and ensure common access to client information by staff.

Lack of Integrated Client Data

Staff usually enter client information collected during the intake process into an information system that supports only one specific service program. Since many clients receive services from multiple programs, information must be entered into multiple systems, thereby increasing burden on staff and reducing the time they have to spend working with clients. Maintaining information in separate automated systems reduces the ability for staff to access all relevant information about the client and inhibits the potential to share updates and progress. Maintaining data in separate systems often results in inaccurate and inconsistent information across multiple systems inhibiting the ability of workers to fully understand client program participation. An integrated client data system would assist the County through sharing information across programs and reduce the need to enter and maintain the same set of client information.

6.2.3 Contributing Factors to Common Ground Implementation

Standardized initial assessments are evident in two of the services centers. This is an important first step toward integration of service delivery.

- The North Fulton and Neighborhood Union service centers have a similar intake process that includes an Integrated Services Questionnaire
- The Integrated Services Questionnaire is a useful tool in that it introduces clients to services they would not have known about otherwise
- The Integrated Services Questionnaire provides a formal mechanism to help clients access additional services

6.2.4 Preventing Factors to Common Ground Implementation

The following list identifies aspects of initial intake and assessment that Fulton County should focus on to move to a more complete ICSD model for the initial activities performed with clients.

- The Integrated Services Questionnaire is currently used only at the North Fulton and Neighborhood Union sites
- Client information collected during the intake process is usually entered into an information system that supports only one specific service program
- Maintaining information in separate automated systems reduces the ability for staff to access all relevant information about the client

6.3 Standard Clinical Services

In the Common Ground Mid-Year Update report Fulton County states a goal to provide clients with a “medical home” where they can receive a standard set of clinical services, including: primary care, mental health, and dental services. This effort is consistent with national trends that acknowledge clients frequently have difficulty navigating the medical services systems and often forego prevention and primary care, seeking treatment only when a critical need occurs. Prevention and primary care are recognized, cost effective approaches to medical, dental, and mental health treatment and are seen to reduce the incidence of more serious (and expensive) interventions in the future.

6.3.1 Leading Practices

Co-location of services is often one key strategy for providing a physical “medical home” to clients where they receive the full range of medical, behavioral health, and dental services. However, it is possible that staff can work in the same building, but rarely communicate. Co-location is an important component of ICSD in the context of other important strategies such as shared intake and common assessment, common staffing of cases, sharing of information, and working together as a team. In Jackson County, Oregon staff advocates, representing ten different programs, work together in service integration teams that focus on families with multiple needs.⁴

In the State of Maine, the Maine Community Action Association (MCAA) supported its “one-stop shop” policy in ten agencies by acquiring commercially available software designed to streamline the screening and assessment process.⁵

6.3.2 Fulton County Current State

The Common Ground Mid Year Report states that a primary goal with regard to clinical services is to provide the “opportunity for residents to establish a medical home” where they can access primary care, mental health, and oral health services. To realize this goal, the County co-located these services at many of the regional health centers. For example, the College Park Regional Health Center, North Fulton, and Neighborhood Union service centers offer multiple clinical services. Staff members at these locations indicated that clients often access multiple clinical services, sometimes on the same visit. While the referrals between these programs may vary by location, staff also reported that co-location greatly enhances client utilization of the services offered at the centers.

⁴ Ragan, M. (2003). *Service Integration in Oregon- Successful Local Efforts Influence Major State Reorganization*. Albany, NY: State University of New York, Nelson A. Rockefeller Institute of Government for the Casey Strategic Consulting Group.

⁵ Hoyle, V. (2011). *First Call to Last Call: The Exemplary Practices Project*. Augusta, ME: Main County Community Association.

Full Array of Services

College Park Regional Health Center, North Fulton Service Center, and Neighborhood Union Service Center offer the full set of standard clinical services. KPMG conducted 26 client interviews at two sites (North Fulton and College Park) to obtain the client perspective on their experience in receiving services from these centers. Clients indicated having a single location for these services a positive experience. Co-location enhances both access and client consumption of multiple health and human services thereby achieving greater health and life situation outcomes.

Community partnerships also enhance the ability for clients to access services, particularly primary care. Each of the Fulton County's service centers partners with a community hospital to provide primary health care. For example, Grady Health System provides primary care at the North Fulton Service Center. Staff in the Grady Health System clinic noted that they regularly help clients locate additional primary care services at other Grady hospitals and clinics throughout the County.

While College Park, Neighborhood Union, and North Fulton offer the full array of clinical services, staff at other locations noted that the addition of clinical services could be beneficial for their clients. Staff at the Jefferson Place Assessment Center noted many of their clients have significant physical and oral health needs. However, Fulton County does not offer physical and oral health services at the Jefferson Place Assessment Center.

Community Awareness Impact on Service Availability

HHS program staff noted that as community awareness of available health and dental services increased, there was a greater demand for services, to the extent that there is insufficient capacity to meet the demand. For example, staff at both North Fulton and Neighborhood Union stated the demand for dental services far exceeds the County's current ability to provide these services. At Neighborhood Union, wait times for dental appointments can be as long as three months. While Fulton County has been successful in promoting awareness of the services available at the service centers, the inability to provide these services in a timely fashion may discourage future use of these services.

6.3.3 Contributing Factors to Common Ground Implementation

The following list provides examples in Fulton County that support standard and accessible clinical practices, a goal of Common Ground and the ICSD model of services.

- College Park Regional Health Center, North Fulton, and Neighborhood Union offer the full set of standard clinical services
- Interviews with a random sample of clients indicated having a single location for these services as a positive experience
- Co-location enhances client access to multiple health-related services

6.3.4 Preventing Factors to Common Ground Implementation

The following findings suggest additional areas needing attention to continue the progress toward effective implementation of clinical services consistent with the ICSD model.

- Program staff noted that, as community awareness of available health and dental services increased, there was a greater demand for services
- Staff at both North Fulton and Neighborhood Union stated that the demand for dental services far exceeds the County's ability to provide these services
- The inability to provide services in a timely fashion may discourage future use of these services

6.4 Needs-Based Services

Another component of Common Ground's ICSD model is providing Needs-Based Services. Each service site offers targeted public health interventions and social service programs designed to respond to the particular needs of the clients in the community. Staff identify needs by analyzing health outcome and social indicator data for the service delivery area. Thus, the types of services and interventions provided at each service center vary based upon the specific issues affecting the surrounding community.

6.4.1 Leading Practices

In 2005 the New York State Office of Children and Family Services released the results of a five-year evaluation of the Integrated County Planning (ICP) initiative, a multi-county demonstration project designed to coordinate planning within the human service delivery system across New York State.⁶ The authors reported that target population issues were a major challenge. For example, counties had to decide if they were to offer services to all children or only to at-risk children. Traditionally New York counties focused services on children and youth. However, other counties wrestled with the service needs of adults and challenged the assumption that integrated services meant a focus on youth.

In Jackson County, Oregon staff warned against "cookie cutter" approaches to service delivery.⁷ Different target populations, even within a single county, may require a willingness to experiment with different approaches to meet varying needs of the target population. When serving target populations, the placement of the facilities in locations most accessible to them presents its own challenges. Los Angeles County wanted to place a new facility close to where the target population of clients lives. Concerns arose over placing the building in an unsafe neighborhood. Unless assigned to the facility voluntarily, staff members were given the option of transferring out after one year and many staff exercised the option to transfer.

6.4.2 Fulton County Current State

Fulton County has a large and culturally diverse client population. HHS recognizes that there are inequities in the distribution of resources to help families and communities – which was part of the impetus behind the establishment of the Common Ground model. A strategy for meeting the service needs of its citizens is strategic placement of service centers in areas most in need. These centers offer an array of services that are useful in improving access to, and participation in, social services programs. As HHS moves forward with the implementation of the Common Ground model, it should continue to explore the specific needs in each of its communities and implement programs at the centers that are responsive to these needs. This is a difficult challenge in that it requires Fulton County to reconcile the need for increasing availability for services already offered with the need for newer and more targeted programs that may not currently be available.

Targeted Populations

The Community Health Education Program is a community-level program that:

- Provides health education services
- Promotes the availability of health-related services in the County
- Links community members to personal health services
- Collaborates with community agencies to improve health outcomes through education and increased awareness

⁶ Greene, R., McCormick, L.L., & Lee, E. (2005). *Integrating the Human Service System: Final Evaluation of the New York State Integrated County Planning Initiative*. Albany, NY: Center for Human Services Research, College of Public Affairs and Policy.

⁷ Ragan, M. (2003). *Service Integration in Oregon- Successful Local Efforts Influence Major State Reorganization*. Albany, NY: State University of New York, Nelson A. Rockefeller Institute of Government for the Casey Strategic Consulting Group

The Community Health Education Program is located at College Park Regional Health Center. The Center receives requests from the community for educational materials, seminars, and workshops. Program staff work with community health leaders and educators to identify efforts that would be most beneficial based on each community's needs. Classes for parenting, well-baby care, high blood pressure management, and cancer prevention are popular topics on which program staff develop targeted materials for the community.

The Neighborhood Stabilization Program (NSP) targets the needs of specific communities within Fulton County. Through the NSP, Fulton County buys, renovates, and re-sells properties that are designated as foreclosed, blighted, or vacated. Because the focus of the program is to enhance the stabilization of specific communities based on the Housing and Urban Development (HUD) guidelines, the County buys houses in clusters within targeted areas, based on many factors such as number of homeless individuals, number and rate of foreclosures, and unemployment. The program is well-funded and NSP's impact is significant. During the first wave of program funding, which began in 2009, the County purchased 97 single-family homes in targeted areas of South Fulton County.

While not focused specifically on communities, many programs within Fulton County do appear to work effectively with targeted populations within a community to affect change. For instance, the Transforming the Lives of Children (TLC) program works with a specific client population – children ages birth to 5 years with developmental delays. The program's goal is to positively impact young children and address complex physical, emotional, social, and developmental needs. TLC staff developed an Individualized Education Plan that outlines steps to enhance the child's developmental challenges and then works with a number of partners to ensure the County executes on the plan.

6.4.3 Contributing Factors to Common Ground Implementation

Most implementations of integrated services provide a focus on specific needs of target populations. As noted in the findings below, some Fulton County programs have implemented targeted needs based approaches.

- The Community Health Education Program attempts to identify the specific needs of its population through requests from the community for educational materials, seminars, and workshops
- Through the Neighborhood Stabilization Program, Fulton County targets the housing issues of a specific sector of the community. NSP buys, renovates, and re-sells properties that are designated as foreclosed, blighted, or vacated
- Fulton County purchased 97 single-family homes in targeted areas of South Fulton County
- Transforming the Lives of Children program works with children ages birth to 5 years with developmental delays
- Fulton County should continue to explore, through feasibility studies or other research, the specific health needs in each prospective community and implement programs at the centers that are responsive to those needs

6.4.4 Preventing Factors to Common Ground Implementation

The following findings suggest challenges to addressing specific needs of target populations.

- The County recognizes that there are inequities in the distribution of resources to help families and communities
- Fulton County will have to reconcile the need for services already offered with the need for newer and more targeted programs that may not currently be available

6.5 Case Management

One component of ICSD is the provision of integrated case management. Case management starts with the intake process, which should collect standard client information through an initial screening. Integrated case management is a unified approach to managing a client's participation in services over time, either through a single integrated case manager or an interdisciplinary team of service providers who monitor progress and service delivery. An integrated care plan, with ongoing monitoring and regular updates, is a key component of integrated case management.

6.5.1 Leading Practices

In many integrated services models, the case manager reviews client history across all programs to identify what needs have been determined, what services are being provided, and what additional assessments are necessary. The case manager may also assess the client directly to help ensure that all needs are identified. Based on history and assessments, the case manager sets objectives in discussions with the client, establishes the integrated care plan, and monitors ongoing service delivery. The case manager evaluates whether or not sufficient progress has been made in achieving case objectives and goals. The case manager may either coordinate services for the client directly or, if a multidisciplinary team is in operation, works through the team to help ensure that all needed services are in place and working toward the goals and objectives of the integrated plan.

In Jackson County, Oregon, clients go through a single point of entry that includes a common assessment.⁸ Staff participates in the assessment process on a rotating basis. A primary case manager is responsible for working with clients and service providers to ensure that clients and providers comply with case plans. Families participate in developing their case plans along with representatives of contract providers. Formal staffing of cases is interdisciplinary and held monthly. The service mix may include TANF and other income support programs, child support enforcement, public health and behavioral health services, employment services, as well as connecting clients with Head Start and child welfare services as needed.

In Hennepin County, Minnesota, staff transfer eligible clients for financial, social, or health services are from a Case Management Assistant (CMA) to a Long-term Case Management Team.⁹ The teams provide service planning, service coordination, assessment/reassessment, and monitoring. Staff may include social workers, chemical health counselors and nurses. The teams may also enlist the aid of financial case aides and/or community health workers.

In an evaluation of an integrated services project, called The Initiative to Improve Outcomes for Hard-to-Employ Welfare Recipients, the author describes TANF recipients meeting with family facilitators who help develop a care plan that addresses both client strengths and challenges.¹⁰ The plan often results in referrals to additional service providers. Family facilitators attempt to maintain regular contact with clients to monitor progress. Many clients meet with family facilitators on a weekly basis and may be in contact by phone as frequently as every day.

⁸ Ragan, M. (2003). *Service Integration in Oregon- Successful Local Efforts Influence Major State Reorganization*. Albany, NY: State University of New York, Nelson A. Rockefeller Institute of Government for the Casey Strategic Consulting Group

⁹ Hennepin County Human Services and Public Health Department. (2011). *Delivering Services in the 21st Century*. Hennepin County, MN: Author.

¹⁰ Martinson, K., Ratcliffe, C., Vinopal, K., & Parnes, J. (2009). *The Minnesota Integrated Services Project: Final Report on the Initiative to Improve Outcomes for Hard-to-Employ Welfare Recipients*. Washington, DC: The Urban Institute.

6.5.2 Fulton County Current State

KPMG observed a case management process at one of the six service centers. At the Oak Hill Child, Adolescent, and Family Center, staff use the same tool to assess families participating in the Fulton Family Care Network (FFCN), after which staff create a Family Development Plan. The Family Development Plan specifies the entire range of services that a family will receive during their participation in FFCN. The program assigns each family an Advocate, whose role is to manage the plan and to work with the family to help ensure they receive the needed services.

KPMG observed a formal case management process in the Jefferson Place Assessment Center. Staff assign each client entering the program at Jefferson Place with a case manager who administers the Barriers to Housing Stability Assessment (BHSA) and then creates and manages a case plan that cuts across program areas. These case plans typically include services for physical and behavioral health services, workforce development assistance, and family counseling.

KPMG further observed a formal case management structure in the Adult Day Care program at the HJC Bowden Senior Multipurpose Center. A certified nursing assistant (CNA) is assigned to each participant and records a daily log of activities. The CNA updates the client's chart with progress notes on a monthly basis.

Limited Provision of Case Management

Other than the case management components in place at Oak Hill and Jefferson Place, the responsibility for creating and managing a client's case plan rests with staff in individual programs. Staff perform elements of integrated case management in the jail diversion programs of the Department of Behavioral Health and Developmental Disabilities. Staff in the program creates and manages a client's case plan which often includes services from multiple programs.

Staff providing public health and behavioral health services appear more likely to address services beyond their own service delivery system. This may be due to the fact that staff typically work with clients over a long period of time and therefore are more attune to client needs that are external to the health and mental health domains. As a result, clients were more likely to be referred to other programs. However, KPMG observed that case management was often narrowly defined as referring clients to other services without specific follow-up.

In most of the programs examined, staff described case management as a process of conducting administrative activities, such as determining whether a client was meeting the eligibility requirements for ongoing participation in a specific program. Program staff provide limited oversight of a client's participation in other programs and do not routinely follow-up with a client after services are complete. This was particularly true in the area of primary health care, where Fulton County does not directly employ the clinic staff, but rather contracts staff from a local health care organization. Employees of the contracted health-care group have little incentive to track a client's participation in other programs. In addition, clients often only require one service to meet their needs (e.g., immunizations, sports physical, etc.) therefore eliminating the need for follow-up.

6.5.3 Contributing Factors to Common Ground Implementation

The case management concept is a key component for the implementation of integrated service delivery and the vision of the Common Ground ICSD model. The findings below are important contributing factors toward building this component of ICSD.

- KPMG observed a focused case management process at two of the six service centers
- At the Oak Hill Child, Adolescent, and Family Center, staff use the same tool to assess families participating in the Fulton Family Care Network (FFCN), after which staff create a Family Development Plan At Jefferson Place, the program assigns a specific case manager

- The FFCN plan specifies the entire range of services that a family will receive during their participation
- FFCN assigns each family an Advocate, whose role is to manage the plan and to work with the family to ensure that they receive the identified services
- KPMG witnessed elements of integrated case management practices in the Jefferson Place Assessment Center
- The jail diversion programs, administered by the Department of Behavioral Health and Developmental Disabilities, create and manage a client's case plan, which often includes services from multiple programs
- KPMG observed that public health and behavioral health program staff were more likely to work with a client long-term and therefore were more attune to the client's needs

6.5.4 Preventing Factors to Common Ground Implementation

Although the above findings provide evidence of efforts to implement cross-program case management, as noted below, additional efforts are needed.

- Except where noted above, the responsibility for creating and managing a client's case plan generally rests with staff in individual programs
- Staff described case management in a relatively narrow sense – as a process of conducting administrative types of monitoring, such as determining whether a client was meeting the eligibility requirements for ongoing participation in a specific program
- In some instances, program staff members indicated that they provide limited, if any, oversight of a client's participation in other programs and did not routinely follow-up with a client after services were completed - particularly true in the area of primary health care where the clinic staff are not employees of Fulton County

6.6 Trained Staff

Trained staff refers to highly skilled and culturally competent professionals who are performing the services that compose the ICSD. To fully implement ICSD, staff members may need to develop new skills in collaboration and to gain the knowledge to participate in common assessment and case planning. Integrated service delivery involves specific policies and procedures that involved staff need to know and accept. Potential new information system processes may also require training regarding documenting and accessing comprehensive client information. Staff training within the context of ICSD must itself be formulated on a cross-program approach so that personnel from different agencies share the same training experiences. Participation in mutual training begins to build the relationships and interagency understanding required to successfully implement an ICSD model.

6.6.1 Leading Practices

In Los Angeles County, the 8300 Vermont Initiative is one of seven demonstration sites in which the County is testing an integrated system of services, information sharing, and community-based supports. The following County departments are co-located at the 8300 Vermont facility: Children and Family Services, Mental Health, and Public Social Services. There is common reception and intake despite locating each department on a separate floor. Clients come to reception and fill out a common form for the three programs. If clients inquire about TANF, for example, reception is trained to ask about child welfare and mental health needs. After filling out the form, clients are referred to intake. To support the implementation of the integrated care program, the county conducted co-training with reception and

intake staff. The training is important, but as one individual said, "It takes time for staff to learn what other programs are doing."¹¹

Some general lessons from the field include:

- Use a train-the-trainer model to communicate knowledge to staff, contracted providers, and the public
- Plan a training program that is ongoing so that refresher courses are available to address updates on new services, changing eligibility requirements, and new rules and regulations

6.6.2 Fulton County Current State

HHS invested in training staff at the new North Fulton service center. Prior to opening, managers from each of the programs at North Fulton participated in a series of weekly meetings and a multi-day retreat to discuss goals, objectives, and operational parameters for the centers, which included training that would help staff members at the site perform effectively within the Common Ground framework. During the site visit to North Fulton, KPMG noted staff displaying knowledge of the ICSD model and a foundational understanding of how ICSD applied to day to day work activities.

At both the North Fulton and Neighborhood Union locations, new or relocated staff receive a comprehensive tour and orientation to the facility to help ensure they understand the breadth of programs offered and how the referral process works. In addition, both centers conduct regular meetings with staff from all programs in the center. The goal of these meetings is to share information about programs so that staff is knowledgeable about what other services are available and how clients can access those services.

Limited Training Opportunities

Staff, operating from sites that the County is not yet designating as Common Ground/ICSD sites, reported receiving limited or no training related to integrated services. During site visits, KPMG observed confusion among several staff that seemed to think ICSD is limited to co-location of services.

The need for training was a common theme in the JAQ. Many staff cited the lack of communication and training as a key factor restricting implementation of the Common Ground ICSD model. At the time of this report, there does not appear to be ongoing, systematic training of staff to orient and garner staff support for Common Ground.

6.6.3 Contributing Factors to Common Ground Implementation

Effective implementation of the ICSD model requires that all involved staff understands the ICSD concept, policies, and procedures and can effectively communicate and work within the team concept of ICSD. KPMG found evidence of effective training in some facilities.

- Fulton County invested significantly in training staff at the new North Fulton service center
- During the site visits to North Fulton and Neighborhood Union, KPMG noted staff knowledge of the ICSD model and positive applications of the model to daily work activities
- At both the North Fulton and Neighborhood Union locations, staff from all programs participates in regular center-wide meetings

¹¹ Los Angeles County, California. (2012). *Integrated Services and Partnerships*. Retrieved April 2012, from <http://ceo.lacounty.gov/SIB/isp.htm>.

6.6.4 Preventing Factors to Common Ground Implementation

The following findings indicate that additional efforts Fulton County should undergo to train staff in the Common Ground approach to ICSD:

- Staff, operating at sites the County does not yet designate as Common Ground/ICSD sites, reported receiving limited or no training related to the County's attempts to more effectively integrate services
- Many staff cited the lack of communication and training as a key factor restricting the implementation of the Common Ground ICSD model
- At the present time there is no ongoing, systematic training of staff to orient and garner their support for Common Ground
- KPMG observed confusion among some staff who seemed to think that ICSD is limited to co-location of services
- Staff at some of the regional health centers indicated they knew little about Common Ground
- The need for training was a common theme in the Job Activity Questionnaire

6.7 Partnerships

Partnerships are a core element within any framework for service integration. A central view of service integration is that disparate programs should work together to provide a holistic approach to managing a client's participation in available services. Partnerships between these agencies are therefore essential to achieve the goals and objectives of service integration.

6.7.1 Leading Practices

Maintaining strong relationships among multiple public and contracted service providers is the basis for connecting clients to services, facilitating the referral process, coordinating planning and service delivery, and ensuring that clients receive all services and in the most efficient manner. Partnerships are an essential underpinning for any integrated service delivery model. Partnerships help remove cross-Agency barriers to service and enhance the coordination of client services through the use of cross-Agency teams.

In Coos County, Oregon, efforts were made to work cooperatively among agencies that provide health and human services to families, because they often found themselves serving the same clients.¹² Efforts to build partnerships moved slowly until one agency identified the need for a new facility. This opened up opportunities to move other agencies into the new facility and drove efforts to design the building around one-stop offices.

6.7.2 Fulton County Current State

Many examples of partnerships exist among the programs providing services through Common Ground, as well as with other County and State organizations. As mentioned earlier in this report, HHS created the Fulton Family Care Network, a "system of care designed to provide Fulton County families with a 'no wrong door' approach to accessing services and supports". Managed by staff who operated from the Oak Hill Child, Adolescent and Family Center, the Network helps to integrate multiple services for children and families in Fulton County through collaborative partnerships of County and community organizations. Key partners involved with the Network include Departments of Behavioral Health and Development Disabilities, Health and Wellness, Juvenile Court, the Police, and the Fulton County Library.

¹² Ragan, M. (2003). *Service Integration in Oregon- Successful Local Efforts Influence Major State Reorganization*. Albany, NY: State University of New York, Nelson A. Rockefeller Institute of Government for the Casey Strategic Consulting Group

Tenet Healthcare, Grady Health System, and West End Medical Centers operate primary care services at the College Park, North Fulton, Neighborhood Union, and the Adamsville Service Center. Staff from each of the primary care providers expressed positive experiences about their working relationship with Fulton County, and felt that their placement in the service delivery sites has afforded many clients with enhanced access to primary care. One staff member indicated that many clients that come to the service centers would not otherwise access primary or preventive care given their general apprehension about going to a hospital or other private provider. With the primary care clinics located at the service delivery sites, many individuals feel more comfortable requesting services.

The Atlanta-Fulton Library System is a key partner in the Common Ground/ICSD initiative. Library staff is located at several of the service delivery sites, and they administer a number of programs that help provide necessary support for families receiving services. The Books for Babies project provides new parents with information about reading with their children to promote a positive attitude toward reading and learning. The Atlanta-Fulton Library System also maintains a GED training and testing program, as well as a robust set of online training classes and job-support tools that staff promote to clients receiving workforce development skills.

Fulton County and the Georgia Department of Family and Children Services

The Georgia Department of Family and Children Services (DFCS) has an Ancillary Services Team that works with HHS to coordinate numerous services for children that are in foster care, such as medical examinations, substance abuse assessment and treatment, and mental health. State personnel interviewed noted that the partnership is positive and the services HHS provides help to complete the array of services that children in foster care need.

On the other hand, KPMG did not observe examples of DCFS working with HHS as part of an ICSD interdisciplinary approach to case management. Leading practices indicate child welfare services are often an organizing focus of service integration efforts. Families known to and receiving services within the child welfare system are typically among individuals requiring the most comprehensive care, management, and array of services. In Fulton County, child welfare services are not specifically recognized as a part of the Common Ground initiative. This may be attributable to the organization of child welfare services under DFCS, which has its own organizational hierarchies, policies, procedures, and targeted funding streams that cannot be consolidated with funding in other programs.

From the KPMG interviews and observations, it appears that Fulton County has limited success in forging partnerships with faith-based organizations. Such organizations may offer potential services and/or facilities to support the countywide integrated services program.

6.7.3 Contributing Factors to Common Ground Implementation

The Common Ground model seeks to be an inclusive model of integrated services in Fulton County. Partnerships are in place with some community organizations as noted below.

- Many examples of partnerships exist among the agencies providing services through Common Ground, as well as with other County and State organizations
- Tenet Healthcare, Grady Health System, and West End Medical Centers operate primary care services at the College Park, North Fulton, and Neighborhood Union service centers. The Atlanta-Fulton Library System is a key partner in the Common Ground initiative



6.7.4 Preventing Factors to Common Ground Implementation

Although staff from DFCS noted that the relationship between Fulton County and DFCS is positive, KPMG did not observe a formal partnership in support of the Common Ground ICSD model.

6.8 Community Outreach/Engagement

An important objective of the Common Ground initiative is to enhance the overall well-being and health outcomes of the communities in Fulton County. The model for Common Ground includes significant community engagement to gather input about programs and services, establish priorities for implementation, and determine what additional programs Fulton County should add to the existing service delivery locations.

6.8.1 Leading Practices

Oakland County, California created the Health, Housing and Integrated Services Network (HHISN) in the late 1990s.¹³ HHISN is a collaboration of public and private agencies that provides housing, social services, and health services. Homeless persons with disabilities are a target population for these services. Planning groups in each county consisted of executive directors and/or senior staff members of nonprofit housing providers, social services providers, consumer advocates, and city and county agencies. The planning meetings provided orientation to the concept of an ICSD model, formulated programmatic goals, and explored potential funding sources. In the implementation phase, the County formed three distinct, but overlapping groups — the Oversight Committee, the Operations Group, and the Integrated Services Teams — from the organizations that formed the HHISN in each county.

The Oversight Committee, which evolved from the planning committee, included executive directors or senior managers from all HHISN services and housing providers, local government agency representatives, consumers of HHISN services and housing, and advocates for consumers. The Oversight Committee, which meets quarterly, has the responsibility for general oversight in the development and maintenance of the Network. Tenant representatives and advocates for consumers are the direct links to the tenants served by HHISN.

In Multnomah County, Oregon, a Community Forum initialized the ICSD. A local judge organized the forum, consisting of numerous stakeholders in the community, including parents. The forum created a strategic plan for the ICSD, marketed the idea to the larger stakeholder community, and helped identify potential benefits of, and challenges to, the initiative. The forum then created an ongoing Executive Committee to oversee what became known as Wraparound Oregon.

The Executive Committee continues to oversee the initiative, particularly in maintaining commitment to the team structure. When problems arise, the issue can be brought to the Committee or to the judge who chairs the Committee. The Committee is especially helpful identifying available funds to help clients.

6.8.2 Fulton County Current State

One of the challenges in community outreach is defining the community and then determining what outreach will look like. Fulton County directed initial outreach efforts toward groups associated with services the County directly provides. For Fulton County to expand its reach into public policy and prevention efforts, it should consider taking into account greater participation by smaller, grass root,

¹³ Lenoir, G. (2000). *The Network: Health, Housing and Integrated Services*. San Francisco, CA: Corporation for Supportive Housing. (Oakland County, California).

community and advocacy organizations. Such organizations can reach a broader clientele and may have resources that support additional needs of these populations.

In creating the Fulton Family Care Network (FFCN), HHS worked extensively with community partners to establish a continuum of care where children and families can access a broad range of services. Community partners involved with the FFCN include the Georgia Center for Child Advocacy, Georgia Parent Support Network, and the Georgia branch of Mental Health America. When HHS was forming the program, HHS conducted outreach events to gather input from community groups and individuals.

Community Outreach at the Service Centers

While community engagement is not yet reaching all potential facets of the community, the service centers offer an excellent infrastructure for facilitating community involvement. Each of the service centers have multi-purpose and meeting space, which provides a setting where members of the community can come together to discuss relevant community issues as they pertain to Common Ground. In particular, the North Fulton Service Center has a large conference facility with teleconferencing equipment. In the past, North Fulton has hosted meetings for the Fulton County Board of Commissioners (BOCC). Additional BOCC and other meetings of note can be held at the site, and coordination of these meetings to coincide with significant Common Ground events can provide an opportunity to generate enthusiasm for, and community engagement with, the Common Ground initiative.

Faith-based organizations are specifically mentioned in the initial Common Ground blueprint as a group of community organizations that HHS should include in Common Ground planning and execution. To date, HHS does not have a structured program to engage faith-based organizations. A more rigorous approach to incorporating faith-based organizations can provide additional – and insightful – input for future planning efforts given the relevance of these organizations to a large segment of Fulton County residents. To the extent that these organizations offer community-based services that complement County programs and services, HHS has the potential to broaden the scope of services through increased partnerships with faith-based service organizations.

Further Opportunities

In interviews with community partners, it is apparent that opportunities exist to enhance the overall array of services the County provides. For instance, partners in the FFCN noted that many families often need help obtaining secure housing. Enhanced support and counseling for fathers separated from their children – above what is offered in parenting classes – was also identified as an area where additional services can be beneficial. Representatives from agencies that provide these services are not currently a part of the FFCN.

6.8.3 Contributing Factors to Common Ground Implementation

The following list identifies contributing factors supporting the ongoing outreach and engagement efforts that support Common Ground implementation in Fulton County.

- In creating the Fulton Family Care Network, Fulton County worked extensively with community partners to establish a continuum of care where children and families can access and engage in a broad range of services
- The existing Fulton County service centers offer an excellent infrastructure for facilitating community involvement

6.8.4 Preventing Factors to Common Ground Implementation

As noted in the observations below, additional outreach and engagement potential exists.

- Fulton County has not leveraged greater participation by smaller, grass roots, community and advocacy organizations

- To date, Fulton County does not have a structured program to engage faith-based organizations
- Partners in the Fulton Family Care Network noted that many families often need additional help such as obtaining secure housing and support for fathers separated from their children – representatives from agencies that provide these services are not currently part of the network

6.9 Capital Improvements

Capital improvements create the physical infrastructure that enables the implementation of ICSD in strategic locations within the community. One of the Common Ground goals is to create physical infrastructure that supports the integrated care service delivery model and enhances programming and services. Fulton County invested substantially in renovating and constructing facilities to support Common Ground goals.

6.9.1 Leading Practices

Oakland County, California, in creating the Health, Housing and Integrated Services (HHIS) recognized that the physical location for services, and the building structures themselves, can facilitate the delivery of services or can add an extra challenge to service provision.¹⁴ Certain practices lend themselves to a building design that will assist clients in accessing services. Some best practices:

- Community partners and clients must be involved in decisions about where services will be delivered and staff offices located
- In the case of new construction or substantial building rehabilitation, community partners and clients should be involved in the building design and placement of services inside the building
- Services should be located in areas that are easily accessible to clients and the facilities housing these services should create a comfortable setting for clients to participate in services

Capital improvement costs can be an impediment to the implementation of the ICSD model for integrated services. Hennepin County, Minnesota stated they need more money to increase and renovate physical space. Current facilities do not lend themselves to collaborative, team based case management. To accommodate their team approach to ICSD, they need multiple conference rooms of sufficient size to accommodate the members of the teams.

6.9.2 Fulton County Current State

Capital improvement is a key feature of Common Ground. The County dedicated resources for capital improvements and asset improvements for health facilities delivering services through Common Ground. As of 2009, approximately \$5.7 million was obligated for construction/renovation of HHS buildings - the Oak Hill Child Adolescent and Family Center, the Neighborhood Union Service Center, the North Fulton Service Center, and the Adamsville Service Center. These facilities underwent significant renovation to accommodate the integrated service delivery model.

Staff interviewed at these locations indicated an overall level of satisfaction with the physical attributes of the service centers and reported that the improvements enhance their overall job satisfaction.

The North Fulton Service Center is a key example of a facility design that supports the ICSD model. The common reception/intake area sets the tone for the building. It supports the “One Stop Shop” and “one team” model environment of the facility. The Common Ground branding Fulton County uses throughout

¹⁴ Lenoir, G. (2000). *The Network: Health, Housing and Integrated Services*. San Francisco, CA: Corporation for Supportive Housing. (Oakland County, California).

the building promotes the “one team” feeling. Staff indicated that the new facility has a positive effect on staff and clients.

Capital Improvement Challenges

While establishing Neighborhood Union as an integrated service center, the existing layout presents challenges. Neighborhood Union has three entrances with three reception areas for different services. Clients must determine which door to enter based on the specific service they are seeking. Without a common reception area, clients must navigate to different areas in the building to inquire about and receive more than one service. Each reception area operates differently depending on the services provided in their area. Common intake/screening processes have been difficult to establish due to unique program procedures and staffing.

Branding and Signage

Creating an environment where clients can access multiple services through a single entry point for an array of services provides the sense that they will receive assessment and treatment in a comprehensive, holistic manner. Clients also recognize staff will transfer them from one intake process to another, where staff typically ask the same information repeatedly. North Fulton has extensive branding (signage) throughout the building that is a continuous reminder of the integrated service model. Signage appeared absent at College Park.

6.9.3 Contributing Factors to Common Ground Implementation

The Common Ground vision and ICSD specifically, requires adequate facilities and infrastructure to support the implementation of integrated service delivery. Several of the capital improvement efforts to date are furthering the overall Common Ground implementation.

- Capital improvement is a key feature of Common Ground
- The Oak Hill Child Adolescent and Family Center, the Neighborhood Union Service Center, and the North Fulton Service Center underwent significant construction/renovation to accommodate the Common Ground integrated service delivery model
- The Adamsville Service Center opened in June 2012
- Staff interviewed at Common Ground services centers indicated an overall level of satisfaction with the physical attributes of the centers and reported that the improvements enhance their overall job satisfaction
- The North Fulton Service Center is an example of a facility design that supports the ICSD model
- The Common Ground branding used throughout North Fulton promotes a unified atmosphere

6.9.4 Preventing Factors to Common Ground Implementation

The following list identifies observations that indicate considerations for future capital improvement consideration:

- While establishing Neighborhood Union as an integrated service center, the existing layout continues to present challenges for creating an environment that supports the ICSD model
- Service centers without a common reception area obligate clients to navigate to different areas to inquire about and receive services
- North Fulton has extensive branding (signage) throughout the building that is a continuous reminder of the integrated service model - signage appears absent at College Park

6.10 Program Evaluation

Staff perform program evaluations to assess the effectiveness and quality of services. The results allow managers to identify processes and methodologies that achieve intended outcomes and ones that do not

achieve intended outcomes. Objective program evaluation is important for determining the effectiveness of programs, identifying where the County needs to adjust service delivery processes, and applying resources in the most efficient and effective manner possible. Program evaluations can also demonstrate to stakeholders that funding is well spent and continued support of the program is worthwhile. Two states – New York and Minnesota—have conducted formal evaluations of ICSD initiatives.

6.10.1 Leading Practices

In 2005, New York evaluated its Integrated County Planning (ICP) initiative. The overall goal of ICP was to improve outcomes for children, youth and families by integrating planning around seven key concepts:¹⁵

1. Locally controlled interagency planning coordination
2. Stakeholder involvement
3. Human development continuum approach
4. Community asset building
5. Outcome based orientation
6. Family-centered perspective
7. Resource allocation prioritization

The team evaluating the ICP initiative used a multi-faceted approach that included document review, surveys, in-depth interviews, focus groups, and observation. The evaluation presents three major findings.

1. All counties organized core coordinating teams with a broad range of stakeholder participation. Team members reported developing a shared vision of the initiative
2. At the State level regional forums were convened; a statewide listserv was created, and periodic training and networking conferences were conducted
3. On a conceptual level, confusion existed around the purpose and utility of the planning documents, problems in defining target populations, and issues in balancing State leadership with local control

In 2009 the State of Minnesota published the results of an evaluation of its Integrated Services Projects (ISP) in eight sites across the State.¹⁶ The ISP sought to address the needs of long-term cash recipients, many of whom were in danger of “timing out” of benefits. The Department of Human Services provided grants to eight sites to improve both economic and family-related outcomes. The purpose of the evaluation was to:

1. Describe the changes in the economic and family-related outcomes over a two-year period
2. Infer relationships between ISP participation and outcomes
3. Provide policy recommendations based on the experiences of the ISPs

The results were instructive given the challenges of providing services to high risk populations in Fulton County. The authors concluded an ICSD model is characterized by co-located staff with expertise in a number of services such as employment, public health, behavioral health, substance abuse, and domestic violence.

¹⁵ Greene, R., McCormick, L.L., & Lee, E. (2005). *Integrating the Human Service System: Final Evaluation of the New York State Integrated County Planning Initiative*. Albany, NY: Center for Human Services Research, Rockefeller College of Public Affairs and Policy.

¹⁶ Martinson, K., Ratcliffe, C., Vinopal, K., & Parnes, J. (2009). *The Minnesota Integrated Services Project: Final Report on the Initiative to Improve Outcomes for Hard-to-Employ Welfare Recipients*. Washington, DC: The Urban Institute.

“Across all the sites, employment and earnings levels were very low both before and after enrollment in the program, indicating the significant challenge of designing effective program services for this population”.¹⁷ The findings are consistent with other studies that demonstrate the difficulty of improving the economic success of high risk populations. At the same time, the non-economic benefits of the programs were difficult to quantitatively measure, but are recognized as important given the broad range of services provided.

6.10.2 Fulton County Current State

The Fulton County Manager’s Office created the Strategy and Organizational Development Division (SODD) in 2009. SODD collects and evaluates information about the performance of the County’s governmental agencies. In 2012, SODD began measuring Fulton County agencies on Key Performance Indicators (KPI’s). SODD created a framework that each Agency uses to create and measure KPIs. While still early in its development, the SODD framework with KPI’s is beginning to provide valuable information on HHS service performance. The framework has KPIs that include information on referrals between services. However, the primary focus of the KPIs is on individual service performance, not on integrated services.

Several programs in Fulton County are collecting and evaluating information that addresses aspects of the ICSD services. The Family Advocates in the Fulton Family Care Network complete FAT that measures 14 family stability factors. At the Jefferson Place Assessment Center, staff track client’s wages and length of employment to help determine employment and income history. The Jail Diversion programs, offered by the Department of Behavioral Health and Developmental Disabilities, also track outcomes such as recidivism rates of former clients.

Other programs track a variety of service delivery statistics, but not service delivery outcomes. For example, measures for many of the primary and mental health care programs focus on service statistics such as number of patients seen, number of immunizations provided, and number of mental health assessments conducted.

There is little historical empirical data to completely evaluate Common Ground and the implementation of ICSD. Staff reported there is little correlation between each agency’s KPIs and Common Ground goals and objectives.

6.10.3 Contributing Factors to Common Ground Implementation

Future efforts to implement Fulton County’s ICSD model and to reach the goals of Common Ground rely on implementation of an effective strategy for evaluating performance and determining where to focus resources and programming efforts. The findings below evidence positive steps taken to date.

- The Fulton County Manager’s Office created the SODD in 2009
- In 2012, SODD began measuring Fulton County agencies on KPI’s
- The Family Advocates in the Fulton Family Care Network complete a FAT that measures 14 family stability factors
- At the Jefferson Place Assessment Center, staff track client’s wages and length of employment to determine whether or not the client has maintained employment and increased their income
- The Jail Diversion programs, offered by the Department of Behavioral Health and Developmental Disabilities, also tracks outcomes such as recidivism rates of former clients

¹⁷ Martinson, K., Ratcliffe, C., Vinopal, K., & Parnes, J. (2009). *The Minnesota Integrated Services Project: Final Report on the Initiative to Improve Outcomes for Hard-to-Employ Welfare Recipients*. p. ES-14. Washington, DC: The Urban Institute.

6.10.4 Preventing Factors to Common Ground Implementation

The following are findings that suggest the limitations of County program evaluation processes.

- Other programs track a variety of service delivery statistics, but not service delivery outcomes
- Currently, there is a limited comprehensive data collection for program evaluation to evaluate Common Ground and the implementation of ICSD over multiple years
- The County did not design Agency KPIs to directly correlate to Common Ground

6.11 Lessons Learned and Challenges

In the beginning of this section the team described HHS's model for delivery of comprehensive health and human services. HHS's ten components were used to describe some of the leading practices implemented across the nation as they relate to Fulton County's Common Ground ICSD model. KPMG found variation in the structures and operations of ICSD across the United States and Canada. Variations aside, based on KPMG's review of ICSD implementation in other jurisdictions, a few issues stand out as lessons learned and challenges to the implementation of integrated service delivery.

6.11.1 Lessons Learned

Core Components of ICSD

Several core components of ICSD exist to define integration and make ICSD more than simply wraparound services or consolidated delivery models. Although co-location, a team model for delivering services, and capital improvements are mechanisms that support ICSD, the model cannot be fully realized without integrated, individual needs assessment, cross-program case management, and an integrated care plan.

1. The individual needs assessment refers to a centralized intake process and initial client screening or assessment. The purpose is to systematically identify service needs at the initial contact with clients, with further elaboration as staff complete more in-depth assessments. When technology further supports, staff can enter client identifying information, assessment data, and initial referral history only once and consolidated information about each client becomes available to all service providers involved in the case. This information becomes the basis of multidisciplinary case planning
2. The purpose of case management is to help ensure that client needs identified during the assessment process are addressed during the life of the case. Case management helps mitigate duplication of services, ensure staff coordinate services and client communication, and supports quality assurance during the period of service delivery
3. Development of an integrated care plan provides a central tool for all service providers to ensure that they are working toward the same goals and objectives. KPMG recognizes that the service mix will vary depending on client needs. For example, the services the County offers to families with troubled teenagers will not resemble the service mix associated with adult day care. However, regardless of the specific mix of services and service providers, the integrated care plan helps clearly assign responsibilities, communicate changes in service delivery needs, and assess progress as the County delivers services.

Technology

Technology is critical to the full and effective implementation of ICSD. Technology is more than a support system, it is a means to track data for a single client through services received across programs. IT helps facilitate ICSD by driving the same processes to all users regardless of program and creating accountability through data visibility.

In White City, Oregon, a single computer system supports one deliver center with similar equipment for all staff.¹⁸ There is a common case narrative system for monitoring client progress and tracking activities. The delivery center uses software that allows multiple programs to access information from each desktop. Each worker can review case plans and review types of benefits and services a family is receiving.

6.11.2 Challenges

Fulton County's model for delivery of comprehensive health and human services incorporates many industry leading practices. However, each component of the model comes with its own set of challenges. KPMG found no model of ICSD across the United States immune to these challenges. Two factors are further discussed in the following paragraphs. .

Rules, Regulations and Funding

Fulton County provides direct services to its citizens through a combination of programs that are administered and funded by numerous local, State, and Federal programs. Most of these programs have distinct funding streams, information systems, rules, and regulations. This creates difficulty for Fulton County to combine funds and provide integrated and holistic services that include services from multiple programs. The County is starting to overcome these challenges through co-location of services at the service centers. However, the County has great opportunity to be more effective integrating client case management across programs.

Individual funding streams and program regulations reinforce programmatic silos. Several U.S. counties secured foundation and community-based funding that is not subject to federal and state regulations and therefore, provides some flexibility in how the counties use funds. For example, the Wraparound Oregon project, located in Multnomah County, received several multi-year non-governmental grants to fund case managers that facilitate and coordinate services across various programs. Milwaukee, Wisconsin received a managed care waiver that allowed for consolidating funding streams from various HHS-related programs.

Technology

Fulton County staff use a variety of federal, state, and county information systems to maintain client information, manage cases, and produce required reports. These information systems do not interface to share client information. As a result, staff often must enter client information multiple times across different systems. In addition, the use of multiple, disparate and non-interfacing systems restricts the ability of case workers to access comprehensive client information when coordinating services and making case management decisions. As the County moves forward with integration efforts, the County should consider how to integrate the related client care technology systems so that staff from multiple programs can access a complete client service history and help build a consolidated client record.

¹⁸ Ragan, M. (2003). *Service Integration in Oregon- Successful Local Efforts Influence Major State Reorganization*. Albany, NY: State University of New York, Nelson A. Rockefeller Institute of Government for the Casey Strategic Consulting Group

7 Recommendations and Road Map

KPMG developed 16 recommendations for the County's consideration to help continue to advance Common Ground initiatives and goals. This section provides the County with recommendations based upon observations discussed in Sections 4-6. The report should be read in its entirety to gain a full understanding of the context and analysis performed resulting in the recommendations.

Opportunities for improvement were identified within the work streams, as outlined in Section 2 Project Overview. Multiple recommendations identified within this report are the result of the County's desire to achieve Common Ground goals, including implementing the ICSD model. Today, the County has made significant progress towards certain goals outlined in its Common Ground initiative in 2008. The recommendations presented in this report will help the County continue to achieve Common Ground goals and positively impact health outcomes for Fulton County citizens.

7.1 Recommendations Details

The recommendations provide actionable items towards achieving Common Ground initiatives in an appropriate timeframe. Each recommendation is detailed in a table containing the following elements:

- **Estimated Complexity** – Defined as high, medium, or low effort for implementation. High complexity requires substantial commitment of staff effort, financial resources, and coordination among multiple stakeholders both internal and external to HHS and the County. Medium complexity requires moderate staff effort, financial resources, and coordination among stakeholders. Low complexity requires minimal disruption to day-to-day staff responsibilities, limited financial commitments, and is not dependent on multiple stakeholders.
- **Estimated Cost** – Defined as high, medium, or low cost for implementation. High estimated cost requires a financial investment of \$500,000 or more. Medium estimated cost requires a financial investment of between \$100,000 and \$500,000. Low estimated cost requires a financial investment of less than \$100,000
- **Estimated Duration** – Short-term implementation is a period less than 12 months. Long-term implementation is a period greater than 12 months
- **Statement of Need** – Refers to observations identified in Sections 4-6
- **Activities** – High level action steps needed to achieve each recommendation
- **Benefits** – Potential positive impacts from implementing recommendations
- **Outcomes** – Expected positive results from implementing recommendations
- **Details** – Further comments regarding implementation of recommendations



7.2 Recommendations with Implementation Strategy

The following pages show each of the 16 recommendations.

A. Implement a Common Ground Governance Model	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Medium	Long Term
STATEMENT OF NEED			
There is limited consistent and clear governance of ICSD objectives and execution across HHS personnel. (see Section 4)			
ACTIVITIES			
<ul style="list-style-type: none"> • Create an ICSD Executive Steering Committee comprised of senior-level executives from each participating department and grant it with decision-making capability regarding Common Ground/ICSD operations and policies • Consider employing the current vacant HHS Agency Director vacancy, the individual that reports directly to the County Manager and is the direct manager for the Department of Health and Department of Housing and Human and Services to have comprehensive, strategic visioning across all programs within HHS • Assign a full-time professional staff member to be the ICSD Project Director. This individual will oversee the day-to-day operations of the Common Ground initiative and should be vested with responsibility for implementing the Common Ground policies, operational models, and recommendations • Assign an ICSD Manager at each of the integrated service centers (or to manage multiple service centers). This individual should not have program delivery responsibility but should be accountable for ensuring the implementation and operations of Common Ground/ICSD at the center and for the ongoing interaction and connection between programs • Create a more defined chain of accountability so that individuals with responsibility for executing the Common Ground vision are evaluated on their performance. All stakeholders with purview over components of Common Ground must be held accountable – this includes the day-to-day director, ESC members, and heads of organizations/departments that are part of Common Ground operational model 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> • Dedicated Common Ground staff will provide implementation and management resources, which will improve ongoing efforts to realize Common Ground objectives • Executive Steering Committee will increase visibility of and commitment to Common Ground at the highest levels of the HHS Agency • Clear lines of accountability and measures to evaluate performance will enhance ongoing Common Ground implementation 		<ul style="list-style-type: none"> • Daily focus on driving Common Ground initiatives to implementation 	
DETAILS			
<p><u>Executive Steering Committee</u></p> <ul style="list-style-type: none"> • ESC Membership <ul style="list-style-type: none"> ○ Leadership from participation departments/agencies: Dept of Health, Dept of HHS, Dept of Administration ○ The Director of the HHS Agency should chair the group (note – as of 5/2/2012 this position remains unfilled at this time, and should be filled prior to creating the ESC). ○ At least one member from the Community Stakeholder Group ○ At least one representative for the caseworker (line staff) community. This could be a union representative. ○ At least one client or former client to provide client-level perspective – in many engagements similar to this, the parent/client will be both a former client and a member/leader or a community advocacy group ○ The full-time Common Ground Project Director (non-voting) ○ Others TBD • ESC Duties: <ul style="list-style-type: none"> ○ Define / revise goals, objectives, and desired results from Common Ground 			

A. Implement a Common Ground Governance Model	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Medium	Long Term
<ul style="list-style-type: none"> ○ Approval-authority for Common Ground operations, such as service delivery models, staffing structures, budget, capital expenditures, outcome/evaluation plan ○ Serve as Common Ground “spearheads” within their departments to establish support and community goals/objectives ○ Advocate for policy, regulatory, and statutory changes at local, state, and federal levels in pursuit of realizing Common Ground objectives. ○ Head effort to more effectively engage community members and organization ○ Problem resolution ● ESC Meetings: <ul style="list-style-type: none"> ○ Meet quarterly ○ Agenda would include updates/decisions on operations, budgeting, new initiatives ○ Problem identification and management 			
<p><u>Full Time ICSD Director</u></p>			
<ul style="list-style-type: none"> ● Reports to the HHS Agency Director ● Works jointly with the ESC and the Directors for the Dept of HHS and Dept of Health. ● Roles & Responsibilities <ul style="list-style-type: none"> ○ Manage day-to-day operations for Common Ground Initiative, county-wide ○ Make staffing decisions for any dedicated Common Ground staff members ○ Direct the integration of programs, services, and staff from participating departments ○ Manage the ongoing effort to forge and maintain community partnerships ○ Work with ESC to identify and advocate for policies and laws that advance the objectives of Common Ground ○ Work with departments and County IT Agency to formulate and execute a long-term technology plan to assist with integration of services ○ Direct activities of the ICSD Managers at the service centers ○ Implement recommendations and policies approved by the ESC 			
<p><u>Full-time ICSD Managers at the Service Centers</u></p>			
<ul style="list-style-type: none"> ● Oversee the implementation of Common Ground/ICSD operations and policies at the service centers and any other service delivery locations under their purview ● Work with service centers partners (e.g., other Fulton County agencies, community groups) to implement programs at service centers ● Work with local groups and individuals in the service center area to identify the specific array of services that are needed at the service center ● Implement training and communication policies to promote ongoing knowledge and integration of programs and services at the service center(s) ● Report to the ICSD Project Director 			
<p><u>Enhanced Structure for Accountability</u></p>			
<ul style="list-style-type: none"> ● Detailed performance standards that capture measureable outcomes should be developed for all dedicated Common Ground staff. These standards should be placed in their job descriptions and the staff members should be evaluated against them on their yearly performance evaluations. ● Appropriate evaluation measures should be created for department managers whose programs participate in the Common Ground initiative. ● Staff members (case workers) who deliver services at the service centers, or other Common Ground service delivery locations, should have performance measures that relate to how well they coordinate services between programs. 			
<p><u>Assumptions and Dependencies</u></p>			
<ul style="list-style-type: none"> ● Funding is available to fill the current vacancy for the HHS Agency Director and to create new positions for the ICSD Project Director and the ICSD Managers for the various service centers 			

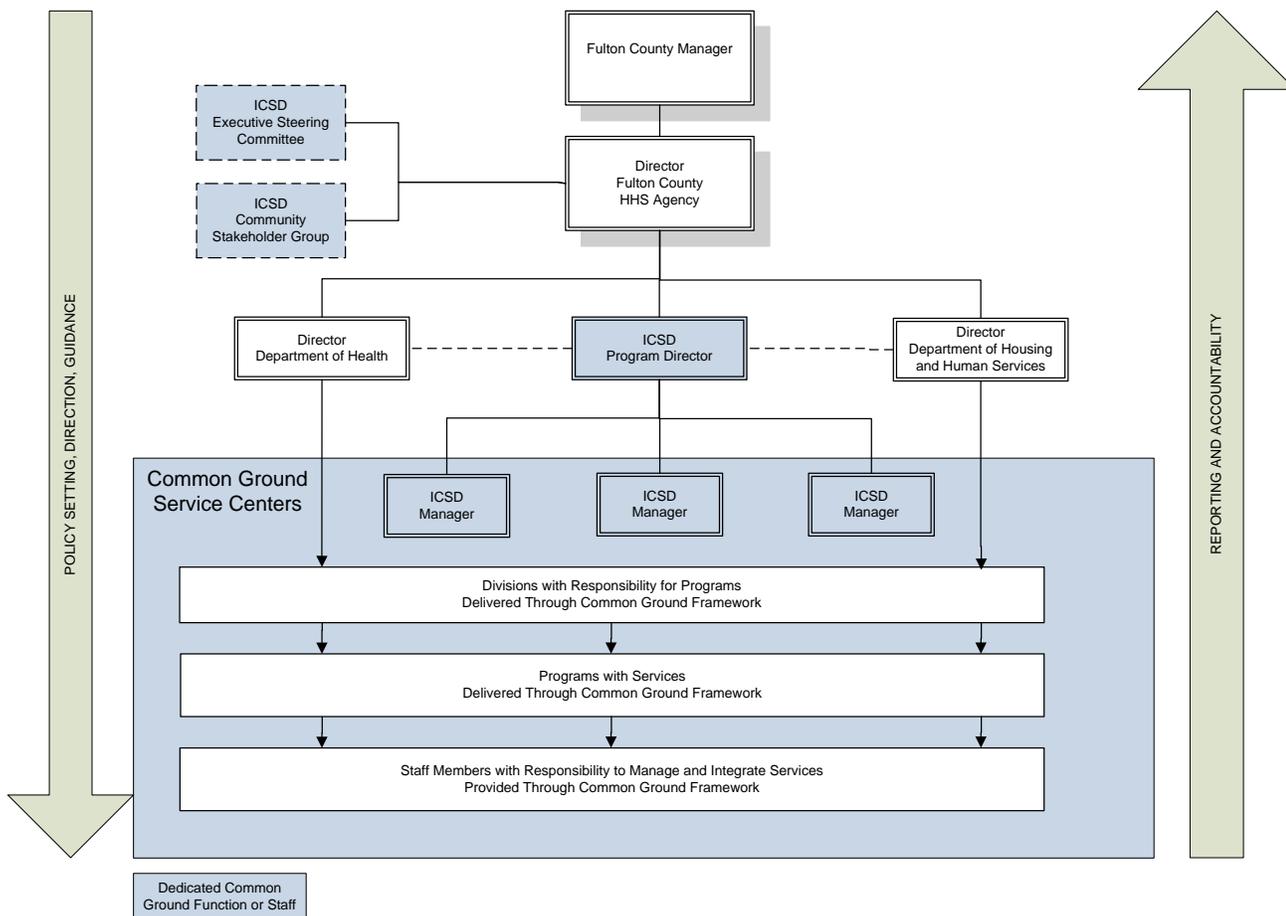
Summary of Organizational Changes

By making the following organizational changes, the County will create a governance model to oversee Common Ground initiatives and implementations:

- Fill the vacancy for the HHS Agency Director
- Create a full-time position for a ICSD Project Director
- Create one or more positions for ICSD Managers
- Revise existing job descriptions to include performance measures that capture the extent to which each staff member participating in Common Ground is achieving outcomes related to the integration of programs and services

A potential programmatic ICSD governance structure is presented in the exhibit below. The exhibit below does not represent all divisions within HHS, but shows a potential programmatic ICSD governance structure.

Exhibit 7.1



Implementation Timing

We recommend that the governance model be one of the first initiatives undertaken as the ESC should have into how the other recommendations contained in this reports should be implemented and the timing for their implementation.

B. Create and Execute a Change Management Strategy	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Medium	Long Term
STATEMENT OF NEED			
A strategic coordinated approach is needed to transition the staff/organization, community partners, stakeholders, and clients to the ICSD approach from the current state. (see Section 4 and 6.6)			
ACTIVITIES			
<ul style="list-style-type: none"> Develop a strategic change management (CM) outline that defines the goals of the CM activities. The outline should include a high level strategic plan with goals for the individual components - marketing, communication, and training – as they relate to the staff/organization, community partners, stakeholders, and clients. The outline should recognize that the three core activities (marketing, communication, and training) are interrelated and some activities may serve multiple purposes Develop and execute a detailed work plan for marketing of the ICSD model Develop and execute a detailed communication work plan Develop and execute a detailed training plan 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> Increase the awareness of the benefits of the ICSD model Increase the acceptance of the changes Decrease the resistance to the changes Increase staff ability to execute the ICSD model 		<ul style="list-style-type: none"> Coordinated and holistic method for driving Common Ground operational changes consistently throughout all HHS programs 	
DETAILS			
A recommended change management model is the ADKAR® by Prosci (http://www.change-management.com/). This model uses five key goals: <ul style="list-style-type: none"> Awareness of the need to change Desire to participate and support the change Knowledge of how to change (and what the change looks like) Ability to implement the change on a day-to-day basis Reinforcement to keep the change in place <p>The ADKAR methodology begins with planning for the marketing of the change. Fulton County needs to clearly identify the goals, benefits, and how the change will be implemented for each audience. This activity should include identifying the sources of potential resistance to the change by soliciting input from the intended audiences (staff, stakeholders, and clients). CM materials, including website development, should be prepared as the tools to be used for marketing, communication and training for the various audiences.</p> <p>A Communication Plan should be developed that identifies the activities that will be performed to inform all audiences of:</p> <ul style="list-style-type: none"> The need and benefit of the change and how the changes will affect each specific audience The relationship of these changes to Fulton County’s ICSD model The activities that will be implemented to communicate with each of the key audiences <p>The initial goal of these communications is to make the audiences aware of the change and to build support for the changes. Once the purpose and benefits of ICSD are understood and support has been garnered, specific information should be provided about how the change will be implemented, including the timing of the changes.</p> <p>A Training Plan is required to train all parties in the methods and procedures of the ICSD model. The Training Plan is not limited only to staff, but also addresses the new procedures that will affect all partners in the referral and service delivery system, as well as the clients who will participate in ICSD program.</p>			

B. Create and Execute a Change Management Strategy	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Medium	Long Term
<u>Assumptions and Dependencies</u>			
<ul style="list-style-type: none"> • Initiatives and specific activities have been developed to move the organization to the ICSD model • The benefits of the ICSD model are clearly defined for communication and training purposes 			

C. Review and Develop Public Policies that Impact Social Determinants of Health	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Low	Short Term
STATEMENT OF NEED			
There is currently a limited focus on reviewing and developing Public Policy that aligns with ICSD. (see Section 4.1)			
ACTIVITIES			
<ul style="list-style-type: none"> • Designate additional staff responsible for continual review of public policies to carry out Common Ground and other key County initiatives • Perform a gap analysis between policies, programs, and desired outcomes for the purpose of identifying inconsistencies and potential impact on communities • Determine the need for policies that influence social determinants of health, but do not have a direct link to a service provided by Fulton County. Examples include zoning for fast food restaurants, liquor stores, and fast cash and loan establishments • Include community stakeholders in the review 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> • Aligns policies with programs and outcomes • Identifies policy gaps • Increases sustainability of County initiatives with program outcomes 		<ul style="list-style-type: none"> • Improved Social Determinants of Health through alignment of public policy and Common Ground initiatives 	
DETAILS			
Improving quality is the most effective way to improve outcomes. A clear focus on care delivery and its alignment with public policy is a prerequisite to improving health outcomes for Fulton County citizens. Effective public policy can help to reduce costs and improve system sustainability.			
<u>Assumptions and Dependencies</u>			
<ul style="list-style-type: none"> • Establishing policies strengthen rules, regulations, and laws within the County • The County will review policies on a consistent basis (annually) 			

D. Enhance the Hiring Process	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Low	Short Term
STATEMENT OF NEED			
The County hiring process offers little flexibility and the DAS has limited input and control throughout the process. (See Section 5.1)			
ACTIVITIES			
<ul style="list-style-type: none"> • Increase communication with the CPO throughout the recruitment process • Develop procedures by which HHS input is maintained throughout the hiring process, including initial advertisement, and resume selection • Create defined policies and procedures specific to the interview process to mitigate risk • Create a trained resource pool of personnel to select from to conduct interviews. These personnel are interchangeable during candidate interviews • Develop a process that allows position descriptions to be flexible to meet specific HHS needs 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> • Allows HHS HR to exercise greater influence over the hiring process to support Common Ground initiatives • Decreases the amount of time from identification of need to candidate selection • Enables a skilled applicant pool as a result of customized position descriptions tailored for HHS needs and Common Ground initiatives 		<ul style="list-style-type: none"> • More accurately meet hiring needs in a timely manner 	
DETAILS			
<p>To successfully restructure the interview panel, HHS needs to invest in training personnel on clearly defined processes and procedures. If HHS has a trained personnel pool to draw from, and allows for flexibility in the members of the panel, the interview process may be completed in a more timely fashion. For example, if three members are chosen for the panel, and one cannot make it for a particular interview time, that individual can be readily replaced by another member from the trained interviewee pool.</p>			
<p><u>Assumptions and Dependencies</u></p>			
<ul style="list-style-type: none"> • HHS HR has the time and resources to devote to training a selected pool of personnel for the interview panels • HHS HR has the time and resources to develop comprehensive policies and procedures around the interview process to satisfy risk management concerns • CPO and DAS expressed willingness to enhance communication throughout the recruiting cycle • DAS is subject to policies and procedures established by the County Central Personnel Office 			

E. Streamline HHS Internal Purchasing Process	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Low	Short Term
STATEMENT OF NEED			
DAS lacks clear, enforceable, and consistent procedures for requisitions. Current processes are not uniformly applied across all HHS departments and require numerous approvals which may result in process delays. (see Section 5.2)			
ACTIVITIES			
<ul style="list-style-type: none"> • Centralize the purchasing process across HHS departments • Evaluate opportunities to automate the purchasing process • Identify and develop a process for requisitions that fits the needs of all departments • Identify the maximum number of approvals required for micro-purchases to eliminate duplicative reviews of P-Card requests • Identify appropriate approval thresholds • Update policies to include revised procedures, including approval thresholds, and communicate changes to the organization utilizing steps identified within the change management recommendation • Mandate purchasing policies and procedures throughout HHS to promote consistency and compliance with approved policies 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> • A streamlined purchasing process that focuses on integration • Clearly defined processes and procedures helping to increase ownership and accountability • Increases turnaround time from request to delivery • Provides concise data analytics enabling strategic management purchasing decisions • Increases data integrity with automation and reduces staff touch points / duplication of efforts 		<ul style="list-style-type: none"> • Reduced administrative burden and costs, allowing employees to focus more on client service delivery 	
DETAILS			
<p>The current arrangement is not supportive of the integration indicative of the Common Ground initiative. The lack of incorporation and coordination of HHS departments in a standardized purchasing process may result in a less cohesive Agency and further fragmentation of departments and Agency-wide strategic goals.</p> <p><u>Assumptions and Dependencies</u></p> <ul style="list-style-type: none"> • DAS has the authority to implement a standard purchasing process across HHS departments • DAS is subject to policies and procedures established by the County Department of Purchasing and Contract Compliance • The County requires all HHS departments and programs to comply with revised policy 			

F. Create and Define Agency-wide Policies and Procedures for Grants Management	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Medium	Short Term
STATEMENT OF NEED			
There is not a defined grants management function for HHS. Grant management responsibilities are primarily decentralized and executed at the program level. (see Section 5.3)			
ACTIVITIES			
<ul style="list-style-type: none"> • Clearly define the grants management function within HHS • Designate staff or job description to take ownership of a grants management process across HHS departments • Identify and develop processes and procedures for financial and programmatic monitoring on a regular basis; bearing in mind grantor agency (federal, state or other) regulations • Create a schedule, by program, for grant monitoring • Define DAS's role in the review of grant applications and determine the appropriate level of involvement • Examine all touch points in the grants management process 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> • Decreased risk of mismanagement of funds or returned grant dollars as a result of noncompliance; increases internal controls • Increased awareness of grant programs and potential funding sources that support Common Ground initiatives • Maximize the impact of grant dollars on Common Ground initiatives, as allowable • Potential additional funding or revenue stream opportunities 		<ul style="list-style-type: none"> • Reduced risk around grant non-compliance 	
DETAILS			
Develop, document, and enforce grant management policies and procedures that include defining roles and responsibilities between Finance and all other Departments. Policies and procedures should include:			
<ul style="list-style-type: none"> • Grant administration • Performing and receiving drawdown of federal funds • Monitoring grant operations against federally-approved grant program plans • Completing field reviews • Maintaining grant records 			
Develop and implement audit procedures for field reviews that include review of program specific requirements such as participant eligibility, federal reporting, matching requirements, and allowable activities. Conduct ongoing, annual monitoring activities for all major grant programs.			
<u>Assumptions and Dependencies</u>			
<ul style="list-style-type: none"> • The Administrative Services Department has the time and the resources to devote to a formalized grants management function • HHS invests in staff training to facilitate understanding of grants management processes and monitoring procedures 			

G. Redesign HHS IT Support to Better Align to Established Countywide IT Policies and Processes.	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Low	Short Term
STATEMENT OF NEED			
DAS IT processes and initiatives do not consistently align to DoIT's operating model or the County's overall IT strategy. There is limited coordination between HHS technology efforts and DoIT technology efforts. (see Section 5.4)			
ACTIVITIES			
<ul style="list-style-type: none"> Assess the HHS IT support operating model and align to the Countywide IT support operating model Migrate the Administrative Services IT functions that provide traditional IT services (e.g. Help Desk, Project Management) into the DoIT organization. Allow HHS technology support to focus on providing specialized support to specific HHS processes and applications Clearly define roles, responsibilities, performance measures, and procedures of HHS technology resources in accordance with Countywide IT strategies Leverage established DoIT or other leading practice processes to develop a formal framework for HHS technology support processes. See specific areas below 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> Greater alignment between the Departments and traditional IT functions Provide better accountability, responsibility, and consistency through defined methodologies, tools, training and IT operating model Provide holistic view of systems and components within the IT infrastructure and improve stability and overall reliability of systems Ensure planning, coordination, monitoring and control of changes to the technology infrastructure Accurate record of incidents and workloads helps management perform analytics on incident types, mean time to resolution 		<ul style="list-style-type: none"> Improved service delivery and more consistent IT support processes 	
DETAILS			
<u>System Management</u>			
<ul style="list-style-type: none"> Develop a centralized repository of systems, server mapping, interfaces, architecture artifacts, functional owners, and technical owners Work with DoIT to develop a governance process for communicating and monitoring architecture changes 			
<u>Change and Release Management</u>			
<ul style="list-style-type: none"> Work with DoIT to develop a governance process for communicating and monitoring change and release activities Leverage existing DoIT processes and tools and develop a more comprehensive Change Management process based on industry standards (e.g. ITIL) 			
<u>Incident and Problem Management</u>			
<ul style="list-style-type: none"> Establish processes for logging all Help Desk calls to establish an accurate record of incidents and work load and enable analysis of trends in recurring technology issues Leverage the current DoIT processes and tools and develop a more comprehensive Incident and Problem Management process based on industry standards (e.g. ITIL) Formalize processes for end-user incident reporting and integration with related service management processes Standardize and publish resolution procedures, known errors, workarounds, and ensure availability of procedures in a shared environment 			
<u>Assumptions and Dependencies</u>			
<ul style="list-style-type: none"> DoIT resources and tools are made available 			

G. Redesign HHS IT Support to Better Align to Established Countywide IT Policies and Processes.	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Low	Short Term
<ul style="list-style-type: none"> • Technology and business areas will adopt formal procedures • DAS is subject to policies and procedures established by the County Department of Information Technology 			

H. Integrate Client Service Information Management Applications and Supporting Business Processes	Estimated Complexity	Estimated Cost	Estimated Duration
	High	High	Long Term
STATEMENT OF NEED			
HHS client information management systems do not currently provide an integrated, holistic client record. Business processes for client service management are not consistent across HHS departments. (see Section 5.4 and 6.2)			
ACTIVITIES			
<ul style="list-style-type: none"> • Conduct a Business Process Analysis of current and future HHS IT needs; conduct a gap analysis • Assess current IT infrastructure and capability, including pending upgrades and releases • Compile business requirements and application design considerations for an integrated technology solution and determine if existing technology platforms can meet Agency needs • Pursue federal and other funding opportunities for enhancing client service management • Consider partnering with other health districts in Georgia 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> • Efficiency gain on cross functional sharing of Client data for integrated service delivery • Allows systematic tracking of services delivered to Clients • Ability to measure effectiveness of service delivery outcomes through data analytics and reporting 		<ul style="list-style-type: none"> • Established technology foundation necessary for integrated service delivery 	
DETAILS			
<p>Capturing, sharing, and integrating client data throughout HHS programs is essential to the success of Common Ground. In order for HHS to holistically treat a client, the Agency must provide services from a common and complete understanding of a client's history and use of HHS services.</p> <p>The County will need to create a strategic plan that provides clarity, vision and a consistent approach to technology that supports Common Ground initiatives. Top administrators and political leaders will need to articulate a strong vision for health and human services technology that engages all stakeholders and formalizes the integration of care as the predominant objective. Without a shared vision and consistent policy on technology, Agency directors and system managers will find it increasingly difficult to achieve value for their investment or better clinical outcomes for clients. This doesn't necessarily mean mandating a system-wide approach, but it does require everyone to be heading in the same direction.</p> <p>Technology initiatives focused primarily on cost-cutting or back-office consolidation will not likely add up to a whole system. Instead, technology should be championed as a method for delivering a safer, more responsive and more efficient form of healthcare; only then will it win the support and active engagement of stakeholders. Indeed, the top-down approach of mandating a certain software or program will likely not succeed in creating integrated, electronic healthcare technology platforms, particularly given that service providers need to be convinced they are making the right investment decisions for their patients.</p> <p>The County should focus on core elements that drive the greatest and most consistent benefits for the largest number of people. EHR and other health and human services technology initiatives are massive projects and simply can't be done in one step. Some of the more successful systems are the ones that start by focusing on the most common elements of the healthcare process (such as client records, discharge letters, diagnostic tests and prescription records) and then incrementally add components once the core system has been developed and adopted.</p> <p><u>Assumptions and Dependencies</u></p> <ul style="list-style-type: none"> • HHS initiatives will adhere to state, federal and other regulatory requirements. This includes HIPAA privacy regulations, and Health Information Exchange (HIE) requirements • DAS is subject to policies and procedures established by the County Department of Information Technology 			

I. Identify and Implement Models for Integrated Case Management for Target Populations	Estimated Complexity	Estimated Cost	Estimated Duration
	High	High	Long term
STATEMENT OF NEED			
There does not appear to be a systematic approach for comprehensive case management across HHS. (see Section 6.5)			
ACTIVITIES			
<ul style="list-style-type: none"> • Enhance the co-location of services by identifying and implementing models for integrated case management for target populations • Steps in this process: <ol style="list-style-type: none"> 1) Identify the target populations that might be suitable for an ICM approach (see below) 2) Determine scope of services for each target population 3) Determine the ICM models based on the populations 4) Determine staffing and organizational changes/supports 5) Conduct and evaluate a pilot program 6) Rollout out where feasible and/or go through process again for other populations 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> • Will move the County towards integrated and targeted case management that will improve outcomes for clients • Augments the County's current efforts to co-locate services by expanding the continuum of services available to clients • Fosters data sharing among program staff that will improve targeting and delivery of services, thereby improving client outcomes 		<ul style="list-style-type: none"> • Decreased burden on the client to identify service needs and eligibility 	
DETAILS			
<p>There are a number of steps involved in establishing a successful model for integrated case management. Provided below is a sequential explanation of these steps that generically discusses how the County can establish such a model. In addition, we have provided concrete recommendations for establishing an integrated care model for one specific population.</p>			
<ul style="list-style-type: none"> • Identify the target populations. <ul style="list-style-type: none"> ○ Integrated case management is appropriate for clients that require services from a number of different programs that cut-across government HHS agencies. In Fulton County, the Fulton Family Care Network is an excellent example of integrated case management for children and families who are at-risk of separation and who need multiple services to improve their family functioning and maintain an intact family unit. A family advocate oversees the coordination of services for each family and ensures that all services identified are received. Nationally, systems of integrated care management often wrap around families with multiple needs and where children are at-risk of placement. We recommend that Fulton County continue and expand ICM services for this population ○ There are other populations that may benefit from integrated case management services. In Fulton County, we recommend that the Common Ground model initiate an ICM pilot program for clients at the Jefferson Place Assessment Center (using model 2 below). After an evaluation of the pilot, the ICM model can be expanded to more clients and/or rolled out to other populations • Determine the ICM models based on the populations <ul style="list-style-type: none"> • From a methodological perspective, we recommend two potential models for integrated case management services, each of which have been proven in various programs throughout the U.S., and each of which may be suitable for different client population <ol style="list-style-type: none"> 1) <u>Model 1: Case Facilitator / Coordinator</u> <ol style="list-style-type: none"> a. Use of a facilitator/case coordinator that oversees coordination of case work across agencies. The facilitator would be assigned a series of cases and would work with caseworkers from the various programs providing services to the members of the case. The facilitator would not deliver specific services, but rather would be responsible for 			

I. Identify and Implement Models for Integrated Case Management for Target Populations	Estimated Complexity	Estimated Cost	Estimated Duration
	High	High	Long term
<p>ensuring that each client has a unified case plan, that the plan identifies the appropriate services, and that client's access and receive the services which have been identified in the case plan</p> <ul style="list-style-type: none"> b. As noted, this model is similar to what is already in place at the Oak Hill/Family Care Network. As discussed in the best practices section of this report, this model was also seen in other counties, notably the "Wraparound Oregon" project and a similar effort in Indiana c. We recommend that the County continue to provide services at Oak Hill using this model, and that the program be expanded to include a greater number of families by implementing at other County sites <p>2) <u>Model 2</u>: Multidisciplinary Team (MDT) Approach</p> <ul style="list-style-type: none"> a. The MDT approach to ICM involves a set of staff members working collectively on multiple cases, where all staff members work together to assess the client's needs and develop the care plan. Then, each staff member focuses on delivering the services for specific aspects of the client's care plan. Typically there is one staff member with the primary responsibility for managing the overall team. Often, the staff member with the lead for the case works in the program that addresses the client's greatest need. For example, if the client's most severe needs are for mental health services, the mental health staff member would be the logical lead for the case. However, unlike the case facilitator model, all staff members involved in the case has service delivery responsibility b. MDT approaches work well in situations where program staff are co-located, so that they have immediate and consistent access and can meet to discuss their cases on a regular basis. Having multiple programs available at a single location also facilitates the client's access to these services c. We recommend that Fulton County pilot an MDT approach in the Jefferson Place Assessment Center (JPAC). Clients at JPAC are centrally located and there are staff members in each service area <ul style="list-style-type: none"> • Determine staffing and organizational changes/supports <ul style="list-style-type: none"> ○ To implement either of these models, some staffing changes are necessary <ul style="list-style-type: none"> ▪ For the facilitator model, Fulton County needs to identify individuals with the right skill sets to coordinate cases across a variety of programs, and also must find the funding for these individuals. This may be a challenge given the current economic conditions, especially considering that these workers are not providing services for specific programs, so cost allocation may be difficult. In similar programs across the U.S., this model was often funded through support from local or national foundations with an interest in service integration ○ For the MDT approach <ul style="list-style-type: none"> ▪ From an organizational standpoint, the JPAC is well-designed for an MDT approach. Full-time staff members are already located at JPAC and collectively, the program already offers services for homelessness, workforce training/job placement, substance abuse, and some mental health supports. All of these staff members would participate on the MDT. In addition, interviews with the JPAC staff indicate that clients often require additional services to regain stable housing, such as primary health care, dental care, family counseling, and enhanced mental health services. In order for the MDT approach to be successful, JPAC would need to build in connections to other programs and have staff from these programs service on the MDT ○ For either approach, a key organizational principle is to ensure that the integrated teams are held accountable for achieving the desired outcomes for the clients. To ensure this accountability, the County must establish outcomes for the programs in general as well as the specific clients. As well, measures for evaluating how well the teams do in realizing these outcomes for their clients must be built into the County's performance evaluation system • Conduct and evaluate a pilot <ul style="list-style-type: none"> ○ We recommend a pilot first for the MDT program so that Fulton County can work through the nuances of the implementation prior to rolling it out for a larger number of clients. In addition, in further discussions to define the composition and work of the MDT, the County may decide that the program should be restricted to only certain types of clients (e.g., those with the most severe array of needs) and therefore implementing the program for a wide range of clients would not be appropriate ○ As the pilot progresses, the County should continually monitor not only the processes used to manage the program (and the individual cases) but also to evaluate the program's effectiveness. Interim and 			

I. Identify and Implement Models for Integrated Case Management for Target Populations	Estimated Complexity	Estimated Cost	Estimated Duration
	High	High	Long term
<p>longer-term client outcomes should be specified and measured on a regular basis. The County should compare these outcomes against outcomes for similar clients that are not part of the MDT pilot to see whether the MDT program is procuring better results</p> <ul style="list-style-type: none"> ○ Elsewhere we have recommended that the County establish partnerships with research institutions and universities for the purpose of constructing a rigorous program evaluation process. We recommend that the evaluation of the pilot ICM program include an evaluation conducted by one of the County's research and evaluation partners ● Rollout out where feasible and/or go through process again for other populations <ul style="list-style-type: none"> ○ Depending upon the successfulness of the pilot, the county should expand the program to include additional clients at JPAC or other service locations <p><u>Assumptions and Dependencies</u></p> <ul style="list-style-type: none"> ● Policies that currently assign case responsibility within various programs are assessed to determine consistency with, or changes needed for, integrated case management ● Information sharing policies allow information to be disclosed to the parties participating in integrated case management 			

J. Develop Common Practices for Service Delivery that are Consistent with Common Ground's Philosophy	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Medium	Long Term
STATEMENT OF NEED			
A consistent and ongoing method for standard business processes and uniform branding is not currently in place across service centers. (see Section 6.3-6.4)			
ACTIVITIES			
<ul style="list-style-type: none"> Continue to use feasibility studies to determine which programs and services should be included at each of the County's health centers and then bring those programs to the centers Brand all health centers with Common Ground logo Develop and implement common business practices for functions that are common across programs 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> Adding additional programs to what is currently available at some of the centers will further integrate services and simplify the program enrollment and participation processes for clients Implementing common processes across the centers will enhance the client's experience, more accurately identify the entire range of services needed by a client, provide more uniformity in common processes (e.g., intake, screening, referral) and generally make service delivery more complete. 		<ul style="list-style-type: none"> Increased awareness and delivery of Common Ground goals 	
DETAILS			
<u>Identify and implement common programs and processes at all health centers</u>			
<ul style="list-style-type: none"> While the North Fulton and Neighborhood Union service centers have a comparable array of services, other health centers do not have as broad an offering. For example, the College Park Regional Health Center does not offer workforce development or housing services. We recommend that the County continue to identify any additional programs that should be included at all of the health centers . 			
<u>Common Ground Branding</u>			
<ul style="list-style-type: none"> In the program evaluation, interviews with staff at some of Fulton County's health centers revealed that many staff members do not feel a connection with the Common Ground program. To some extent, the connection can be established through greater branding of the health centers with Common Ground materials, literature, and signage 			
<u>Assumptions and Dependencies</u>			
<ul style="list-style-type: none"> Budget and organizational authority exist for adding additional programs to regional health centers Physical space limitations either do not exist or could be overcome as new programs and staff is added to the regional health centers 			

K. Develop a Common Intake and Screening Process at Each Common Ground Delivery Site	Estimated Complexity	Estimated Cost	Estimated Duration
	Low	Medium	Long Term

STATEMENT OF NEED

Service centers have multiple client intake entry points resulting in inconsistent client processes. (see Section 6.2)

ACTIVITIES

- Create a common registration form that collects basic client data for all clients and lets clients check the services they need/desire across programs and service centers
- Create a short screening tool that assesses client needs (as documented on the registration form) with the eligibility standards for County programs
- As the technology recommendations are implemented, record the client information, service requests, and eligibility screen results in whatever technology systems is implemented, so that there is a record of all client interactions with County staff

BENEFITS	OUTCOME
<ul style="list-style-type: none"> • A common registration form and process will standardize the initial client experience throughout the client, help ensure consistency, and also enable clients to have information about all of the services for which they may be eligible • Collecting a standardized set of information will support cross-program data sharing, research and evaluation, and outcome tracking 	<ul style="list-style-type: none"> • Enablement of the County to more accurately match services offered to client needs

DETAILS

Create a common registration form

- A common registration form should be given to each client that enters a Fulton County service center. The registration form should collect a common set of data for all clients, which can then be used to help screen the client against program eligibility standards. Information that should be collected on the registration form includes:
 - Client name, address, phone, email, and other relevant contact info
 - Basic client descriptive information, such as gender, age, marital status, pregnancy status, and current receipt of state- and county-administered benefits
 - Current income and approximate level of monthly expenditures
 - Names of each additional individual in the client's household
 - Household composition and relationships of each household member to one another
 - A list of county services that allows the client to check the services in which they have an interest
- As referral and case management information systems are developed for the County, the information from the client registration form should be entered into the relevant systems so that the County has a searchable online history that case workers can access from a secure portal

Create a short screening tool

- A screening tool is something that could be used by Fulton County staff members to assess each client's potential eligibility and need for specific programs based on the information provided on the common registration form. Such a tool would enable a front line staff member (e.g., service center receptionist, eligibility clerk, etc.) to quickly see what programs the client has requested, determine whether they may be eligible for those programs, and then route the client to appropriate service delivery location
- In many state HHS agencies, the screening tool is an automated system, where information is entered into the system; rules are applied against the information, and the system returns a list of programs for which the client may be eligible. An example of this type of tool is the Georgia Compass system (<https://compass.ga.gov/selfservice/>) where clients are able to conduct a self-screen to determine potential eligibility for state-administered programs
- However, screening can be done manually, where the intake worker collects the registration form and performs the screening based on the client's interest and situation. Once a technology system is implemented, we recommend that the systems' functionality include a screening tool

K. Develop a Common Intake and Screening Process at Each Common Ground Delivery Site	Estimated Complexity	Estimated Cost	Estimated Duration
	Low	Medium	Long Term
<p><u>Assumptions and Dependencies</u></p> <ul style="list-style-type: none"> • Individual programs accept the concept of common registration and initial assessment • Administrative and legislative policies do not restrict programs from participating in a common registration and screening approach or can be amended to allow this 			

L. Develop a Standardized Referral Process with Required Follow-up Actions	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Medium	Short Term
STATEMENT OF NEED			
The lack of a single, integrated referral process limits client access to other programs. (see Section 6.1)			
ACTIVITIES			
<ul style="list-style-type: none"> • Develop a standard process for referring clients between programs. • Develop and standardize a referral form for all service delivery locations so that all program staff use the same form • Institute tracking and follow-up requirements so that someone follows-up on all referrals to determine whether the client received the identified service 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> • A standardized process promotes consistency in the service delivery process and helps facilitate the processing and coordination of referrals • Referral follow-up helps fosters better casework practice and helps ensure that clients receive the services they need to attain self-sufficiency and improved health 		<ul style="list-style-type: none"> • Increased positive client outcomes by guiding clients through standard referral process 	
DETAILS			
<u>Standard Referral Process</u>			
<ul style="list-style-type: none"> • We recommend that the common referral process be based on the current referral processes at the North Fulton or Neighborhood Union service centers. The critical elements are that the process include: <ul style="list-style-type: none"> ○ A common referral form that is accessible to and used by all staff – A standard referral form should be developed to ensure a common understanding across all workers and all program staff. The form should support referrals from any program and referrals to any program ○ Training and communication to workers to ensure that all staff members are aware of the common referral process and standards ○ Documented standard operating processes and associated time frames for completing referrals. These should be used in any training or communication with workers about the new referral process • The process should include a standard business process flow, list of required inputs and outputs, and mechanism for tracking and follow-up 			
<u>Technology Support</u>			
<ul style="list-style-type: none"> • As new technology supports are implemented, the referral process should be automated. If possible, depending on the technology system(s) used to automate referrals, we recommend that the County build automatic triggers into the system. These triggers should automatically notify the referring worker if and when a client actually applied for referred services and the disposition of the application. This will help with follow-up and tracking and ensure the client actually access and receive the services to which they were referred • Added components that are not necessary but would enhance the overall referral process <ul style="list-style-type: none"> ○ Create a county-based Information and Referral system, with a self-service function, where an individual can enter basic information about their family and their situation and then conduct an initial eligibility screen. The screen would identify services for which an individual or the members of their family be eligible. An alternative solution would be to work with the Georgia Department of Human Resources to determine whether specific Fulton County resources could be incorporated as reference data into the GA COMPASS website. This would enable Fulton County residents to conduct an eligibility screen for both State and County programs ○ Integration of the referral mechanism with community agencies. This would enable Fulton County staff to refer clients (or citizens that are not clients because they are ineligible) to community agencies that offer non-County services or other non-means tested benefits that would help an individual and her family. A significant amount of work would be required to identify the county agencies, organize their service offerings via a standard taxonomy, and then load the information as system reference data 			

L. Develop a Standardized Referral Process with Required Follow-up Actions	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Medium	Short Term
<u>Assumptions and Dependencies</u> <ul style="list-style-type: none"> Individual programs accept the concept of, and method for, standardized referrals from and to their programs All programs accept the responsibility for performing follow-up activities related to referrals for other services 			

M. Develop a Process and Supporting Infrastructure for Sharing Client Data Across Programs	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	High	Long Term

STATEMENT OF NEED

HHS maintains multiple client data systems resulting in duplication of data entry efforts and limited client data sharing. (see Sections 5.4, 6.1-6.5)

ACTIVITIES

- Develop practices for sharing data across the various programs and services available through Fulton County's HHS programs
- Develop a workgroup to address the many issues that need to be resolved to effectively share data across programs
- As technology reforms are made, emphasize cross-program sharing and include these principles as part of the design of all systems

BENEFITS	OUTCOME
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- | | |
|--|---|
| <ul style="list-style-type: none"> • Enhanced data sharing fosters more holistic and integrated case management • More sophisticated outcome analysis and program evaluation is possible when data are aggregated across multiple programs | <ul style="list-style-type: none"> • Established technology foundation necessary for integrated service delivery |
|--|---|

DETAILS

Data sharing

- One of the key findings from the program assessment was that client data are not shared across Fulton County's various departments and programs within the HHS area. This inhibits holistic and integrated case management, as case managers in one program are often making service planning decisions without access to a client's complete record of needs, assessment, and service history. With greater access to information, the service planning and delivery channels can be improved and thereby improve client outcomes

Develop an interagency workgroup to address data sharing concerns

- While data sharing is cherished goal in the abstract, there are numerous implementation hurdles to overcome prior to truly integrating client data and providing it to workers:
 - Numerous federal and state statues and regulates provide parameters and what data can be shared, the methods for sharing, the individuals that are permitted access
 - Each of the various HHS programs and departments require a different set of information, so protocols need to be established as to what information are maintained, and how and where in the service application and delivery processes they are collected
 - Interagency agreements and protocols related to data creation, viewing, updating and deletion (CRUD) need to be developed and followed by all workers
 - Security protocols need to be established and implemented in the various technology systems where data are shared to ensure that only authorized users are allowed to access client information
 - A common and unique identifier needs to be established and maintained for each client, so that as clients access services from various programs and locations, they are not reentered into the system as a new client
 - Multiple partners are involved in the delivery of HHS services in Fulton County. For example, primary care services are provided by community hospitals, each of which has its own information systems and client confidentiality restrictions. Sharing data between Fulton County agencies and the County' external provides will require significant effort from an organizational and technical perspective

Technology Support

- To be truly effective, data need to reside in a system to be shared. While hard copy information maintained in file folders can be passed among workers, this approach is inefficient, does not ensure workers view up-to-date information, and lacks any real assurance that confidentiality can be maintained

M. Develop a Process and Supporting Infrastructure for Sharing Client Data Across Programs	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	High	Long Term
<ul style="list-style-type: none"> • Currently there are little technology infrastructure for sharing information across HHS' programs. Both the mental health and public health staff use the M&M system, yet they use different installations that do not share client data. As an interim solution, a common identifier could be created for clients in both systems so that public health and mental health workers can at least access information on clients known to both systems • Longer term, as the County initiates technology reforms, strategies for sharing information across the various solution components and systems must be embedded into the design of each system <p><u>Assumptions and Dependencies</u></p> <ul style="list-style-type: none"> • Administrative and legislative policies are reviewed to determine the scope and limitations of information that may be shared across programs • Technology support for information sharing recognizes the specific data elements that may be shared and those that cannot be shared on a program by program basis 			

N. Create and Execute a Community Engagement Strategy	Estimated Complexity	Estimated Cost	Estimated Duration
	Low	Low	Long Term

STATEMENT OF NEED

There is not a coordinated effort to engage and develop community partnerships. Most partnerships are developed at the program level. (see Section 6.7)

ACTIVITIES

- Develop and execute a plan for enhancing the input and participation from relevant community organizations. Plan specifics provided below
- Create a Community Stakeholder Group (CSG) that has at least one voting member on the ESC. Details on CSG below
- Implement ongoing methods for obtaining feedback from individual community members, such as through town hall meetings
- Create a strategy for interacting with the media and other community stakeholders that can influence public opinion and actions around key Common Ground objectives

BENEFITS	OUTCOME
<ul style="list-style-type: none"> • Enhance coordination of services between Fulton County programs and community services • Increase community awareness of and participation in Common Ground goals, objectives, and programs • Solicit more input from community regarding necessary programs, services, and policies • More effectively target the portfolio of services available at each Common Ground location • Publicize successes to foster enhanced support for new initiatives among potential funders 	<ul style="list-style-type: none"> • Amplified ability to impact community health factors

DETAILS

Community Engagement Plan

- The Community Engagement Plan should include the following components:
 - County's objectives for enhanced community engagement
 - Enhanced understanding of what is needed
 - Better targeting of services with Fulton County communities and at Common Ground service centers
 - Expansion of the Common Ground care network to include interactions with community-sponsored programs
 - Increased community support (among groups and individuals) regarding Common Ground goals, objectives, and programs
- The specific community groups that are targeted for increased involvement, including the rationale and specific objective for each community group's participation
- What the objective is for each community group with which the County wants to engage
- The communication strategy between Fulton County strategy for each group (this should dovetail with the change management plan)
- The Fulton County individual with responsibility for engaging each community group

Common Group Community Stakeholder Group (CSG)

- The CSG would be a formal organization under the Common Ground rubric that provides a structured method for soliciting and obtaining community input
- Membership
 - CSG members would be representatives from large and/or influential community agencies, including some with Common Ground-related partnerships. Some potential community groups could include:
 - Representatives from the primary care clinics that partner with Common Ground (Grady, Emory, West End)
 - Representatives from the Fulton Family Care Network
 - Other larger social services/non-profit organizations (e.g., United Way, etc.)

N. Create and Execute a Community Engagement Strategy	Estimated Complexity	Estimated Cost	Estimated Duration
	Low	Low	Long Term
<ul style="list-style-type: none"> ○ Advocates for particular populations, such as children, persons with developmental disabilities, or the elderly ○ Representative from local businesses <ul style="list-style-type: none"> ▪ Business leader with a particular interest in foster enhanced community well-being in the area, such as a VP For Philanthropy or Community Affairs at Coke ▪ Representative from the local chamber of commerce ○ Others TBD based on Fulton County's specific objectives for the CSG • Duties <ul style="list-style-type: none"> ○ Provide input to ESC decisions on Common Ground operations, policies, etc. ○ To the extent possible, work to broaden the continuum of care available via Common Ground by fostering service partnerships between Common Ground and community agencies ○ Serve as liaisons between the community and Common Ground ○ Help to solicit input from individuals in Fulton County through structured events such as town hall meetings, as well as through informal networks • Meetings <ul style="list-style-type: none"> ○ Meet quarterly ○ As discussed in the governance model, an ESC is proposed. There should be at least one representative from the CSG on the ES • Implement ongoing methods for obtaining feedback from individual community members, such as through town hall meetings <ul style="list-style-type: none"> ○ In addition to gathering input and participation from groups, it is important for Fulton County to get input from a broader cross-section of County residents. To do this, the County should create mechanisms for feedback from individuals, such as regular town hall meetings that are open to the public and functionality on the Fulton County website that allows users to submit information specifically about Common Ground and offer advice or strategies on how health outcomes could be improved at the community level • Create a strategy for interacting with the media and other community stakeholders that can influence public opinion and actions around key Common Ground objectives <ul style="list-style-type: none"> ○ The Common Ground philosophy targets reducing health disparities and increasing overall community well-being. To do this, the County must reach out past the population served through Fulton County HHS programs. By creating a media strategy, the County can begin to inform community members about relevant health factors, such as the benefits of preventive health care, information on maintaining a healthy weight, and information on the programs and services available to improve overall health and well-being. As such, working with the media and other community stakeholder that can influence the larger public discussion is a vital part of realizing the overall objectives of Common Ground 			

O. Clarify Outcomes for Each Service	Estimated Complexity	Estimated Cost	Estimated Duration
	Medium	Medium	Short Term
STATEMENT OF NEED			
There does not appear to be consistent or standardized categorization of key performance indicators and outcome measures across HHS departments. Methods to track evidence based outcomes are inconsistent across HHS. (see Section 6.10)			
ACTIVITIES			
<ul style="list-style-type: none"> • Create a map showing the theory of change, interventions, process measures, and outcomes (including Key Performance Indicators) for every service provided by Fulton County • Make sure outcomes are linked to specific interventions. For example, a program that attempts to reduce homelessness may accomplish its goals, but not result in the reduction of poverty in a community • Review the map with staff for feedback and possible revisions • Include measures from local, State, and Federal reporting requirements 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> • A prerequisite for evaluation or any quality improvement effort 		<ul style="list-style-type: none"> • Readily available relevant data to make service delivery decisions 	
DETAILS			
Outcome based evaluations are important for determining the effectiveness of programs and identifying necessary adjustment to service delivery. In addition, understanding the long term impact to the client can help the County understand the effectiveness of the programs or services.			
<u>Assumptions and Dependencies</u>			
<ul style="list-style-type: none"> • A theory of change specifies what interventions are assumed to cause change. For example, family counseling results in better communication within the family 			

P. Implement Ongoing and Comprehensive Program Evaluation	Estimated Complexity	Estimated Cost	Estimated Duration
	High	Medium	Long Term
STATEMENT OF NEED			
There is little historical data to comprehensively evaluate Common Ground and the implementation of ICSD across HHS programs over multiple years. (see Section 6.10)			
ACTIVITIES			
<ul style="list-style-type: none"> • Make evaluation an ongoing function of service delivery • Shift the emphasis from process measures commonly used in reporting requirements to outcomes that actually demonstrate benefits to children and families • Continue to develop research and evaluation partnerships with third party organizations such as the recent experience with Georgia State University • Allow clients and staff to participate in the planning and design of research and evaluation. • Create feedback loops that allow staff to benefit from the lessons learned and potentially correct inefficiencies in service delivery • Consider creating the position of Research Director. These individuals in public settings conduct research, provide TA to program staff, serve as the primary contact with third party evaluators, coordinate State and Federal reporting requirements, and often support IT departments in data analysis and report writing beneficial to program staff 			
BENEFITS		OUTCOME	
<ul style="list-style-type: none"> • Evidence of program effectiveness and benefits • Staff oriented to continuous quality improvement. • Creates an atmosphere conducive to data driven decision making • Supports the development of evidence-based practices • 		<ul style="list-style-type: none"> • Readily available relevant data to make management decisions regarding health and human service provision in the County 	
DETAILS			
Not linking outcomes to specific interventions greatly increases the odds of getting false negative results. Staff may have had negative experiences with evaluation in the past. For example, staff may have been required to do data collection and then never given the evaluation results			
<u>Assumptions and Dependencies</u>			
<ul style="list-style-type: none"> • Defer the evaluation of new or under-developed programs until the programs are fully implemented • It is not necessary to evaluate every program at the same time 			

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