Strategies for Strengthening Substance Use Prevention, Treatment, and Recovery Systems:

Provider Networks and Impact on the Workforce

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PARTNERS for recovery

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ACKNOWLEDGMENTS

The State Associations of Addiction Services (SAAS), under the guidance of Abt Associates, prepared this report based on information gathered from a series of nine case studies of behavioral health care networks, a review of selected literature, and input from a broad constituency of professionals working in the field of addiction. This report was authored by Joseph Hyde, consultant to SAAS, with support and guidance from Abt and SAAS staff. Initial data collection, interviews, and draft materials for the case studies in this report were completed by Jim Scarborough, former Research Director of SAAS. Shannon B. Taitt, M.P.A. served as PFR's Project Officer.

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DISCLAIMER

The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT).

EXECUTIVE SUMMARY

This study illustrates nine successful alcohol and other drug (AOD) addiction provider networks that are highly diverse in size, scope, complexity, and service array. These case studies are vignettes of the origins, current operations, strengths, and challenges of these networks. The reader will see how these organizations mounted strategies to address problems and challenges that are common throughout the addictions system.

The addictions treatment provider system is confronted with a variety of challenges in today's environment, including shrinking resources, increasing demands to demonstrate outcomes, patients with complex sets of problems calling for increased staff skills, and changes in business practices. These and other factors place high demands on the addictions treatment system. Small providers are especially hard-hit, unsure if they can continue to exist in this current environment, but large providers are not immune from the same struggles. Recruitment, retention, and professional development of staff are ongoing challenges to the field. Staff turnover rates in some areas are said to rival those in the fast-food industry (McLellan, Carise, and Kleber, 2003). To survive and grow, agencies must find new methods of collaborating in order to maximize resources, retain staff, find strength and stability in a changing marketplace, and provide higher quality services based on sound and appropriate evidence-based practices. In a report entitled "Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce" (Whitter, Bell, Gaumond, and Gwaltney, et. al, 2006), it is recommended that network strategies be fostered in order to strengthen the infrastructure of agencies and sustain the workforce.

Although networks and collaboration are not new concepts, it is important to examine various types of collaborations for strategies and structures that can strengthen and support providers. Lessons that might be learned from these organizations may be replicated in other communities. Some of the challenges in one part of the country are truly not that different in other regions. This report provides a unique opportunity to look at how other communities brought solutions to these common problems.

BACKGROUND AND PURPOSE OF STUDY

The Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) Partners for Recovery (PFR) initiative supported the development and implementation of this study of provider networks. It builds on recommendations from an earlier report entitled "Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce" (Whitter, et. al., 2006). Within the Infrastructure section of the earlier report, recommendations were made to foster network development among substance use service providers. An excerpt from the report follows:

> As the addiction field faces agency closures, particularly among smaller treatment providers, networks represent an important mechanism for ensuring agency viability and service availability. In addition, in some cases, networks can provide career paths for addiction professionals and potential staffing pools for member organizations.
>
> In an effort to help strengthen management efficiency and ensure long-term sustainability, small addiction treatment providers may benefit from collaborative engagement in a network or use of a shared management organization to assist with human resource needs and clinical and administrative functions.
>
> This sharing of resources results in economies of scale for participating agencies and also makes available critically needed supports, many of which would not be affordable otherwise to member agencies.

This sharing of resources results in economies of scale for participating agencies and also makes available critically needed supports, many of which would not be affordable otherwise to member agencies.

The current report is based on nine case studies of addictions provider networks and illustrates a range of collaborative approaches. Case studies cover a broad range of prevention and treatment agencies and networking strategies. The report describes

- a diversity of network structures, including networks that have become freestanding nonprofit organizations, networks where one organization is the administrative lead, and networks that are non-incorporated coalitions of providers;
- a diversity of collaboration, such as sharing staff, joint projects, shared management functions, and shared purchasing;
- a diversity of networking mechanisms, including joint funding, co-location, common client-tracking systems, and cross-training;

- a diversity of agreements, from negotiated contracts to "good faith" verbal agreements; and
- diverse scopes of service within networks, including both services to the community and services to network members.

Additionally, the report provides

- a demonstration of the value of networks,
- a discussion of strengths and challenges in networks, and
- a description by network members of considerations in founding networks.

Networks were selected for these case studies on the basis of diversity of collaborations, networking mechanisms and strategies, network agreements, and demonstrated effectiveness of networking. Networks were selected from across the country reflecting urban, suburban, and rural communities. Some selected networks had diverse populations, and others had targeted populations; some selected networks were composed of just a few agencies, and others were composed of many agencies.

The motivation for this report came from issues of workforce development in addictions systems. There have been numerous reports in recent years describing the workforce crisis in the field of addictions. The question has been raised, "What role can and do networks play in addressing workforce development?" At the time of network formation, workforce development ranked as a secondary issue for most of the networks surveyed. The two primary motivations for forming networks came from (1) very real concerns about the financial survival of community programs associated with sweeping changes in States such as the introduction of managed care and (2) a sincere commitment by providers and community leaders to build or strengthen capacity and build the workforce to provide quality services, including building capacity to provide recovery support services. As networks came together and became fully functioning, issues of workforce development came to play a more prominent role.

PROJECT APPROACH AND METHODOLOGY

Identification and Selection of Provider Networks

The State Associations of Addiction Services (SAAS) initially asked its member State provider associations to identify and submit names of potential networks for this report. Networks were loosely defined as collaborations between providers for the purpose of improving access to specialized services, expanding services, coordinating care, treating people with co-occurring mental or physical disorders, sharing staff, sharing information technology, sharing other administrative and management functions, co-locating staff or programs, achieving economies of scale, or enhancing revenue. These networks or collaborations could range from informal associations to highly organized and structured entities.

Nine criteria for the final selection of case studies were developed:

1. The network must consist of at least two separate cooperating agencies.
2. The network must have been operational for a period of time.
3. The network should assist in responding to workforce challenges.
4. At least one network member needs to be an organization whose primary function is providing addictions treatment.
5. At least one network must include member organizations that provides non-addictions-related services, such as housing and homeless, primary care, mental health, educational, vocational, or employment services.
6. At least one network should consist of only two agencies.
7. At least one network should be a large, formalized network that is separately incorporated or is based on memoranda of agreement that commit members to significant levels of collaboration, service coordination, and staff and/or resource sharing.
8. At least one network should serve minority or underserved populations (e.g., Native Americans, African-Americans, or homeless persons).
9. The selected networks should, to the extent feasible, be distributed geographically across the country.

The response to this initial request to the State provider associations identified 54 networks of various sizes and configurations involving as few as 2 agencies to as many as 50 and more agencies. Services provided within the networks were highly

The network selection reflected various degrees and types of infrastructure and a wide range of network membership services.

diverse. At the level of direct service, networks providing a full continuum of care were represented, and within the continuum of care an array of services was provided by traditional and nontraditional providers. In other networks, effective collaboration resulted in the operation of a single treatment program. The network selection reflected various degrees and types of infrastructure and a wide range of network membership services. For purposes of this project the decision was made that all networks had to be in operation for at least 5 years; one of the selected networks had been in operation for more than 40 years. SAAS received approval to conduct the case studies after submitting a preliminary selection of proposed networks to Abt Associates and CSAT under the PFR initiative.

Development of Interview Protocol

The next task in this project was to develop a standardized protocol for information to be collected. This protocol enabled more consistent collection of information across sites and comparisons of how different networks addressed core issues, and it guided telephone interviews and prompted collection of print and other information when available. In addition, public domain financial reports on nonprofits (Internal Revenue Service [IRS] Form 990), available through GuideStar (www.guidestar.org), were reviewed for a number of organizations.

Initial interviews were conducted during 2007, and follow-up contacts were made during the spring and summer of 2008. Case studies were drafted based on the data collected. These case studies are primarily descriptive and illustrate network operations. This report aims to provide options and illustrate real-world possibilities for networks that can strengthen the addictions infrastructure. Founders and operators of these networks are viewed as pioneers who took chances, worked very hard, and created sustained entities that have added value to their communities and to the lives of the persons they serve.

An effort was made to create a degree of uniformity within the case studies to make it easier to compare features across networks. Each case study addresses the following content areas:

- Organizational History
- Mission, Values, and Vision
- Network Structure
- Membership
- Geographic Area
- Staffing
- Range of Services
- Collaborative Efforts
- Workforce Development
- Strengths of the Network
- Challenges of the Network
- Considerations in Forming a Network
- Looking to the Future

Nine Case Studies

Nine networks were chosen for case studies from nine different States. The networks are organized by State and shown below (see also the appendix for a summary of the networks, including Web site information when available):

- ***California—California Association of Addiction Recovery Resources (CAARR).*** CAARR is a large multiservice membership association providing training, technical assistance, legislative services, other membership services, and management oversight to several small nonprofit programs; hosting one of the State's counselor certification boards; and training and certifying "Sober Living Environments" (e.g., sober houses or recovery homes).

- ***Florida—Central Florida Behavioral Health Network (CFBHN).*** CFBHN is a management entity (Administrative Services Organization) operated by 19 mental health and substance use providers in nine counties in the Tampa Bay area and across central Florida managing and providing publicly funded behavioral health services to this region. Additionally, CFBHN coordinates county-based planning, training, and technical assistance to providers.

- ***Illinois—Project WIN (Wellness Initiative Network).*** Project WIN is a federally funded network of substance use and other service providers to address the needs of homeless adults with addiction and co-occurring disorders.

- ***Maine—Maine Juvenile Treatment Network (MJTN).*** MJTN is a network of providers supported through the Maine Office of Substance Abuse. This group of providers has developed unique sets of skills and evidence-based practices to treat the needs of adolescents with substance use disorders. The MJTN also serves as a statewide resource to support the screening and referral of youth into appropriate services.

- ***Massachusetts—Behavioral Health Services Network (BHSN).*** BHSN is a decentralized system of providers that includes private, not-for-profit agencies in the area providing supportive housing, substance use disorders treatment, and a range of community mental health services for persons with substance use and co-occurring disorders. The Somerville Mental Health Association serves as the lead agency for the network.

- ***Nebraska—Touchstone.*** Touchstone is an intensive residential treatment program serving adults with co-occurring disorders. The program was created and is operated by two collaborating agencies in Lincoln.

- ***New York—North Country Behavioral Healthcare Network (NCBHN).*** NCBHN, a rural behavioral health care network serving a large geographic region, provides an array of services for adults, adolescents, children, elderly people, and Native Americans. Through North Country Management Services (NCMS) the network also provides a wide range of training, technical assistance, management support, and legislative liaison to its member agencies.

- ***North Carolina—Guilford County Substance Abuse Coalition (GCSAC).*** GCSAC is a coalition of organizations providing prevention and treatment services for substance use and mental health disorders. Members of GCSAC represent various sectors of the community, including hospitals, physicians, schools, law enforcement, local government, community organizations, and faith-based organizations.

- ***Oregon—Oregon Treatment Network (OTN).*** OTN is a network of providers for the treatment of substance use and co-occurring disorders. The network, which serves central Oregon, is part of the National Institute on Drug Abuse Clinical Trials Network.

CASE STUDIES ON PROVIDER NETWORKS BY STATE

Case Study 1: California—California Association of Addiction Recovery Resources

Data Sources

- *Interview*: Susan Blacksher, Executive Director
- *Other sources*: printed materials, web-based materials, IRS Form 990 for 2006 and 2007

Organizational History

The California Association of Addiction Recovery Resources (CAARR), originally founded in 1972 as the California Association of Alcoholic Recovery Homes, is a 501(c)(3) membership organization with headquarters in Sacramento. CAARR was originally established as an association for recovery homes and has significantly expanded its size and scope of services since that time. Currently CAARR has over 150 member agencies, over 100 recovery homes, and a number of individual members; the association has an annual operating budget of approximately $1.5 million.

CAARR was originally established as an association for recovery homes and has significantly expanded its size and scope of services since that time.

Members of the association subscribe to a social model of alcohol and other drug (AOD) recovery (California Department of Alcohol and Drug Programs, 2007). CAARR is a professional membership association, which also contracts with agencies to provide administrative services. The following services are provided by CAARR:

- Membership services
- Managing the statewide certification process to become a Certified Alcoholism and Other Addiction Specialist. Currently over 6,000 people are certified or in the process of becoming certified.
- Conducting statewide training and workforce development programs, including a year-long counselor training institute preparing persons in recovery to become certified as addictions treatment professionals. There is a regular schedule of training and continuing education programs.
- Conducting regional conferences
- Making technical assistance available to AOD programs statewide at no cost through a contract with the California Department of Alcohol and Drug Programs. Assistance is in the areas of program startup, executive coaching, policies and procedures development, program certification,

program licensing, program design, board development, and fiscal management.

- Legislative monitoring and advocacy for AOD abuse programs and professionals
- Administrative management of recovery programs that lack sufficient business capacity to be self sustaining

CAARR is supported through a variety of grants and contracts that make up approximately 70 percent of the total revenue. The remaining income is based largely of member fees.

In 2000, CAARR expanded its scope of work beyond training, technical assistance, and advocacy to include administrative management of small recovery-oriented programs. This was originally done on a 1-year (trial) contract with a single small residential program on the verge of closure. CAARR now provides administrative management for four small programs, allowing these programs that would have otherwise closed to continue and prosper. It currently administers two of these programs while the other two are now successfully operating on their own.

Mission, Values, and Vision

The mission of CAARR is to encourage the development, expansion, and continuing quality of social model programs in California through advocacy, education, training, and positive role modeling.

The *social model* has been broadly described as a sociocultural model like Alcoholics Anonymous (AA). Those who subscribe to the social model believe that addiction is a multifaceted disease, one that is caused by a combination of factors: spiritual, biological, psychological, and social/environmental. Treatment and recovery are defined in relation to the person, community, and/or program, as compared to a traditional medical model that stresses the doctor-patient relationship. The model promotes the respect and dignity of the individual while also promoting personal and social responsibility. Recovery is characterized as something beyond thoughts, feelings, and behaviors and includes a change in lifestyle, which could include changes in the family, peers, and other groups. Community involvement in support of recovery is valued.

Network Structure

CAARR is an incorporated 501(c)(3) nonprofit membership organization with more than 300 active members. The organization is led by a full-time executive director and is governed by an elected board of directors. The board of directors is comprised of 15 individuals, with 3 alternates, representing CAARR's statewide membership. The board of directors elects officers for the board. All board and officer seats have term limits. The board of directors meets five times each year, and

a full membership meeting is held annually in March. Elections to the board of directors are held during the annual full membership meeting.

CAARR routinely assesses the needs of its members and, through its members, the perceived needs within the community. CAARR develops long-range strategic plans that are approved by the board and the membership.

Board Committees

The board maintains a number of standing and ad hoc committees in such areas as training and workforce development, legislative affairs, membership services, program standards, and counselor certification. There is also an executive committee.

Membership

The network is supported by three categories of membership: Program Members, Supportive Business Members, and Individual Members.

Program Members: Any California community-based, peer-group–oriented, alcoholism or alcoholism and drug recovery corporation, sole proprietor, or partnership is eligible to become a voting member. Dues for program membership are based on the program's annual budget. Program Members represent the full continuum of services from prevention to treatment and recovery support services.

Supportive Business Members: These are businesses that support Program Member organizations and their efforts but may not be actively involved in the delivery of client services. Supportive Business Members are not voting members.

Individual Members: All individuals who have an interest in social model programs, prevention, and recovery and wish to support CAARR and its mission can apply for membership.

Geographic Area

CAARR provides services statewide.

Staffing

CAARR is a funded and staffed organization with a full-time executive director, three other full-time employees, several part-time employees, a large cohort of paid consultants and trainers, and significant volunteer efforts from CAARR membership. The organization also retains the services of a registered lobbyist to monitor legislation and to support advocacy efforts on behalf of the organization.

Range of Services

Membership Services

- *Technical assistance and support.* Technical assistance can address a range of direct service and management needs and can include training, onsite consultation, meeting or process facilitation, and product development. Technical assistance is accessed through a simple written request process. Technical assistance recipients may assume a portion of the expenses for the service.
- *Advocacy.* The network retains the services of a registered lobbyist, who monitors legislation that could affect members and supports advocacy efforts for the network with the State legislature.
- *Discounts on insurance programs and other resources.* Through group-purchasing capacity, the network offers discounts to members on a range of insurance products and other goods, materials, and services.
- *Discounts on training and education.* Members are given discounts on CAARR-sponsored training events.
- *Formal and informal communication.* CAARR publishes an association newsletter and actively uses electronic systems to disseminate information to members. CAARR also maintains a membership bulletin board for announcements and job vacancies. The association supports and facilitates ongoing informal communication and networking among members at all levels of the organization.

Administrative Management

CAARR provides administrative management for a number of smaller programs. Under a written management agreement with CAARR, CAARR staff provide administrative and programmatic oversight, including fiduciary management, for these programs. These programs maintain their separate corporate status with active governing boards and benefit from reduced overhead expenses and some economies of scale due to being managed by a larger entity.

Initially, there were concerns regarding potential conflicts of interest from within CAARR due to having a membership association provide oversight of a program (even contractually). It was described as an important process for the board to openly discuss and debate this action in depth before the board of CAARR ultimately voted in favor. CAARR providing administrative services was ultimately viewed as a way for some smaller entities to continue operation with a degree of autonomy, preserving the culture of the organization.

Profitability is difficult to achieve and maintain in small freestanding residential programs operating without additional sources of funding and support. A fee-for-

service payment system, which has become standard for behavioral health reform across the country, is usually not able to cover all costs that an agency incurs in the operation of a successful program. Access to other sources of funding has become necessary for program survival.

Consolidation of services and functions enhances financial viability of these small programs. For example, something as simple as bulk buying for groceries for combined agencies lowers costs to each agency. Other and more significant cost-savings measures include having one functional executive director serving all agencies, one finance director to perform fiscal operations, and shared clinical supervision. These savings are reinvested into the programs through enhanced direct service staffing and program activities. The CAARR executive director is proactive in "joining" the staffs by being routinely accessible and by attending staff and case conference meetings at the programs. CAARR also supports a number of team-building activities, including a level of transparency in decisionmaking and seeking active staff participation in planning and decisionmaking.

CAARR has made a commitment to professional growth and development of staff members working in these programs. All staff members are allowed to attend training (at no charge to the staff member) in support of staff member efforts to become certified. When staff members are ready to become certified, CAARR pays the fees for certification. For certified workers, continuing education is available at no charge.

Beyond expected business functions, as part of the administrative management activities CAARR works with organizations to develop enhanced organizational practices to make the programs more successful within the current marketplace. Strategies to reduce waiting lists and to fill empty beds more quickly are used to enhance cash flow. Planning efforts are undertaken to diversify funding streams. CAARR, working with the agencies, has been successful in obtaining additional contracts to support program operations.

This model of contracted management is described as being successful, in part, because special attention has been given to making sure the staff and boards of each of these small agencies remains actively involved in decisionmaking. All major decisions are subject to board discussion and, when necessary, approval. The success of these efforts has resulted in saving programs that without intervention would have closed and has increased the stature of CAARR in the State.

Technical Assistance

CAARR has a contract from the Single State Authority to provide consultation and technical assistance to nonprofit, community-based providers of substance use disorders services. Management and program consultation is available for existing programs and to build capacity for startup ventures.

Technical assistance is available to the provider community in the following areas:

- program startup, including needs assessment, feasibility, plans for capacity building and community mobilization;
- executive coaching;
- development of policies and procedures;
- program certification;
- program licensing;
- program design;
- development of programs and services for special populations;
- funding and development;
- boards of directors development; and
- fiscal management.

A smaller and more specific consultation contract managed by CAARR is for "peer review" services. Peer review activities are required on an annual basis by the Federal block grants for substance use programs receiving block grant dollars. CAARR recruits, trains, and coordinates the efforts of peer reviewers.

CAARR provides specific technical assistance and training under the California Disability Access Project to increase opportunities for, as well as the abilities of, people with physical, sensory, and cognitive disabilities to address their AOD-related problems by

- reducing attitudinal, architectural, programmatic, communication, and fiscal barriers to accessing appropriate treatment and recovery services for people with disabilities;
- enhancing the cultural and linguistic appropriateness of AOD treatment and recovery program services for people with disabilities;
- improving the quality, quantity, and outcomes of these services; and
- providing training and/or technical assistance to the State and local AOD agencies and disability agencies statewide.

Technical assistance services include program and policy development, disability awareness and sensitivity training, introduction to AOD for disability agencies, clinical approach/treatment protocol development for persons with disabilities, architectural surveys, resource development, community forums, and telephone consultation when appropriate. The Disability Access technical assistance project

serves AOD prevention, treatment, and recovery service providers and organizations, as well as allied disability service providers statewide.

CAARR has distinguished itself in several highly innovative collaborative efforts.

Collaborative Efforts

CAARR has distinguished itself in several highly innovative collaborative efforts. CAARR provides contracted administrative services for a number of small programs, including administrative oversight, clinical supervision, and fiscal management, while allowing these programs to remain programmatically distinct. This collaborative effort helps to reduce operating costs and enables these programs to continue to survive.

CAARR hosts a substance use counselor certification board, which also helps to reduce operating costs. Co-locating the board onsite with one of the major State training contractors seems to provide a level of positive synergy for both training and certification.

CAARR provides training, support, standards, and a collective voice for "Sober Living Environments" (SLEs), entities that in other parts of the country are called sober houses, recovery homes, or Oxford Houses. In other parts of the country these sober programs operate with little or no support, programmatic standards, or oversight.

Workforce Development

CAARR operates a number of major training and workforce development programs. Costs for these programs are substantially covered by State contracts, so training can be offered at little or no charge or are supported by individual tuition. These programs are described below.

CAARR Institute

The CAARR Institute, which is fully self-supported was created in 1978 to offer an alternative form of education for recovering people working in the AOD field. Many had found recovery through participation in AOD programs and then chose to work in programs providing peer leadership and experience. It was found that although these individuals might understand the process of recovery that worked for them, they might lack the technical skills and knowledge necessary to be effective serving others. These adult learners in early sobriety were often hesitant to return to a traditional classroom setting. The institute was established and designed to be offered in easily accessible locations, in a setting and approach that was more conducive to an adult learner audience. Instructors recruited to teach the curriculum also came with significant field experience and could share real-life experiences with their students. Today the institute curriculum is based on SAMHSA's TAP 21 "Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice" (CSAT, 2006). The CAARR Institute recruits and trains

approximately 850 trainees annually; the trainees participate in a 46-part (270-hour) series that helps to prepare them to work as entry-level substance abuse counselors and to become certified as addiction professionals. This program is conducted in both Spanish and English.

CAARR Training Programs

CAARR has State contracts to provide an array of substance use disorders training programs. These courses are approved for continuing education credits and are provided at no cost to participants.

Continuing Education Courses

CAARR offers a range of continuing education courses statewide, under contract with the Single State Authority. They conduct 300 days of training annually.

CAARR operates a number of major training and workforce development programs.

Intensive Management Training

Intensive Management Training is an advanced curriculum taught by experienced program managers. It includes modules that address the basic principles of management as well as areas of management unique to AOD programs.

CAARR II, Advanced Alcohol and Drug Studies

This advanced practice training series addresses acquisition of advanced clinical skills and also addresses co-occurring health and mental health issues in addictions treatment.

CAARR International

At the request of recovery providers in neighboring Mexico, the CAARR training programs were translated, and bilingual CAARR training staff traveled to Mexico to initially provide instruction at the CAARR Instituto de Mexico to students and then complete a training of trainers. This training program is now self-sustaining and operated by recovery professionals in that country. A similar program was developed for representatives from Korea. Classes are conducted using the CAARR Institute materials in both Korea and Los Angeles.

CAARR Sober Living Institute

This training program targets the unique set of needs of persons or groups seeking to set up or operate an SLE (recovery home, sober house, Oxford House). The program defines an SLE and provides information on program siting, zoning laws, landlord/tenant laws, business types, business practices, recommended house policies and practices, good neighbor policies, and ethics, in addition to other content unique to AOD programs.

Special Training Initiatives

CAARR routinely receives discretionary contracts for specific training initiatives. Currently, "Trauma Informed Care" is being integrated into residential programs. In recent years, these initiatives have also included training and supporting providers adopting evidence-based practices.

Counselor Certification

CAARR hosts and supports one of the State counselor certification boards. The board is an independent entity. Hosting the certification board through the association helps to greatly reduce costs for counselor certification. With 6,000 persons currently certified through this board, the cost savings are many thousands of dollars annually to counselors and providers.

Outreach and Recruitment of Targeted Counselors

As part of a commitment to recruit, train, and support a more diverse workforce, CAARR has developed local resources and scholarships to provide counselor training and mentor African-Americans and persons who are deaf or hard of hearing. Each year funding is provided for 12 African American trainees and 7 deaf trainees.

Sober Living Environments

SLEs, sometimes called recovery houses, sober houses, or Oxford Houses, began in the mid-1970s and operate in nearly all States. In California, they are not subject to any licensing or oversight by the State. Many of the persons operating these houses are persons with strong ties to the 12-step recovery community. Concern for the care and safety of vulnerable persons in early recovery coupled with reports of abuses and misconduct in some of these programs has led organizations such as CAARR to create voluntary processes for an SLE to become registered with the association and agree to a set of standards and to make available training and support to SLE operators.

In 1993, CAARR developed minimum standards for SLEs based on input from community program providers and consumers. Standards were viewed as the first step in asking this emerging industry to regulate itself. The second step was to develop a process whereby programs can be recognized by their peers for establishing and meeting minimum standards and agreeing to abide by those basic standards.

CAARR has established a registration process for homes meeting the Sober Living Standards. In this process, a facility states that it meets the standards and declares that it will continue to abide by the standards. The process includes annual visits by peers from other SLEs, who review them to assure that the standards are maintained. SLEs are listed on the Member Homes Section of CAARR.

Strengths of the Network

- This organization began over 30 years ago as a membership association for residential recovery programs, and, while it has grown dramatically in size and scope to more than 300 members today, it remains faithful to its founding principles.
- The association supports multiple opportunities for general members and the governance board to discuss and decide on the future and direction of the organization. This includes allowing opportunities for board members to actively discuss and come to agreement on, at times, controversial issues.
- The association created categories of membership whereby affiliate or complementary organizations and individuals who were not necessarily recovery service providers were allowed to become CAARR members.
- The association provides a wide range of membership services, including technical assistance and support, legislative advocacy, group purchasing with resulting discounts on insurance programs and other goods and services, discounts on training and education, and support for formal and informal communication among members.
- The association is strategically positioned as an entity that is part of a vital infrastructure supporting the operations of community-based providers through the dissemination of information, monitoring state legislative processes affecting the industry, delivering training and technical assistance, recruiting and training entry-level workers, and credentialing part of the workforce.
- The association has diversified its scope of services and its funding base.
- The association operates multiple innovative training and workforce development programs, including a training institute for persons in recovery seeking to work in the field of addictions, large-scale statewide continuing education programs, programs that support the adoption of evidence-based treatment practices, programs that support a Spanish-speaking workforce, programs that provide addictions recovery support services for persons who experience a range of physical and cognitive disabilities, and programs for supervisory and management training.
- The association hosts one of the State-recognized counselor certification boards. Through hosting the board, costs for certification are kept lower and savings are passed on to individuals and agencies.
- CAARR has taken a proactive approach to the proliferation of SLEs in California and in 1993 developed the first set of voluntary standards for SLEs. The association developed a voluntary registration process for SLEs whereby participating entities agreed to certain sets of standards.

The association is strategically positioned as an entity that is part of a vital infrastructure supporting the operations of community-based providers through the dissemination of information, monitoring state legislative processes affecting the industry, delivering training and technical assistance, recruiting and training entry-level workers, and credentialing part of the workforce.

- CAARR expanded administrative management capacity by assuming the administrative operations for four small programs. Through this effort they have been able to sustain these programs in the community, allowing them to maintain their separate programmatic identity while sharing management, thus reducing administrative, fiscal, and supervisory expenses and benefiting from economies of scale in purchasing. CAARR has also provided technical assistance for these programs to enhance practices and to diversify funding.

Challenges of the Network

- The single greatest challenge confronting the association relates to the financial crisis in the State of California. A number of the association contracts were reduced mid–contract year, resulting in fewer services to members.
- The association must navigate a number of highly complex matters where issues of "dual relationship" need to be carefully worked through. For example, the association assumed management of four small programs, supported the certification board, and took a proactive stance regarding standards for the SLEs and registration of SLEs.
- Careful succession planning is required to develop and replace successful managers and leaders.
- There are significant challenges associated with "Proposition 5" (California's Nonviolent Offender Rehabilitation Act) and other nonviolent drug use offender legislation that involve serving a greatly expanded criminal justice systems (CJ) client population. At the client service level, often these clients present with higher levels of antisocial and "criminogenic" personality and behavioral features, requiring modifications to program operations and causing real concern about blending more hardened prison populations with nonprison populations. Further complicating the issue is that CJ clients are incentivized for admissions through being reimbursed at a higher per diem rate than community referrals; thus, the CJ clients will be admitted over the community referrals. The treatment gap for non-CJ clients appears to be widening. Inherent in this dilemma is a problem with systems capacity, particularly at the residential level. There is a shortage of residential service capacity perpetuated by the higher costs of opening and operating these programs and community opposition to residential programs, particularly those programs serving those with addictions and criminals.

Considerations in Forming a Network

The leadership was asked to describe what they viewed as important considerations in forming a network. They identified the following considerations:

- The organizations involved must be committed and solidly behind the mission and the implementation model for the program.
- It is important that the association have a mechanism that supports open and productive communication of these concerns. Issues that involve potential conflict of interest usually occur; if a program is going to provide a more complex array of services, then these issues must have a forum for discussion and consideration.

Measuring the success of an organization is based ultimately on how well it serves the needs of its membership and how well it responds to the needs of the community.

Looking to the Future

Initiatives on the horizon for the association include building on membership capacity to serve more diverse populations, including persons with co-occurring disorders; supporting providers in adopting evidence-based practices; and assisting Supportive Living Environment's initiatives to support women in treatment.

Case Study 2: Florida—Central Florida Behavioral Health Network

Data Sources

- *Interview*: Richard Brown, CEO, Agency for Community Treatment (ACTS), Tampa; Chair, Regional Council for Hillsborough County
- *Interview:* Linda McKinnon, CEO, Central Florida Behavioral Health Network
- *Interview*: Robert Rihn, President, Central Florida Behavioral Health Network and CEO of Tri-County Human Services, Lakeland
- *Interview*: Lucia Maxwell, Management Consultant
- *Other sources*: organizational documents and Web-based materials

Organizational History

The Central Florida Behavioral Health Network (CFBHN) is a not-for-profit 501(c)(3) community services network incorporated in 1997 initially as a collaboration of substance use providers. Today CFBHN is a management entity for 19 mental health and substance use providers in nine counties in the Tampa Bay area and across central Florida. Starting in 2005, an additional 275 faith- and community-based providers were funded through a Federal Access to Recovery (ATR) grant. Although the ATR grant was not renewed in the State of Florida beyond 2007, the impact of the grant is noteworthy for the organization's history and current development. In 2006, CFBHN and the Polk County Health Plan entered into a contract for the provision of behavioral services. The following counties are currently served by the network: Pinellas, Pasco, Hillsborough, Manatee, Sarasota and De Soto Counties, Polk, Highlands and Hardee.

Today CFBHN is a management entity for 19 mental health and substance use providers in nine counties in the Tampa Bay area and across central Florida.

Through the organization's members and other contracted entities, mental health and substance use disorders programs are provided for low-income and other populations determined to be at high risk of substance use and co-occurring disorders in central Florida. This network is best described as an Administrative Services Organization (ASO). The board of directors is composed of representatives of provider organizations and selected community members.

An ASO is defined as a contractual arrangement under which an independent organization handles the administration of claims, benefits, and other functions for an insured group or on behalf of a public entity, such as a State Medicaid program. While an ASO manages some levels of risk conducting business within a fixed administrative cost structure, it usually does not assume any medical risk of its own. Rather, the insured group or public entity assumes ultimate medical and financial risk for the covered population. Beyond this basic core definition, ASOs can take on a variety of forms and functions and perform a broad array of administrative and management

This network is best described as an Administrative Services Organization (ASO).

services. Administrative functions often include planning; human resources management; provider enrollment; regulatory compliance; information systems; contract management; provider and member services; claims administration; and data reporting. An ASO might also conduct utilization management and prospective review or authorization for care services. In addition, it may provide retrospective review and case management and develop clinical guidelines and credentialing services. An ASO may perform other functions beyond those of traditional managed care, such as staffing, training, quality improvement initiatives, and other activities to support the workforce and community wellness and prevention services (National Health Law Program, 2006).

Through its network of providers, a full array of treatment, early intervention, prevention, and recovery support services are provided, spanning all levels of care.

CFBHN is the lead organization in this region for contracting and purchasing of publicly funded mental health and substance use services, regional planning, cross-systems collaboration, care integration, and systems improvements and innovations. The network manages the distribution of State and Federal funds for treatment and prevention of mental health and substance use disorders in its targeted region. Overall, more than 35,000 adults and children receive treatment services each year through the network, and 77,000 youth and adults benefit from prevention services. Through its network of providers, a full array of treatment, early intervention, prevention, and recovery support services are provided, spanning all levels of care.

Mission, Values, and Vision

The goal of CFBHN is to provide well-managed and integrated behavioral health service delivery systems that increase access to care, improve continuity of care to vulnerable populations, prevent duplication of effort, reward efficiencies, and encourage exemplary practices within their regional geographic areas. This goal is to be accomplished through the network's guiding principles:

- To create a model for behavioral health and human service needs that embraces managed care concepts and is community based and client driven
- To be recognized as the community leader in providing behavioral health and other human services in the field
- To determine and promote best practices in services at the State and community levels
- To provide services for persons with mental health, addictions, and co-occurring disorders
- To maximize network capabilities through agency operability, emphasizing sharing of expertise in all administrative, clinical, automation, and management functions

Network Structure

Legal Structure

CFBHN is an incorporated 501(c)(3) nonprofit membership organization; currently it has 19 active member agencies and 5 community representatives. The member agencies span a nine-county geographic region covering approximately one-fourth of the State. The network is divided into four regions, each with its own elected regional chair and advisory committees. The regional councils are staffed by network staff, board members, and community stakeholders. These councils, which are permanent committees of CFBHN, meet monthly to plan for their areas, provide oversight into how providers are utilizing funds, look at outcomes, study different areas of service design that need further development, and recommend fund allocations.

Board members are elected and nominations are put forward to the network by a nominating process the board has developed. The bylaws require that member agency representatives account for 80 percent of the board's membership. The board also has five public or community members through various community stakeholders than can include consumers. These five members are chosen by the board, which seeks to broaden its scope with these choices and also looks at maintaining good geographic distribution within the total area of CFBHN. Public funders require that public members or consumers serve on boards in order to receive grants. The public members in the past have included

- a local minister;
- a professor of business from a local university;
- a local president of a NAMI (National Alliance on Mental Illness) chapter;
- a professor of anthropology (who served on a substance abuse and mental health planning council and has a lengthy history with, and knowledge of, the service delivery system); and
- a former administrator from the State Juvenile Justice System.

The CFBHN board has an internally elected executive committee, which meets monthly. The full board meets at least six times per year. CFBHN has an active committee structure that includes an executive committee, a finance committee, a management information systems committee, a quality improvement committee, and it has member services, and the four regional councils. The network also has multiple ad hoc committees that are driven by current or emerging needs (e.g., co-occurring disorders, children's services).

The network also plays an active role in training and workforce development within the region, as discussed in a later section.

CFBHN's administrative office in Tampa maintains departments for program development, quality management, contracting, finance and accounting, billing, management information systems, purchasing and resource management functions, human resources, and provider services.

Regional Councils

The regional councils have expanded in scope over time and are now used for a number of different tasks. Meeting monthly, they provide oversight into how the providers are using their funds, monitor different areas of service design that need to occur, and provide assistance to agencies developing a business plan. The councils have played a central role in monitoring, planning, and recommending resource allocations. This has been accomplished by using performance measurements and benchmarking, assessing agency capacity to deliver services, and fully utilizing funds and ensuring contract compliance. Each regional council reviews all provider performance in their region on a monthly basis and has the capacity to recommend fund re-allocation. These recommended changes in fund allocation must be ratified by CFBHN's full board. Any re-allocation in excess of $50,000 requires the approval of the State contract office. Allocations less than $50,000 can be made internally within the network. In general, services to be covered are funded according to priorities established by the regional council planning, the State's gap analysis process, and the State plan for substance use and mental health services. Any new funding that becomes available to CFBHN is allocated to each county based on an agreed-upon equity formula unless it has been earmarked for a target population. Lastly, if no current network member can provide a specific service, the council can make and approve recommendations for new service providers.

CFBHN seeks to be inclusive outside its membership. Stakeholders and providers in the area who are not members are invited to participate in regional councils, quality improvement committees, and other meetings if there are agenda items of interest to those nonmembers.

Membership

There are currently 19 organizational members in the network representing a full range of addiction prevention, treatment, and recovery services and mental health/psychiatric services. To be a full network member, the organization must be a 501(c)(3) nonprofit holding contracts and necessary licenses with the State substance use and mental health program office, be an eligible Medicaid provider, have national accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (now the Joint Commission), and demonstrate financial stability and a commitment to the core principles and values of the network. Members enter into a contractual agreement joining CFBHN and agree to pay (nominal) annual dues as members. Other community providers participate in the network as contracted providers.

Geographic Area

The counties currently served by the network are Pinellas, Pasco, Hillsborough, Manatee, Sarasota and De Soto Counties, Polk, Highlands and Hardee.

Staffing

Currently, there are 22 full-time employees; consultants are hired as needed.

Range of Services

- *Provider network management.* This includes defining continuum of care and service array within the continuum; determining the types, number, and qualifications of providers based on community needs; selecting providers; credentialing; communication with providers; and training and technical assistance to providers.
- *Strategic planning for CFBHN.* This includes review of service data, utilization data, access, outcomes, and satisfaction; needs assessment; gap analysis and provider input; setting measurable goals and objectives; and developing action plans and plans to monitor and evaluate.
- *Regional planning.* This planning is conducted through the regional councils and communicated to the full board.
- *Quality improvement / quality management.* The utilization management process includes definition of which services require prior approval, definition of "medical necessity," monitoring use of least restrictive levels of care, reviewing continued medical necessity, setting continued care criteria, and conducting retrospective review.
- *Utilization management.* The utilization management process defines which services require prior approval, definitions of "medical necessity," monitoring use of least restrictive levels of care, review of continued medical necessity, continued care criteria and retrospective reviews.
- *Financial management.* This includes regulatory compliance, proper accounting safeguards, analysis of clinical utilization and cost data, rate setting, claims processing, member services, and quality improvement activities and reporting.
- *Information management.* This includes client tracking, admissions, authorization, continued stay, integration of assessment and service planning data, supporting "seamless" transitions across levels of care, claims management, aggregate reporting, and outcomes and utilization analysis.
- *Provider services.* These services include business management technical assistance, clinical practice development (adoption of evidence-based practices), training, and education.

Because this administrative service entity is primarily organized around efficient service delivery and not as a profit center, the cost of managing public dollars is greatly reduced.

Collaborative Efforts

Through this collaborative entity regional service providers have come together to assume expanded responsibilities for community needs assessment, service planning, fund management, service delivery, and monitoring of outcomes for services to clients within their region. Access to services has been improved and coordination of efforts across programs has been enhanced through this collaboration. Because this administrative service entity is primarily organized around efficient service delivery and not as a profit center, the cost of managing public dollars is greatly reduced.

Workforce Development

CFBHN conducts a number of workforce development initiatives.

Quality Improvement / Evidence-Based Practices

The network, through its quality improvement processes, has made a commitment to supporting the adoption of evidence-based practices within the provider system. In recent years, this has included all CFBHN members that have co-occurring disorders capability with a strong emphasis on "systems of care" development and recovery-oriented systems. Systems of care is an approach to services that recognizes the importance of family, school, and community and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural, and social needs (http://www.systemsofcare.samhsa.gov/). Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems (CSAT, 2005).

Clinical Supervision

The role of clinical supervision in providing quality care and staff growth and development has been well recognized, but it has suffered significantly within the highly managed fee-for-service environment of most systems. CFBHN, through advocacy, has been successful in obtaining reimbursement for clinical supervision.

Training

CFBHN has received the appropriate designation required to offer Continuing Education Units for licensed clinicians. The network is able to share training opportunities across the system, resulting in savings to providers, shared knowledge, and collegial networking and support among practitioners. The network has also developed some online course capacity.

Increased Negotiating Power

The advocacy of the network has allowed CFBHN to obtain reimbursement rates for substance use disorders services moving toward parity with mental health services rate structures.

Sharing of Staff

CFBHN has facilitated staff sharing and co-location. Staff from different provider agencies have been co-located to provide services with other agency programs. Agencies have come together to share a physician staff position, which helps cut costs at each agency. Two agencies also shared a bond issue and purchased a building together.

Technical Assistance

CFBHN has provided significant assistance in working with agencies to develop information technology (IT) systems and provide assistance to new member management staff that were unfamiliar with management and responsibility for public mental health and substance use disorders funds managed through the network.

Administrative Process

CFBHN has been the recipient of a NIATx STAR-SI (Strengthening Treatment Access and Retention-State Implementation) grant for treatment improvement. This is an infrastructure cooperative agreement program that promotes systems-level implementation of process improvement methods to improve access to and retention in treatment (https://www.niatx.net). In the first year of that grant, two of the network's providers participated; they have now become mentors/leaders for other providers in the network that choose to participate. Not only was the NIATx model used for treatment improvement with providers, but CFBHN was able to use NIATx principles to improve internal administrative process for their staff.

Strengths of the Network

- The 19 member agencies are all committed to the success of the network and to changing the way behavioral health care is planned, administered, and implemented, consistent with a data-driven and consumer-focused planning process.
- The administrative costs for operating the network are low—approximately 5 percent in fiscal year (FY) 2007. This rate is dramatically lower than administrative costs commonly associated with managed care organizations (MCO).
- As the management entity for multiple streams of funding, the organization has the unique capability to braid and blend public dollars in order to create unique service arrays for persons served. It also helps to reduce overhead and unnecessary duplication.

The 19 member agencies are all committed to the success of the network and to changing the way behavioral health care is planned, administered, and implemented, consistent with a data-driven and consumer-focused planning process.

- There is a commitment to operationalizing systems of care and recovery-oriented systems of care principles and values within the network.
- The network maintains a high-quality professional staff.
- Network staff demonstrate a high level of membership service (customer service).
- The network has the capacity to facilitate collaborative ventures among members.
- The network provides multiple venues for members and the community to provide formal and informal input into needs assessment and planning processes. The regional councils are inclusive of community stakeholders.
- The network has developed a highly sophisticated management information system.
- The network has achieved the highest levels of outcomes in the State. They have served more people than anywhere else in the State, with the highest outcomes for treatment success, and they have lowered wait list times.
- The network has developed sufficient infrastructure and capacity to compete successfully with any managed care or health maintenance organization in the State and at a much lower operating cost.
- The network has improved continuity of care.
- The network allows economies of scale that result in lowered administrative costs and maximization of resources to serve clients.
- The network administers Federal and State funds through a provider-operated system rather than a government entity or a traditional MCO. This demonstrates to State government and to private funders that a private, not-for-profit entity of provider-sponsored networks can offer a standard method of administering services to those with substance use and mental health disorders.
- The network hosts providers across the continuum of behavioral health care and primary health care. These providers include primary care hospitals, health centers, mental health facilities, and substance use disorders facilities (including both inpatient and outpatient); prevention agencies; and agencies with an emphasis on domestic violence and criminal justice services.

This network has created a platform for representatives from multiple agencies to sit together at both the regional planning council level and at the full network board level; this greatly benefits clients by enhancing coordination of services and reducing service silos. It is known from both experience and the data that in many cases these clients use the services of more than one member agency.

Challenges of the Network

- The high level of oversight and reporting to funders is a challenge. This has resulted in what has been describes as "meticulous" financial monitoring and safeguards that are labor intensive.
- The initial network had been greeted with a degree of caution as public dollars were distributed through a network to providers who control the actions and direction of the network. The performance of the organization over the past decade has reduced much of this caution.
- A major obstacle to beginning a network is the lack of a sophisticated IT infrastructure. Lack of an IT system severely limits the amount and types of data on clients, funding streams, and other information necessary for operating a successful program.

Considerations in Forming a Network

The leadership of CFBHN was asked to describe what they viewed as important considerations in forming a network. They identified the following considerations:

- Developing successful IT systems is a necessary capital expense.
- Regularly assess needs of your members and of the communities you serve.
- Commit to quality improvement processes.
- Clearly define your vision for the organization based on a commitment of services to the community.

Looking to the Future

Despite the loss of ATR funds to the State of Florida, there have been important lessons learned by the network that efforts are being made to sustain. These include the use of a Web-based voucher system where consumers of service exercise greater control over location of services, use of nontraditional recovery support providers, and use of recovery coaches. Preliminary data showed that the use of recovery coaches was highly instrumental in reducing or eliminating the need for longer term residential care in a number of cases. The network is in discussion with the University of South Florida to participate in a research study project to look in depth at some of these outcomes.

Recent changes in the State will result in the opportunity for Community Mental Health Services Block Grant (MHBG) funds to be managed through an ASO or MCO. The network is preparing for the opportunity to compete for these funds in their service region. The management entity structure developed by CFBHN is becoming the model for the State.

Project WIN is a multiagency, multiservice collaboration to provide coordinated care in the areas of mental health, medical health, and substance use treatment and housing to homeless adults

Case Study 3: Illinois—Project WIN

Data Sources

- *Interview*: Terry Johnson, Vice President and Chief Clinical Officer, South Suburban Council on Alcoholism and Substance Abuse, Chicago
- *Other sources*: organizational documents and Web-based materials

Organizational History

Project WIN (Wellness Initiative Network) was created as the result of grant funds provided by the U.S. Department of Housing and Urban Development (HUD) to the Cook County Department of Public Health (CCDPH) of Illinois. The Federal funding was to support the provision of a wide array of services to a targeted population of homeless adults in the southern and western part of the metropolitan Chicago / Cook County area. Project WIN became the collaborative work of eight agencies in the metropolitan Chicago area. CCDPH functions as the lead (and fiduciary) agent for Project WIN, and the participating agencies operate within the program through written partnership agreements. CCDPH provides most of the staff and administrative functions, receives all the funds, channels those funds in accordance with the agreements to the various agencies supplying services, receives all the reports from those agencies, and reports to HUD. Overall, the agencies see more than 400 homeless persons annually through Project WIN.

Project WIN is a multiagency, multiservice collaboration to provide coordinated care in the areas of mental health, medical health, and substance use treatment and housing to homeless adults. To engage homeless persons in these critical services, a team of clinicians provides active outreach and onsite services to clients. The network provides an expanded and coordinated array of services for a target population.

Mission, Values, and Vision

Project WIN is designed to overcome the geographic and bureaucratic obstacles that perpetuate a debilitating cycle of homelessness experienced by individuals who are undomiciled and suffering from a mental illness, an addiction, and/or a chronic medical condition.

Network Structure

Project WIN functions through partnership agreements approved by HUD; all participating organizations are freestanding, nonprofit, community-based organizations. Although there is no official "board" of the network, there is a formalized structure to monitor and assure that the work of the network continues according to the approved statement of work. Each participating organization contracts to provide a certain array of services as specified in their agreement.

Three standing committees have been established to assist the network in its operations:

- *Executive Committee / Quality Assurance.* This committee meets quarterly and interprets grant deliverables, provides oversight for progress on the grant goals and objectives that are reported to HUD, and oversees operations and fiscal requirements.
- *Supervisor's Operations Committee.* This committee meets monthly to plan and execute the implementation and coordination of services.
- *Shelter Interdisciplinary Team.* This group consists primarily of staff from the four homeless shelters who meet to discuss case-specific issues of the shelters' programs.

These active working committees are essential to ongoing success in the network. They involve key personnel from the various agencies and foster a sense of ownership of the process for all the partners.

All network partners participate in active data collection to track outcomes. Data collection is completed through a Homeless Management Information System supported by HUD. Each of the partners has identified measurable goals to meet within the agreement and data to collect. Beyond the requirements of the grant, these data provide valuable information on the clients, including

- an accurate, unduplicated count of homeless persons who seek services in the region;
- accurate demographic information of the region's homeless population;
- the frequency with which the services are requested;
- the services an individual is currently, or has previously, obtained;
- longitudinal tracking of services provided to an individual; and
- the service and housing patterns of clients within the continuum of care.

The following are core deliverables of the project:

- Seventy-five (75) percent of homeless persons who become engaged in behavioral health services (mental health and/or substance use) will be able to maintain their eligibility for emergency shelter.
- Twenty-five (25) percent of homeless persons enrolled in Project WIN will be linked to housing by the end of the grant period.

- Twenty-five (25) percent of homeless persons identified in the shelter as being eligible for Project WIN (persons with a medical condition, mental health issue, substance use disorder, and/or developmental disability) will engage in case management services.
- Fifty (50) percent of homeless persons enrolled in Project WIN will secure and/or increase their income through either employment or entitlement benefits.
- Forty-five (45) percent of homeless persons completing the Project WIN health assessment with an identified health concern will follow up with a referral to a primary care setting.

The four participating homeless shelters are the focal points for service delivery. Rather than having clients travel to clinics for services, service personnel travel to the shelters.

Eighty (80) percent of the funding for this partnership agreement is provided by the HUD agreement. This totals $1.1 million per year for each year of the agreement and covers the services listed in the project agreement. This is a service agreement; no capital expenditures are allowed. Specific dollar allocations are outlined in the individual partnership agreement. A 20 percent cash match is also required, so other funding streams must be secured and the cooperating agencies must put in funds of their own to meet the Federal requirement.

Membership

Seven nonprofit organizations and CCDPH constitute the network. In the past there were other members, but they no longer participate.

Geographic Area

The service region for this network includes southern and western neighborhoods of Chicago.

Staffing

Administrative staff for Project WIN are provided by CCDPH. Direct service staffs work for their employing agency and are assigned to provide particular services at the homeless shelters as part of their work duties. For example, South Suburban Council on Alcoholism and Substance Abuse provides one full-time addiction counselor to work onsite at the various homeless centers, providing addiction counseling and other services for those clients with an addictive disorder. That employee travels to the various locations.

Range of Services

Through Project WIN, a focused array of services addressing the needs of mentally ill, substance-abusing homeless adult, including persons with developmental disabilities, is made available.

- Shelter
- Care coordination
- Comprehensive assessment
- Mental health services, including onsite assessments, counseling services, psychiatric referrals, medication management, respite care, and crisis intervention services
- Addictions treatment and recovery services, including detoxification, inpatient treatment, halfway houses, and community-based outpatient services
- Primary health care services, including medical prescriptions, and coordinated health prevention services (e.g., flu shots, vaccinations), disease detection (e.g., HIV/AIDS testing, tuberculosis screenings), sexually transmitted disease (STD) testing, and prenatal services
- Entitlement and disability benefits assistance
- Emergency dental/oral services
- Eye exam and eyeglass referrals

Collaborative Efforts

Project WIN is a highly collaborative effort to bring together a more comprehensive service array to a targeted population. Collaboration helps to improve access and engagement in services, and as a result of collaboration economies of scale have been created. Collaborations for specific projects such as this are an economical way to fulfill the intent of these projects. Through collaboration, there is access to a wider array of services. This is beneficial not just to clients but to staff who come in contact with an interdisciplinary cadre of primary and behavioral health care professionals.

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Workforce Development

Workforce development efforts do not play a major role in this program other than the network serving as a convener of a broader team to serve a population of adults with multiple problems.

Strengths of the Network

- Project WIN is an engineered network where specific community agencies are brought together to provide an expanded service array for a targeted population and to reduce access barriers to these services.

- Roles of network members are clearly defined through written partnership agreements.
- Standing committees guide the operations of the network.
- Direct service staff go to the client and provide site-based services.
- Difficult-to-treat clients are better served; services are higher quality and are provided in a more coordinated fashion.

Challenges of the Network

- Establishing this network required matching funds by participants.
- Staff turnover at operational levels of providing services challenged service continuity.
- There were challenges setting measurable goals.
- The fiscal agent became the default leader.

Considerations in Forming a Network

The leadership of Project WIN was asked to describe what they viewed as important considerations in forming a network. They identified the following considerations:

- Know your partners.
- Build on collaboration and minimize competitiveness in membership.
- For this type of network, complementary members work best. Complementary members are defined as programs that offer a range of noncompeting and necessary services and supports that help to expand the array of supports to the person served.
- Access nontraditional sources of funding. For example, the Substance Abuse Prevention and Treatment (SAPT) Block Grant and Medicaid are more traditional payers of services. HUD is but one example of a source of funding that would not be seen as a traditional source of funding for substance use disorders.

Looking to the Future

Commitments, formal obligations, and partnership agreements between agencies led to successes and positive outcomes that should continue into the future.

Case Study 4: Maine—Maine Juvenile Treatment Network

Data Sources

- *Interview:* David Faulkner, Executive Director, Day One, Inc.
- *Interview*: Pam Marshall, Director of Prevention and Intervention, Day One, Inc., and Program Manager for the Maine Juvenile Treatment Network

Organizational History

The Maine Juvenile Treatment Network (MJTN), initiated in 1996, is a funded program that coordinates a statewide system to identify, screen, and refer adolescents with substance use issues to participating substance use treatment providers. MJTN is a supported and coordinated effort of the Maine Office of Substance Abuse, Single State Authority (SSA), the Maine Department of Corrections, the Maine Juvenile Drug Treatment Courts, local law enforcement, substance use and mental health treatment providers across the State, other community agencies, and the public schools. The network is operated and supported through a contract from the Maine Office of Substance Abuse to Day One, Inc., for approximately $350,000. Day One is a 501(c)(3) nonprofit, community-based prevention and treatment agency in Portland.

The Maine Juvenile Treatment Network (MJTN), initiated in 1996, is a funded program that coordinates a statewide system to identify, screen, and refer adolescents with substance use issues to participating substance use treatment providers.

MJTN is not incorporated as a 501(c)(3) entity. The network is a contract of Day One, which serves as the fiscal and managing agency. Day One strives to operate this program with neutrality, maintaining a focus on the overarching goals of improving access and coordinating assessment and referral for adolescents with substance use disorders.

As MJTN has grown and changed over the 12 years, it has increased in both number of providers and number of referral sources. From its beginning with relatively few providers, MJTN now has 54 member providers with multiple members in all regions of the State. In the early years, nearly 100 percent of the referrals were from the juvenile justice system. More recently, the number of referrals from schools across the State, parents, and other sources has increased. The network screens and refers approximately 1,000 youth annually.

The network is viewed as a highly valuable resource in the State because it provides a central place for screening and referral; proactively works to reduce barriers to service; assures that the providers possess the programmatic competencies that are needed to effectively serve an adolescent population; and participates in activities to build the capacities of the adolescent treatment system.

Mission, Values, and Vision

The network's goal is to expand the capacity of the State to effectively treat adolescents with substance use disorders and enhance this continuum of care for

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juveniles. In addition, MJTN offers support and facilitates collaboration statewide among the Department of Corrections, the Maine Office of Substance Abuse, community-based organizations, school personnel, and treatment providers.

MJTN facilitates regular communication, meetings, and training addressing a variety of issues, including case-specific problems/issues, best-practice approaches to treatment, communication and information sharing, identification of gaps in and barriers to treatment services, and other community issues.

MJTN uses the following global strategies to ensure success of this program:

- Identify youth who have a problem via network partners, including juvenile corrections officers; teachers, guidance counselors, or principals at local middle schools or high schools; local law enforcement; and parents.
- Provide a standardized screening/assessment tool (Juvenile Automated Substance Abuse Evaluation [JASAE]) to identify whether or not further service is needed.
- Maintain an extensive database of qualitative and quantitative data based on JASAE to inform decision making for service delivery and fund distribution.
- Refer youth to a local network substance use provider member.
- Ensure that providers maintain professional integrity of licensing and certification standards.
- Ensure that the provider offers a sliding fee scale for clients.
- Ensure that potential barriers for treatment are eliminated to the extent possible.
- Provide funds for treatment when a child does not have private insurance and does not qualify for Medicaid (i.e., be the "payer of last resort").
- Provide funds for transportation if needed.
- Provide incentives and benefits to become a member and part of the MJTN team.
- Provide opportunity for provider networking.
- Provide continuing education opportunities for members via conferences and workshops.
- Provide opportunities to give feedback on MJTN policies and procedures via an advisory group.
- Disseminate information to the community.

Network Structure

MJTN is a collaborative effort of member organizations and other interested agencies that provide screening, treatment, referral, and other services for substance-affected juveniles (under the age of 18) throughout the State of Maine. When the network was first implemented, very few agencies in Maine were providing services for adolescents. This funding to support network and capacity building was seen by the State agencies as a method to engage more agencies to provide treatment for substance-affected youth. Member agencies were encouraged and supported to participate in the network through positioning MJTN as the "payer of last resort" for adolescents and as a payer for services that would not customarily be paid for by traditional funding sources, including transportation and childcare. Currently 54 agencies are involved. Additionally, 50 high schools are engaged, along with juvenile corrections officers and other community service organizations.

Funding for Network

MJTN is primarily funded through a sustaining contract for $337,396 for services covering the entire State of Maine. Approximately 25 percent of the funds are allocated for treatment and complementary services. The bulk of funding is allocated to operating the statewide program. Additionally, the network has pursued other competitive funds to support its activities.

Network Governance

It is recognized that MJTN is a contract of Day One and operates within this organization's system and structures. As such the network does not have a formal and truly independent governing board. There is an Advisory Council to provide direction and guidance to the network and its staff. The Advisory Council is composed of representatives from the participating agencies. The direction and input of the council informs and shapes the actions of MJTN.

Membership

To become a participating member in MJTN, agencies complete an application. There is no fee to become a member. Agencies that join MJTN agree to adhere to and maintain certain requirements and certifications required under their membership agreement and contract with the SSA for alcohol and drugs. Agencies must

- be licensed by the SSA,
- be Medicaid eligible,
- provide outpatient and/or intensive outpatient substance use disorders services in one or more service locations, and
- adhere to network policies.

Further, direct service providers commit to the following activities and goals:

- participate in network-sponsored training events;
- attend a minimum of three network meetings in a year;
- incorporate into adolescent treatment programs use of evidence-based or best practices as defined by the network in collaboration with the SSA and supported by research;
- use network-developed protocols and forms for communication between MJTN, network member treatment providers, Department of Corrections, and community organizations;
- collaborate with other network members and participants to identify gaps in services and work cooperatively to fill those gaps;
- participate in a network screening and referral system designed to match client needs with provider strengths and capacity;
- participate in network development of policy, procedures, and training designed to implement network goals and support provider conformance with these goals; and
- complete in a timely manner required SSA admission and discharge forms with the appropriate network coding.

Geographic Area

This program offers services statewide.

Staffing

MJTN currently has one full-time and four part-time staff positions. Staff are primarily involved with screening and referral activities, providing network member services, and supporting network capacity building.

Range of Services

With membership and participation in the network, agencies receive the following benefits:

- *Funding.* MJTN is a payer of last resort for outpatient treatment services available for qualifying youth served by network providers.
- *Training and workforce development.* MJTN provides a range of ongoing training and technical assistance for the purpose of building the overall competence and effectiveness of the adolescent treatment workforce in Maine. Participation in training is free for network-sponsored events
- *Initial telephone screening.* MJTN provides initial telephone screening for youth in need of services.

- *Client screening.* The JASAE is administered on a face-to-face basis.
- *Client referrals.* As a participant in the network, members make and receive referrals of adolescents in need of assessment and treatment services.
- *Client support.* MJTN assists clients in reducing access barriers to services.
- *Needs assessment and systems capacity building.* There is input into the development of network policy and a system of comprehensive care for adolescents.
- *Data collection and analysis.* A comprehensive database has been created for data extracted from the common assessment form completed by all clients. Providers contribute to data collection and data analysis. These data are used for systems improvement through identifying gaps in and barriers to treatment services throughout the State.
- *Networking and communication.* MJTN hosts regular meetings to facilitate communication between referral sources and treatment providers.

The development of a trained and competent adolescent treatment workforce is a high priority for MJTN and has been since its inception.

Collaborative Efforts

Through the collaborative efforts of MJTN, a network of treatment providers with special expertise in working with adolescents has become operational. Through this network, cross-systems collaboration with education, juvenile justice, and other youth-serving organizations is improved. Collaborative efforts also support regional and statewide data collection, analysis, gaps identification, adoption of evidence-based practices, and ongoing efforts for systems improvement.

Workforce Development

The development of a trained and competent adolescent treatment workforce is a high priority for MJTN and has been since its inception. A number of workforce development initiatives have been supported by this program.

- *Assessing workforce training needs.* Through its Advisory Committee, network provider meetings, and other sources, MJTN gathers information identifying current and emerging training needs.
- *Providing training.* Training is supported through MJTN resources.
- *Implementing and adopting evidence-based practices.* The MJTN has supported providers to build capacity for implementing youth specific evidence-based practices.
- *Requiring best practices.* All agencies participating in the network agree to evidence-based and/or best practices as part of the contractual arrangement the network has with the State Office of Substance Abuse.

- *Facilitating communication and network among providers.* Many providers in this State exist at a distance from other providers. The network provides a platform for providers to come together in a collegial environment to interact and exchange ideas. This peer-to-peer collegial support has been a valued by-product of this collaboration.

Strengths of the Network

- The treatment provider system is highly invested in the network because the network addresses multiple needs by being a payer of last resort, a payer of services not usually funded by insurance, a source of training that is reflective of the providers' identified needs, and a source of networking among colleagues.
- The network has been a successful vehicle to build statewide capacity for adolescent services.
- The network provides an identified statewide resource to assist referral sources in placing adolescents.
- The network sets standards of care for their treatment provider membership.
- The network supports the adoption of best practices and evidence-based practices for serving adolescents.
- The network uses a common screening tool across the system.
- The network has developed IT capacity to collect data about youth and families served and to use this information in planning and improving service delivery.
- The network is viewed as a real and successful model of collaboration and partnership among community agencies and State youth-serving agencies.
- The network is viewed as a highly affordable model that could be replicated and could have similar benefits of building systems capacity to serve youth or even other populations.
- The network provides collective advocacy for addictions treatment issues.

Challenges of the Network

- Recently, there have been growing concerns in the network that school systems are moving away from "social and restorative models" and moving toward a more punitive interpretation of the "zero tolerance" substance use policy; with the latter policy, adolescents found using substances are expelled from school rather than being referred for evaluation and services. Concurrent with this trend has been a reduction in federal funding for Safe and Drug Free Schools school-based programs.

Considerations in Forming a Network

The leadership of Day One and MJTN were asked to describe what they viewed as important considerations in forming a network. They identified the following considerations:

- Have the State agency be a partner and funder of the network.
- Create an environment where providers can build collaborative (not competitive) relationships; building collaborative partnerships among members is viewed as "key."
- Develop infrastructure that is responsive to the needs of the population served and the network membership.
- Develop database capacity for client services, management, and long-term planning.
- Have a reliable common screening tool that can be used for screening and referral, provider communication, client services, data collection, analysis, and planning.

Looking to the Future

Areas of future growth for the network include

- better engaging community referral sources that have historically underutilized the network, with a goal for these referral sources to more consistently use the network;
- seeking out additional resources that would allow the network to expand its capacity to deliver expanded "wraparound" types of services for youth;
- exploring the expansion of this type of collaboration, which is currently unique for adolescent services, to the adult population; and
- diversifying the base of network funding. Currently, the network is dependent on State grant funds for its operations. Diversification would not only allow for expansion but also build a stronger financial base (sustainability) in case of State funding reductions.

Case Study 5: Massachussetts—Behavioral Health Services Network

Data Sources

- *Interview:* Peter Lenrow, Executive Director, Somerville Mental Health Association
- *Other sources*: documents and the Web based materials

Organizational History

Somerville Mental Health Association (SMHA), the lead agency in the Behavioral Health Services Network (BHSN) in Somerville, was founded in 1964 by a coalition of parents, school administrators, and the Massachusetts State Department of Mental Health. SMHA was established in response to Federal legislation that funded community mental health centers across the country and was part of a decentralized behavioral health system being established to serve Somerville and Cambridge. This decentralized system includes private, not-for-profit agencies in the area providing supportive housing, substance use disorders treatment, and a range of community mental health services. SMHA has always operated as part of a system of collaborating providers.

The agency is a functioning community mental health center. Its largest population consists of adults with severe and persistent mental illness, and over 60 percent of agency clients experience co-occurring substance use disorders.

BHSN was also founded in the mid-1960s, through the efforts of SMHA. This network was born out of a commitment to quality care through collaboration among diverse agencies. BHSN has made it possible to provide more comprehensive services to people with a range of mental illness, substance use disorders, and co-occurring disorders.

Mission, Values, and Vision

The primary mission of SMHA has been to meet the behavioral health needs of people who live or work in Somerville, giving priority to those with low incomes and other underserved, socially marginalized persons. To address these needs, SMHA provides both preventive and clinical services designed to "enable individuals to experience greater competence and social support in the least restrictive environments and to promote respectful and supportive qualities in community life that can nourish such healthy changes." SMHA serves children, families, and individual adults.

The philosophy underpinning the network is very consistent with systems of care principles and values (Child Welfare Information Gateway, 2008). Within this framework, local agencies partner with families and communities to address the multiple needs of persons and families involved in the systems. At the heart of the effort is a

shared set of guiding principles that include interagency collaboration, individualized strengths-based care, consumer involvement, community-based services, and accountability. The interagency collaboration created through the network reduces barriers, improves access to services, and aids in coordination of efforts.

BHSN has developed over the years as a resource and referral network through which clients have access to a wide range of services.

Network Structure

This network is an informally organized coalition of more than 24 nonprofit community-based programs who provide an array of services in mental health, substance use disorders, homelessness, primary health, early childhood education, suicide prevention, and youth crisis. BHSN has developed over the years as a resource and referral network through which clients have access to a wide range of services. It is the intent of the network to be somewhat invisible or seamless in appearance to the clients. With a coalition structured in this manner, many of the elements of a formal network are not present. Each agency maintains its own board, budget, policies, and procedures. A memorandum of understanding exists only with the four public or quasi-public agencies participating in the network:

- Massachusetts Department of Public Health, Bureau of Substance Abuse Services
- Massachusetts Department of Mental Health, Metro-Boston Area
- Cambridge Health Alliance (psychiatric emergency services for Somerville)
- Somerville Court Department of Probation

The network agencies have a wide range of relationships with each other, ranging from a "handshake agreement" to formal contracts for services.

The network has launched a Web site, www.somervillementalhealth.org, to serve as a resource guide to assist potential clients, providers, and the public in finding services in the area. The site describes all mental health, substance use disorder, and co-occurring disorder services available in the community (within the network) and provides the information needed to refer a client to any agency within the network. The network of providers itself is largely invisible to the client. Service providers within the network primarily use other network members when there is a need for other levels of care or other collateral services. To facilitate this process, SMHA is adopting a standardized comprehensive assessment tool that eventually will be used with all clients, both at intake and then approximately 6 months later to gauge the effectiveness of treatment. For clients in need, SMHA has the capacity to provide case management services to aid the client in navigating the network and accessing services. Additionally, SMHA holds several State contracts that allow the purchase of targeted client services from providers within the network.

The network agencies have a wide range of relationships with each other, ranging from a "handshake agreement" to formal contracts for services.

Legal Structure

The network is not a formal legal entity such as a 501(c)(3) nonprofit or an incorporated membership association. There are no elected officers and no designated staff for the network. Communication activities and network support are primarily provided by SMHA staff. The executive director of SMHA functions as a spokesperson for BHSN.

Membership

Network members include a wide range of community nonprofit service providers who serve clients in the Cambridge/Somerville area.

Geographic Area

BHSN serves the Cambridge/Somerville area.

Staffing

Designated staff positions are not dedicated to BHSN activities. The SMHA executive director is the identified spokesperson for the network and takes the role of convener of BHSN meetings and facilitator of communications among members.

Range of Services

The services provided by BHSN can be described within two frameworks: (1) services that support providers in the network and (2) services available to consumers within the community. A common Web site is used to inform and guide potential service recipients and provides a place to exchange information, share resources, and collaborate. Further, shared resources are available for training. The network participates in the ongoing assessment of service needs for the community. In the absence of a common data system within the network, this needs assessment process is mostly anecdotal and qualitative.

For consumers of services, the network offers a broad array of clinical treatment, primary health care, and other complementary services that are often needed by a behavioral health treatment population. The network helps to reduce access barriers and improve coordination for consumers.

The following services are provided by the network:

- *Community mental health services:* outpatient assessment, psychotherapy, psychopharmacology, community rehabilitative support, case management, day treatment, assertive community treatment, substance use and dual diagnosis treatment, family crisis intervention, hospital-based and mobile psychiatric emergency services, and inpatient assessment and treatment
- *Health promotion:* Early Head Start and Mental Health Consultation, Head Start, early intervention, pediatric care, and oral health services

- *Family recovery services:* services for substance-abusing parents and/or adolescents requiring treatment and documented abstinence in order to be reunited as a family
- *Homelessness prevention:* community outreach, case management, and housing assistance
- *Suicide prevention:* support groups for parents, siblings, and close friends of youth who have died by suicide or overdose
- *Somerville youth crisis response network:* a collaboration among the Somerville Health Department and trained crisis workers from multiple agencies and community volunteers

Collaborative Efforts

There are noteworthy collaborative efforts of the network. First is the previously described Web site, where services and access to service are described in a manner that is client driven. Second, services are delivered by multiple entities in an informal manner. The third effort, which is under way, is the development of a common assessment tool to be used across providers.

Workforce Development

- A principal workforce development activity of this network is shared in-service education opportunities.
- Enhanced communication and collegial contact among providers have developed.
- Training is available using shared resources

Strengths of the Network

- This network is truly a grassroots community effort to build and support a network of service providers. It exists largely through the in-kind contribution of staff time and other resources, without formal structure and with little funds from outside sources.
- The network brings together behavioral health, primary health, housing, education, child care, and other social service organizations.
- The network includes providers of services, payers, and State licensing/ regulators.
- Through collaboration, innovative and expanded services are available to the community.

This network is truly a grassroots community effort to build and support a network of service providers. It exists largely through the in-kind contribution of staff time and other resources, without formal structure and with little funds from outside sources.

Challenges of the Network

- The absence of formal structures for the network, including an identifiable business entity, staffing, data systems, and strategic planning processes, limit the scope of activity that can be accomplished.
- The absence of resources to support the network infrastructure limits membership services, including enhanced workforce development activities.
- The scarcity of overall resources hinders network development.

Considerations in Forming a Network

The Executive Director of SMHA was asked to describe what he viewed as important considerations in forming a network. He identified the following considerations:

- Assess the needs within the community.
- Identify how your organization and others can respond to those needs.
- Assess the readiness and willingness of providers to collaborate in forming a network.
- Involve clients in identifying how the network should benefit the clients.
- Identify how the network would benefit the participating organizations.

Looking to the Future

Future goals for the network include plans to initiate a common psychosocial assessment among participating agencies.

Case Study 6: Nebraska—Touchstone

Data Sources

- *Interview*: Jason Conrad, Executive Director, Houses of Hope, Lincoln
- *Other sources*: organizational documents and Web-based materials

Organizational History

This collaborative program began in 1997 between two nonprofit agencies in Lincoln: the Houses of Hope and CenterPointe. Both are well-established residential programs for adults ages 19 and older. One agency, Centerpointe, primarily serves a mental health population and the other agency, Houses of Hope, serves an addictions population. In the late 1990s, the State regional center providing substance use residential services was closing, and the State decided to redistribute these beds according to their historical allocation formula across the six mental health regions of the State. A Request for Proposals (RFP) was posted by the State, and Houses of Hope decided to bid on the RFP.

In responding to the RFP, Houses of Hope proposed to implement a program with integrated co-occurring disorders capacity. To this end, they approached CenterPointe about a partnership in this proposal and the resulting program. The two agencies had a history of cooperation and were located within a few miles of each other. CenterPointe had complementary service capacities that Houses of Hope did not have at that time, namely nursing, psychiatry, and medication management. CenterPointe readily agreed to be part of the RFP, and the Touchstone program was born. The State funded the proposal for Touchstone, and services began shortly after that.

Today Touchstone is a highly structured short-term residential substance use and co-occurring disorders treatment facility for adults, offering individual and group counseling, psychotherapy, psychiatric consultation, medication management, nursing, and case management. Touchstone treats patients with chemical dependency and co-occurring disorders through a 12-step facilitation and cognitive/behavioral therapy orientation to treatment. Beyond the acute treatment phase, Houses of Hope provides a range of community-based treatment options plus intensive care management and supportive housing. The program and this collaboration are now in its 11th year providing services in the Lincoln urban area.

Mission, Values, and Vision

The Houses of Hope programs provide quality affordable residential treatment services to individuals in recovery from substance dependence.

While both Houses of Hope and CenterPointe maintain their separate boards of directors, Touchstone has a Project Management Committee comprised of staff members from each agency to provide day-to-day oversight for the collaboration.

Network Structure

Touchstone remains under the corporate umbrella of Houses of Hope and has not separately incorporated as a nonprofit agency, though the two founding partners are both 501(c)(3) nonprofit agencies.

Since Touchstone began in 1997, the two agencies have operated under the terms of a written contract with the State of Nebraska Department of Health and Human Services. This contract is renewed annually. The two agencies have developed a joint Memorandum of Understanding (MOU) that has been in effect from early 1999 and has 2-year renewal cycles. This MOU defines duties, tasks, and responsibilities of each partner, which are described below.

While both Houses of Hope and CenterPointe maintain their separate boards of directors, Touchstone has a Project Management Committee comprised of staff members from each agency to provide day-to-day oversight for the collaboration. Overall program administration and oversight is provided by the Touchstone Advisory Committee, comprised of two board members from each organization, as well as the executive directors of both agencies and the clinical director from CenterPointe. The Project Management Committee recruits, selects, and supervises the director of the Touchstone program, who, in turn, supervises the staff dedicated to running this 24-hour-a-day service. Though the Project Management Committee does not have public members or consumers on the committee, feedback is obtained through voluntary satisfaction surveys completed by residents and family members of the residents.

Part of the unique nature of this collaboration has been the ability of both agencies to assess and capitalize on their strengths and provide services accordingly. To that end, the two agencies have assigned responsibilities for the administrative functions of Touchstone according to their respective capacities. Houses of Hope serves as the fiscal agent and provides office staff support. CenterPointe coordinates data collection for quality improvement and program evaluation. The agencies share in the provision of clinical services, with Houses of Hope providing counselors, technicians, and an office assistant and CenterPointe providing the program director, a case manager, a recreational therapy assistant, medical staff, and a cook. Funding through House of Hope is allocated so as to support this shared staffing model.

Membership

The Touchstone collaboration is between two organizations; Houses of Hope and CenterPointe. Both agencies are 501(c)(3) nonprofits with facilities in Lincoln.

Geographic Area

This program primarily serves a defined service region in Nebraska, but it has the capacity to serve clients statewide.

Staffing

This program uses a highly creative co-located staffing model, but staffing challenges have occurred. To address these issues, a joint management infrastructure was developed. As issues of administrative/organizational structure between the two agencies emerged, the Touchstone Advisory Committee studied the issues and made recommendations to the boards of the agencies so that the issues could be resolved jointly. Staffing for the program was accomplished through a joint agency hiring process, regardless of which agency ultimately employed the staff member. The overall management infrastructure was built around collaboration and shared decisionmaking.

Part of the unique nature of this collaboration has been the ability of both agencies to assess and capitalize on their strengths and provide services accordingly.

Range of Services

Touchstone provides a 22-bed (9 females and 13 males) short-term residential program (average lengths of stay 30-45 days); one of the beds is dedicated to referrals from the Indian Health Center. On average during a year, the program treats approximately 175 clients. Of the 22 beds, the State contract funds 18. The remaining beds are contracted to other purchasers, including Medicaid and vouchers from State Probation and Parole Office.

Program components include

- intake assessments and diagnostic services;
- individual services planning, reassessment, and discharge planning;
- individual, group, and family counseling;
- nursing and medical services, including psychiatric consultation and pharmacological services as needed;
- case management services;
- community / daily living skills training;
- recreational therapy services;
- crisis response services;
- an introduction to self-help programs; and
- followup postdischarge.

The primary source of funding for this network is the State contract. Additional funding streams have been added over the years. Medicaid now covers a small portion

of clients, and the State Probation and Parole Office provides vouchers for services. The program is at maximum capacity for clients at most times, with waiting lists of up to 6 months.

Collaborative Efforts

This program showcases the benefits and some of the challenges of collaboration. Through the collaboration of two organizations, a new program has been created that would have been beyond the individual capacities of either individual partner. Collaboration is demonstrated throughout the program model, program staffing, management, and administration. The creation of the joint management structures is identified as core to the infrastructure making this program successful.

The work atmosphere created at Touchstone has been described as very positive, and the program has enjoyed almost no turnover in staff; many clinical staff have been employed for a number of years. It is thought that this stability is partly due to these structures that support planning, problem solving, and staff development.

Shared staffing is a cornerstone of innovation in this program.

Workforce Development

A number of innovative workforce development initiatives are identifiable in Touchstone:

- Shared staffing is a cornerstone of innovation in this program.
- Developing a successful joint management infrastructure has enabled this program to problem solve issues as they occur and has built cohesion within this program.
- Staff professional development is a value within the organization. Staff for Touchstone provides support so that staff can become dually credentialed as both mental health providers and licensed alcohol and drug counselors. All credentialing and re-credentialing fees are paid by the network.
- All training events that staff attend for both initial credentialing and renewal of credentials are paid for by the network. The program contributes to college education costs.
- A common understanding of the program and its components has been created by a common language among staff.

Strengths of the Network

- Through collaboration at all levels of the program, these two agencies have demonstrated true synergy: the two coming together have been able to create something that neither individual party could have created alone.
- The creation of a shared management structure is viewed as central to the strength and success of the program.

- An integrated model for the treatment of co-occurring disorders is provided through collaboration.

Challenges of the Network

- Developing a common language and common vision for the program is an investment of time and resources.
- Collaborative decisionmaking can be time-consuming and at times cumbersome. No unilateral decisions are made. All decisions go through a process that might involve both parent agencies and both boards.
- Adequate funding is always a challenge in public programs.
- In the past, staffing challenges included
  - program staff coming to Touchstone from differing philosophical and clinical approaches,
  - developing a unified approach to treatment,
  - developing protocols for new staff hires,
  - developing program policies and procedures across two agencies, and
  - a number of human resource issues based in different agency practices.

Considerations in Forming a Network

The leadership of Touchstone was asked to describe what they viewed as important considerations in forming a network. They identified the following considerations:

- Work out as many of the management details in advance as possible.
- Create forums for discussion and problem solving.
- Look carefully at the mission and culture of your partners to see if they are complementary.
- Seek to create equality between partners in decisionmaking, program development, operations, successes, profits, and losses. The convergence of interests and commitment will be crafted through heated dialog, but this dialog ultimately brings out the best of each agency to create a positive and real commitment to the mission and goals of the venture.
- Collaborations can occur with many agencies or between just two.

Looking to the Future

Staff of Touchstone report that sometimes success breeds its own challenges. The program is heavily utilized and nearly always has a waiting list for services. They have begun the exploration for larger quarters.

There have been discussions of a merger from time to time between Houses of Hope and CenterPointe. To date the two agencies have not determined that merger

Through collaboration at all levels of the program, these two agencies have demonstrated true synergy: the two coming together have been able to create something that neither individual party could have created alone.

is the best avenue for them, although each entity brings particular strengths to the table, which makes a merger seem more desirable. The agencies are committed to their programs and value the unique cultures of their organizations. They do not see the need or value for the creation of a "mega-agency" in their region.

Case Study 7: New York—North Country Behavioral Healthcare Network

Data Sources

- *Interview*: Barry Brogan, (founding) Executive Director and CEO, North Country Behavioral Healthcare Network
- *Interview*: Lowell Warner, Director of Membership Services, North Country Behavioral Healthcare Network
- *Other sources*: organizational documents and Web-based materials

Organizational History

North Country Behavioral Healthcare Network (NCBHN) was incorporated in December 1997 as a 501(c)(3) nonprofit, tax-exempt organization, following several years of cross-agency collaboration in a rural region of northeastern New York State. NCBHN covers the six upstate New York counties of Clinton, Essex, Franklin, Jefferson, Lewis, and St. Lawrence. A rural area, these six counties on or near the Canadian border have a combined total population of just 450,000 (in a State of over 19 million) and span more than 200 square miles of territory. The initial motivation that brought this group together was the perceived challenges of a managed Medicaid system being implemented in the area. It was the belief of participating organizations that collaborative efforts would provide support in infrastructure development, assist with potential economies of scale, and overall provide a competitive advantage within a managed care payer environment. The participating agencies that formed NCBHN collaborated to investigate various network models they might adopt as a region, thus giving them more negotiating power with potential managed care companies.

It was the belief of participating organizations that collaborative efforts would provide support in infrastructure development, assist with potential economies of scale, and overall provide a competitive advantage within a managed care payer environment.

At about the same time, the New York State Department of Health launched the Rural Health Network (RHN) Development Program. The purpose of the RHNs was (and is) to help rural communities strengthen their health care systems through networks or partnerships by the integration of administrative, clinical, financial, and technological functions across their organizations. These RHN programs were supported by the State to help reduce fragmentation of health care services in rural areas, improve coordination of services, and achieve economies of scale. The State provided up to $150,000 per network to support startup and establishment as an RHN. A successful application was filed for one of these grants by the newly formed NCBHN; the application emphasized a unique strength of linkage between behavioral health care and primary health care. The initial grant monies from the State commenced in early 1998, and NCBHN became staffed and operational at that time. Managed Medicaid services were never implemented in this region because it was determined that the small population and rural nature of the area did not lend itself to a successful implementation of managed Medicaid products. Despite this change, the

Today, the network members provide an array of services for adults, adolescents, children, elderly people, and Native Americans.

participating network members viewed the network as valuable and have continued to do so to this day.

With the initial incorporation of the network and the establishment of a modest dues structure, concerns emerged among the public sector (State and county) agencies that had been part of these initial operations. Anecdotally, it was reported that the public agencies withdrew from the network citing concerns for potential conflict of interest. These public agencies, in addition to providing some direct services, saw themselves as charged with certain regulatory, enforcement, and program funding obligations. Additionally, several nonprofit organizations decided not to join because of the fees associated with membership.

Today, the network members provide an array of services for adults, adolescents, children, elderly people, and Native Americans. Services are provided in the following areas: primary health, mental health, developmental disabilities, substance use disorders, temporary housing, prevention, education, and advocacy. Behavioral health care services span the continuum from acute inpatient services to community-based outpatient and recovery supports.

In 2001**,** the North Country Management Services (NCMS) LLC was formed as an outgrowth of NCBHN to provide an array of business products and services, including: management consulting, IT services, accounting services, administrative support, training, event management, project management, grants development and administration, employee benefits, and group purchasing. NCMS is co-located at NCBHN headquarters and is staffed by network employees. NCMS is owned and managed by network members and serves the dual purposes of providing a range of business services to network members (and others) for a fee and generating income for the network.

NCBHN remains an open system and accepts new organizations as members.

The network is supported through a variety of sources including a variety of grants, membership dues, income generated by NCMS, and fees.

NCBHN remains an open system and accepts new organizations as members. The network provides its members with a level of communication, collaboration, and regional advocacy that has positioned network providers to shape and influence emerging behavioral health care policies and practices, particularly those that impact service quality and access. In addition to the shared voice the network brings its members, it also offers its members many tangible services that will be described later in this case study.

Mission, Values, and Vision

The network has clearly articulated statements of mission, values, and vision:

- *Mission:* NCBHN connects and supports behavioral health providers to strengthen the service delivery system in northern New York.
- *Values:* NCBHN is committed to and accountable for achieving excellence through collaboration and builds on the mutual trust, respect, and values of its partner organizations.
- *Vision:* NCBHN will be widely recognized as a leading voice for northern New York's behavioral health care continuum, bringing the necessary resources for the connection of advocacy efforts, technology development, and best practices among partners.

Network Structure

Legal Structure

NCBHN is an incorporated 501(c)(3) nonprofit membership organization; it currently has 20 active members. As framed in the organizational bylaws, there are nine board members who can be elected from the executive directors / CEOs of the member organizations. All board members and board officers have term limits so that over time all member organizations will serve as board members for the network. Officers of the board are elected by board members. The board maintains a highly active and influential system of committees in which all NCBHN members participate. Committees are actively engaged in assessing community need, planning, implementation of specific projects, and evaluation. Quarterly, there are full meetings of all NCBHN members where plans and performance of the network are reviewed and discussed and where current or emerging needs in the community are identified. There are currently six positions in the network, including the CEO.

The board and the staff rely on the strategic plan, now in its fourth iteration since the beginning of the network to determine the direction of the network. To make sure the strategic plan is followed, the board president and the executive director hold a conference call regularly that is dedicated to evaluating adherence to the strategic plan. In addition, elements of the strategic plan are now included with the annual contract with the State.

Committee Structure

NCBHN has an active and involved committee structure, including an executive committee and committees on membership services, strategic planning, assessing community need and strategic planning, special project management, and quality improvement.

Membership

There are currently 20 organizational members in the network. Eleven members provide a range of addictions treatment and recovery services and mental health / psychiatric services. Four organizations are youth-and family-serving organizations. There are three prevention programs, two health centers, and one advocacy organization for persons with serious and persisting mental illness. Membership in the network is highly stable.

Members enter into a contractual agreement when joining the network and agree to pay annual dues ranging from $250 to $1,000. Each member has one vote, regardless of organizational size. A high level of commitment is expected from the member organizations. The CEO or executive director must be the board representative, or if the CEO has sent a person in his or her place, that person must be vested with sufficient authority to vote on binding network matters. Other member organization staff can participate on committees as might fit with their expertise and interest.

Geographic Area

NCBHN covers the six upstate New York counties of Clinton, Essex, Franklin, Jefferson, Lewis, and St. Lawrence. Some limited services have been provided outside of these counties, but no member organizations have sites outside this geographic area.

Staffing

Currently there are four full-time and two part-time employees, as well as consultants as needed. The CEO/ executive director, director of member services, office manager, and financial manager are full-time positions; the IT specialist and the project specialist / training coordinator are part-time positions.

Range of Services Provided by NCBHN

- Organizational capacity building, particularly in areas related to information technology and electronic records implementation
- Facilitation of collaborative efforts
- Advocacy at the State and Federal levels
- Community needs assessment and planning
- Public education and outreach
- Individual member services
- Training and workforce development

Range of Services Provided by NCMS

NCMS offers business products, business management services, and IT support to members and non-network members. Currently the most actively used services are accounting and IT services, followed by training, benefits services, and group purchasing of materials and supplies. Training is offered through conferences, classroom training, and online/Web-based learning. Grant management services that include prospecting, writing, and managing are also offered. Services are described in more detail below.

NCMS offers business products, business management services, and IT support to members and non-network members.

Management Consultation

- Executive transition
- Operating policies and procedures manuals
- Cost reduction / profit improvement
- Business and marketing plans
- Operational analysis / process improvement
- Organizational change/restructuring
- Fraud detection and recovery

Accounting Services

- Bookkeeping: Providing computerized bookkeeping services using QuickBooks and Peachtree, for use at the member's office or remotely
- Payroll: Providing payroll services in conjunction with bookkeeping services or separately; includes preparation and filing of all payroll tax reports
- Audit preparation: Preparing annual audit and audit report
- Financial controls: Designing policies and procedure that can help alleviate the possibility of fraud and waste in the organization; additionally, reviewing books and reconciling bank accounts on an ongoing basis as part of a plan of assurance that accounts are being properly maintained
- Accounting software implementation: Installation (by certified QuickBooks Pro Advisors) of QuickBooks or Peachtree software in the organization and providing training and support for staff

Information Technology

- IT support services: Administration, maintenance, and support on a weekly basis to help organizations maintain and support applications, backups, network connectivity, servers, users, security, and workstations
- Strategic and implementation services: Development and enhancement of IT strategy to reach business goals

- Infrastructure and network services: Identification of needs and a project plan that will lead to implementation
- Project management
- Overall grant project management
- Tracking project timelines and milestones
- Meeting management
- Reporting

Transition Management

- Analyzing and documenting the duties of a staff position
- Temporarily performing the tasks related to the position
- Training new hires
- Supplementing staff skills with temporary or ongoing assistance

Employee Group Benefit Plans

- Medical
- Dental
- Life insurance
- Vision
- Statutory disability insurance (under New York State's Disability Benefits Law [DBL])
- Disability
- 401(k) retirement
- Voluntary benefits

The network currently facilitates a number of collaborative programs and initiatives.

Collaborative Efforts

The network currently facilitates a number of collaborative programs and initiatives. The role of the network varies depending on the specific initiative, ranging from facilitating collaboration among network members to developing "cooperative agreement" grants, serving as the lead and fiscal agent for the grants, and grants management.

Children's Mental Health Initiative

The Children's Mental Health Initiative is a collaborative effort by network members in Essex and Franklin Counties to expand access to children's mental health services in the region. The initiative was funded in 2003 though the Federal Health Resources and Services Administration (HRSA) Office of Rural Health

Policy. Strategies pursued as part of this initiative have included efforts to recruit a board-certified child and adolescent psychiatrist to provide services in the counties, placement of a school-based mental health worker in the school district serving St. Regis Mohawk Reservation students, and development of a telepsychiatry program in Franklin County schools and the clinics serving the two counties.

Fort Drum Regional Health Planning Organization Behavioral Health Committee

The Behavioral Health Committee is one of four committees formed by the Fort Drum Regional Health Planning Organization (FDRHPO), a not-for-profit corporation recently formed in Jefferson County, New York. This committee is part of a U.S. Department of Defense pilot program that is exploring the feasibility of building cooperative health care arrangements between military installations and local nonmilitary health care systems. Staffed by NCBHN, the FDRHPO Behavioral Health Committee focuses on planning and evaluating the provision of behavioral health care service to Fort Drum military personnel, their families, and residents of the communities surrounding Fort Drum.

North Country Network of Care for Behavioral Health

The North Country Network of Care for Behavioral Health is an initiative that created a Web-based "Network of Care" for Essex, Franklin, Jefferson, and St. Lawrence Counties in northern New York. Each county Network of Care Web site provides individuals, families, and care providers easy online access to information about mental health, substance use, and developmental disability services in the region. NCBHN is providing data collection and verification services and technical assistance to the community services directors at the four county sites since 2007.

Northern New York Technology Alliance

The Technology Alliance is a group of 13 NCBHN members working to develop a HIPAA (Health Insurance Portability and Accountability Act of 1996)–compliant Integrated Advanced Information Management System (IAIMS). Also known as a Health Information Technology System (HITS), the system will improve quality and increase access to care by sharing critical clinical data between behavioral health providers (including mental health and substance use services) and primary care physicians, clinics, and hospitals. HRSA's Office of Rural Policy recently awarded the Technology Alliance (through NCBHN) grant funding to move forward with development of this initiative.

Points North Housing Continuum of Care

The Points North Housing Continuum of Care is comprised of representatives of more than 50 agencies and faith-based groups as well as individuals concerned with meeting the needs of the homeless and those at risk of homelessness in Jefferson, Lewis, and St. Lawrence Counties. The group recently received funding for two initiatives: the Shelter Plus Care program and the Homeless Management

Information System (HMIS). The Shelter Plus Care program offers qualified Jefferson County residents (disabled persons, including those with mental health and/or substance use problems) a rental voucher for up to fair market value if the client agrees to accept other in-kind support services available to them, including health care, child care, education support, and case management. HMIS is a Web-based database that will allow participating providers to collect data on the homeless and access information about resources available throughout the region. Ultimately, HMIS will help the Points North Housing Continuum of Care to develop a more accurate view of the severity of the homeless problem in northern New York, and to maximize resources available.

Tri-County Pathways to Balanced Nutrition

A volunteer coalition of school and community health professionals joined together in 2004 to address the need for early assessment and treatment of eating disorders among students in Jefferson, Lewis, and St. Lawrence Counties. To date, the coalition has engaged in community outreach and education, developed clinical expertise, and established a case management program to help families navigate the system. They have also developed a partnership with Strong Memorial Hospital in Rochester for expert case consultation, including telemedicine and clinical supervision, for NCBHN mental health and primary care providers. The network has provided financial, staff, and logistical support since the project's inception.

NCBHN has been credentialed by the State of New York as a substance use training provider.

Workforce Development

NCBHN has been credentialed by the State of New York as a substance use training provider. They have crafted core curricula to train clinicians preparing to become certified substance use counselors, and they provide continuing education for credentialed providers. They also have a cooperative agreement with an organization that provides online courses. The training capacity of the network has helped to develop a more skilled and credentialed workforce in the region and has aided in workforce recruitment in a geographic area that has workforce shortages. Training through the network also provides opportunities for formal and informal networking among clinicians, which it is hoped will aid in workforce retention. The network also assists with recruitment of workers through advertising (primarily); for some positions the network staff will prescreen candidates. The network is just beginning to explore a possible role in facilitating job sharing, particularly for positions such as psychiatrists that are very hard to recruit.

Strengths of the Network

- The network has maintained a high-quality professional staff with significant nonprofit business management expertise.
- Network staff demonstrate a high level of membership service (customer service).

- The network has developed an organizational culture where organizations can come together in a noncompetitive and collegial environment benefiting from peer-to-peer interactions.
- The network has the capacity to facilitate collaborative ventures among members.
- The network provides multiple venues for members to provide formal and informal input into needs assessment and planning processes.
- The network has a governance structure that is highly responsive to member needs.
- The network has a high level of commitment and involvement among member organization senior leadership.
- The network has a proven track record and consistent support from the State.
- The network offers an array of services that support the business infrastructure as well as professional development for the direct service workforce.
- NCMS not only provides useful and important business services to members, but it also generates revenue for the organization.

Challenges of the Network

- The biggest challenge identified by the organization is its overreliance on grant dollars to support the infrastructure and operations of the organization. They are hopeful that NCMS will continue to grow and provide increasing revenue to the organization.
- Although the membership has been stable for a period of time, increasing membership in the network would enhance its collective influence and provide further opportunities for service and collaboration.

Considerations in Forming a Network

The leadership of NCBHN was asked to describe what they viewed as the most important consideration in forming a network. They identified the following considerations:

- Incorporate democracy into the operations of the organization.
- As quickly as possible, incorporate and establish a recognizable identity.
- Charge dues to build a sense of ownership.
- Senior leadership of member organizations must be involved.
- Move away from having a fiduciary agent as soon as you are able.
- Regularly assess needs of your members and of the community you serve.

- Provide the best membership services you are can.
- Allow the members to set the agenda.
- The organization must be responsive to the needs of the members.
- In the governance policies have "one member one vote," term limits on board officers, and multiple ways for members to provide input.

Looking to the Future

Staff of the network is extremely optimistic about the future of the organization. It has a solid foundation of service to its members and continually assesses the needs of members and the community through its members. They are engaged in what they believe are a number of highly important initiatives that are of value to the members and to the network. Most notably, they are working with providers to develop and successfully implement electronic patient records and build stronger linkages between behavioral health care and primary care.

Case Study 8: North Carolina—Guilford County Substance Abuse Coalition

Data Sources

- *Interview*: George Coates, Executive Director, Guilford County Substance Abuse Coalition
- *Other sources*: organizational documents, Web-based materials, and IRS Form 990 for 2006 and 2007

Organizational History

The Guilford County Substance Abuse Coalition (GCSAC) is an incorporated 501(c)(3) nonprofit founded in 2002. GCSAC is a coalition of organizations providing prevention and treatment services for substance use and mental health disorders, including local government, hospitals, physicians, social service providers, public schools, colleges and universities, libraries, law enforcement, community organizations, and faith-based organizations.

GCSAC was formed following a health conference held in May 2002 at Guilford Technical Community College near Greensboro. This event mobilized community leaders to recognize that substance use disorders are matters of serious public health concern in Guilford County. Recommendations growing out of the event called for

- a community coalition to be formed to study the issue,
- assessment of available resources and gaps in services, and
- establishment of a system for ongoing planning of services and monitoring of services and community needs.

GCSAC emerged at a time when the State of North Carolina was undergoing a radical transformation of its mental health and substance use disorders service delivery system. Previously most services had been provided by public State and county agencies. Sweeping mental health reform was under way in the State, and most services were being privatized. This change provided both impetus and opportunity not just in Guilford County but also across the State to begin new programs, because many clients would be transitioning from public programs to private sector programs financed by Medicaid and the SAPT Block Grant funds. To build a responsive community-based system of care, it was essential to assess service delivery capacity and gaps, and GCSAC became the agent for that assessment in the community.

Early in its formation GCSAC was a recipient of a SAMHSA Drug Free Communities Grant to support its development. Subsequently GCSAC membership became actively involved in Community Anti-Drug Coalitions of America

GCSAC established five standing committees to begin the work of the coalition: steering, needs assessment, best practices, monitoring and planning, and community awareness.

(CADCA), a 501(c)(3) nonprofit organization that works to strengthen the capacity of community coalitions in their effort to create and maintain safe, healthy, and drug-free communities. CADCA supports its members with training and technical assistance, public policy advocacy, media strategies, marketing programs, conferences, and special events.

GCSAC was formed by representative stakeholders and individual citizens of Guilford County, an urban county in north central North Carolina. GCSAC established five standing committees to begin the work of the coalition: steering, needs assessment, best practices, monitoring and planning, and community awareness. Members were drawn from local service providers and community residents. The Moses Cone–Wesley Long Community Health Foundation and the Community Foundation of Greater Greensboro provided funding to GCSAC, and the coalition hired an executive director.

From that initial group of 40 agencies and individuals in 2002, GCSAC has nearly doubled its membership. Today there are 72 members, including organizations and community members. Given the size of the membership and its policy and commitment to inclusion, GCSAC decided to establish a 15-member board of directors to help with the workflow.

The founders of GCSAC believed a network should be diverse and inclusive and should support comprehensive approaches to treatment and prevention services, using evidence-based practice to integrate substance use and mental health disorders treatment with primary care. This comprehensive approach and improved integration could be supported by increasing the coordination and effective utilization of community assets and by addressing the gaps between treatment programming based on traditional unit-based State and Medicaid funding categories and the needs of persons affected by substance use disorders. GCSAC recognized the limitations of traditional treatment systems and sought to increase the array of longer term recovery support services, including housing and supportive programming options.

Mission, Values, and Vision

Mission Statement: The coalition brings together the provider community and Guilford County residents to develop a partnership through advocacy, education, collaboration, and support of best-practice principles to effectively address substance use.

Civic and community leaders and GCSAC members felt that GCSAC should be a long-term alliance between providers, schools, social services agencies, public services agencies, and the community as a whole. GCSAC goals would be to

- establish and maintain a stable and functioning coalition;
- conduct a comprehensive community substance use needs assessment that includes an inventory of community resources and identification of gaps;
- encourage and support the implementation of best-practice principles for substance abuse prevention, treatment, and aftercare programs;
- establish and maintain an ongoing monitoring and planning of service system; and
- build community awareness of substance use disorders through social marketing, education, and advocacy.

The founders of GCSAC believed a network should be diverse and inclusive and should support comprehensive approaches to treatment and prevention services, using evidence-based practice to integrate substance use and mental health disorders treatment with primary care.

Network Structure

GCSAC is an incorporated 501(c)(3) nonprofit organization with 72 active organizational and community members. An elected board of directors is nominated from GCSAC's membership. Membership to GCSAC is an open-enrollment process; the only requirement is either being a resident of Guilford County or doing business in the county. The organization receives funding through several grants and has an annual budget of approximately $175,000.

The original board was formed from the Steering Committee, but now the board is elected through a process by which a Nominating Committee, composed of the committee chairs, brings forward names to the board on an annual basis. The Nominating Committee seeks a cross-representation of the community. Terms for board membership are for 3 years, with one-third of the board rotating off annually.

In addition to the Nominating Committee, GCSAC currently has committees on needs assessment and monitoring, education and training, community awareness and advocacy, finance, and steering.

As with most new organizations, establishing an organizational structure and increasing membership were important early goals. To guide their efforts, GCSAC developed a strategic plan. Within the current strategic plan, the following four objectives are the areas of focus:

- Develop an organizational structure.
- Establish and maintain a planning and monitoring system.
- Raise awareness about GCSAC.
- Promote best practices.

Membership

GCSAC currently has 45 organizational members and 27 community members. Organizational members include representatives from local government, social service providers, substance use service providers, mental health service providers, hospitals, libraries, and community organizations, schools, law enforcement, and faith-based organizations. The community members include individuals and business representatives.

Geographic Area

GCSAC primarily services Guilford County but also participates in some statewide planning efforts.

Staffing

GCSAC has two paid staff positions: an executive director and a support staff position. Committees and other activities rely heavily on volunteering coalition members.

GCSAC is an incorporated 501(c)(3) nonprofit organization with 72 active organizational and community members.

Range of Services

- *Maintaining an active and engaged coalition of community stakeholders.* To support this effort GCSAC holds regular coalition meetings, prepares and distributes a quarterly newsletter, conducts community forums, and participates in a broader coalition of nonprofit service providers.
- *Facilitating.* The primary role of GCSAC is *not* one of direct services; rather, it facilitates community mobilization, planning, and implementation of services for the county.
- *Assessing substance use service needs for Guilford County.* GCSAC contracted with a consulting company to complete a community assessment and draft a written report for distribution. A survey was developed and completed by more than 500 persons representing a broad base of input. Aggregate data were studied, and a published report assessing community substance abuse needs with accompanying recommendations was completed in 2005. This document has been widely distributed and has been used by county planners and service providers to assist with planning activities. To sustain the ongoing efforts of community needs assessment, GCSAC has a standing Needs Assessment and Monitoring Committee.
- *Supporting the adoption of evidence-based practices.* GCSAC has funded and hosted a number of training events for the adoption of specific evidence-based practices for providers, including Solution Focused Therapy (SFT); Life Skills Training (LST); Screening, Brief Intervention and Treatment (S-BIRT); and Motivational Interviewing (MI). These training events have been offered at no charge to local providers. Further, GCSAC financially supported the delivery of LST to sixth graders in county schools.

- *Building community awareness.* GCSAC has conducted multiple activities to build community awareness regarding substance use, prevention, treatment, and recovery.
- *Supporting targeted efforts for prevention of substance use among youth.* GCSAC has conducted a number of youth-specific activities, including funding LST, hosting a youth substance abuse summit, educational activities at high schools and colleges, and supporting a range of other youth activities.
- *Disseminating information.* The coalition serves as a clearinghouse of substance use information in the county. GCSAC publishes a quarterly newsletter and has created a community resource directory for Guilford County. The resource guide includes listing and contact information for all substance use and mental health resources, other social service organizations, 12-step groups, and other self-help and recovery support groups.

Collaborative Efforts

A fundamental principle of GCSAC is to facilitate collaboration within the county for the planning and delivery of quality substance use services that are responsive to the unique needs of this community. Collaboration is evidenced in the organization's makeup, with broad-based stakeholder membership. GCSAC's collaboration with service providers includes supporting their efforts in planning appropriate services and adoption of evidence-based practices. GCSAC membership has been enlisted to provide education and training for the members and the community. In 2006, for example, GCSAC provided SBIRT and MI training. Lastly, GCSAC collaborated with the Guilford County corrections system to create a reentry program for persons leaving the county corrections facility.

A fundamental principle of GCSAC is to facilitate collaboration within the county for the planning and delivery of quality substance use services that are responsive to the unique needs of this community.

Workforce Development

GCSAC was created to give a voice to community stakeholders as co-planners in the development of this new system in North Carolina. Beyond planning and development activities, GCSAC has played a more targeted role in training and the adoption of evidence-based practices. The creating of the community resource directory also was described as an important aid to staffing.

Strengths of the Network

- The network was created with broad-based community representation to support capacity building for substance use services, including prevention, intervention, treatment, and recovery support services.
- The network is inclusive of both organizations and individuals.
- The network plays a key role in the community, assessing needs for services.

- The network provides a neutral forum where diverse interest groups can come together and build consensus on strategies to address community needs.
- The network is a support and advocate to the provider network.

Challenges of the Network

The following challenges have been identified:

- Ensuring the network would not become too provider heavy and lose some of its broad-based stakeholder focus
- Maintaining the commitment and the enthusiasm of members
- Avoiding turf conflicts between providers over limited resources
- Sustaining resources to support operations

Considerations in Forming a Network

The GCSAC leadership was asked to describe what they viewed as important considerations in forming a network. They identified the following considerations:

- The total community should be involved because addiction is a total community issue; no one segment of the community can solve it alone.
- To sustain a coalition such as this, members require continued support and motivation to remain involved, and, ultimately, members must believe that their efforts are making a difference in their communities.

Looking to the Future

The leadership believes that one of the major accomplishments of GCSAC is that the organization helped shape services at the community level during the rapidly changing environment of mental health reform in North Carolina. Three major commitments for the future are efforts to improve access to services for persons in need, providing ongoing support to providers adopting and implementing evidence-based practices, and continuing to assess community needs.

Case Study 9: Oregon—Oregon Treatment Network

Data Sources

- *Interview:* Bruce Piper, Oregon Treatment Network
- *Other sources*: organizational documents, Web-based materials, and IRS Form 990 for 2006 and 2007

Organizational History

In 1995, the State of Oregon announced a plan for a Medicaid redesign. The redesign possibilities included a managed care option, rebidding of Medicaid contracts, and other options that could place smaller providers at a disadvantage. The possibility of these changes brought five substance use service providers together to form a statewide network, the Oregon Treatment Network (OTN). It was their belief that forming a network could give provider members an improved ability to approach any statewide or regional payer from a position of greater strength. Contracting with OTN gave these providers the ability to cover the entire State or any of its regions.

Ultimately, Oregon did not implement a Medicaid managed care option, as was originally discussed. Beyond the original motivation in forming the network, members saw inherent value in continuing its operation and have expanded and redefined its goals and services during the past 12 years. Today OTN is primarily a network of providers for the treatment of substance use and co-occurring disorders serving central Oregon.

OTN became a 501(c)(3) nonprofit organization in 1998. The corporate entity of OTN serves as a fiduciary agent for a series of grants for network members and provides other member services. OTN is a closed member system; unless there is an identified unmet need within their system, OTN does not solicit new members.

A full continuum of substance use treatment services are provided through the network, spanning all levels of care. Additionally, OTN provides a range of specialty services, including integrated co-occurring disorder treatment; intensive adolescent outpatient and residential treatment; specialized women's and children's programs; Latino/Hispanic programs; agonist therapy, including methadone treatment and buprenorphine; DUI programs; smoking cessation; life skills development; relapse prevention; transitional housing; permanent drug-free housing; childcare; and problem gambling treatment.

The network provides services at all levels of clinical care across most of the State in rural, suburban, and urban communities. It serves all age groups and has specialized programs for youth and women with children. It also has the capacity to serve diverse racial and linguistic groups.

The network has positioned itself uniquely by creating common quality assurance and quality improvement protocols across the system to establish a certain level of uniformity in processes and a capacity to collect and analyze data both within an individual organization and across the system.

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Mission, Values, and Vision

OTN brings together and coordinates the efforts of five nonprofit treatment and prevention organizations in central Oregon. With 100 years of collective experience, OTN provides quality substance use prevention, intervention, and treatment services that are more comprehensive and diverse and cover a wider geographic area than any single provider in Oregon. Timely access to services, commitment to quality care, and services offered at a reasonable cost to payers are values of the network.

Network Structure

OTN is a 501(c)(3) nonprofit. To maintain the work of OTN, there is a small governance structure. There has been an ongoing decision by the OTN board to not grow the OTN infrastructure and to pass the resources that would have been used for growth on to the members. The executive directors of the member agencies serve as the board of OTN under its bylaws. Staffing of the network is provided by the member agencies. The network funds two part-time positions: an accountant and a legislative liaison.

The network has an annual budget of $2.4 million, primarily from grants. Annual dues are paid by each member in the amount of $5,000. In addition to the member dues, OTN retains 1 percent of each contract to support administrative costs of the network. Since nearly all of the grant monies are passed through to member agencies, if a particular grant requires a higher level of administrative activity this function is subcontracted to one of the member agencies.

The network has both standing and ad hoc committees, including an executive committee, a legislative committee, quality improvement, and training.

Membership

Membership in the network has been based on a number of considerations, including location, service region, and service array. Five members are in the network.

Geographic Area

OTN provides services statewide.

Staffing

Staffing of the network is largely provided through in-kind services from its members. There was an early decision made in creating the network to not invest

significant resources in program infrastructure costs. The two part-time positions are paid by the network, and if grants call for higher levels of administrative support these functions are subcontracted to the members.

OTN brings together and coordinates the efforts of five nonprofit treatment and prevention organizations in central Oregon.

Range of Services

Membership Services

OTN provides a number of services, including marketing of membership services, serving as a fiduciary agent on contracts, supporting cross-organization collaboration and cross-systems quality improvement activities, and legislative advocacy. OTN has managed a number of training contracts that have benefited the members and other providers.

Clinical Services

Through the network membership a full array of clinical services for adults and youth with substance use and co-occurring disorders is available, including treatment, intervention, and prevention. Treatment services include detoxification, outpatient, intensive outpatient, methadone maintenance, residential, and intensive residential. The network also provides specialty services, including transitional housing, day care, transportation, specialized outpatient, intensive outpatient, and residential treatment for women, adolescents, adult corrections clients, and dual-diagnosed clients. Though all of these services are not available in every OTN location, they represent a diverse continuum of services available from one source in the State.

Each OTN member follows specific quality assurance procedures, which are standardized across the system. Each OTN member has a long history of excellent clinical performance as measured against the Oregon Administrative Rules (OARs) that are the State standards of care governing the delivery of services. Client Satisfaction Questionnaires (CSQs) indicate that 93 percent of clients felt very positive about their treatment and 90 percent of them would return in the future if necessary; 83 percent were pleased with the timeliness of the services rendered.

Participation in the National Institute on Drug Abuse Clinical Trials Network

A unique capacity of the network is its ability to participate as the community treatment provider system for the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN) conducted through the Oregon Health Services University. The mission of CTN is to improve the quality of drug abuse treatment throughout the country using science as the vehicle. CTN provides a platform in which NIDA, treatment researchers, and community-based service providers cooperatively develop, validate, refine, and deliver new treatment options to patients in community-level clinical practice. OTN participates in this endeavor as its members provide treatment sites across the entire State of Oregon. Their participation also helps them increase and improve the quality of their evidence-based practices.

OTN's participation in CTN is based on their capacity to span multiple service-related domains, including diversity of clientele (in age, gender, and racial and linguistic groups) and type of community (rural, suburban, and urban); their capacity for cross-site collaboration; and their capacity to generate a sufficient cohort of clients for the research projects.

Collaborative Efforts

There are a number of noteworthy collaborative efforts within OTN.

- There is a high level of interagency collaboration in the delivery of client services.
- There is collaboration between network members on quality assurance and quality improvement practices.
- There is interagency collaboration on grants.
- There is interagency collaboration on staff training.
- There is collaboration with NIDA CTN. The CTN effort is simplified by working with one entity that spans multiple domains of service, geography, and populations.

Workforce Development

OTN has managed various training contracts over the years to provide training for the staffs of the member agencies. Through their contractual involvement with CTN, clinical and program staff have enjoyed a rich opportunity to be a "greenhouse" for evidence-based clinical practices. Staff enjoy close working relationships with practice developers and researchers, including high-quality implementation training, supervision, and coaching that supports high levels of implementation fidelity. Further, representatives of OTN participate in CTN advisory workgroups helping to facilitate a "science to service" and "service to science" dialog.

Clinical staffing within OTN is described as highly stable. In part, this speaks to the stability of the organizations, but it also speaks to the clinically and intellectually rich environment in which practitioners work.

Strengths of the Network

- The network offers all levels of clinical care.
- The network spans most of the State, serving rural, suburban and urban communities.
- Minimal competition exists within the network because network members have geographic service regions.

- The network spans all age groups and has specialized programs for youth and women with children.
- The network has the capacity to serve diverse racial and linguistic groups.
- The network has created common quality assurance and quality improvement protocols across the system.
- The network has a close working relationship with a major research institution that is a source of revenue and a rich source for staff professional development.
- The network is a conduit of revenue for members.
- The network supports governmental and legislative liaison and support for members.
- Peer-to-peer sharing, support, and problem solving is an extremely valuable aspect of the network.
- The strong "state-of-the-art" clinical programs of OTN provide a competitive advantage to the network with regulators and payers of services.

The strong "state-of-the-art" clinical programs of OTN provide a competitive advantage to the network with regulators and payers of services.

Challenges of the Network

- OTN does not maintain an open enrollment practice for new members. It is recognized that competitive relationships with other non-network agencies in the State exist.
- Changes in State funding strategies are a continuing concern. Oregon has adopted a system of "Home Rule Charter" for counties where planning and funding for services is increasingly directed by locally elected county planning boards. The county boards are obligated to formulate written plans for substance use services. The counties have the option of contracting out services or delivering those services directly by county employees. There are concerns that Home Rule Charter approaches do not interface as easily with networks. This type of county purchasing system curtails the degree to which the network will grow.
- The large geographic area of the State creates access problems for network members to frequently meet face to face. This has been ameliorated by use of technology.

Considerations in Forming a Network

Network leadership was asked to describe what they viewed as important considerations in forming a network. They identified the following considerations:

- Pick your partners very carefully.

- There must be real value created through the network for it to survive. Too many coalitions are formed where a structure is created that just perpetuates itself and does not really provide any value either to programs or to persons served.
- The relationships among members should be complementary and supportive.

Looking to the Future

OTN leadership advocates for the State to have a role in helping alleviate perceived issues and limitations created through county-based purchasing. They support the creation of incentives for communities or regions developing local networks for substance use disorders services. They believe that private providers are more agile and more able to effect program changes and implementation in a timely manner.

Another concern looking to the future for the network centers on the aging of its senior leaders. There are concerns that the next generation of leaders may not share the same vision of the power and benefit of networks.

SUMMARY OF CASE STUDY FINDINGS

Networks have existed in health care for decades and have been a growing presence in behavioral health since the 1960s. The importance of networks and collaborative relationships became part of public behavioral health policy dialog with the introduction of "systems of care" in mental health services (http://www.systemsofcare.samhsa.gov/). Interest and at times urgency toward forming networks has been driven by State- and national-level changes in the payer system, increased reporting demands, and rates of reimbursement that have not kept pace with costs of doing business. Many States have moved away from historic grant and aid contracts to fee-for-service models that require further changes in the infrastructure of organizations, including changes in staff roles and organizational structures and the need for more sophisticated information systems. Networks were viewed as strategies to remain competitive in the marketplace, create economies of scale, share resources, and create a stronger voice in State agency and legislative processes.

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Another and equally important driving force in network formation is the actual patients served in a program. Clients entering the publicly funded treatment system have multiple problems (CSAT, 2007). In fact, most patients experience problem-saturated lives. The formation of networks enables providers to better create a continuum of care and within that continuum a richer array of services at all levels of care. These networks can improve access and retention, improve coordination of care, improve team approaches to service, enhance collegial input, and create rich opportunities to train and develop the workforce.

Types of Networks

In this study, five of the nine networks have become freestanding 501(c)(3) nonprofit corporations. Boards of directors are drawn from network membership in CAARR, CFBHN, NCBHN, GCSAC, and OTN. Three networks have an agency serving in a role as the lead and fiduciary agent (Project WIN, MJTN, and Touchstone). BHSN is a coalition of providers that have come together in a loosely formed coalition to cooperate as they serve patients.

Network Services

Network services to membership span a full range of options and appear to be largely determined by the needs and the interests of the participants.

- *Provider network management:* defining continuum of care and the service array; determining the types, number, and qualifications of providers based on community needs; selecting providers; credentialing; ongoing communication with providers; and training and technical assistance to providers

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- *Strategic planning for network:* needs assessment, gap analysis, setting measurable goals and objectives, developing action plans and plans to monitor and evaluate, and community and regional planning
- *Shared quality improvement / quality management:* focus on enhancing access to care, coordination of care, quality of care, efficient use of resources, risk management, and monitoring of State-mandated outcomes. Quality improvement includes ongoing performance improvement initiatives that are based on data.
- *Financial management:* regulatory compliance, grant coordination, proper accounting safeguards, analysis of utilization and cost data, rate setting, claims processing, member services, quality improvement activities, and reporting.
- *Information management:* client tracking, including admissions, authorization, and continued stay; integration of assessment and service-planning data; supporting "seamless" transitions across levels of care; claims management; aggregate reporting; outcomes and utilization analysis
- *Workforce development:* technical assistance, clinical practice development (adoption of evidence-based practices), training, education, and staff sharing
- *Organizational capacity building:* particularly in areas related to information technology, electronic records implementation, improved business practices, and developing new program models
- *Facilitation of collaborative efforts between and among providers*
- *Advocacy at the State and Federal level*
- *Public education and outreach*
- *Accounting services:* bookkeeping, payroll, audit preparation, financial controls
- *Group purchasing:* group benefits plans, program insurance, goods and services
- *Program design*
- *Acting as a fiduciary agent*

Several network practices are innovative and effective. For example, CFBHN has become a provider-governed ASO for the SAPT Block Grant, Medicaid, and other public dollars coming into their region. The network's performance over the years has gained significant attention and admiration because they have consistently demonstrated better-than-average utilization, retention, and outcomes, plus a capacity to creatively configure services to meet patient needs. Their success as a quasi–self-governing entity represents a radical alternative to traditional or managed payer systems and at a cost dramatically lower than the administrative fees of most managed care companies. The State of Florida is planning to replicate this model statewide.

CAARR has become the management entity for other small programs. Through this process of shared administrative, fiscal, and supervisory functions, these small programs strengthened and survived, while maintaining their individual program identity.

Touchstone is the smallest network described in this report. Two local agencies came together to form Touchstone, a short-term residential treatment program. These two companies successfully co-located staff from each agency to form this third program. They capitalized on their complementary strengths and were synergistically able to create and successfully operate something that neither could do alone.

These three networks are mentioned as examples of creative and new structures that were successful through networks and collaboration responding to contemporary needs.

Commonalities Among Networks

The networks in this study were chosen to showcase diversity. Regardless of configuration, size, or mission, there are commonalities among the networks:

- Successful networks add value to the membership.
- Competition among providers is viewed as counterproductive to the network.
- Networks are highly participatory.
- Collegiality and peer-to-peer networking is viewed as a highly valuable intangible of the network.
- Formal and informal technical assistance is available through networks.
- Advocacy is a function of most networks.
- Networks support and promote collaboration among members.
- Workforce issues are common among networks.

Benefits of Networks to Providers

- Networks can aid the survival and sustainability of an organization.
- Networks can provide shared administrative functions across programs.
- Participation in a network provides access to resources that otherwise may be unavailable (e.g., IT resources and technical assistance).
- Networks can provide competitive advantages pursuing grants and contracts.
- Networks can provide advocacy.

- Networks can provide access to funding, collaboration on grants, advertising and marketing, shared staffing, group purchasing, and other economies of scale.
- Networks can provide peer-to-peer assistance.

Benefits of Networks to Communities

- Networks represent partnerships among providers, allied service organizations, and the community.
- Service networks can improve access and coordination of services to persons in the community.
- Networks bring together a broad array of services to support the person in treatment and recovery.
- Networks can improve communication among patients and those organizations involved in services.
- Patients generally have better responses to treatment when care is coordinated and networks provide enhanced opportunities for integrated responses.
- Networks can play a vital role in community needs assessment, gap analysis, and service planning.

IMPACT OF NETWORKS ON WORKFORCE AND WORKFORCE DEVELOPMENT

For this report, workforce development is described as multiple processes related to the recruitment, training, employment, retention, and professional development of the substance use workforce. At the beginning of nearly all the networks described herein, workforce development was a relatively low priority. Responding to marketplace challenges and community needs were at the forefront of what motivated the creation of networks. Over the past decade workforce issues have risen to become major priorities in most networks, and networks find themselves with unique capacities to respond to workforce issues.

Network Infrastructure

Networks have many of the infrastructure elements to support high-quality workforce development, particularly in areas of recruitment, training, professional development, and credentialing. Networks usually have a physical location with meeting space where training can be conducted. Networks also have fairly direct access to the workforce. The value and impact of a training system is directly related to its responsiveness to the needs of the participants it intends to serve. Networks afford rich opportunities to gather direct input from directors, supervisors, and line staff to more accurately understand the functioning competencies and deficits and reasonable learning objectives. Networks provide rich opportunities for expanded training and professional development opportunities, from traditional workshops to more in-depth skills-focused training, coaching, and mentoring.

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Recruitment

Although networks play traditional roles in employee recruitment, they also have the capacity to play innovative and creative roles. Traditional roles include advertising, job posting, job fairs, and outreach to higher education. Innovative roles in recruitment were noted in several case studies. For example, there is job sharing of more expensive professional positions, including physician, executive director, accountant, and clinical consultant, across several organizations. Job sharing is either negotiated through the network or facilitated by the network. Another innovative strategy involves the co-location of staff from two or more agencies to deliver services to a common client population. This strategy has enabled certain programs to operate where they otherwise might not and has improved client access to a richer array of services to meet his or her needs.

Retention

Defined strategies for staff retention were not overtly identified in these case studies, but a number of retention strategies can be inferred. The importance of

peer-to-peer support and assistance was consistently identified across the case studies. This support aids in restoring and empowering workers and helps to reduce burnout. Clinical supervision, staff training, and professional development activities (including the subsidization of training and credentialing costs) reinforces staff commitment to the agency.

Professional Development

Rich opportunities for professional development are evident within networks. Several networks have been awarded State contracts for staff training, including both classroom and online courses. These include contracts to prepare workers for certification and licensing. Interestingly, one of the networks also hosts one of the State-authorized counselor certification boards. Many networks provide training and education opportunities, and a number of networks conduct implementation training and other services to support the adoption of evidence-based practices. Lastly, networks provide supervisory training, coaching, and mentoring.

RECOMMENDATIONS AND CONCLUSIONS

Recommendations

The leadership of the networks was asked to describe what they viewed as important considerations in forming a network. Their recommendations can be summarized as follows:

- Clearly define your vision for the organization based (ultimately) on a commitment of services to the community. Impediments to starting and maintaining an association/network are minimal as long as the organizations involved are committed and solidly behind the mission and the implementation model.
- Regularly assess needs of your members and of the communities you serve.
- Identify how your organization and others can respond to those needs.
- Commit to an ongoing process of quality improvement.
- Having the State agency as a partner and/or funder of the network can be a great benefit.
- Identify how the network will be of benefit to the participating organizations.
- Identify the value created through the network.
- Create an environment where providers can build collaborative (not competitive) relationships. Building collaborative partnerships among members is viewed as key to success. It is important to have a mechanism that supports open and productive communication to resolve any issues and differences among providers.
- Develop infrastructure that is responsive to the needs of the population served and the network membership. Create forums for discussion and problem solving. If a program is going to provide a more complex array of services with potential dual relationships, then these issues must have a forum for discussion and consideration.
- Network partners should be selected based on their ability to be complementary and supportive to others in the network.
- Seek to create equality between partners in decisionmaking, program development, operations, successes, profits, and losses. Partners' interests should converge, and there should be a positive and real commitment to the mission and goals of the venture.

- Incorporate democracy into the operations of the organization. Members should set the agenda. Governance policies should specify one vote per member, term limits for board officers, and multiple ways for members to provide input.
- Incorporate and establish quickly a recognizable identity. Move away from having a fiduciary agent as soon as you are able.
- Ensure that senior leadership of member organizations is involved.
- Networks should have access to an IT infrastructure that includes a database capacity to capture client data and information on funding streams. This will support client services, management, long-term planning, and successful program operations.
- Networks can benefit greatly from using a reliable common tool for screening/ assessment, referral, provider communication, client services, data collection, and analysis.

Conclusions

Richly illustrated in this report are varieties of successful networks. Some networks were driven by the availability of public funding to provide a more comprehensive array of services and to improve access and coordination of care to a targeted population. Other networks grew out of shared provider concerns due to changes and perceived challenges in the communities in which programs had historically conducted business. In a world of increasing patient needs and shrinking dollars, providers considered new and innovative methods of staying in business, so they could continue to serve their communities.

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Network models provide structure, resources, and supports to help agencies build more effective business and programmatic capacities. Network programs often have increased access to IT resources, opportunities for funding, technical assistance and resources to build business capacities and a stronger workforce, marketing advantages, and improved governmental and legislative presence, to name a few advantages. Clinically, networks support development of continuums of care, expanded service arrays, improved access and coordination, improved staff skills, and the implementation of evidence-based clinical practices. Successful new configurations of business and clinical practices that are responsive to the needs of the patients and communities served have grown out of these networks. These new structures stand in contrast to business as usual, which in many locations struggles to survive.

These successful systems grew out of the dedication, inspiration, and hard work of individuals working to provide quality services to patients suffering from the disease of addiction. The organizations described in this report shared information about their network generously and freely.

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APPENDIX: LIST OF NETWORKS AND AGENCIES

State: California
Network Name: California Association of Addiction Recovery Resources (CAARR)
Network Description: nonprofit membership association
Type of Services: training, technical assistance, management services, counselor certification, advocacy
Web site: http://www.caarr.org/
Members: 300

State: Florida
Network Name: Central Florida Behavioral Health Network (CFBHN)
Network Description: provider-operated Administrative Services Organization serving central Florida
Type of Services: managing Federal block grant, Medicaid, and other public behavioral health funds; regional planning, training, and technical assistance
Web site: http://www.cfbhn.org/
Members: 19

State: Illinois
Network Name: Project WIN
Network Description: network of providers funded by the Cook County Department of Public Health
Type of Services: substance abuse, mental health, and primary health care services; housing; enrollment in entitlement programs
Web site: none
Members: 8

State: Maine
Network Name: Maine Juvenile Treatment Network (MJTN)
Network Description: network of providers serving adolescents with substance use disorders; managed by Day One, Inc., through a contract from the Maine Office of Substance Abuse
Type of Services: screening, assessment, and treatment services; provider training and technical assistance; data collection and systems improvement
Web site: http://www.juveniletreatmentnetwork.org/
Members: 54, http://www.juveniletreatmentnetwork.org/jtnmap.html

State: Massachusetts
Network Name: Behavioral Health Services Network (BHSN)
Network Description: coalition of behavioral health, primary health, housing, and other service providers serving Cambridge and Somerville
Type of Services: primarily mental health, substance abuse, primary health, and housing services
Web site: http://www.somervillementalhealth.org/
Members: 24 nonprofit community based agencies

State: Nebraska
Network Name: Touchstone
Network Description: residential treatment program for persons with co-occurring disorders
Type of Services: integrated residential treatment
Web site: http://housesofhope.com/ ; http://www.centerpointe.org/
Members: 2

State: New York
Network Name: North Country Behavioral Healthcare Network (NCBHN)
Network Description: rural behavioral health care network and membership association
Type of Services: member services, training, technical assistance, management services, grants development, advocacy
Web site: http://www.behaviorhealthnet.org/home.cfm
Members: 20

State: North Carolina
Network Name: Guilford County Substance Abuse Coalition (GCSAC)
Network Description: incorporated nonprofit coalition of substance use providers and a broad range of community programs and other stakeholders
Type of Services: community needs assessment, service monitoring, planning, training and capacity building, information and referral
Web site: http://www.gcsac.org/about.html
Members: 72

State: Oregon
Network Name: Oregon Treatment Network (OTN)
Network Description: treatment provider membership association and service network
Type of Services: prevention, intervention, and treatment services; member of the National Institute on Drug Abuse Clinical Trials Network at the Oregon Health Services University, which provides training to OTN staff
Web site: http://www.adaptoregon.org/Otn.html
Members: 5