REPORT TO THE LEGISLATURE

Service Delivery Pilot Projects

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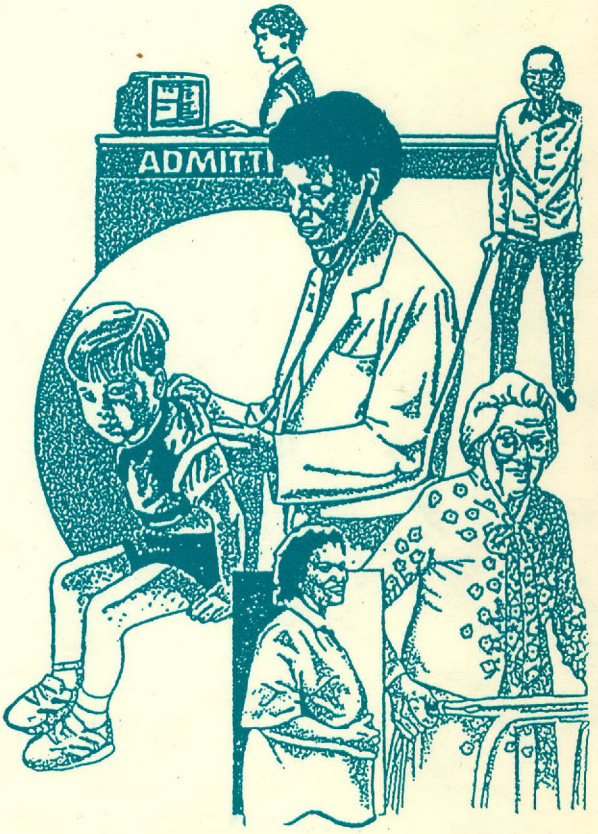

Texas Health and Human Services Commission

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Service De
Pilot Projec

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Service Delivery Pilot Projects

Introduction

In July 1991, John Sharp, the Texas Comptroller for Public Accounts, published Breaking the Mold, New Ways to Govern Texas, which recommended numerous ways to "reinvent" government. One of these resulted in House Bill 7, which created the Health and Human Services Commission and directed the Commission to improve access to health and human services for the people of Texas.

The legislation states that the Commission is "... responsible for ensuring the delivery of state health and human services in a manner that uses an integrated system to determine client eligibility, that maximizes the use of federal, state, and local funds, and that emphasizes coordination, flexibility, and decision making at the local level." House Bill 7 directed the Commission to develop a client access package and test it in at least three pilot sites.

The service delivery model is being tested in Dallas, Lubbock, and Schleicher counties. The purpose of this model is to eliminate many of the problems identified in Breaking the Mold, including multiple locations, different eligibility requirements and lack of interagency cooperation. The service delivery model merges city, county, state, federal and private agencies into a collaborative effort which improves access and is more responsive to Texans.

Reaching People in Need

A Schleicher County family found themselves desperately in need of help after a tragic truck accident left their son a quadriplegic. They suddenly had to deal with a complex health care system and astronomical expenses, including a $20,000 wheelchair. They asked for help from every place they could think of, but as in many rural counties, there was simply a lack of resources. The only source for help used to be the county judge's office. That is, until the Schleicher County Community Resource Center came along. The center serves as a central point for people to apply for health and human services. There are even some transportation services coordinated through the center.

The one-stop shop, located near the courthouse in Eldorado, Texas, provides a variety of services including immunizations, food and other health care assistance. People can also apply for food stamps and Medicaid, ask about Social Security or even get help drafting a resume. For that family, the center proved to be just what they needed.

Staff at the Community Resource Center were able to help the family access and coordinate state and local services that would help their son to get his education and live independently. Today, thanks to these efforts, the young man is a successful sophomore at Texas A&M University.

The Service Delivery Model

The service delivery model is based on the concept of one-stop connection to services. It aims to create a seamless system in which a person could receive most health and human services through a single point of entry. This means that staff can screen an applicant for potential eligibility, determine eligibility, provide some, if not all, services on site and connect with other service providers when necessary.

The three projects share similar features. Local units of government or non-profit providers are responsible for leadership, decision making and coordination. All state agencies under the umbrella of the Commission participate with varying levels of responsibility, and other state agencies such as the Texas Employment Commission and the Texas Education Agency are also involved.

The projects share these elements:

- Collaboration among private, state and federal providers and local units of government.
- Co-location of offices.
- Removal of architectural, communications, programmatic and transportation barriers.
- Centralized client intake and automated eligibility screening.
- Appointment scheduling.
- Coordinated information and referral.
- Case management for individuals or families with multiple needs.

The projects mix these elements as appropriate for each community. Each project takes a different approach:

- Dallas County started with a single service center targeted to specific types of consumers that has expanded into several centers in one building complex.
- Lubbock County offers services through a core location linked to satellite offices.
- Schleicher County operates a multi-purpose center staffed with a full-time casework assistant who screens for potential eligibility for services, and provides access to local county services. Itinerant workers also provide services.

A critical element in the projects is the use of the Client Access Process Software (CAPS). This software automates intake and screens for potential eligibility for most state and community services available at the project. Intake workers use CAPS to gather information from a consumer to determine service needs and make referrals. This software reduces the need for the consumer to repeatedly provide the same information.

The varied pilot structures offer different environments in which to apply the one-stop connection concept and the automated intake process. They demonstrate the flexibility of a common model for intake and service delivery. The evaluations show that the pilots have improved both access and service delivery using the model.

Findings

The Evaluation

The evaluation of the pilot projects also used a collaborative technique. The Commission convened a consortium of social scientists from Texas state universities. They developed strategies for evaluating the projects. The evaluation was conducted by interdisciplinary, inter-university teams using three methodologies. These included:

- **Service Delivery**: The development of a baseline of services provided by health and

human service agencies for programs with computerized statewide reporting: **A. James Schwab and John Trapp, University of Texas at Austin.**

- **Participant Satisfaction**: A telephone survey of consumers and participating staff. In the rural project this included a community survey. In the Dallas and Lubbock projects this included a community needs assessment: **Allen Rubin, University of Texas at Austin, and James J. Glass, University of North Texas.**
- **Project Development, Implementation and Maintenance**: On site interviews and observations with project team members to develop an understanding of the participant's experiences and perceptions: **Laura Lein, University of Texas at Austin, and Marcia Sanderson, University of Houston.**

The complete reports are included following this summary of the findings.

Since the Lubbock site was the last to open, some data applies only to the Dallas and Schleicher County sites. The Lubbock project staff felt that it was premature to participate in parts of the evaluation. Also, the automated system at Lubbock did not yet contain a list of consumers from which to sample consumer satisfaction. Interviews with Lubbock staff helps to document experiences in the mid-sized site. It should be noted that the rural site in Eldorado opened three months before the Dallas urban site which opened six months before the Lubbock mid-sized site.

"This increased interaction led to an increased sense of identity as a united health and human services community."

Comment from evaluator

Success in Testing the Model

Consumer Satisfaction

Perhaps the most meaningful measure of any product is consumer satisfaction. In each of the sites, the majority of consumers were satisfied with the service provided. Consumers found the staff to be helpful, respectful and interested in meeting their needs. The automated screening saved time and provided for much appreciated personal attention because the referrals tailored to each consumer required the worker to spend some time explaining them.

Little dissatisfaction was expressed. Where it was, consumers wanted more interest from the staff or wanted to receive all of the services they needed and to receive them quickly.

Sixty percent of consumers were satisfied with the overall effectiveness of the system. The level of satisfaction did not vary by ethnicity, gender, income or age.

Many in the community continue to believe that requesting services from health and human service providers can be a demeaning experience. However, the overwhelmingly positive responses of consumers who have received services from the projects demonstrate that staff in these projects have made a real change in the way that services are delivered.

Staff Satisfaction as Providers

In large measure the consumer's satisfaction is affected by the delivery staff's level of satisfaction doing their jobs. Workers reported that the service delivery model improved their ability to provide services. Most staff felt that the project did not increase stress or make it more difficult to provide services.

Coordination of Services and Referrals

The automated screening simplified and improved the referral process. Workers usually received sufficient information from the original intake worker and were seldom frustrated by inappropriate referrals or, in the rural area, by delays in receiving information needed. Workers provided consumers with more referrals and received more referrals from other staff.

The model also improved the patterns of referrals at all three sites. A new formal referral network replaced an informal network that had several disadvantages including the need for personal connections, lack of follow-up and mistrust among providers. The formal network was nurtured by provider proximity, increasing awareness of each other's services and a spirit of cooperation.

The service delivery model provided a scheduling system for staff and consumers. Many consumers preferred to make their own appointments. Some declined services for which they were eligible. Many wanted to discuss the referral with family members. Furthermore, many consumers, like most workers, had constrained time schedules and preferred to make their own appointments. In the rural site, when consumers requested assistance, staff made the appropriate appointments.

Some providers were surprised by the demand that developed as the pilots progressed. With the greater number of people being referred to them, some ran out of resources in the last two weeks of the month just when people need them the most. The project coordinators felt this problem would be solved through experience with the referral system.

"Many of the service providers felt that the nature of their workload changed in that they were able to serve clients more effectively."

Comment from evaluator

Changes in Workload

Although it is too early to judge the full impact, it appears that caseloads may have increased without noticeable increase in paperwork or workloads. Workers in all three sites report that they were able to use their time more efficiently. They could see more clients more quickly and provide more interaction. Co-location produced easier communication, faster and more accurate information and less need for emergency vouchers.

Benefits and Problems Associated with Co-Location

Some workers reported that the new service delivery model had additional benefits, giving them the time to break out of old molds. Others, who tended to maintain an agency-centered viewpoint, were worried about outside scrutiny.

While co-location was a convenience for consumers, it caused difficulties for some staff. Agencies brought workers on board in different ways, which resulted in staff working in close proximity with differing levels of commitment to the job. To staff who were brought in early and included in the planning, the pilots were an exciting experience. When staff were ordered to participate and told what to do, they were less open to the benefits of co-location. Some staff reported that perceived differences in work loads, holiday and work schedules caused misunderstandings and jealousies.

Reaching People in Need

"The story that really gets to me is about a young mother who is 20 years old with a one-year-old child. She came to Community Health Center of Lubbock because she had received an eviction notice and was going to be thrown out of her house by the end of the week (it was Friday afternoon).

"When she came in she looked so pale, with dark circles under her eyes. No one thought much about it until she told us during a screening that the reason she couldn't pay her rent was because she had missed work to undergo chemotherapy treatments. That just about did us all in.

"Rent assistance is almost non-existent in this town, especially on Friday afternoon. We were at a loss. We called the Salvation Army, but they said that she would have to stay with their other clients, who are mostly recovering drug and alcohol addicted men. Next, we tried the Guadalupe Economic Services Corporation and they said they would take her, but they had no facilities to accommodate the baby.

"Finally, we found her shelter through First Presbyterian Church. We verified her story and got her food, diapers, baby formula and clean clothes from Neighborhood House. In addition, me and couple of co-workers scraped up enough for her bus fare. She stayed with a family in the church for several weeks. Her family finally came to take her home. We still wonder how she is."

Staff feared that the model would be too successful. They worried that large numbers of consumers might abandon their usual service delivery sites if they became aware of the speed and the quality of services at the pilots. Workers feared being unable to meet the demand. Consequently, in the urban site, agencies had restricted services at the co-location site to new consumers. In the rural site; several agencies increased the number of staff or the number of days they provided services at the service site.

"Many of those interviewed, including state employees, told me that 'turf-mindedness' and 'lack of a predisposition to cooperate' were common characteristics at the state level."

Comment from evaluator

Experience with New Technology

There was little computer sophistication among project staff who would be using the equipment. Software training was provided at each site. Staff found the CAPS software easy to use, requiring less time than anticipated to screen each applicant. It made information readily available and reduced paperwork.

Staff at the rural site seemed to adapt most easily to the new technology. County staff had no automation before and took quickly to the new tools. They enjoyed the convenience and speed. State workers, who had their own automated systems, did not use the CAPS

software because county staff did all the screening.

The urban and mid-sized sites required that more staff learn new technology, many of whom had never used computers before. Like the staff at Eldorado, they learned the routines quickly and found the system easy to use.

The installation of the equipment in each site brought confusion and trauma. Experimental as it was, the technology was new to both site personnel and technicians. Conflicts arose over differing expectations. The Austin technicians were relatively comfortable with the process, seeing it as 'not unusual' for an experimental system. But local staff saw it as a working system and were frustrated and irritated by the various problems.

The computer equipment quickly developed a poor reputation. Early failures of faulty, low bid hardware contributed to ongoing anxiety over potential system failures and work stoppages. Additionally, because the development, modification and control of the system was in Austin, staff were uncomfortable with their dependence on off-site experts. It was sometimes inconvenient when problems had to be solved from Austin.

"At times the frustration with technical problems threatened to overshadow all the other, more positive aspects of the project."

Comment from evaluator

Staff accustomed to taking the initiative, solving problems, and acting quickly were frustrated by their dependence on equipment and outside expertise.

Reaching People in Need

The Dallas County Client Access Pilot helped a man recently who was suddenly unable to support his pregnant wife and young daughter after a near-fatal accident. A gun shot wound to the neck forced him to leave his job as an apartment maintenance technician, his only source of income.

The man was interviewed by a Homeless Outreach Coordinator who helped to arrange housing assistance from the Dallas County Department of Human Services. We then referred him to the Texas Rehabilitation Commission who is helping him with job skills and job placement.

He had been previously enrolled in TRC services, but had not followed through with the program. The extra attention he received from the combined efforts of the on-site TRC caseworker greatly contributed to his success to date in his current TRC program.

At the time of the evaluation, the urban and mid-sized sites were still experiencing some problems with the automated system that were not problematic in the rural site. While it is likely that the longer experience in Eldorado accounted for this, further study of the automated system itself would identify unique aspects of the urban and mid-sized site that might need to be accommodated.

Staff Satisfaction as Project Team Members

The project teams at the three sites reported somewhat different experiences in the development and implementation of the service delivery model, due to differences in schedules, processes and the personalities of team members.

Project teams included supervisors and directors of local service agencies, Austin-based staff from the Health and Human Services Commission and other state health and human service agencies. Some delivery staff worked on the project as planners as well as providers. Relationships among team members were built primarily on existing informal relationships with varying degrees of cooperation, but which were generally amiable and mutually beneficial.

In all sites the nature of these existing relationships changed as a result of the pilot project. The project formalized existing relationships and brought in new players. Through the pilots, staff developed working relationships founded on common interest in the success of the project, shared mission and goals and mutual knowledge of each other's programs.

Co-location improved existing relationships. However, proximity in itself did

Reaching People in Need

"When a 22 year-old-man found himself unable to work after a crippling back injury, he turned to us at the Community Health Center of Lubbock in hopes of getting food for his young family. We gave the man a screening in order to better assess his needs. Afterwards, he was excited to discover that not only would we help get him food, but also give him medical assistance and connect him with other much needed community services.

"Neighborhood House gave the family food and a small amount of rent, while the United Coalition Pharmacy helped to fill the man's prescriptions. We eventually referred the man to UMC Neurology Clinic for back surgery.

"Later, our staff did an up-date on the family and found that they were still in need of food and were having problems with their utilities. More food came from Catholic Family Services and Lubbock Neighborhood Community Outreach helped with the utilities. We called the Texas Rehabilitation Commission who accepted the man as a client. He is now getting the help needed to once again become a productive citizen.

"Not bad for someone who originally just wanted food!"

not create a seamless service system. The framework of collaboration stimulated the cooperation in which service providers and consumers were able to work together to address the service needs. Within the framework of collaboration, each provider maintained a strong sense of autonomy while focusing on client needs rather than agency needs.

Working together in the projects provided an opportunity for staff members to learn about other levels of government and other types of organizations. However, differences in agency culture--the degree of autonomy, the targeted populations, funding sources, policies and regulatory and communication practices--created challenges to communication and implementation.

Team Process

All three projects used an organizational structure that can best be described as a matrix, a consensus-building process to reach decisions and cooperation to complete tasks. Staff accustomed to working in hierarchical organizations initially felt uncomfortable with the matrix organization. Some local staff felt that no one was in control. Some remained unsure about their roles and responsibilities. Turnover of leaders at one site increased this confusion and left some staff feeling uncomfortable. This discomfort was gradually overcome through the successful experience with this organizational model.

Team Leadership

Leadership was crucial to success of the pilots. In each site there was a local organization that took the lead in managing the process, expending funds and complying with the contract developed between the Health and Human Services Commission and the pilot projects. This organization led by persuasion, consensus building and attention to provider needs. While local leadership received high marks from most of the staff who responded to the survey, some team members expressed concerns about stability and strength of leadership and the quality of communication about goals and expectations.

Collaboration and Communication

Staff at the rural site felt that there was adequate collaboration and communication among providers and that the project had expedited this. In the urban site, some staff reported similar experiences while others felt there was a need for improvement. One source of frustration was the practice of sending alternates to the meetings. Some found it irritating that meeting time was spent bringing newcomers up to speed. Communication, typically a problem within large organizations, was a challenge for these inter-agency teams. Members felt that improvements could be made in the abundance, clarity and usefulness of information. Each type of organization had its own practices and expectations, which occasionally caused misunderstandings. Most team members felt encouraged to speak up, but in each of the projects there was some need for assistance in resolving conflicts.

"We are inventing things and it is fun."

Comment from team member

Existing relationships among state agencies affected the quality of collaboration. Before the project began, staff had little knowledge of the operations and services provided by their counterparts in other agencies. At some sites, employees who had learned to put their

agency's interest first tended to be mistrustful and competitive. As a result, energy was diverted into blame rather than problem solving.

Performance of Health and Human Services Commission

The performance of Commission staff in implementing the projects was rated as quite good. In each of the sites, local project team members were grateful for the management and organizational assistance of Commission conveners who helped local staff implement the model. However, the level of appreciation varied by site. Problems could be traced to previous experiences with state agencies' perceptions about state employees, events that occurred during planning and implementation, and the ease with which the program model and the automation system were installed at each site.

Some local staff did not differentiate among state agencies. State staff were "state", whether they worked for the Commission, for one of the state health and human services agencies in Austin or one of the agency regional offices. Thus, comments about state staff combined reactions to a variety of people with a variety of responsibilities doing a variety of tasks.

The quality of the automation equipment created problems in the relationships between state and local staff. State staff was blamed for accepting what turned out to be inferior equipment. That called into question their judgment and ability. The experimental nature of the automation system also caused friction because local staff saw it as poorly planned and incompetently implemented while state staff understood the limitations of such a system.

Reaching People in Need

A Dallas County Department of Human Services' Homeless Outreach Coordinator recently helped a middle-aged man who was unable to continue employment due to severe asthma. In the past, he had tried several other programs designed to increase his employability, but none of them were helpful enough for him to complete. He was referred to the on-site TRC caseworker and subsequently enrolled in a computer skills course at El Centro College. TRC will provide job placement assistance upon completion of the class.

Meeting Goals

The goals for the Health and Human Services Commission in HB 7 were the foundation for pilot project goals. By developing mission and value statements, each project site set goals tailored to community needs (see Appendix Z). In agreeing on common goals, participants were able to set aside different agency backgrounds and priorities.

The HB 7 goals were not necessarily the primary goals and concerns of the local sites. Some sites had other primary goals, and team members had many personal goals. This caused confusion over the nature and purpose of the project. Commission conveners clearly informed local staff that they would be pilot testing the service delivery model as specified in HB 7, and contracts with the pilots reflected that. But there remained disagreement over the meaning of "local control". Commission

staff encouraged local control, but some team members interpreted this as autonomy over the model.

In spite of these misunderstandings, team members defined success similarly in all the sites. They generally agreed that success meant improved access to services, easier application procedures, better availability of information on services and better cooperation among service providers. For some, success also meant that more people would be served and that they would receive more services.

Improved Access

Improved access is especially important for families who need services from multiple agencies. In the urban sites, there is considerable overlap. For example, 345 (15%) of Texas Rehabilitation Commission's 2,231 consumers in Lubbock also receive Aid to Families with Dependent Children (AFDC) and Medicaid.

In Dallas 1,019 (8%) of Mental Health Mental Retardation consumers receive AFDC and Medicaid and 1,131 (9%) also receive services from the Rehabilitation Commission. As might be expected 3,879 (28%) of the 13,329 Women, Infants and Children consumers also receive AFDC and Medicaid.

In Schleicher County the greatest overlap was for consumers who received both Women, Infants and Children aid and AFDC and Medicaid. It is important that staff in the Dallas and Schleicher sites, which had been operating for several months, felt that they were better able to address these families' needs through the pilot than they had before the inception of the automated screening service.

Serving People with Multiple Needs

- In Lubbock 345 (15%) of Texas Rehabilitation Commission's 2,231 consumers also receive Aid to Families with Dependent Children (AFDC) and Medicaid.
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Easier Application Procedures

One of the goals of the HB 7 legislation was to reduce the number of times that people have to repeat the same information. The present system requires a new application for each service. Most consumers in the rural and urban sites had to repeat the same information no more than twice.

The application process, which uses the CAPS software, took about 15 minutes to complete. It captured all of the common information that the various programs used to process an intake. It projected potential eligibility for programs and produced a single set of referrals. The worker doing the screening then told the consumer what documents would be necessary for the first appointment. Because the consumer was better prepared for the eligibility appointment, fewer appointments were needed.

Better Availability of Information on Available Services

Before the pilot projects began, staff in Lubbock and Dallas had local resource directories that provided information for making referrals. The CAPS software improved their ability to use these resources, by specifically identifying all of the services for which the consumer might be eligible. Staff also reported that through the project they had learned more about the services available and were able to make better referrals.

In the Schleicher County site there was no central resource directory. Local staff developed a resource directory, and agencies provided brochures and posters to the Community Resource Center. This project advertised the Community Resource Center to the community and surrounding counties.

Better Cooperation Among Service Providers

Service providers developed more cooperative working relationships. Regular project team meetings provided a way of getting to know others and of developing common purpose. Co-location improved knowledge of each others' programs and staff's ability to work with each other.

Perceived Accomplishments

In the rural site, staff felt that the model achieved its goals. In the two urban sites, staff felt it was too early to judge. Even so, staff reported that they felt good about the accomplishments of the project team. Co-location sites had been well chosen, the sites were geographically well located for consumers, and building architecture was not a barrier for consumers. The quality of services and the speed of delivery improved, and the quantity of services provided increased. Those needing multiple services obtained what they needed. In Schleicher County one in 10 consumers needed multiple services. In Lubbock, it is one in five.

Local staff expects further improvements in the second year as they work on improving communication and cooperation among service providers, reducing further the number of contacts consumers must make and improving the model in the rural site.

"One good thing is that now all people in the city know each other."

Comment from team member

Issues

Automation

Scarce resources caused questions about automation, including the ability to link to the network and maintenance of the software.

In two of the sites there were still concerns over who was linked to the network or how those who were not could afford to be connected. Some private providers with limited funding could not afford to purchase the needed equipment to link into the network and to use the screening software.

The CAPS software was adapted to include screening for local providers. There remained concerns over capacity to include all local services and flexibility to adapt to locally provided services. This applied not only to local private providers but to locally tailored state programs.

There was also concern over the sites' lack of resources to support the software once they

stopped receiving state financial support. As new services are developed and existing ones modified or discontinued, software that is not maintained locally would lose its usefulness.

Confidentiality

Confidentiality was a major concern for all the projects. Some programs are limited by state and federal confidentiality requirements which differ from program to program. While each pilot site developed a satisfactory strategy for handling this issue, it remains a problem that must be addressed at the state and federal levels.

"Several workers cited confidentiality as a major concern while others speculated that the real issue was turfism described as confidentiality."

Comment from evaluator

Funding

The three pilots received approximately $450,000 from the Commission in fiscal 1993 for computer equipment, other start-up costs and operating expenses. Funding for fiscal 1994 is $212,587, primarily for operating costs. Some providers have made and continue to make in-kind contributions.

Several funding issues emerged, the key one involving the limited size of the grants. In the urban sites some smaller local providers came to the project hoping to increase their funding through the pilot project grants. There was considerable disappointment and some providers chose not to participate when the grant amounts became known. In the rural site, there is a real concern that the project will close when state funds run out because county officials say they cannot add more dollars. The Eldorado Community Resource Center now has non-profit status and is applying for grants.

Another problem at Eldorado occurred during the start-up period when participants were asked for in-kind contributions. Some staff were uncomfortable asking their superiors for contributions. The result was that team members at higher levels in their agencies were more likely to make the contributions.

Attitudes Toward Evaluation and Assessment

Team members were generally positive about the evaluation. They were helpful, enthusiastic, open, accommodating and cooperative. Some saw it as an opportunity to learn and analyze their own and their agency's role in the project. Anxieties included worries over whether they would look like failures because of the developmental stage the pilot was in at the time of the interviews and suspicion about why an evaluation was necessary if the project was doing well.

Implications

Critical Success Factors

The following factors contributed to the success of the pilot projects in Lubbock, Dallas and Schleicher Counties:

- **Leadership**, preferably by a visible leader on site who is a cheerleader for the project, facilitates communication and maintains momentum.

- **Staff participation**. Staff who are involved early, develop a clear understanding of the project's goals and have a voice in the implementation are enthusiastic about the potentials of the model. Staff who are told to participate and given little information about the project or their role tend to be skeptical and negative.
- **Common purpose**. This is critical to the ability to stay on target and achieve goals. Common purpose is developed through frequent discussions that identify and reinforce the common goals.
- **Communication** within and among organizations.
- **A common program design and cooperative working relationships** among the organizations provide the foundation for co-location. Co-location alone will not achieve improved access.
- **Willingness** to try new things.
- **Managers who promote innovation, flexibility and consider errors to be opportunities for improvement**.
- **Combining local resources** freed up resources for people who needed services.
- **Adequate consultative support** on service programs, team process or technology, including technical expertise to install and maintain complicated electronic equipment and outside perspective on problems or relationships.
- **Training** in management and new technologies reduces frustration and increases efficiency.
- **Planning**. There will always be some trial and error, but adequate, informed, ongoing planning maximizes resources.

Barriers

Collaborative projects require the cooperative efforts of staff from a variety of organizations that use a variety of operating procedures to provide a variety of services to

Reaching People in Need

"Recently, a young mother appeared at the Community Health Center of Lubbock with her three children, one of whom had multiple disabilities. They were wet, sick and the smallest child was having seizures because he didn't have his medication. They had been abandoned at a street corner in the rain by the woman's boyfriend.

"Our staff ascertained that while the family was not in immediate medical danger, they did have many needs. We called the woman's father in Fort Worth and asked him to send money for bus fare for the family to go back home. In the meantime, we were able to get them food from Neighborhood House and United Coalition Pharmacy filled the child's prescription without charge.

"When the money never came we called back and discovered that the woman's father had changed his mind and did not want the woman to come back home with her children. Immediately, we sought help from Women's Protective Services, where luckily the woman qualified for services on grounds of abandonment.

"We checked on her a few weeks later and she was much improved. She has decided to stay in Lubbock, work and attend beauty school at night. Maybe it wasn't the end of the world, when she was left in Lubbock!!"

a variety of individuals. This type of project has inherent problems. The projects identified a number of barriers:

- **Conflicting goals** cause confusion.
- **Misunderstandings and missed communications**. While everyone around the table hears the same words, the interpretation of those words is influenced by the staff member's experience in their own organizations, the perceived benefits of the project and personal goals for participation.
- **Conflicting agendas and varying levels of cooperation**. Some organizations continuously demonstrate complete commitment to the project, some do not. Long standing problems and competition among the state agencies appear as a lack of cooperation and commitment and obstructed progress. Because participation was voluntary and decisions are made by consensus, there is no way to require compliance.
- **Conflicting perceptions of control** create difficulties for some participants. The Commission conveners encourage a matrix style of organization that gives equal weight to each organization. But many staff members are accustomed to a hierarchy and expect some agencies to be more important or have more control than others. HHSC staff try to produce decisions through consensus, a tactic which confuses staff used to top-down management.
- **Fairness** is difficult to achieve because larger organizations tend to play a larger role. Staff in smaller organizations need encouragement and specific roles.
- **New technologies** require careful planning and implementation. A greater understanding of this experimental nature improves communication between technicians and users.
- **Lack of ongoing systematic assessment** which helps maintain the focus of the project and corrects for departures from the plans.
- **Existing relationships and past experience** with collaboration are a mixed blessing. It results in some working relationships and skill in collaboration, but where things have gone badly it increases skepticism.
- **Deferred decisions about automation and other problems tend to immobilize** the entire project and waste valuable time and resources.
- **Resource flow** is a problem for small providers. They need assistance in managing the requests for assistance.

Recommendations

These recommendations are based upon the Health and HumanServices Commission's experience with the service delivery model and the evaluation findings. In some cases, we disagree with the evaluators' recommendations, and point that out.

- Replicate the model in other areas, especially in rural counties.
- The evaluators recommended advertising the existence of the service center in Dallas and Lubbock counties. We do not support this recommendation at this time because the response could be so overwhelming that the site would fail. We advise advertising the centers once an adequate number of sites are operating in a community. Marketing strategies can help distribute workload among the centers.
- Provide adequate consultation and automation support to all project sites. Consultation should help develop roles and

responsibilities of project team members, collaborative processes and a working program model.

- Expand the client access model into a fully coordinated service delivery model and test it in one or more sites.
- Select and implement statewide a single automated intake and screening tool.
- Develop and implement statewide a single client release form for sharing client data.
- Proceed with the development of an integrated client data base that maintains service delivery records for all consumers receiving any health and human services. The database should be implemented statewide and made available to all service providers. This will require the resolution of interagency confidentiality problems.

The One-Stop-Connection Pilot Projects Sites

- **Lubbock County**

  Community Health Center of Lubbock
  1318 Broadway
  Lubbock, Texas 79403
  806/744-3577

- **Schleicher County**

  Community Resource Center
  105 W. Calendar
  Box 536
  Eldorado, Texas 76936
  915/853-2574

- **Dallas County**

  Dallas County Human Services
  2377 Stemmons Freeway
  Suite 200
  Dallas, Texas 75207
  214/819-1845