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Report to the Chairman, Subcommittee on Children, Family, Drugs and Alcoholism, Committee on Labor and Human Resources, U.S. Senate

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INTEGRATING HUMAN SERVICES

Linking At-Risk Families With Services More Successful Than System Reform Efforts

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The Honorable Christopher J. Dodd
Chairman, Subcommittee on Children,
Family, Drugs and Alcoholism
Committee on Labor and Human Resources
United States Senate

Dear Mr. Chairman:

This report, prepared at your request, reviews approaches that federal, state, and local governments have used to integrate the delivery of health and other educational and social services to at-risk families and examines barriers to designing and implementing integrated service delivery systems.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 10 days from the date of this letter. At that time, we will send copies to the Secretary of Education, the Secretary of Health and Human Services, and other interested parties.

This report was prepared under the direction of Gregory J. McDonald, Director, Human Services Policy and Management Issues, who may be reached at (202) 512-7225 if you or your staff have any questions. Other major contributors are listed in appendix III.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

The number of people in poverty—now about 34 million—has remained high throughout the past decade. One in five children is poor, and increasing numbers of them are at risk of such outcomes as child abuse and educational failure. Many poor families find it difficult to care adequately for themselves and their children or to obtain the health, education, social, and child welfare services they need from the existing service delivery systems. Those who seek services often find a system fragmented and difficult to access. Many may take advantage of only the services offered by the first agency they contact. If they know of, or are referred to, other programs or agencies, they must typically go to other locations and face eligibility requirements and demands for information that are confusing and conflicting.

Efforts to improve the delivery of health, education, social, and child welfare services are not new. The Congress, federal agencies, and others have tried for more than 30 years to reorganize and reshape the way human services are delivered with marginal success. Federal, state, and local governments have used different approaches to integrate the delivery of health and other educational and social services to at-risk children and their families. To understand the factors that have influenced their actions, the Chairman, Subcommittee on Children, Family, Drugs and Alcoholism, Senate Committee on Labor and Human Resources, asked GAO to identify (1) barriers different approaches face in designing integrated service delivery systems and (2) policy options for future federal initiatives.

Background

The Congress and federal, state, and local officials have recognized that most public and private human service agencies are organized to deal with single problems. To better serve those in need, public and private officials from all levels have initiated efforts to improve the delivery of services through integration—creating methods to unite or link the services provided by different agencies to serve the same population.

Experts characterize service integration efforts as either "system-oriented" or "service-oriented," depending on their goals. System-oriented efforts have ambitious goals, such as to eliminate the fragmentation of human services by looking for ways to create a new system that would deliver services more comprehensively. These efforts seek to change the way agencies plan and fund programs and eliminate conflicting eligibility and data collection and reporting requirements of programs serving similar clients.

Service-oriented efforts are much less ambitious. They attempt to link clients to existing services and unite various service providers without altering the way program officials budget and fund programs, service agencies' responsibilities, or agencies' organizational structure. Service-oriented efforts encourage agencies and providers to share information and collocate many services at one center.

Figure 1: Goals of System- and Service-Oriented Efforts

System-Oriented Goals	Service-Oriented Goals

• Develop new service delivery structures and approaches
• Create new services
• Eliminate conflicting program requirements
	• Link clients with existing services through such methods as:
	  • collocation of providers
	  • using case managers

Over the past 30 years, the federal government has supported both types of efforts. Historically, system-oriented efforts have met with limited success; they have been plagued with such problems as the inability to obtain political support among key federal officials or establish and sustain resource commitments from participating agencies. Service-oriented initiatives have been more successful. Programs that created methods to link families to services—by using case managers, for example—improved client access to comprehensive service.

To illustrate the difficulty and potential for success of efforts to integrate services, GAO reviewed two federal programs suggested by the Subcommittee—Project Head Start and Part H of the Individuals with Disabilities Education Act (formerly known as Part H of P.L. 99-457, Education of All Handicapped Children Act)—and a state-private child welfare initiative supported by the Annie E. Casey Foundation.

To illustrate the system-oriented approach, GAO examined how Part H and the Annie Casey initiatives implemented reforms at the state level. Part H requirements give states 5 years to develop comprehensive and coordinated health, education, and social services for infants and toddlers with handicaps and their families. The Annie Casey initiatives asked state agencies to reconfigure the way they organized responsibilities for child welfare services and combine the health, education, and social services

funds supporting these services to reduce out-of-home placement of abused and neglected children.

To illustrate the service-oriented approach, GAO examined Head Start and the local level service delivery components of the Annie Casey initiatives. Head Start is a federally funded comprehensive child development program that attempts to link low-income, preschool-aged children and their families with a variety of services available from local providers. These projects either arrange for the delivery of health and supportive services at local Head Start centers or schedule appointments for families at area clinics or social service agency offices.

GAO also reviewed an extensive body of literature and studies prepared over the last 30 years on efforts to reform service delivery systems.

Results in Brief

Broad-based and ambitious system-oriented efforts have faced many obstacles and met with limited success. These initiatives have only marginally altered the way agencies planned or financed human services and generally have not developed a comprehensive care system. In addition, the efforts GAO reviewed were unable to (1) get parties responsible for ongoing programs to reach consensus on the nature and extent of problems they are facing and how they should be addressed; (2) overcome agencies' concerns about protecting their own identities, ideologies, roles, and resources; and (3) get agencies to address problems jointly by combining personnel and resources. The lack of political support for these efforts and the inability of program officials to reach consensus on project objectives and intended outcomes further impeded the attainment of program goals.

In contrast, the less ambitious service-oriented efforts GAO visited were able to link at-risk families to human services programs and provide a combination of health and other supportive services. Programs like Head Start would often use staff to identify and arrange for these services—acting like a case manager.[1] These efforts also improved communication and cooperation among service providers. Because these efforts did not attempt to reorganize agencies' administrative structures, they improved service access by: (1) convincing service providers of the need to coordinate, (2) getting them to agree on common goals, and (3) creating an administrative structure to implement changes.

[1]The function of case managers can include a variety of activities to assess an individual's health and social service needs, promote client independence, provide care in the least restrictive environment, and establish caseloads that allow for sufficient contact with clients.

Service-oriented efforts like Head Start have been more able than system-oriented efforts to improve at-risk families' access to health and social services care. These efforts, focused at the point of delivery and adapted to local conditions, are a more practical, realistic approach to improving service delivery.

Principal Findings

System-Oriented Efforts Have Limited Success

The Part H program and the Annie Casey initiatives GAO visited were generally unable to create new organizational structures or develop multi-agency service plans and budgets. The efforts were unable to obtain and sustain political support from the project's design phase through implementation to make interagency commitments endure. Recessionary economic conditions, a decline in federal support for human services, and changing political administrations hampered the initiatives' ability to obtain and sustain support from mayors, county executives, and governors. These factors and others made it difficult for Part H and Annie Casey officials to convince their counterparts in other state agencies to cooperate.

Agencies and organizations responsible for the system-oriented efforts GAO reviewed lacked authority to pool personnel and fiscal resources. Further, state and local agency officials had conflicting personal and organizational ideologies and were reluctant to change traditional agency roles or offer resources to the projects. The initiatives were often unable to get affected parties to agree on what problems needed to be addressed and how best to address them. For example, in one case, state officials considered the Annie Casey Child Welfare Reform Initiative's principal objective to be the reduction of high-cost out-of-home placements; local officials responsible for implementing the reform thought its main purpose was to improve the scope and intensity of services.

Service-Oriented Efforts Are Promising, Easier to Achieve

The service-oriented efforts GAO reviewed faced fewer barriers and were able to provide comprehensive care by creating methods that linked at-risk families to community services and improving communication among service providers. These efforts were easier to achieve because they did not attempt to change state and local organizational structures. Consequently, while they needed to gain and sustain commitment among

providers, they did not require the same level of state or local political support as did system-oriented efforts. Moreover, service-oriented efforts were less threatening to human service agencies.

In contrast to system-oriented reform efforts, agencies were not required to participate in service-oriented efforts. Rather, project officials established agreements among local service providers in which all parties would benefit. For example, a Head Start project established a satellite child care center in a family homeless shelter. This allowed the Head Start program to serve more needy neighborhood children while giving families in the shelter additional on-site services. Officials of service-oriented programs also believed that informal oral agreements reduced conflicts and fostered greater communication.

The Head Start projects GAO visited did experience problems when needed services were not available in the local community. In addition, participating agencies said that establishing and sustaining service agreements among area providers required large time investments beyond their normal day-to-day activities.

Policy Consideration

The Congress and federal executive agency officials seeking to reshape the human service delivery system are faced with a 30-year history of marginal success. Efforts designed to effect broad and fundamental changes in the way human service agencies organize and deliver health, education, and social services face large barriers. Obstacles preventing state and local program officials from reorganizing service agencies, creating new funding and service agreements, and divesting authority from their own agencies are difficult to overcome. Therefore, GAO urges caution when the Congress considers initiatives that call for state and local governments to make fundamental changes in service delivery systems. Although the potential benefits of these efforts may be great, so are the obstacles and the risks of failure. Congressional mandates alone are unlikely to secure the significant time and resource commitments needed from officials—both those charged with directing the reforms and those closest to the point of delivery.

When exploring ways to improve at-risk families' access to health and social services, the Congress may wish to consider promoting service-oriented efforts like Head Start. This approach, focused at the point of delivery and adapted to local conditions, is a more practical,

realistic approach to improving service delivery—particularly in the short term given current fiscal constraints.

Agency Comments

As agreed, GAO did not request written agency comments on this report. However, GAO discussed it with officials at the Departments of Education and Health and Human Services, who generally agreed with the findings and conclusions. GAO incorporated their comments as appropriate.

Contents

Abbreviations

AFDC	Aid to Families With Dependent Children
CAA	Community Action Agency
CAP	Community Action Program
GAO	General Accounting Office
HHS	Department of Health and Human Services
ICC	Interagency Coordinating Council
SITO	Service Integration Targets of Opportunity

Introduction

For over three decades, the federal government has supported efforts to strengthen our nation's human services delivery system. However, many families are in need and looking for assistance from a human service delivery system that is already overburdened. Recent demographic trends put increased numbers of families at-risk, including parents unable to care adequately for themselves and their children. The number of people in poverty—now at about 34 million—has remained high during the past decade; one in five children is poor. There has been a dramatic rise in households headed by single parents and teenagers. During the 1980s, 30 percent of ninth graders failed to graduate from high school in 4 years. Our delivery system has been unable to adequately deal with such serious outcomes of these problems as child abuse and neglect, welfare dependency, and homelessness. These problems alone are reason for concern. However, what is truly alarming is that these problems tend to concentrate in the same families. This situation places them at greater risk for long-term negative outcomes, such as dependence on public assistance.

Our current service delivery system has been unable to adequately address the multiple needs of at-risk families. The problem is not simply a lack of services to meet the growing needs of this population, but an inability to design services that consider the interrelated nature of at-risk families' problems. Society's sense of compassion and obligation to care for these families alone cannot meet their needs. Experts agree that at-risk families require an array of services that ideally would be provided through close coordination among complementary service providers—for example, between special education and health. At-risk families require providers to take a more generic orientation, or "holistic"[1] approach, rather than a condition-specific orientation, or "crisis" approach. However, service providers often respond only to the most immediate service needs of the family. For instance, a local health department may assist in providing treatment to a child with pneumonia, but may do little or nothing to improve the inadequate heating in the child's home that contributed to the illness.

[1]A "holistic" approach considers the whole set of needs of the client and provides services to address multiple and interrelated problems.

Service Delivery System Unable to Serve Multiple Problem Families

The failings of our nation's service delivery system are well documented. This system is generally unable to provide at-risk families with the combination of services they need. It is difficult for providers to accurately assess the long-term needs of the family and provide the services needed. No one service can be delivered to ameliorate their situation. Complex problems require a clear understanding of a family's difficulties and a comprehensive response. However, providers acknowledge that they are often unable to address multiple problems effectively and for the most part respond only to individual crises as they occur.

Experts argue that funding streams that support narrowly focused, condition-specific service programs prevent providers from delivering comprehensive services. This narrow focus also makes access to services difficult. Figure 1.1 lists and gives examples of commonly cited failings of our service delivery system.[2]

[2]Lisbeth B. Schorr, Within Our Reach, Doubleday, 1988; Institute of Medicine, Prenatal Care: Reaching Mothers, Reaching Infants, National Academy Press, 1988; The Education and Human Services Consortium, What It Takes, 1991.

Figure 1.1: Failings of Current Service Delivery System

Problem	Examples
Needed services are difficult to access	• Clients must travel to multiple locations • Clients must complete many applications, undergo multiple assessments
Needed services are unavailable	• Specialized service is not available in every geographic area • Available services are insufficient to meet demand
Services delivered lack continuity	• Service providers fail to coordinate the planning of their services • Comprehensive service plans not developed for clients
Services are crisis-oriented	• Preventive services are inadequate; clients must wait for problem to reach crisis before receiving services
Service programs lack accountability	• Programs receive funding based on number of clients served rather than on outcome of service provided • Few providers collect data to evaluate the success of their programs

What Is Service Integration?

Service integration[3] is a term used to describe a broad spectrum of activities that range from providing services from several agencies at one convenient location, to creating state and local interagency service planning and budgeting. One strategy to understand service integration, advanced by researchers at Yale University's Bush Center in Child Development and Social Policy,[4] is to categorize the goals of an initiative as either system-oriented or service-oriented. Each approach has different goals and means of accomplishing them, as illustrated in figure 1.2.

In general, the goals of system-oriented initiatives are to (1) develop new human service delivery systems or alter the way existing agencies are structured to produce a holistic service approach that ensures agencies will work together to provide services to meet client needs, (2) create new services to fill gaps in available services or expand current services to

[3]The literature uses many words to describe the activities of service integration, most commonly: cooperation, coordination, and collaboration. Our study does not differentiate between these terms, but describes different approaches to service integration.

[4]Sharon L. Kagan and others, Collaborations in Action: Reshaping Services to Young Children and Their Families. The Bush Center in Child Development and Social Policy, Yale University (Jan. 1991).

address unmet demand, and (3) reduce conflicts and inconsistencies among service programs to make it easier for clients to apply to and be accepted by programs. In essence, the overarching goal of system-oriented initiatives is to reform the delivery system.

Figure 1.2: Two Approaches to Service Integration

Approach:	System-Oriented	Service-Oriented:
Goals:	• Develop new service delivery structures and approaches • Create new services • Eliminate conflicting requirements among service programs	• Link clients to services
Accomplished by:	• Creating new organizational structures • Developing multi-agency budgets • Developing multi-agency service plans	• Using case managers • Developing individualized service plans • Developing informal and formal agreements among service providers

To accomplish their goals, system-oriented initiatives attempt to change how agencies plan and finance services. They attempt to reorganize various public agencies around either a common population, such as a handicapped infant, or a common problem, such as child abuse and neglect. In addition, they attempt to create more coordinated planning and funding of those services needed to comprehensively address these problems and their causes.[5] System-oriented efforts seek to develop multi-agency budgets that provide more flexible funding. They may try to get individual agencies to pool[6] discretionary funds for a single population or provide fiscal incentives for agencies to coordinate. Finally, system-oriented efforts seek to develop multi-agency service plans that document the responsibility of each agency to provide services. Through joint planning, state and local officials hope to ensure that state regulations,

[5]For example, in 1989, the governor of Maryland established the Subcabinet for Children, Youth and Families to coordinate the services of the state's four human service agencies that serve at-risk children and their families.

[6]"Pooling" is a financial management technique whereby funds from various sources are combined into one account and support a broad range of services.

administrative procedures, and reporting requirements do not conflict, while gaps in and duplication of services are eliminated.

In contrast, service-oriented efforts have more modest goals: to link clients to services and to deliver multiple services to single clients. Service-oriented efforts seek to inform clients of available services and help them obtain these services. To meet their goals, service-oriented efforts often attempt to develop informal and formal agreements among service providers and use case managers to develop individualized service plans. Case managers are responsible for documenting all the needs of a client, deciding what services are available to address these needs, and developing a plan by which the client will receive these services. Cooperative agreements among service providers identify what services are needed and who will provide them. Agreements can also centralize intake[7] and referral procedures, or provide for a common assessment and the sharing of client information. Improved coordination among providers allows them to look at a client's needs more broadly.

Lessons Learned From 30 Years of Experience

Since the 1960s, the federal government has supported both system- and service-oriented integration initiatives. In general, evaluations have found that system-oriented initiatives could not coordinate the use of the different categorical programs at the federal level and had only limited success at the local level. (Appendix I presents a summary of evaluation findings and program descriptions of different federal system- and service-oriented integration initiatives.) Officials leading these efforts were unable to

- obtain consensus and cooperation from other human service agencies;
- direct health, education, and other agencies to share their access to categorical funds; or
- establish and maintain federal, state, and local political and resource support.

Service-oriented projects, smaller in scope and with modest goals, linked families to the core services of other agencies, such as health exams, and provided cross-agency case managers. These methods improved client access to needed services. In addition, these types of linkages fostered strong informal relationships between agencies and made them more responsive to the service needs of at-risk families.

[7]Intake is the process by which service providers respond to a client's application for services. It may include determining eligibility and completing forms.

Past federal integration initiatives and other evaluations of programs designed to improve our nation's service delivery capabilities have identified the following tasks that are important when federal, state, and local program officials attempted to develop, administer, and deliver comprehensive services to multiple problem families. Whether system- or service-oriented, programs must:

Gain Commitment

- Gain and sustain strong political support from key officials to ensure participation of service agency officials.
- Provide strong incentives, often financial, to agency officials, program managers, and service providers to ensure not only participation in the effort, but cooperation.

Build Consensus

- Establish early ongoing relationships, when appropriate, between levels of government.
- Get key officials to agree on the need for change, the goals of the initiative, and the process by which changes will be designed and implemented and the roles to be played by each party.
- Sustain consensus among key individuals and groups—both in and outside of public agencies.

Create an Effective Administrative Entity

- Create an administrative entity with the authority to alter agency roles, assign financial responsibility, and resolve disputes.
- Institutionalize the changes made and create a forum for ongoing communication.

Objectives, Scope, and Methodology

The Chairman, Subcommittee on Children, Family, Drugs and Alcoholism, Senate Committee on Labor and Human Resources, asked us to examine the potential that different service integration strategies have to improve the human services delivery system. Our objectives were to characterize different approaches federal, state, and local governments have used to integrate the delivery of services to at-risk children and their families, identify barriers to the design of integrated service delivery, and suggest policy options for future federal initiatives.

To obtain a detailed perspective on the history of integration efforts, we reviewed studies on the integration of services and interviewed federal, state, and local program officials and service delivery experts. We identified past federal initiatives to integrate services and summarized lessons learned. In reviewing the literature, we focused on the processes state and local governments go through to design and implement integration strategies. We also looked for potential barriers to success.

To illustrate the difficulty and potential for success of efforts to integrate services, we reviewed two federal programs suggested by the Subcommittee—Project Head Start and Part H of the Individuals with Disabilities Education Act (formerly known as Part H of P.L. 99-457, Education of All Handicapped Children Act)—and a public-private child welfare initiative supported by the Annie E. Casey Foundation (appendix II contains descriptions of these three programs). We examined how Part H and the Casey initiatives implemented reforms at the state level to highlight the system-oriented approach to integrate services. Head Start and the local level service delivery components of the Casey initiatives were used to highlight the service-oriented approach. In examining the different processes and events states experienced in implementing the reforms, we did not attempt to determine the impact of these programs on individual clients. Further, while characterizing the barriers that officials face when implementing both types of integration efforts, we are not generalizing to all Part H or Head Start programs.

We visited the three Annie Casey Child Welfare Reform Initiatives in Connecticut, Maryland, and North Dakota, and visited the same states to examine the implementation of the Part H Education of the Handicapped program. To select Head Start sites, we asked Department of Health and Human Services (HHS) regional offices (Regions I and II) to identify centers most experienced in collaborating with other community programs. We visited the recommended Head Start centers in Prince Georges County, Maryland; Philadelphia, Pennsylvania; and Warwick, Rhode Island.

We did our work between May 1990 and January 1992 in accordance with generally accepted government auditing standards.

System-Oriented Initiatives Had Limited Success, Faced Numerous Barriers

Summary

Problem	System-Oriented Solution	Results
At-risk families have difficulty identifying and accessing human services to meet their multiple needs from a fragmented system in which agencies operate independently and do not deliver comprehensive services	Part H and Annie Casey attempted to: • create new organizational structures • develop multi-agency service plans • develop multi-agency budgets	Neither initiative: • gained commitment from necessary agency officials • got key officials to reach consensus on problems and solutions • created the necessary administrative structure to oversee the effort

The Part H and state-level operation of the Annie Casey initiatives we reviewed have been unable to accomplish their system-oriented goals because they could not create new organizational structures, develop multi-agency budgets and service plans, reach consensus on important programmatic issues, or create an effective administrative structure to oversee the effort. Changes in political leadership and lack of political support, worsening state and local fiscal conditions, and conflicting agency ideologies inhibited these initiatives.

Reform Efforts Unable to Alter Service Delivery System

Part H and Annie Casey tried to get the different service provider agencies to jointly plan and budget services to meet the needs of the people they were serving. These initiatives concluded that incremental changes to the current service system, such as simply adding to or revising current programs, could not ensure that at-risk families would receive the comprehensive services they needed.

Initiatives Unable to Reorganize Agency Structures to Plan for Comprehensive Services

Neither the Part H nor the Annie Casey initiatives were able to get state agencies to agree on how they would go about providing more comprehensive services to at-risk children and their families. Although they got agencies to sign agreements that formalized their commitment to improving coordination and providing more comprehensive care, the

agencies still focused most of their attention and efforts on their own program priorities.

Many state officials involved in the Part H and Annie Casey initiatives characterized their most significant progress in the area of information sharing. A member of Connecticut's Part H Interagency Coordinating Council (ICC)[1] noted that they expected six regional centers in the state to provide care for about 4,500 handicapped infants and toddlers. However, after 3 to 4 years of planning, service providers could not agree how to expand capacity beyond its initial level of 1,200 children.

The director of the Maryland Part H effort noted that the agency responsible for leading the effort to provide service to handicapped children had little influence over the budgets or priorities of other agencies. While it could suggest program goals, funding levels, and program priorities to other state agencies, it had no means of ensuring that its suggestions would be carried out. Similarly, the Annie Casey initiatives could only bring agencies together to discuss how they could improve the delivery of services to at-risk children and reduce foster care placements. It had no means of leveraging other agencies to make changes in the way they delivered care. While Casey tried to get agencies to put more emphasis on preserving the family unit and avoiding the out-of-home placement of children, the tasks of setting agency policy and priorities and determining operating procedures still had to be carried out by the administrators of other agencies.

Reforms Could Not Create New Strategies to Fund Service Programs

The Annie Casey and Part H initiatives sought to (1) create fiscal incentives to get agencies to change the way they delivered services, (2) develop ways to make funding sources more flexible to meet the needs of at-risk families having multiple problems not easily addressed by existing programs, and (3) redirect funds as necessary. Overall, Part H and Annie Casey officials said that these tasks were almost impossible to accomplish.

The Annie Casey initiatives had a separate pool of foundation money, and state agencies provided some additional funds and some in-kind contributions, such as personnel and support services. However, only creating another pool of funds—either through private sources or combining both public and private—did little, according to program

[1]The act requires the establishment of a State Interagency Coordinating Council and specifies its composition, rules, and management authority. The ICC's charge is to provide advice and help the designated lead Part H agency develop and implement policies for the statewide system.

officials, to change how child welfare services are funded. Officials involved in the project in Maryland commented that once the Casey foundation stopped providing support, the funding structure would be as it was before the initiative. The deputy director of the Prince Georges County Casey project noted that the project had not changed the way child welfare services were funded. In her view, funding streams remained inflexible.

The Maryland Part H director told us that agencies in that state had no authority to co-budget or co-plan programs for handicapped children. Although the Part H director had identified instances where other state agencies had earmarked funds for infants and toddlers, the program was unable to pool these funds for Part H activities. She said the Maryland Part H program would like more flexibility to pool funds from other sources to expand services for handicapped children. The Connecticut ICC chairman commented that Part H had a difficult time identifying services that would be allowable for handicapped children under different funding streams.

To allow state agencies to be more responsive to multi-need families, the Maryland state legislature passed a "flexible funding" provision. This provision stated that certain funds appropriated to the Departments of Health and Mental Hygiene, Human Resources, and Education could be used to develop a broad range of services to assist in returning children with special needs from out-of-state placements. This strategy, however, did not change funding dramatically, providing case managers at the local level with only a small pool of funds.

The system-oriented efforts we reviewed had mixed results in providing fiscal incentives. The Connecticut Annie Casey project, for example, could not create any financial incentives for state agencies to participate in their reform efforts. In contrast, state agencies involved in the Maryland Annie Casey effort told local agencies that if they could provide intensive in-home services and prevent out-of-home placements—and the associated high costs to the state—they would be allowed to keep and use the money saved for family preservation services. Maryland Part H officials required local service agencies to serve more handicapped children but could not provide them additional resources to accommodate this increase in clients.

Lack of Commitment, Support, and Administrative Authority Thwarted System Reform Efforts

Neither the Part H nor the Annie Casey efforts significantly improved interagency coordination, in part because they were unable to offer adequate incentives for key participants to cooperate in system reform. Moreover, officials of these two programs were unable to vest other state agency officials in the projects, in part because of a lack of political support for the reform initiatives. In addition, agency officials affected by and involved in these efforts were often unable to reach broad-based agreement on the need for change, the goals of the effort, and how reform would be accomplished. Faced with this lack of commitment and support, neither program was able to create a strong administrative entity with the authority to make and enforce decisions.

Dispersed authority among state agencies forced both initiatives to seek support from many officials. But the withdrawal of federal support for state and local social programs, worsening fiscal conditions and changes in administrations and policy agendas, and conflicting agency ideologies and priorities impeded efforts to establish common goals among participants. Finally, as system-oriented initiatives sought to alter agency roles and responsibilities, participants often felt threatened by possible changes and were reluctant to relinquish authority to another administrative entity.

Funding Uncertainty and Changes in Political Leadership Weakened Support

Experiencing sporadic political support and faced with fiscal uncertainty, neither the Annie Casey nor the Part H initiative could gain needed resource commitments from other state human service agencies. The Annie Casey initiatives had difficulty gaining political support in states where several people, often in competing agencies, shared the political power and authority necessary to create change. In addition, some efforts were unable to sustain political support over time, particularly during a change of political administration.

In some cases, dispersed or decentralized authority over various state and local programs made securing necessary support difficult. In North Dakota, the key elected officials associated with the Casey project were the Superintendent of Public Instruction, the Director of Health, and the Attorney General. The number of agencies involved made it difficult for the Governor to secure support for the initiative. A similar situation existed in Connecticut. One official described the state agency structure as a collection of fiefdoms since each major agency is autonomous.

Such factors as a change in the political leadership of a state can make it difficult to sustain the political support needed for system-oriented efforts. A change in administration, such as in Connecticut in 1988, ended a key element of the effort's political support. The Connecticut Annie Casey initiative was one of the first programs cut by the incoming Governor as the state's fiscal health began to suffer. Though program officials saw the new Governor as a strong child advocate, they said that the adverse fiscal conditions of the state and the fact that this was not his initiative provided an opportunity to reduce the state's contribution to the project. Another official echoed the problems of changing political leadership, noting that any reform effort must be institutionalized early to insulate it from the whims of political change.

These new initiatives were begun during favorable economic conditions. Efforts designed to affect broad system-oriented changes must assume that fiscal conditions may worsen. This became the case in the states we visited. In general, state fiscal conditions in 1991 were the worst in nearly a decade, with almost every state facing budget shortfalls. In both Maryland and Connecticut, these conditions adversely affected the health of the system-oriented efforts. State officials reported that dwindling federal support, coupled with many competing forces for scarce state dollars, effectively removed fiscal support as an incentive for agencies to participate in these efforts. Moreover, state Part H officials told us they were reluctant to enter their fifth year of funding under Part H because they were afraid of the uncertain future costs that might be associated with programs that guarantee service to all eligible clients.

Conflicting Priorities Inhibited Consensus

Agency staff did not generally welcome change; they often felt threatened by such efforts or overwhelmed by the time required to participate. Agency ideologies often conflicted. Staff from different agencies could not reach consensus on the specific focus the reform initiatives should take and how to address the goals of the initiative. As a result, the Part H and Casey initiatives were unable to gain widespread consensus and agency commitment.

State agency officials struggled to reach consensus on the Annie Casey reform goals, recognizing that the responsible state agency's perspective was often different from its local counterparts. In North Dakota, for example, both the Director of Management and Budget and the Director of Special Education stated that there were at least two and perhaps as many as four views on what the goals of the initiative should be. Also, local

agencies and providers often felt the state agency officials did not (1) consider them as partners in the initiative, (2) consult them concerning changes in program priorities or the best methods of implementing the program, or (3) share available resources. In each Casey project, local officials felt that the state was reluctant to give up control and "micro-managed" the local projects.

This lack of consensus between state and local officials was important, because Part H and Annie Casey officials both agreed that affecting systemwide change in service delivery—at the point of delivery—cannot be accomplished through mandates alone. They found that consensus only among state agency officials—ignoring the need for agreement between levels of government—was not sufficient to change point-of-delivery strategies and procedures. Likewise, consensus only at the local level is insufficient to produce systematic change; there are many areas, such as overall planning and funding of services, that local governments cannot address.

Ideological differences among participating agencies also prevented the two system-oriented initiatives from gaining consensus. In Prince Georges County, Maryland, four major agencies delivered services to children, each with its own state agency counterpart. The education and health agencies were rather autonomous; they had wide discretion in making policy and budgeting decisions. County juvenile services and social services policies, in contrast, were decided primarily by the state agencies. Thus, the four agencies did not have the same authority to make decisions about integrating services. Moreover, program officials in the four agencies generally had an unequal stake in the success of the system-oriented efforts; some individuals felt the efforts would help them accomplish their goals more than others, and thus were more dedicated to it. Each of the four agencies had its own program responsibilities and delivered different services to slightly different populations. They sought to protect their "turf"—that is, their responsibility for certain programs, populations, and resources.

Another reason that Part H and Casey had difficulty gaining consensus was that they were designed to change the way services were delivered and, therefore, change the roles of staff. However, service agency staff, in some instances, did not welcome change; they saw it as onerous, threatening, or unrelated to their jobs. Some felt that they would be given additional work, more demanding tasks, or less interesting assignments. Others feared they might even lose their jobs due to changes in policies

that would make their role unneeded. Moreover, change takes time. Some agency officials felt overworked and did not welcome the added work that service integration initiatives required. For example, officials on the North Dakota Children's Coordinating Committee that administered the Casey program resented the time it took to design, plan, and implement a new program. One official noted that the Governor created the committee to handle all issues related to children, but the Casey initiative took up 90 percent of their time, leaving little opportunity to focus on other programs relating to children.

Officials Reluctant to Relinquish Authority to New Initiatives

Because neither initiative could gain strong political support and reach widespread consensus, neither could create an effective administrative structure. State agencies participating in Part H and Annie Casey were reluctant to yield authority to either project's administrative entity. Thus, strong political support and effective consensus building—attributes already in short supply—became even more critical in efforts to establish an administrative entity that could create reform.

Part H and Annie Casey had difficulty creating an administrative entity removed from the ideology of any one agency, yet not considered an "outsider" removed from the existing government structure. The programs found that undue influence of one ideology could alienate other agencies, while "outsiders" ran the risk of becoming isolated from key program officials. When the Maryland Casey project began, officials placed it in the Department of Human Resources, and the initiative made little progress. It was not until the Governor moved the project into a new organization in his office—the Office of Children, Youth, and Families—that other state agencies viewed it as separate from other human services programs. A similar situation occurred with the Part H program in Maryland, as the lead agency was changed three times and the program made little progress until it was placed in the Office of Children, Youth, and Families.

Agencies would not voluntarily submit to change but did participate under political pressure. In Maryland, the Governor convinced unwilling state agencies to participate in the Casey initiative. However, program officials were reluctant to relinquish some of their power and vest authority in a new administrative entity. Thus even in Maryland, where the Governor can exercise considerable control over the state agencies and their budgets, officials did not agree to cede needed authority to the project's administrative entity.

Both initiatives realized that an effective administrative structure was essential to make and enforce decisions, alter agency roles, assign financial responsibility, and resolve disputes. However, neither Part H nor Annie Casey could create an entity with the authority to make system-oriented changes. The entities could not force an agency to commit resources to the initiative nor make agencies agree to be responsible for delivering a particular service to a given population. Part H officials in each state we visited noted that neither the lead agency nor the ICC had enough authority to influence state agency policies or funding streams. The Connecticut Part H director identified the lead agency's limited authority as a barrier to implementing the program since it could not compel another agency to follow in the direction of the program. The Connecticut ICC chairman claimed that the lead agency had all of the responsibility without any authority.

Service-Oriented Initiatives Linked At-Risk Families to Comprehensive Care

Summary

Problem	Service-Oriented Solution	Results
At-risk families have difficulty identifying and accessing human services to meet their multiple needs from a fragmented system in which agencies operate independently and do not deliver comprehensive services	Head Start and the local Annie Casey efforts linked clients to available services and delivered multiple services to meet client needs by: • using case managers to create individualized service plans • developing agreements among service providers	Both efforts: • convinced service providers of the need to coordinate • reached agreement on goals of the initiative • created an administrative structure to implement change

Head Start and the local level service delivery components of the Annie Casey projects were generally able to link at-risk families with more comprehensive services. These initiatives were able to accomplish this, in part, because they (1) convinced program officials and service providers of the need to cooperate and developed incentives for them to participate in the effort, (2) were able to get key participants to agree on the goals of the initiative and the roles each party would play in implementing changes, and (3) established an administrative entity to institutionalize the changes made and create a forum for ongoing communication.

To achieve their goals, the efforts we reviewed used various means, such as offering an array of services at one convenient location, creating client "advocates" to manage services, and developing formal and informal service agreements among providers. They also developed and implemented strategies to

- educate families about locations of services,
- provide families transportation to local services, and
- identify and develop service plans containing "packages" of combined health, education, and supportive services, to the extent they were available in the area.

Unlike the system-oriented efforts, the informal linkages that the service-oriented efforts formed left existing agency structures intact. Although the efforts required project directors and staff to dedicate time to identifying area providers and establishing and maintaining relationships, officials were able to complete these tasks.

These efforts, however, had to overcome various obstacles. Program officials at the service delivery level believed efforts to expand the scope of services to their clients and improve overall access competed for dwindling resources with the delivery of existing services. The human service agency staff directly involved with families often felt overwhelmed by existing caseloads or pulled away from what they believed to be their "traditional" role.

Service-Oriented Initiatives Linked Families to Services

The service-oriented initiatives we reviewed sought to help at-risk families gain access to existing services and provide them with comprehensive care within the service limitations of the area. Since local agencies do not fund programs themselves, service-oriented efforts generally do not seek to fill gaps in available services, as did the system-oriented approaches. The service-oriented initiatives designated certain staff to act as liaisons to other local service providers, developed methods to increase client awareness about the need for and availability of services, and occasionally provided transportation to families so they could access providers.

Case Management Used Extensively

Although all projects we visited cataloged available family services in the community, they also sought to develop multi-provider service agreements. Moreover, both Head Start and the local service delivery component of the Annie Casey projects used case management services to link clients to existing services. Prince Georges County's Commission for Families called for a case manager to perform a comprehensive family assessment within 24 to 48 hours after first contact. Case managers could refer families to various departments, such as Juvenile Services, Social Services, Health and Mental Hygiene, and Education. Head Start centers used various staff members to act as health, social service, and nutritional coordinators. Together, these Head Start personnel assessed a family's health, social support, and nutritional needs, provided information on available community resources and how to obtain and use them, and, when necessary, made referrals to local service providers. In other instances, the:

- Prince Georges County Head Start center referred clients to the local mental health agency, health department, and county therapeutic nursery as appropriate. In addition, the center's health coordinator secures appointments at the local health department for prospective Head Start students to get their required physical free of charge.
- Annie Casey projects used case managers to assess the families' situation and needs, engage and motivate families, develop a service plan with the family, secure the resources to implement the plan, advocate for the family where necessary, and monitor the delivery of services.
- Head Start centers we visited, although not required to do so, provided transportation to doctor's appointments when Head Start families could not otherwise get there.

Initiatives Secured Participant Cooperation and Developed Effective Administrative Structures

Local officials of the Head Start and Annie Casey initiatives said that they were able to secure local agency cooperation because (1) providers were dedicated to serving children and families and (2) the initiatives accomplished certain critical tasks, including:

- establishing support for their initiatives and reaching agreements among service providers,
- enlisting the cooperation and securing time and resource commitments of agency participants toward common service goals, and
- creating an administrative structure with the authority and credibility to sustain service relationships and facilitate ongoing communication.

Agencies Sought Positive Outcomes From Cooperation

In the service-oriented efforts we visited, agencies were working together to reach agreement on strategies that would improve how services would be delivered to families and their children. This need to work together, this "common vision," was the impetus for agencies to participate in these service-oriented efforts. The director of Maryland's Annie Casey initiative told us that in Prince Georges County, officials of the different human service agencies agreed that individually their agencies were not reducing out-of-home placements of children and some clients were not receiving services. But as a group, these agencies were able to direct their attention more to family preservation strategies in the hope of reducing out-of-home placements.

In Warwick, Rhode Island, service agencies saw potential financial gains for all the participants from providing early childhood intervention services. In this case, the initial concern about the needs of these children

formed the foundation for ongoing and future working relationships among providers. The Warwick Head Start program serves, for example, children with special needs—most with speech handicaps. These children, identified by the local public school system, are referred to the Head Start program, where they were served at a cost of $75 per child per week. If the local school district served these children through its special education program, the cost would be $300 per child per week.

Service Agencies Supported Program Linkages for Mutual Benefit

The Head Start programs we visited were able to establish contact with other providers and reach agreements—some formal and some informal—on methods to meet their families' needs that could not have been accomplished by any one provider alone. Regulations require Head Start grantees to develop separate nutritional, health, educational, and social service plans for their program. Although these plans require Head Start grantees to develop networks of providers to service their families, many relationships established by the grantees fulfilled mutual service needs. For example, a Philadelphia Head Start program agreed to participate in the local Job Opportunity and Basic Skills Program of the Family Support Act of 1988. This program requires states to provide Aid to Families With Dependent Children (AFDC) recipients with training to help avoid long-term welfare dependence. Under the agreement with the local department of public welfare, the Head Start program designed training components for Head Start family members who were receiving AFDC.

Both service-oriented efforts we visited sought to identify overlapping and complementary needs among service agencies and improve client access to care. At the same Philadelphia Head Start center, the director established an informal relationship with a shelter for neighborhood homeless families. The homeless shelter wanted to provide educational and health services to the children of their families but could not afford the additional costs. Head Start wanted to expand its services to meet the growing demands for center services, but the existing location had reached capacity and could not accommodate all the children from the homeless shelter. The solution, cemented only by a handshake, was to open new Head Start classrooms in the shelter.

In some instances, service-oriented initiatives reduced the staff burden and workload of other area providers, which ultimately created situations that benefited both providers and families in need. A court probation supervisor in New Haven told us that a probation officer's caseload could include 20 to 30 children on probation and another 60 who were pending

probation. The court refers the most difficult of these families to the New Haven Family Alliance. According to the court supervisor, when the Family Alliance accepted this type of family from the courts, probation officers' work pressure was reduced because they could spend more time with families having fewer severe problems. At the same time, the Alliance's families will receive a single focal point for multiple services.

Independent Administrative Structures Had Broad Local Representation

Officials of the Head Start program and service delivery components of the Annie Casey project believed it was important to create administrative and management structures that were not formally affiliated with other human service agencies. This, they believed, freed the effort from biases held by clients and other agencies. In addition, these entities were able to (1) enlist key representatives of local human service delivery agencies to participate in program planning and implementation, (2) develop credibility and trust within the existing service delivery system, and (3) foster ongoing communication and service agreements.

Officials of Prince Georges County's Commission for Families and New Haven's Family Alliance established separate organizations that were not a part of any existing human service agency. According to a juvenile court official from New Haven, this had important benefits. Family Alliance staff were not viewed as "an arm" of any particular agency with any of the accompanying historical biases. Being independent of other agencies enabled the Alliance to avoid becoming embroiled in inter- and intra-agency conflicts. The Commission's executive director believed that it was important not to be identified with any one agency. Separation reinforced the belief that the program was different from other service approaches and was not identified with any one particular agency. Finally, it forced staff to physically separate from traditional roles and view themselves as part of a new approach.

Although independent of any one service agency, each administrative entity sought to include all necessary officials in its policy and advisory boards. The Commission for Families' Board of Governors, for example, included representatives from the spectrum of human service directors, including the Departments of Social Services, Health, and Juvenile Services; Superintendent of Schools; and other local political, civic, and community members. The executive director told us that the makeup of the governing board had a positive influence on the work of the Commission—its representatives brought broad awareness of the various

issues facing service delivery and expertise to identify the program's strengths and weaknesses.

Benefits of Service-Oriented Efforts Limited by Available Resources

Program officials said that their efforts depended on the availability and knowledge of resources in the area. They also said that their ability to improve client access depended greatly on the availability of transportation services, the ability to be reimbursed by private or public funds, and other restrictions on funding.

In Rhode Island, for example, CHILD Inc.'s health coordinator indicated the number of local providers willing to serve families on Medicaid has declined. Five years ago, she reported, CHILD Inc. had a list of more than 40 dentists for referral; at the time of our visit, she had 2 dentists, who were overwhelmed with Medicaid patients. She considered herself fortunate to get a dental examination for one of the program's Head Start children. To get treatment for children with serious problems, she had to be a strong advocate for the child and work with the providers "one-on-one." Medical providers, she told us, while more willing to accept Medicaid, were often difficult to reach by public transportation. However, staff at CHILD Inc. would, when necessary, provide transportation.

Case managers sometimes lacked adequate information about available services because of the large number of providers in the local service area. When New Haven's Family Alliance initially charted the local service network, it found 475 private and public health and social service providers offering family services in New Haven. The director of case management at Family Alliance believed the high number of providers caused "tunnel vision" among human service agency staffs. Each provider, he stated, probably knew and networked with, at most, 20 of these. Individual social workers saw their basic role only within their agency and rarely beyond.

Conclusions and Policy Considerations

Head Start and other service-oriented efforts have been more successful than system-oriented initiatives in delivering comprehensive services to clients, linking families to existing services, bringing providers together, and improving information sharing and service planning.

Although a few system-oriented initiatives we studied were able to create some new administrative structures, they were generally unable to accomplish their goals because they could not:

- get key constituent groups to reach and maintain consensus on important program issues,
- obtain and sustain political support for their efforts, and
- create strong administrative units to lead their efforts.

The service-oriented efforts enjoyed greater success, primarily because they are usually locally led, voluntarily undertaken, and, thus, easier to accomplish. System-oriented efforts, often enacted or begun through mandates, tended to be more threatening to participants because they attempt to restructure the delivery system and alter funding streams—both of which can alter the independence of individual agencies.

Since service-oriented efforts are more narrowly focused and take on fewer and simpler tasks, they face fewer barriers than do system-oriented efforts, which typically require:

- state-level agreement or commitment;
- consensus between state and local officials;
- broad political support and financial incentives to obtain commitment; and
- the administering entity to have extensive authority to enforce cooperation.

Policy Considerations

We urge caution when the Congress considers initiatives that call for state and local governments to make fundamental changes in service delivery systems. Although the potential benefits of these efforts may be great, so are the barriers and the risks of failure. Obstacles preventing state and local program officials from reorganizing service agencies, creating new funding and service agreements, and divesting authority from their own agencies are difficult to overcome. Mandates alone are unlikely to secure the significant time and resource commitments needed from service agency officials, whether they are charged with directing the reforms or responsible for delivering a service to a family.

When exploring ways to improve at-risk families' access to health and social services, the Congress may wish to consider promoting service-oriented efforts like Head Start. This approach, focused at the point of delivery and adapted to local conditions, is a more practical, realistic approach to improving service delivery—particularly in the short term given current fiscal constraints. In considering approaches to create more comprehensive care and improve access to human services, the Congress could encourage state and local governments to focus attention on limited scoped, point-of-delivery interventions that use such service-oriented techniques as case planning and management, and collocation.

Past Federal Efforts to Integrate Services

Over the past three decades, federal initiatives have been developed to improve coordination of human service programs and administering agencies; the lessons learned from these efforts can be useful today. This appendix provides more detail on federally sponsored system-oriented and service-oriented integration efforts. A short synthesis of the research findings that are related to issues of integrating human services is presented, followed by information on different federal initiatives.

Summary of System-Oriented Initiatives

During the 1960s, as a part of its overall strategy to better serve the needs of the economically disadvantaged, the federal government supported broad system-oriented integration initiatives, such as the Model Cities and Community Action Programs. These efforts sought to focus and concentrate resources to provide more comprehensive human services to specific populations. These system-oriented efforts attempted to create mechanisms to:

- access and coordinate federal and state categorical funds,
- comprehensively plan for local human services, and
- promote and support interagency communication and cooperation.[1]

Evaluations of these initiatives concluded that they were unable to combine and make coordinated use of the different categorical programs at the federal level and had only limited success at the local level. Experts have concluded that these efforts failed because

- the initiatives had insufficient vested authority to obtain consensus and cooperation from other human service agencies;
- the initiatives were pressured to produce change over a short time;
- health, education, and other agencies were reluctant to share their access to categorical funds; and
- the initiatives were unable to establish and maintain federal, state, and local political and resource support.

The Community Action Program

Community Action Agencies (CAAs) were organizations that administered the Community Action Program (CAP) that was a part of the Economic Opportunity Act of 1964.[2] CAAs were organized at the local community level

[1]See Improving Federal Grants Management. Advisory Commission on Intergovernmental Relations (1977).

[2]Although CAP and the Office of Economic Opportunity were eventually disbanded, local CAAs continue to operate and are eligible for special revenue sharing funds.

and designed to combine and redirect a wide range of federal, state, local, and private resources to make a comprehensive attack on poverty. The Community Action's Program Guide described the need to integrate the efforts of education, employment, family welfare, health services, housing, economic development, consumer information, and credit and legal services. The Advisory Commission on Intergovernmental Relations stated that the more striking organizational and procedural features of this effort were the extent to which it sought to bypass, alter, and restructure the existing federal, state, and local governmental arrangements. These efforts were designed to respond to the multiple needs of the poor.

CAAs Lacked Authority to Promote Reform

CAP lacked sufficient authority and political support at both the federal and local levels to influence agencies' practices and alter service delivery. The Office of Economic Opportunity, the federal administrating entity, was housed in the Executive Office of the President with the hope that it could use this position to gain the commitment of the federal agencies.[3] However, the Chairman of the Office of Economic Opportunity was unable to convince federal agencies to actively participate in a coordinated strategy because he was "outranked" by the officials he was attempting to influence and the other agencies lacked real incentives to cooperate.

The local components of CAP also lacked sufficient authority. Studies have shown that in attempting to build planning groups at the local level, CAAs lacked the authority necessary to unite effectively the many agencies providing services. As one evaluation concluded, any one CAA lacked "either power to assert its will upon other institutions or sufficient standing in the community to prevail upon the competing institutions to accept coordination voluntarily."[4] At both the federal and local levels, the CAAs' experience illustrated how strong the political and administrative forces were that shaped and directed the categorical grant system.

The Model Cities Program

In 1966, President Johnson signed the Demonstration Cities and Metropolitan Development Act, which authorized the Model Cities Program.[5] Model Cities sought to rebuild deteriorated neighborhoods in selected cities by coordinating the resources of the array of assistance

[3]See Improving Federal Grants Management.

[4]See Making Federalism Work: A Study of Program Coordination at the Community Level. James L. Sundquist, Washington (1969).

[5]Model Cities was terminated as of January 1, 1975, by the Housing and Community Development Act of 1974.

programs at all levels of government, particularly in housing, education, health, and transportation. As with CAP, Model Cities attempted to unify the efforts of service agencies. The program's comprehensive planning process best captures the program's system orientation. As stated in its program guide, Improving the Quality of Urban Life, the components of the program—housing, transportation, education, economic development—were not only to be packaged together, but also to be "developed into [an] interrelated system."

Model Cities Lacked Sufficient Political Support and Incentives to Link Human Service Programs

Though the programs were to be of sufficient scope and size to "make substantial impact on the physical, economic and social problems in the model neighborhood area," the results of the Model Cities program were mixed. Multiple evaluations of Model Cities have concluded that the program was

- unable to draw together and make coordinated use of categorical aid and relied primarily on supplemental federal aid and
- unable to overcome the autonomy of participating federal agencies and service providers.[6]

There are many reasons why officials had difficulty changing the structure and procedures of the service delivery system. Since it lacked the support of key officials, especially at the federal level, Model Cities was unable to convince federal human services agencies to commit the resources necessary to support the program.[7] Moreover, the designers of Model Cities did not initially believe that the state should be a key support link in the program, though their cooperation was essential to access formula funds allocated to the state. The lack of commitment by federal agencies, coupled with the limited state participation, left the program without key political support. Evaluations have concluded that this type of participation is essential to sustain support for system-oriented efforts.

Another reason that the local administrating agencies, the Community Development Agencies, did not pull together the resources necessary for the Model Cities program was that they lacked incentives to seek and access existing funding streams. The agencies did not vigorously pursue additional funding as they perceived the community-based planning

[6]See Making Federalism Work: A Study of Program Coordination at the Community Level. James L. Sundquist and David W. Davis, Washington, D.C., Brookings Institution (1969).

[7]Improvements Needed in Federal Agency Coordination and Participation in the Model Cities Program. Washington, D.C., U.S. General Accounting Office, January 14, 1972.

process as the top priority of the Department of Housing and Urban Development. Further, eligible recipients of categorical funds—local health and education agencies, for example—saw no incentive and were reluctant to share their access to these funds. This attitude, according to one major evaluation, was shared by federal agency officials. This lack of consensus on program priorities between levels of government and an absence of incentives to cooperate limited the effectiveness of the Model Cities program.[8]

Summary of Service-Oriented Initiatives

The federal government's experience in supporting efforts to integrate services has not been limited to initiatives with primarily system-oriented goals. The Economic Opportunity Act, which established CAP, also created Head Start, a federal-to-local grant program to develop comprehensive child development programs for disadvantaged preschoolers and their families. In addition, during the 1970s and 1980s, HHS—and its predecessor, the Department of Health, Education and Welfare—funded Service Integration Targets of Opportunity (SITO) demonstration projects. These projects were designed to both merge service agencies' administrative functions and to create linkages between service providers and clients.

Head Start and SITO both encountered some previously cited problems implementing the more system-oriented features, such as consolidating administrative functions. However, the projects did improve client access to services.

Head Start and the SITO projects improved at-risk families' access to comprehensive care. For example, a study prepared for HHS of 58 communities with full-year Head Start programs showed that the program influenced local educational and health institutions to become more responsive to the needs of the poor.[9] Many SITO projects created service-oriented mechanisms, such as case management functions, and substantially improved access to available services. Results of summary evaluations from individual SITO projects showed that developing mechanisms to get families to services—ranging from actually providing core services such as health exams to clients of other agencies to providing cross-agency case managers—improved client access to needed services. In addition, these types of linkages fostered strong informal

[8]See Improving Federal Grants Management.

[9]A National Survey of the Impacts of Head Start Centers on Community Institutions. Kirschner Associates, Inc. (May 1970).

relationships between agencies and made agencies more responsive to the service needs of at-risk families.

Service Integration Targets of Opportunity

The Department of Health, Education and Welfare's Office of Social and Rehabilitative Services initiated the SITO projects in 1972. In all, HHS funded 45 projects. Most of these projects were service delivery efforts carried out by state and local governments intending to provide information on how to integrate the delivery of a wide range of human services.[10]

SITO Projects Successful in Creating Service Linkages

Many SITO projects witnessed improved access to services for clients. However, as with CAP and the Model Cities Program, the SITO projects had limited success in creating system-oriented mechanisms, such as combining or "pooling" categorical funds from other agencies and inter-agency planning groups. Projects that attempted such fiscal linkages were frustrated by federal regulation, state law, and agency boundaries. Also, the projects were not able to counteract agencies' unwillingness to remove fiscal and administrative restrictions. Finally, at least one project that attempted to pool funds found that the process required complex and expensive accounting procedures primarily to assure that funds in the pool were not used for services or for clients that the donor agency could not legally support.

Reviewers concluded that though these projects attempted interagency planning to redesign a local or regional human service delivery system, they had limited success. State and local program officials often felt these exercises threatened their program, budgets, and agency identity. These officials had difficulty reaching consensus during the planning process. For example, a project in Duluth, Minnesota, found that its planning process was ineffective because participants could not agree upon the project's goals.[11] Experts have concluded that projects initiating interagency planning require sufficient authority to enforce full participation by all agencies.

However, many SITO projects did create service-oriented mechanisms and improved access to available services. Results of summary evaluations from individual SITO projects show that developing mechanisms to get families to the core service activities—ranging from actually providing

[10]See Managing the Human Service "System": What Have We Learned From Service Integration? Human Services Monograph Series, Number 4 (August 1977).

[11]Managing the Human Service System: What Have We Learned from Services Integration?

core services to providing cross-agency case managers—improved client access to needed services. In addition, these types of linkages can foster strong informal relationships between agencies and make them more responsive to the service needs of at-risk families. Yet, as with the need for an authority base to urge participation in the service planning process, researchers agree that the impact of the linkages among agencies and clients is greater when projects had some authority over other agencies, such as the power to purchase services.

Description of Service Integration Programs GAO Visited

To illustrate the process by which state and local officials attempted to integrate human services for at-risk families, we examined three service integration initiatives: Part H of the Individuals with Disabilities Education Act—formerly P.L.99-457: The Education of the Handicapped Act Amendments of 1986; the Annie E. Casey Foundation's Child Welfare Reform Initiatives; and Project Head Start. Part H and the Annie Casey initiatives are examples of system-oriented efforts. Head Start and local components of the Annie Casey initiatives illustrate service-oriented efforts.

Part H

In 1986, the Congress passed Part H to create an early intervention program for handicapped infants and toddlers (birth to age 3 years) and their families. Through a required set of program features, Part H requires states to develop a comprehensive, multidisciplinary service program.

Under Part H, the Department of Education is authorized to provide funds to assist states in establishing statewide, comprehensive, coordinated programs. Part H designates the following 14 minimum components that all state programs must contain, including various service level requirements, such as a multi-disciplinary evaluation, service plan, outreach system, and a central directory of early intervention services:

1. State definition of developmentally delayed.

2. Timetable for all appropriate services to be available to eligible children before the fifth year of participation.

3. Comprehensive multidisciplinary evaluation of functioning of eligible children and needs of their families.

4. Individualized family service plan and case management services.

5. Child find and referral system to providers.

6. Public awareness program focusing on early identification.

7. Central directory of services, resources, experts, research and demonstration projects.

8. Comprehensive system for personnel development.

9. Single line of authority in a lead agency designated or established by the governor for carrying out:

- General administration, supervision, and monitoring of programs.
- Identification and coordination of all available resources.
- Assignment of financial responsibility to appropriate agency.
- Procedures to ensure services are provided and to resolve intra- and interagency disputes.
- Entry into formal interagency agreements.

10. Policy pertaining to contracting or making arrangements with local service providers.

11. Procedure for timely reimbursement of funds.

12. Procedural safeguards.

13. Policies and procedures for establishing and maintaining personnel standards.

14. System for compiling data on the early intervention program.

Part H requires the governor of each state to designate a "lead agency" with a single line of authority to identify and coordinate all available resources within the state from all funding sources. In addition, the law requires interagency collaboration as it instructs states to establish interagency coordinating committees.

To receive funds, Part H mandates that participating states change their current service delivery systems. Part H funds are primarily "glue" money to help states organize agencies to plan and deliver improved services. For example, about $175 million was appropriated in 1992 to implement Part H in all of the 50 states; North Dakota received about $400,000; Maryland, $3.2 million; and Connecticut, $900,000. To foster interagency collaboration, Part H requires states to alter the way they do business. Most likely, no single state agency provides all the necessary services to the infant and toddler population; thus, agencies must work together to ensure the comprehensive services Part H requires. Moreover, since no one individual or agency has the authority and power to direct or mandate other agency administrators, interagency agreements must be created through consensus building.

Although participation in Part H is voluntary, all 50 states and the District of Columbia are participating. The Congress, acknowledging that such fundamental system-oriented changes require significant time to implement, established a 4-year phase-in period, after which states must serve all eligible children under Part H. The Department of Education's Office of Special Education Programs oversees the implementation of Part H and provides technical assistance to participating states.

The Annie E. Casey Child Welfare Reform Initiatives

The Casey Foundation is a private philanthropic organization dedicated to improving the nation's foster care system. One of its projects, the Child Welfare Reform Initiative, helps selected states redefine their child welfare role and develop a new more effective policy direction. The Annie Casey reform initiative instructs states to create a new system, one that emphasizes more practical and proactive methods for states and communities to enable parents to better care for their children and prevent families from arriving at the point where traditional child welfare services intervene.

The Foundation asserts that the new system should be both family centered and more comprehensive and flexible, serving at-risk families before the point of crisis. It should also provide local communities strong "ownership" and should recognize and protect the rights of children and families. The reform initiative seeks to prevent unnecessary out-of-home placements by cutting across categorical service boundaries and emphasizing more early, preventive, and comprehensive supports for families. In addition, the initiative should have the authority to plan and lead service delivery changes.

Increased attention to preventing placements requires various reforms. Agencies may have to reorganize their programs to reflect needed changes. Financing of human services must promote, rather than inhibit, the goals of the new delivery system. In addition, the initiative must provide financial incentives to maintain children safely in the home and to support an integrated program for serving at-risk families, rather than reinforcing the current categorical, crisis-oriented child welfare system structure.

The Foundation asked states to take the lead in planning, implementing, and overseeing the development of a new delivery system and select at least one local jurisdiction to pilot test the new system and create a Local Governing Entity to implement changes. With the greater flexibility

provided by system-oriented changes, the Local Governing Entities seek various reforms at the service delivery level. The project directed local pilot sites to create a case management system to ensure that families at risk of out-of-home placements receive whatever comprehensive services they need to prevent placements.

Beginning in 1988 the Foundation awarded 5-year grants for $3.75 million to North Dakota, $7.5 million to Maryland, and $7.5 million to Connecticut. The Casey Foundation selected the Center for the Study of Social Policy, a Washington-based nonprofit research and study organization, to develop and evaluate the initiative.

Head Start

Launched in 1965 as part of the Johnson administration's "war on poverty," Head Start is a federally funded comprehensive early childhood development program for low-income children aged 3 to 5 and their families. Head Start was designed to help break the "cycle of poverty" by providing preschool-aged children of low-income families with a comprehensive program to meet their emotional, social, health, nutritional, and psychological needs. Head Start programs either provide or arrange for a comprehensive, integrated array of services.

Head Start also helps families assess their overall needs and assists them in accessing available community services. Head Start programs have various staff members that act as health, social service, and nutritional coordinators. When a family enters Head Start, these staff members develop a case plan that documents the family's needs, provide information on available community services and how to obtain them, make referrals to appropriate agencies, and follow up to ensure that families receive needed services.

Head Start's 25th Anniversary Silver Ribbon Panel concluded that the program needs strong linkages with other community human service resources to maintain quality in its day-by-day operation and to respond to the comprehensive needs of children and families.[1] The panel recommended increased federal efforts to link Head Start programs with federal, state, and local public and private organizations and individuals with expertise in pediatrics, dentistry, nutrition, mental health, social services, family support, and job training.

[1]Head Start: The Nation's Pride, A Nation's Challenge. The Report of the Silver Ribbon Panel, A project of the National Head Start Association.

Begun as an 8-week summer program, Head Start now serves more than 450,000 children and their families annually. Head Start centers are locally administered through about 1,300 community based nonprofit organizations and school systems. HHS awards grants that are overseen by the Office of Human Development Services.

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