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Jacqueline Marie Kinsley
Successful Leadership in Social
Work: Leadership Characteristics to
Accomplish a Paradigm Shift in
Services

ABSTRACT

The implementation of the Children's Behavior Health Initiative (**CBHI**) as the U.S. Court ordered resolution of the landmark decision of the class action commonly known as *Rosie D. v. Romney* is an opportunity to examine a radical change to the delivery of mental health care for children and the construction of a whole new delivery system on a state-wide basis (Center for Public Representation, 2012). What were the leadership characteristics of and the key decisions made by those who successfully created Community Service Agencies (**CSAs**) to accomplish the delivery of such a paradigm shift in services?

Executives, program directors/managers, and care coordinators from three highly successful CSAs, as determined by the Court Monitor, participated in face-to-face interviews regarding their experiences during the first three years of CBHI.

All three CSAs and parent agencies had employed transformational leadership and establishment of learning organizations as leadership styles that are syntonetic to social work. The degree to which agencies were able to support individual growth, autonomy, and career planning affected their ability to retain experienced care coordinators. All agencies identified difficulties in implementing workable business models in a fee-for-service funding structure and lack of flex funds as the most significant issues in providing excellent wraparound services.

SUCCESSFUL LEADERSHIP IN SOCIAL WORK:
LEADERSHIP CHARACTERISTICS TO ACCOMPLISH A
PARADIGM SHIFT IN SERVICES

A project based upon an independent
investigation, submitted in partial
fulfillment of the requirements for the
degree of Master of Social Work

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Chapter I

Introduction

The implementation of the Children's Behavior Health Initiative (**CBHI**) as the U.S. Court ordered resolution of the landmark decision of the class action commonly known as *Rosie D. v. Romney* is an opportunity to examine a radical change to the delivery of mental health care for children and the construction of a whole new delivery system on a state-wide basis (Center for Public Representation, 2012). What were the leadership characteristics of and the key decisions made by those who successfully created Community Service Agencies (**CSAs**) to accomplish the delivery of such a paradigm shift in services?

Prior to July 1, 2009, children with severe emotional disorders (**SEDs**) could only receive care under Medicaid in Massachusetts in residential institutions. In 2001, eight litigants sued Governor Mitt Romney of the Commonwealth of Massachusetts, and others, on behalf of their Medicaid eligible children with SEDs regarding violation of the Early and Periodic Screening, Diagnosis, and Treatment provision of the federal Medicaid Act, by failing to provide intensive in-home and community-based mental health services and requiring unnecessary hospital stays and long residential placements in order to receive services (Center for Public Representation, 2012).

The Rosie D. Judgment [in 2006] required a paradigm shift for the children's mental health system in Massachusetts. It ... mandated an expanded array of home-based services,...change[d]...the way care was conceptualized[,] and delivered ...highly

individualized, strengths-based, family-driven care...[using] Intensive Care Coordination (**ICC**)...to facilitate a single plan [and a] single team ...[across] agencies and...providers (Center for Public Representation, 2012).

Thirty-two contracts were let across the Commonwealth to establish CSAs. Those contracts provided ICC and Family Partner services and established systems of care organizations within communities statewide to begin operation on July 1, 2009. The menu of new services included: Mobile Crisis Intervention (**MCI**), In-Home Behavioral Services (**IHBS**), Therapeutic Mentoring (**TM**), In-Home Therapy (**IHT**), and Community-Based Acute Treatment (**CBAT**).

Rarely in social work are we called upon to accomplish such a paradigm shift in service delivery (in-home and community-based services) and create new agencies (CSAs), define new career paths (clinical social workers as ICCs), offer a whole new array of services designed to interact with existing systems (child protective services, schools, and juvenile justice), services (outpatient therapy, psychiatry, and pediatric care), and community organizations (day care, before and after school care, recreation).

Successful performance of the CSAs has been measured by the court monitor with respect to fidelity to the wraparound process, satisfaction of the youths and families, quality of medical documentation, and adherence to strict court guidelines for the timely delivery of services. In light of those performance criteria, this study asks: what are the leadership characteristics of and the key decisions made by those who have successfully created Community Service Agencies (CSAs) to accomplish the delivery of a paradigm shift in services?

A major burden of health care costs is generated by persons with complex problems. Wraparound is a recognized delivery system for coordinated services for children with complex medical, mental health, and social issues (Bertram, Suter, Bruns & O'Rourke, 2011). This area

of research is of interest to those considering reducing the cost of health care, wraparound services, caring for veterans and their families, care for the seriously mental ill, the effects of teams in delivery of care, the role of social supports in long term care, and the education of social workers to be leaders of change.

Chapter II

Literature Review

Attitudes About Social Work Leadership

In 2000, Rank and Hutchinson released the findings of their qualitative study of the perceptions of the qualities of social work leadership for the new millennium expressed by social workers in leadership roles in the Council on Social Work Education (CSWE) and the National Association of Social Workers (NASW). The researchers contacted 75 randomly selected deans and directors of CSWE accredited social work schools and 75 presidents and directors of NASW chapters to answer eight open-ended questions over telephone interviews. The findings included five common factors for defining leadership in social work: *Proaction, Values and Ethics, Empowerment, Vision, and Communication*. Some of the themes that were included under *Proaction* were: “to motivate, organize, take risks, facilitate change, mentor, display courage, innovate, be entrepreneurial and persistent” (p. 492). Values and ethics related specifically to those articulated in the NASW Code of Ethics. Some of the themes included under *Empowerment* included: “instilling hope, confidence, and accomplishment, collaboration, influence, and the ability to identify issues and concerns for policy makers” (p. 492). *Vision* was described as: “ability to translate a vision into goals and objectives and leading others to achieve them, understanding and forecasting future directions and leading the way, visualize goals which include the values of the profession” (p. 492). *Communication* was elaborated as “interpreting the mission of the profession to the public” (p. 493). The group differentiated leadership in

social work as being committed to the NASW Code of Ethics, with a ‘systems perspective’, using ‘participatory leadership’ to accomplish ‘altruism’ while promoting the ‘public image’ of social work (p. 491).

Though this survey may not be generalizable to the greater population of social workers and the survey reports other findings with less focus on the purpose of this paper, the study gives us a vision of social work leadership by the holders of the vision of the profession.

Leadership in service changes

Literature regarding leadership in social work is sparse. Unlike the statewide paradigm shift in services in Massachusetts, Connolly’s (2012) descriptive study of the implementation of a single policy change on a single site examined the role of social work leadership in creating change in the delivery of services to children suspected to be at risk for abuse. The pediatric hospital had a single dedicated child abuse team. Best practices indicated an integrated model of care for at risk children with a public motto: “Child protection is everyone’s business” (Connolly, 2012, p. 37). The management approach included strategic planning, consultation with executives and staff, creating enthusiasm for the vision, centralizing intake for family ...services to improve child outcomes, cyclic participatory decision making to address staff concerns, and communication of expectations and training to medical and support staff. The social work leadership described included all five leadership descriptors identified by CSWE and NASW executives. Connolly, however, focused on the steps to change rather than details of the leadership process. This researcher was unable to find examples research regarding a statewide or geographically diverse health care delivery system.

Entrepreneurial Leadership

Alongside the statewide breadth of change in state policy, CBHI required entirely new services. Entrepreneurship is an important leadership skill in bringing an agency to fruition to support an entirely new system of care. However, literature regarding entrepreneurship in social work leadership is difficult to find. Korosec and Berman (2006) used mixed methods to study the role of municipal support for social entrepreneurs, leaders who both identify and initiate new social programs. The authors mailed surveys to 544 city managers of cities having a population of 50,000 or more. They interviewed senior managers who indicated a high or low use of social entrepreneurship in order to acquire a greater depth of information. Researchers inquired about managers' view of current efforts, their roles in supporting social entrepreneurship, and efforts to increase social entrepreneurship in their communities. The researchers found municipal governments supported social entrepreneurs by (1) promoting community awareness of the new programs, (2) assistance in coordinating implementation, and (3) in providing support in acquiring resources. The researchers found that the entrepreneurs who received the most comprehensive support, according to the municipal managers, were those who had experience working with the local government, had a successful track record, and who had community recognition. The findings cannot be generalized to elected politicians, however, as all of the senior city officials in the study were appointed professional city managers. While the study gives us some insight into the importance of the involvement of community in creating and establishing new social services, it does not give us any insight into the leadership traits of the entrepreneurs.

Wraparound: CBHI's New Model of Service

Though the planned CBHI services implemented by the CSAs were new to Massachusetts, the wraparound service model had been used in smaller implementations around the country (Walker, et al., 2011; Bruns & Walker, 2008). Wraparound service facilitates a single individualized treatment plan among the youth and family's various providers and natural supports to address their specific concerns. Literature abounds regarding various aspects of the wraparound process.

Walker and Koroloff (2007) used grounded theory and backward mapping as qualitative approaches to study what the impact was of contextual factors in the community upon the success of wraparound implementation. They also gathered practical information to inform policy decisions in areas where wraparound implementation will be started. Grounded theory imbeds theory in data to avoid investigator bias (Glaser & Strauss, cited by Walker & Bruns, 2007). Backward mapping looks at complex systems from the lens that the aspects of systems closest to the problem are likely to have the most impact on change (Elmore, cited by Walker & Bruns, 2007). The researchers interviewed 28 'expert' wraparound team members from various sites in 12 states regarding what comprises a successful wraparound team and what factors influenced the degree of success of the team. The researchers interviewed peers who had less successful wraparound experiences and interviewed directors and program managers of wraparound agencies. The themes of *collaboration* at all levels of implementation and *accessibility of services and supports* evolved. Additional themes evolved including the need for data proving the effectiveness of wraparound services as a necessary precursor to build support for systemic changes and funding. A framework was developed and reviewed by a diverse group of wraparound experts. The researchers found that a complex array of features effect the

implementation success. The success of the implementation is dependent upon informal community supports (i.e. sports, recreation) to carry out activities in support of the child, but there are few strategies to include these organizations in the planning or to provide discretionary funding to support their activities. Organizational and system level strategies are needed to ensure that each agency is actually using the coordinated plan to guide their activity in support of the child. Wraparound must be imbedded in a system in which communication flows easily upward and downward in the hierarchy and all levels are held accountable for their mission. Walker's and Koroloff's conclusions suggest that in order for CBHI to be most effective, the CSAs and the already existing systems of care (i.e. agencies, hospitals, schools, and providers) need open communication within and between their organizations and with other community resources and a source of discretionary funds with which to carry out the individual care plans.

Bruns et al.'s study (2010) expanded upon Walker and Koroloff's work and identified four system level conditions which are necessary for successful wraparound implementation: (1) access to treatments, (2) personnel who are well trained and supervised, (3) flexible funds that are available for interventions within the community, and (4) *systems of care* are established—cross-agency organizations of senior management of various child/family serving agencies and service providers.

Walker and Karloff (2007), recommended that evidence-based proof wraparound services are effective would be helpful in gaining system-wide support and commitment for service implementation. A necessary precursor to establishing wraparound as an evidence-based service is the establishment of criteria to assess the fidelity of a particular site to the principles of wraparound (Walker & Karoloff, 2007). Bruns, Suter, and Leverentz-Brady (2008) tackled the problem of when fidelity scores are “good enough” to be wraparound. Bruns et al. used national

scores of the Wraparound Fidelity Index (WFI-3) and the scores for ten known sites as a standard measure. Criteria were needed to clearly differentiate among non-wraparound sites, those in the process of implementation, and those wraparound sites with known high outcomes. A calibration was established where a score below 60% warranted a rating of non-wraparound site; sites with superior outcomes scored an 85% or better, and those with a score between 60 and 84% were considered to be in process. They found that a score of 90% or greater was very difficult to obtain. The WFI-3 is one of the fidelity measurements used in Massachusetts to evaluate CSAs as they implemented CBHI. The next step to proving wraparound is evidenced-based is to measure the fidelity of a site and the improvement of outcomes for the children served.

To support the goal of proof of effectiveness of wraparound services, Effland, Walton, and McIntyre (2011) performed a quantitative study of the relationship of wraparound fidelity to youth outcomes using existing data for 515 youth served under a statewide demonstration grant in Indiana. WFI 4.0 was used to measure wraparound fidelity. The Child and Adolescent Needs and Strengths Assessment Tool (**CANS**) was used to measure the youth outcomes, where a decrease in needs (current score-baseline) indicated a positive outcome. A third variable, stage of implementation, was used to differentiate the stage of wraparound implementation of the site: the researchers designated the four stages as contemplation, preparation, action, or maintenance. The researchers found that youths with internalized behavioral health problems (i.e. anxiety, conduct disorder, delinquency, and functional problems) benefited most from wraparound services.

There are difficulties in replicating this study beyond Indiana to a demonstration population in another state, such as Massachusetts. A number of problems made findings related

to fidelity and stage of implementation less valuable. Massachusetts uses CANS as its assessment tool, however, the timing of the assessments is problematic. Outcomes were measured against baseline in the Effland study. By court mandate, the Massachusetts baseline CANS must be completed within the first 10 days. Frequently assessment information from schools, child protective services, probation, and current therapy providers are not available to be included in the initial assessment. The next assessment is done at 90 days, enough time for at least 60 days of progress to have been made against behavioral goals. Allowing 21 days for the completion of the initial CANS would provide better baseline information.

In 2010, in order to encourage social work research in existing gaps related to wraparound research, Bertram, Suter, Bruns, and O'Rourke used the National Implementation Research Network's framework for analysis to survey wraparound implementation research to establish a research agenda. Research regarding definition of wraparound, fidelity, and outcomes were well represented, but other aspects of implementation were neglected or overlooked. There is a dearth of literature related to leadership, motivation, key decisions in implementing wraparound, nor any literature regarding any aspect of social work leadership in creating a new paradigm of services or a new agency.

Theories of Leadership and Motivation

Elizabeth Fisher's (2009) review of motivation and management theories used in social work highlights successful management styles from business practice and business graduate school teachings.

Management by objectives (Drucker, 1954) is one of the most ubiquitously used leadership methods employed in the United States in business. The use of mission, goals, and measurements are commonly used in social service organizations but are not recognized by the

MBO name. The initial use of missions, goals, and objectives in an organization is time consuming and awkward. Once acculturated, MBO allows contributors at any and all levels to have the wherewithal to operate independently to support the overall health of the organization, to promote the organization's goals, and to reinforce the organization's culture and ethics

An organization may be capable of growth and improvement, but leadership and motivation are also essential. Transformational leadership (Bass & Avolio, 1994) is based on (1) *idealized influence*, the ability of a charismatic leader to generate enthusiasm for her vision, (2) *intellectual stimulation*, being an innovative problem solver, (3) *individual consideration*, knowing your team members, coaching and mentoring them, and providing opportunities for them to meet their personal goals, and (4) *inspirational motivation*, to instill confidence, belief in the cause, and high expectations through engagement, enthusiasm, and encouragement.

Transformational management is contrasted with transactional management, giving directions, goals, and measuring outcomes. Individual autonomy and mission, and inspirational leadership and motivation are great, but the leader and the individual contributor cannot manage rapid growth and change in isolation.

Anyone who has ever been on a great team has experience the feeling connected and generative. In 1990 Peter Senge introduced the concept of *learning organizations* built on five disciplines: systems thinking, personal mastery, revealing hidden mental models to prepare for change, shared vision, and team learning. (Senge, 1990, pp. 5-11). The *core learning capabilities* for a team are based on aspiration, reflective conversation, and understanding complexity (systems thinking) (Senge, 1990, p. xiii). Personal mastery is built upon recognition of the "creative tension" between today's reality and our vision, the use of structural conflict by making the commitment "to root out the ways we limit...ourselves" (Senge, 1990, pp. 140-148)

to find the truth, and the support of the subconscious because we don't need all the answers now (Senge, 1990). Senge's concept of learning organizations is highly syntonic with social work. Group supervision is fertile ground to build a learning organization.

The implementation of CBHI as the U.S. Court-ordered resolution of the landmark decision of the action commonly known as *Rosie D. v. Romney*, is an opportunity to examine a radical change to the delivery of mental health care for children and the construction of a whole new delivery system on a state-wide basis (Center for Public Representation, 2012). What are the leadership characteristics of and the key decisions made by the program managers who successfully created CSAs to accomplish the delivery of a paradigm shift in services?

This researcher found examples of the implementation of a single policy on a closed site (Connolly, 2012), a single example of entrepreneurship in social work (Korosec & Berman, 2006), several examples of a particular aspect of wraparound services (Walker & Koroloff, 2007; Bruns et al., 2008; Effland, Walton, & McIntyre, 2010; Walker & Matarese, 2011), and a few examples of aspects of the implementation of wraparound (Bruns et al., 2010; Munsell et al., 2011). When this researcher read Elizabeth Fisher's review of motivation and management theories used in social work, she recognized successful management styles from her experience in business, business graduate school, and social work internship.

As a young supervisor in a worldwide organization of only 500 people, which used MBO, this researcher felt empowered. Every day, no matter what occurred, she knew exactly what she needed to do in her job to support the organization's goals. The ability of contributors at all levels to understand what is important to their mission and where they have autonomy to make change is a precursor for an organization to make rapid growth and continual improvement.

The adept enculturation of Management By Objectives (**MBO**) (Drucker, 1954), the creation of a learning organization (Senge, 1990), and charismatic leadership (Bass & Avolio, 1994) in Wayside Youth and Family Support Network, Inc. supported the creation of a like organization by the program manager of the CSA . The program manager successfully employed these three management theories and acute decision making to establish one of the most successful and effective CSAs as measured by accepted instruments (Effland et al., 2011; Bruns, Suter, & Leverentz-Brady, 2008; Walker & Sanders, 2010) in the Commonwealth of Massachusetts. This researcher's experience as an intern in this CSA, led her to design an inquiry to know more about how the birthing and early years of the CSAs unfolded and key factors in their outcomes.

Studies of social work management in the U.S. are few (Hong, 2011). There is a paucity of literature regarding entrepreneurial management in social work (Korosec et al., 2006) and wraparound implementation (Bertram, et al., 2011; Walker, Bruns, Conlan, & LaForce, 2011) and an absence of literature regarding the management of paradigm shifts in delivery systems, or the Massachusetts experience with CBHI. Therefore an exploratory, qualitative exploration using case studies is the method selected to explore the leadership characteristics of and the key decisions made by the program managers who successfully created Community Service Agencies (CSAs) to accomplish the delivery of a paradigm shift in services. The question leads to several gaps in the literature. Interviews of the key players in the decision and implementation processes will give several perspectives into the question. Executives of parent organizations can tell us why they chose to respond to the request for proposals and their criteria and timeline for hiring program managers and planning the implementation of the CSA. The program managers can tell us their assessment of their management styles, selection and management of personnel,

the geography, demography, and politics of stakeholders in their associated catchment areas, and which decisions they found to be key to the success of the CSA. Clinical social workers who work as intensive care coordinators can give us their perspectives of the program director's strengths and style, populations, and key management decisions to their success in their roles. This study will include case studies of three CSAs within Massachusetts in order to understand how key individuals describe the leadership and key decisions that made birthing and the first three years of operation of a paradigm shift in services possible.

CHAPTER III

Methodology

In order to understand how key individuals describe the leadership and key decisions that made birthing and the first three years of operation of a paradigm shift in services possible.

Sample

Sampling was non-probabilistic and employed a modified snowball methodology (Rubin & Babbie, 2011). CSAs (and their parent agencies) were identified by the U.S. Court monitor to be among the highest performing CBHI-CSAs, based upon her evaluations regarding adherence to court mandates, wraparound fidelity, caregiver satisfaction, and outcomes. The sample size was three CSAs, five persons per CSA (in a range of management/administration levels), for a total of fifteen interviewees in order to produce three agency studies.

Inclusion criteria defining my study population were that participants be English speaking, mental health care professionals, over 21 years of age, who are program managers, intensive care coordinators, and parent agency executives of the CSAs. My study frame included agencies from among the CSAs judged to be among the top performing CSAs during the relevant study period, the program manager, an executive, and three intensive care coordinators, clinical social workers. The relevant study period is July 1, 2009, the first day of CBHI services, through July 1, 2012, the third anniversary of CBHI services. Top performing CSAs were recommended by the U.S. Court Monitor, Karen Snyder, using data she had previously gathered, relevant to the study period, regarding adherence to wraparound fidelity, compliance with Court timelines,

feedback from caregivers provided in local town meetings, and ability to meet study guidelines. Among CSAs, preference was given to CSAs having program managers who had managed the CSA throughout the study period. Among intensive care coordinators for the CSA, preference was given to intensive care coordinators who in their aggregate employment dates spanned the study period. Among CSA agency executives, preference was given to executives who participated in the decision to bid for a CSA contract and influenced the management of the CSA.

Exclusion criteria further defining my study population included: Hiring executives, program managers, or intensive care coordinators who are not currently employed by the CSA or its parent agencies, or were not employed by the CSA within the study period. CSAs were excluded if the agency did not have a hiring manager, a program manager, and three intensive care coordinators who met the study criteria.

Data collection

Parent agencies of the CSAs recommended by the Court monitor were contacted to request the participation of the CSA in the case study. Letters of informed consent were used with all participants to explain the study and the purpose for interviewing the candidate. Data collected were qualitative, based upon audio taped face-to-face individual, open-ended interviews in an private, enclosed office or conference room at the agency, or at another location which supported confidentiality and at the convenience of the interviewee, The interviews at each agency consisted of a twenty minute to two hour interview with the program director, and a twenty minute to one hour interview with a hiring executive from the parent agency, and each of three intensive care coordinators; the interview times depended on the breath of the material provided by the interviewee. There was an additional later opportunity for clarifying questions

via email or telephone. Demographic data were collected from all participants: age, self-identified gender, race, and ethnicity, highest degree attained, professional license(s) held, years of experience in the mental health field. The interview was semi-structured, using an interview guide, around themes of leadership, motivation, and key hurdles and decisions, with respect to the quality of service to clients, the CSA mission and members, cooperation and adequacy of the system of care, and meeting insurance requirements. (See Appendix A for the Informed Consent Form).

Data analysis

Audio taped interviews were transcribed by the investigator. The investigator transcribed audio taped interviews. The investigator collected impressions and observed non-verbal information in field notes. These notes were considered with the coded quotes during the analysis. A case study for each CSA was compiled from the interviews and notes. Transcripts were scrubbed of identifying information. Data were coded three times, manually, to identify themes, and then stored electronically. Triangulation was used to assess interview error. By soliciting from the program manager her personal assessment and examples of her leadership and motivational styles, and by soliciting the same assessments from an executive in the parent agency, and from three of the program manager's direct reports, intensive care coordinators, the investigator was able to use the intersection of the participants' opinions as a measure of validity. The informed consent agreement included provision to contact participants for clarifying questions. Interviews were conducted with the aim to gather detailed, "meaty" descriptions. Negative information and discrepancies were included in the presentation of data.

Chapter IV

Findings

All participants' and agencies' names used in this report are pseudonyms, in order to protect the privacy of participants as well as other staff and clients of the agencies.

The data from the interviews is presented as three case studies drawn from the interviews of participants of each CSA, respectively, and as themes found in the experiences of the individuals in all of the CSAs.

Agency Zenith

Zenith is a well-established agency, which provides mental health services for children and families. Zenith won two CSA contracts to provide services for CBHI. We will be considering the CSA in a catchment area in which Zenith had experience providing outpatient counseling, but had not previously provided wraparound services.

Executive. In August of 2009, two months after the start of CBHI services, Agency Zenith's new CEO, Clare, who has a Masters degree in Social Work (MSW and) and is a Licensed Independent Clinical Social Worker (LICSW) with 35 years experience, came on board. No stranger to CBHI, the CEO had (1) participated as an executive in two earlier wraparound pilots, (2) was a member of the remedy recommendation teams for Rosie D. (3) continued as a member of the CBHI Advisory Panel, and (4) was a principal in drafting the previous agency's CSA proposal:

...for children's agencies in Massachusetts, having the CBHI service become available for children [was a game changer]... The most important thing for me was that finally we had state funding for something that acknowledges the whole family. Now we can look at the rest of the family. This is all very mission focused; it is what we are all about.

Zenith's CSA had begun hiring CBHI personnel without benefit of a business model or a firm idea of client demand. The agency, the new Program Director, the ICC Supervisor, and the initial ICC had participated in a previous Department of Mental Health (**DMH**) funded wraparound pilot, Comprehensive Family Focused Care (**CFFC**), which had no business model or productivity measures. Zenith did have a business model for their other fee-for-service offerings. As the new CEO Clare declared a pause in hiring, called together the CSA staff and Zenith executives to solidify a demand model for hiring new personnel and to professionalize the interview process. The new CSA was able to progress from then on implementing the new productivity goals and the hiring model. Clare noted that the CBHI requirement of offering a face-to-face visit with newly referred families within 72 hours of a request for services is in conflict with any fee-for-service business model. Clare found that Zenith had yet to standardize their policies and procedures across the agency, and spent much of her initial months working with her executive team to put these in place. Across the agency, Zenith has a standard employee performance review based upon NASW ethics and social work practices.

Clare advocates within the CBHI advisory group and with insurance executives for a per diem or per case payment alternative to fee-for-service. She sees the biggest issue facing the CSAs is retention of intensive care coordinators. The insurance carriers have made two pay categories for care coordinators based on their completion of bachelors or masters degrees. Care

coordinators have not gotten a raise at Zenith except via promotion or completion of their graduate degrees. Zenith, however, has absorbed increased medical insurance costs over the three years and has been transparent to the care coordinators regarding the value of this measure. Staff have found that after two years as care coordinators they can make \$20,000 a year more if they go to work for the state in the Department of Children and Families (**DCF**) or DMH. Clare and her executive committee host a retention committee meeting on a monthly basis, with call-in, available to all staff members. “We take their concerns and suggestions very seriously, but we are clear on what can change and what cannot. The productivity goals cannot change without a change in the reimbursement scheme.” Losing a care coordinator is a financial sink for any CSA because hiring and training a coordinator costs staff productivity time, and the average training time for a new coordinator before they can meet full productivity is four weeks.

The fee-for-service model in Massachusetts does not make provision for “flex funds” to help clients engage in their community. Flex funds used to be available through DMH, but have been re-allocated to other purposes once CBHI took effect. Funds that went unspent for their new purpose were eventually spent for summer camp for many clients.

Clare has maintained her LICSW credentials and interest in clinical work. “I still like to go to CSA staff meetings and case reviews ... It’s the families that motivate me.”

When asked about her management style, Clare declared, “I’m a nudge!” Zenith’s CSA Program Manager—now Program Director—Zoe, noted that being autonomous and having independence motivated her. Clare commented, “She’s very good. She does a great job. She’s the future.”

Program Manager. Zoe is a mental health professional with 13 years experience with an MSW and LICSW. Zoe had had five years of experience with in Zenith’s CFFC wraparound

trial program as an ICC, supervisor, and program manager. Zoe is currently the Program Director responsible for the CSA, IHT and TM (the other CBHI services offered), and Site Director for these and the collocated outpatient clinical services. However, she had not been involved in Zenith's bid for the CSA contract, which included a collocated partner agency to provide family partner support. Zoe listed her strengths at that time as (1) being thoroughly familiar with wraparound, (2) experienced as an ICC, (3) had some management and hiring experience, (4) enjoyed a leadership role, (5) looked forward to growing an organization from scratch, and (5) knew two Zenith staffers with wraparound experience, whom she would like to join her in the CSA. Starting the CSA, Zoe found the following to be essential (a) executive management support, (b) relationships within the community, (c) establishing a culture in which her staff felt supported by as well as supported her, (d) availability to provide training to support high fidelity wraparound services, and (e) an existing working relationship with two key hires of ICCs within Zenith who were experienced in wraparound, (f) hiring a terrific office manager right at the start.

Zoe was clear that Zenith executives perceived the success of the CSAs as key to Zenith's future. From Clare's arrival, Zoe had one-on-one supervision with the CEO, weekly meetings of the CSA program managers, CEO, CFO, human resources, and occasionally representatives of state agencies. These meetings resulted in the business model, productivity requirements, demand model for hiring, and formalizing their interview and hiring procedures. These executive meetings continued as the CSA matured, but four years later are now held on a monthly schedule. Continued executive support has assured Zoe that Zenith was meaningfully invested in the growth and success of the CSA. Zoe continues to value her weekly supervision

with Clare. “I really respect Clare. She’s very smart about business. I learn a lot from her. I see her as a mentor.”

The CSA’s catchment area is geographically very small. The largest town is also a refugee resettlement area where twenty languages are spoken. The community service organizations and agencies have a long history of meeting together to share information and of working together to accomplish mutual goals. Zoe immediately began meeting with the other stakeholders “who welcomed me with open arms.” The community had also had some early experience with two wraparound coordinators that were funded by an early SAMSHA grant. The System of Care organization was formalized from the beginning of the CSA. CBHI mandated that each CSA host a System of Care organization, a regular meeting of principals of each of the agencies and stakeholders in the catchment area to facilitate cooperation in providing services for youth served by CBHI.

Zoe envisioned creating a culture of mutual support based upon modeling the principles of wraparound.

I’m not just strength based with my families; I’m strength based with my staff. I’m not just individualized and creative with families; I’m doing it with the staff. So, I’m really trying to build a very nice culture here. On a day-to-day basis, I really pay attention to what is going on here. What’s happening with morale...Someone’s leaving. Someone’s coming. [I’m] always trying to keep my hand on the pulse of that and keeping my managers happy so that trickles down to their staff. This is always at the top of my list because if the staff isn’t feeling good and supported, they’re not going to do good work. Zoe also protects her staff by filtering any political ‘drama’ that may be going on at Zenith.

Zoe believes high fidelity wraparound is key to good care. Training is ongoing, including required initial training; incentives to complete Tier 1 National Certification as soon as possible; weekly individual supervision; group supervision for ICCs and Family Partners, both separately and together, alternating on a biweekly basis; biweekly review of two care plans presented to the entire group for peer suggestions, by request; dyadic supervision for ICC/Family Partner pairs with their supervisors; annual state mandated training; and additional topics based on needs and strengths expressed by individuals, in supervision, or in yearly performance reviews. Each staff meeting contains a “wraparound highlight”—up to 15 minutes featuring a principle or stage of wraparound, and the staff share accomplishments. Every month the CSA brings someone in to provide training, and every quarter there is an all-site meeting, including a training that is pertinent to all of the staff. Discussions keep coming back to the work and to high fidelity wraparound. Peer-to-peer training is supported by the open office configuration so that information is easily shared. Fidelity is measured by the Team Observation Measure (**TOM**), the Wraparound Family Interviews (**WFI**), and the Document Review Measure (**DRM**). The TOM is done by certified supervisors from the CSA. The other two measurements are done by the state.

We are going to more observations of our staff to provide coaching, like having them invite us to a home visit. Supervisors will have an opportunity to meet the families, see ... what they are doing, and help support our staff...and fidelity.

Zenith also presents a series of trainings that fulfill clinician re-licensing continuing education (CEU) requirements at no cost.

The WFI involves interviews with twenty randomly selected CSA families. The measure rates the CSA in many categories, as well as providing a mean score for Massachusetts, and the

national mean score for each category. The TOM and the DRM result in scores for individual ICCs. Feedback from the WFI is shared with staff. Zoe presents them at a staff meeting:

Here are the areas we're shining in and I congratulate and celebrate that. Here are the areas that we didn't do quite as high in. Does that resonate with you? Does that surprise you? Usually the staff feels it makes sense [regarding] the areas [in which] we're strong and not as strong...Then we brainstorm our goals for the year: If we're not as strong in this area, what do you guys think we could do to improve that? We get their buy-in and we try to stay conscious of that throughout the year.

The goals are goals internal to the CSA; senior management is aware of, but does not set fidelity goals.

Having two key ICCs with wraparound experience and a proven working relationship and performance provided the CSA with the talent needed to serve initial families, to hire and train, and to support the culture Zoe envisioned. Hiring a strong office administrator immediately extended Zoe's ability to identify, outfit, and bring on line a new site, establish office procedures and tracking methods, and provides another team member to facilitate difficult insurance problems.

Zoe is motivated by (1) seeing good outcomes with the families, (2) supporting and in turn being supported by staff, (3) being creative, (4) building a new organization, (5) being autonomous.

I try to practice being kind and open to support my staff. I'm very conscious ... [that] I try to model for my staff in whatever I do. I like being creative. I've never been bored with wraparound. There's always something new and creative. I like being the creative force behind...building [the CSA] from the ground up. I like to do my own thing.

Zoe's criteria for hiring ICCs have changed over the first years, more by experience than by different demands in the job.

I hire ICCs for personality. Are they outgoing? Can they command a room? Do they have good people skills? Are they organized enough to manage the productivity goal, but flexible enough to adapt their plans when a family is in crisis? If they have these traits I can teach them wraparound. Early on I didn't think as much about how [a candidate] could facilitate a team meeting.

Retention of ICCs beyond two years has been a problem. Zoe explains that ICCs make a lot of professional connections and after two years they can make more money working for the state or for a school. Sometimes they leave to complete their masters degrees. ICCs who have their masters stay a little longer, but leave because they are burned out. It's a difficult job. ICCs serve an average of eleven or twelve families. However there is great variation. What is important to Zoe is doing good wraparound while meeting the productivity requirement. The CSA does exit interviews with staff and Zenith holds a monthly retention committee meeting. Staff can call in; the executive team seriously considers both the complaints and the suggestions.

Zoe's biggest concern is providing high fidelity wraparound care. Administrative measures that interfere with quality care frustrate her. An alternative payment plan like per diem or per client payment would provide better wraparound care. The time spent on productivity management and documentation is another layer of work. That time could be spent with families. Also, the current policy does not provide the flex funds, which are usually part of

wraparound care needed to provide individualized solutions and encourage engagement in the community.

Intensive care coordinators. The three care coordinators interviewed all have masters degrees and were credentialed, two as Licensed Mental Health Counselors (LMHCs) and one LICSW. Their ages range from 27 to 62 years. All have been with the CSA from 3.7 to 4 years, having started on day one or a few months later. Two of the care coordinators have been supervisors for all or part of the first three years of CBHI.

One former care coordinator, Eva, age 31, has since been promoted to Assistant Program Director in year four of CBHI. Eva identified another type of training beyond those articulated by Zoe. Prior to promotion, Zoe asked Eva to act for Zoe in several of her duties including attending community or executive meetings or facilitating CSA meetings. This not only gave Eva an opportunity to see the concerns that were addressed at a more senior level, but also allowed her to infer what she might do on her own to prepare for more senior responsibility. Zoe maintained that she had confidence that Eva could handle anything Zoe needed her to do. Clare had introduced similar learning opportunities, where Zoe represented Clare in some of Clare's responsibilities.

All of the care coordinators named the management style and support of the Program Director, the principles of wraparound being employed every day in the office, the support of their colleagues, and growth in their (client) families as the biggest motivators on the job.

The two care coordinators who had not changed titles while working in the CSA, felt they repeatedly needed to process their self perception, believing that, after 3.7+ years, they were more valuable contributors than the day they started, but had not received, nor expected to receive any recognition or confirmation in their compensation.

All three care coordinators disliked the productivity goal that came along with fee-for-service. Two of the care coordinators now hold supervisory positions and are exempt from the productivity goal. All expressed that staff carefully managed their productivity hours. One care coordinator explained that staff used vacation time in order to attend trainings because for all day training one would have to make up six hours of billable time. In a stressful job where self-care is important, using vacation time was a strong disincentive to attend optional training, such as the monthly CEU rated training sessions provided by Zenith. All of the care coordinators believed banking excess productivity hours was a positive step. However, the agency's end of year bank cash out program was not universally seen by staff as a bonus, but was perceived by some as a delayed payment of overtime.

All of the care coordinators noted that the lack of flex funds limited their ability to do great wraparound.

Agency Pinnacle

Pinnacle is a seasoned agency with more than twenty years experience providing a variety of services including adult treatment, dual diagnosis treatment, and children and family services. Pinnacle won a CSA contract for a catchment area in which they had provided children and family outpatient counseling services and had contracted to provide services for the Department of Children and Families.

Executive. Ted, who has a Masters degree in Social Work (MSW and) and is a Licensed Independent Clinical Social Worker (LICSW), with 30 years experience, has been CEO of Pinnacle for six years and has spent most of his career working at Pinnacle. Ted tells his story best:

The people who ran the agency when I was first hired really saw their mission as being social entrepreneurs in the sense that they focused on excellence and partnership with government to help solve problems that otherwise might not be solvable... [They] understood that ...by doing excellent work with the people and families we are serving, maintaining great relationships with state partners and funders, and at the same time being fiscally responsible ...you can make that work as a financial model as long as you are creative, flexible, and ... you hire, promote, and retain the right people. We are not reliant on fundraising or grants, to any great degree...We provide services and we get paid for them. Each year we spend a little less than we take in. ... The small surplus allows us to reinvent the agency and to take on things like the CSA.

Pinnacle had an in-house certified wraparound trainer and care coordination and family partners within many of their services long before Rosie D. However, initially Pinnacle was not convinced that the CSAs would be financial successes. The demand for services was still unknown. An executive team, including the Program Manager, decided to try an incentivized pay schedule similar to one that had worked well in another Pinnacle organization. That type of incentive had been proven to “maintain high quality services, high motivation, and a high connection to the work, but still had a focus on productivity.” The model was tweaked to

make sure everyone was paid what they needed to be paid, and the benefit package felt strong, but still maintained an emphasis on productivity and flexibility...Productivity and flexibility are strongly linked. We’ve been able to pay people good money with respect to the market and also give people flexibility in their hours. We have been able to access

[individuals] like young mothers ... who are willing to work hard, but cannot be in one place eight hours a day.

The productivity goal for all care coordinators is a yearly average of 30 billable hours in a 40-hour week. Weekly compensation is determined by a base salary and incentive for every billing hour over the first fifteen hours. Care coordinators must accommodate families who need to meet in the evening or on Saturday.

We offer a defined benefit pension plan to employees once they have been with us for a few years. No other human services agency offers this that I am aware of...[Our pension] is why you don't see people leaving for the state [jobs]. [We are able to do this because] our administrative costs are lower than most. Our tuition reimbursement is really good.

We've brought large chunks of our agency including the community-based services under the horizontal integration of trauma informed care. About 400 staff are trained in psychological first aid. They are available across divisions [to support employees with vicarious trauma] and to teach yoga and self-care. [It's our way of] institutionalizing self-care.

We offer as many opportunities as possible for people to connect to each other and to connect across different divisions.

Pinnacle has a commitment to having staff relate to each other as people as well as provider/employees.

Program manager. Ana is currently Division Director for Pinnacle's community based services, two CSAs, all CBHI services, and two agencies contracted from the Department of

Children and Families. Ana has her Masters in psychology, LMHC licensure, and 21 years' experience in mental health services. Years ago, while working for Pinnacle, Ana became a Certified Wraparound Trainer. Later she started a DCF contracted agency in the same catchment area as the CSA. Ana provided information for Pinnacle's bid for their first CSA because of her familiarity with the location. Pinnacle was notified that they won the bid about three months prior to opening day. Ana became fully committed as Program Manager from that day forward. Ana had wraparound experience, had launched and run another program, had relationships with other agencies and providers in the area, and had a good track record of hiring people who had excelled within Pinnacle. Ana's first priority was to have a strong foundation to build upon. Despite their lack of experience with wraparound, Ana hired a supervisor, a care coordinator, and an administrative assistant with whom she had a track record of working fruitfully and successfully as a team.

I have a fair, but firm management style. I try to be visible and engaged on site. I always go right to wraparound. I do a lot of modeling, training, repetition, and supervision. I emphasize the differences among case management, therapy, and case coordination. I stay aware of a piece of what each coordinator is doing.

We offer great flexibility in meeting a 40-hour workweek and need flexibility in return to meet our families' needs. We have web based service so coordinators are able to work from home and provide hands free and iPhones to keep coordinators connected by email, text, and phone with their peers, families, and providers. We hired professionals and as such we do not micro-manage.

We have sixteen care coordinators and have [had] only had four people leave. Two were planned as part of their career development goals. One's family relocated and we were

able to retain her working within Pinnacle. Philosophical differences resulted in the final departure, which was not a surprise to either party.

Rare and planned departures have allowed the CSA to accumulate high quality resumes, and have a replacement staff in training and ready at departure date. The now-available management and team time that is not spent on hiring and initial training is available for special projects, which are not mandated, but are supportive of the mission of the CSA.

The Family Partners service is subcontracted to Pinnacle's collocated partner. They have maintained a close and integrated organization. Care Coordinators have one hour of individual supervision weekly. Group supervision for Care Coordinators alternates with joint group supervision of Intensive Care Coordinators and Family Partners. Initially group supervision occurred weekly, but has recently transitioned to biweekly. Individuals may request a private case consultation or dyadic supervision with both the Care Coordinator Supervisor and the Family Partner Supervisor to brainstorm interventions or clarify roles. Much of the day-to-day learning happens over cubicle walls, peer to peer, and through emails, texts, and calls over iPhone when they are on the road. Initial training has been systematized and Pinnacle is exploring technology to assist in this process. All care coordinators are required to complete Tier 1 National Certification in Wraparound within ninety days. The CSA offers an incentive for care coordinators to reach higher certifications. All of the care coordinators, except the most recent hire, are Tier 2 Certified. Care coordinators attend mandated trainings. CSA monthly guest speakers and refreshers, determined in both bottom up and top down processes, present a thorough and topical program throughout the year. Each staff meeting includes a "Need and Know" session for brainstorming and resource sharing.

Since the start of the CSA, compensation has been improved via bonuses, increased benefit options, increased mileage reimbursement, and increased vacation and holiday accrual.

The System of Care for the CSA is very active with consistent participation by at least thirty-five stakeholders. Commercial partners have also contributed, including such things as providing meeting space, or pizza for kids' events. Two of the System of Care's goals have continued since year one. 'Teens in Action' is a leadership development group for latency aged kids to help prepare them for transitional age. The group completes monthly volunteer opportunities for the community. The program is very popular and has a long waiting list. The second program, Future Leaders of _____ (**FLO** _____), is open to any young adult in the catchment area and provides eight-week internships in local businesses. CSA staff interviews candidates, as they would be interviewed for a job, and give feedback and coaching on the youth's interview skills. The business members of the System of Care were very creative, and managed to partner with the Boy Scouts of America to provide liability insurance and CORI (Criminal Offender Record Information) checks when needed. The System of Care partnered with the DMH on a grant regarding increasing engagement of transitional age youth. The grant mandated a Youth Advisory Board, which is currently filming a documentary about the Teens in Action and Future Leaders programs. The documentary will be made available to all of the CSAs within the state.

Intensive Care Coordinators. Marie, a Senior Care Coordinator starting day one, explained:

This is the best agency I've worked for. Pinnacle has a culture of learning, respect, and growth. They want folks to make the agency a career, not just a job. Our take-home pay is competitive with state jobs. They invest in training...The environment is wonderful.

There's always a sense that administration is there for you... I'm very proud of the CSA. Pinnacle is always thinking outside the box. I hope to do that in my ... role. I like expanding and doing more than "by the book" and that's Pinnacle. With the open door policy, there's a lot of supervision on the fly in addition to the scheduled supervisions and trainings and peer-to-peer support. Our iPhones keep us in touch during travel time and we can do some work on the road...[Our management is] proactive rather than reactive...[chuckle] [We are handed] red tickets for a job well done; each month there's a drawing and someone wins a gift.

The care coordinators enjoy working and playing with their colleagues. Pinnacle has a big holiday party. The CSA has a summer pot luck and swim party. They enjoy each other's company. Every staff meeting they go around the table to share a personal or professional celebration. "We're a tight knit group." Pinnacle gives training time so that productivity is not a disincentive to embracing opportunities.

A younger colleague who started about six months following opening day told her story: The culture is really positive. Since I've been here I have completed my masters degree, with tuition refund, and have gotten licensed, all while working full time and caring for a family and two little girls. Pinnacle's commitment to flexibility makes it work. When I needed to leave early to get to my classes, there was never a problem. If one of the girls is sick, I can do my work from home. I can work a holiday to be able to go on [my daughters'] field trip. The job is demanding...I'm invigorated. The model works for everyone.

The care coordinators spontaneously talked about the support they had from their supervisors, managers, peers, and Pinnacle. They felt assured of lots of future opportunities because Pinnacle promotes from within. Each person has a professional development plan, which is developed with the supervisor and identifies personal career goals, as well as opportunities for training and experiences that would move them towards that goal.

This group had much energy in expressing their annoyance regarding tracking productivity. Their most significant issues were that time spent on insurance, traveling, conferring with one's family partner, or resolving insurance issues were not billable. Recently their most common insurance carrier replaced their (live person) liaison with an 800 phone number, greatly increasing the time required to effect resolution. Most of their clients were located near the office, but visiting some families required as much as 1.75 hours travel time, one way, in traffic. Care coordinators bill for time spent with most providers, but time spent conferring with their most important ally, the family partner, cannot be billed.

Agency Apex

Apex was a small agency that had a long and successful track record in using wraparound care to support some of the most difficult clients in their area. Apex partnered with a healthcare agency with academic ties and with agencies that provided Family Partner services to win the CSA bid.

Executive. Art, the Apex principle investigator, who earned a Doctorate in Psychology and is a Licensed Psychologist with twenty–six years experience, had been involved with many early wraparound trials. The earliest, sponsored by DMH, combined the functions of in-home therapy and care coordination. Later Art ran two large-scale federally funded projects through an educational institution with whom he is affiliated. In these programs care coordinators were

paired with family partners. One of these programs was named by Judge Ponsor (the federal Judge who presided over Rosie D.) as a model for the remedy to the Rosie D. v Romney suit. Art had some input to the team that formulated the request for proposal (**RFP**) for CSA contracts; Art was able to get family partners included in the model. Art wanted to continue to be involved in wraparound services. He partnered with a community health organization that was also affiliated with the same academic institution, and with small agencies that specialized in family partner services. Art's program already had fifty families who were receiving wraparound services. With the publicity regarding the opening of CBHI services, on opening day, Apex had enrolled thirty-five families, their opening day capacity and had a waiting list of one-hundred families. Apex's previous program utilized care coordinators with a masters degree and several years experience. Art was able to fill program management and supervisor positions from his seasoned care coordinators, but the CBHI fee-for-service rates do not support competitive salaries for experienced care coordinators. Art has come to terms with his experience that he will be employing new graduates as care coordinators. He has added mentoring to Apex's mission statement. "We'll produce good professionals...with all the values we see as so important, kindness, humility, strengths based..."

Art explained that he has been very vocal regarding the culture necessary in a CSA.

The environment must reflect the work. Managers and supervisors must mirror the wraparound principles with staff in order for care coordinators to do good wraparound with families.

Art says he motivates people by "appeal[ing] to [their] enlightened self interest. I like to drive home at night feeling good. [In this work] you can have pride in what you do."

Art is philosophical and spoke of reflecting with the state's wraparound consultants that what was "wrap" in 2001, was not the wrap of 2009. It's time to advocate a new model. Too much energy is being spent on teams. We acculturate team process, but it can't be maintained by parents....[Maybe we should be] coaching families to articulate their needs. We're still in the middle of a court case. When that's done maybe the state can revisit the methodology.

Apex's catchment area is very large, but seventy percent of the families are located in one town. Apex's productivity goal is 72.5 percent of hours worked, twenty-nine billable hours in a forty hour work week. Apex keeps a bank for an individual's billable hours over the productivity goal. Hours in excess of twenty are paid as a bonus at the end of the year.

Art clarified the origins of systems of care:

Systems of Care in wraparound were designed in a model where people who have the power [in agencies] can work together to change the policy. [This is possible] in other states which have county based leadership...Massachusetts policy is state based. [In other states, systems of care] don't need to go back to the state for policy changes.

Program manager. Marie completed her MSW, is licensed as an LCSW, and has fifteen years experience in social work. She has been doing wraparound services with Art for nearly ten years and she currently manages two CSAs. Marie is passionate about modeling the principles of wraparound and the techniques used in team meetings, such as brainstorming options, when she interacts with her supervisors and care coordinators. Marie and her counterpart director for family partners began together as care coordinator and family partner, moved together into

supervision, and now work together as director of care coordinators and director of family partners. Because of their long shared work history, which includes working with Art, they had a common vision of the culture they wanted to engender in the CSA.

One of the tenets of wraparound is ‘when you talk about a family, have the family present.’ Marie explained modeling wraparound in the office through the use of supervision:

The same issues we have in [care] team meetings...we have in supervision. Especially with new staff, [we need to] translate for our staff. [A care coordinator might say] ‘I don’t want her [the family partner] to know I’m struggling with this.’ [Our response], “But this is about her. Is it fair? Is it right?” In supervision we work out, ‘Is this an issue with you?’ We can work it out here, but when it’s not, we try to coach the importance of the dyad [the care coordinator and family partner working as a team and providing service]. A major use of dyadic [supervision, a meeting attended by a care coordinator, the family partner, and both of their supervisors,] is, ‘Why are we [the family, a provider, or the care team] stuck in this particular area? How do we use staff to manage that [situation].’

As Art said earlier, the CSA had 100 families on the waiting list from day one. Marie started with six experienced care coordinators and hired an additional five new MSW graduates. The growth plan indicated a target headcount of twenty care coordinators and two-three supervisors to cover two CSAs. However, because of attrition of the most experienced staff to state agencies, Marie has not exceeded twelve care coordinators. Training for a new coordinator takes four to six weeks, utilizing courses, workbooks and shadowing, before the first family is assigned. A new care coordinator will be on the job twelve to fifteen weeks before serving their full caseload of twelve families. Given the average retention of eighteen months, the average

care coordinator is productive for fifteen months, too short to meet Art's definition of an experienced care coordinator. Though Art teaches the classroom topics, training is also a burden on staff and supervisors. In addition, new hires are being paid without generating compensatory billable hours of service. Apex, at the time of these interviews, employed twelve care coordinators for two CSAs. Seven of the twelve had been on board for less than eighteen months.

During the past year Marie thought things were looking up. There was no waitlist. The team was gaining traction with more wraparound experience. Then the state opened new employee positions at the Department of Children and Families (DCF) and the CSA lost six of their more experienced care coordinators.

Intensive Care Coordinators. The care coordinators at Apex were younger and less experienced than those interviewed at Zenith and Pinnacle. Because of the agency's association with an educational institution, the care coordinators are unionized. They have received small incremental raises.

One care coordinator was just finishing her masters degree. Another had recently had a baby and was eager to start on a masters degree when her life settled down. Jean, the third care coordinator, had a masters degree, had worked at Apex for three years, was interested in developing more senior skills in wraparound, and had started with coaching new hires.

Jean's early training was much more abbreviated than the training today; it did not include shadowing a more senior coordinator and the role and the documentation had not been fully specified. Jean identified herself as being terribly shy before becoming a care coordinator. She took on the role as a challenge. She has always enjoyed learning from her family partners. "I love this work. Families get so much out of it!...Productivity is always a struggle. You keep

[a tally] in your head.” Feeling heard motivates Jean. The strengths based culture at Apex is very important to her.

Rabi finished her MSW last year, but has eighteen years in human services. Rabi has been a care coordinator for two years, but had another care coordination position with DCF for several years. Rabi loves sitting and listening to families, helping them problem solve, offering possibilities, helping them determine what’s best for them, and leaving them with a little bit of hope. Rabi feels strongly that a family and child’s voice and choice be heard without shame or blame, especially when more powerful figures are in the room. She values leadership that will back her up, give her permission to think outside the box, won’t second guess her, will value her for being willing to try, and who provide opportunities to hear other positions. Rabi feels that if she is going to continue working in a job, it’s her coworkers who keep her there.

All three care coordinators emphasized the support of Marie and their supervisors, constantly sharing information with their peers, and the importance of the wraparound principles in framing their work environment. The care coordinators observed used mini laptops at their desks, but informed me that the computers could not be used outside the office and they were not able to do work from home or on the road.

Themes

CSA personnel who had participated in accomplishing this paradigm shift in services, consistently commented on the following themes:

Expectations of leadership. Care coordinators from all three CSAs reported their expectations regarding their leadership to be supportive, proactive, knowledgeable, consistent and fair, available, enthusiastic, encouraging, strengths based, collaborative, and to serve as a role model for their work.

Principles of wraparound as a basis for culture. Wraparound is an evidence-based modality of services built around ten principles of interaction: family voice and choice, team based, natural supports, collaboration, community based, culturally competent, individualized, strength based, persistence, and outcome-based (Bruns, et. al., 2004). Participants from all three CSAs at all levels emphasized the importance of creating a working environment and culture that implemented the principles of wraparound in order to do the best work within a wraparound model for their children and families. Individualized career plans, flexible hours, working collaboratively and making decisions as a team, working from strengths, sharing knowledge, and developing community relationships were particularly important.

Learning organizations. All three CSAs employ the same bottom-up, top-down, and whole group brainstorming along with trainings and individual, group, dyadic, and case conference supervision. All used office plans that encouraged peer-to-peer communication. Each CSA met the criteria for a learning organization and exemplified Senge's core learning capabilities (Senge, 1990).

Retention. The executives and program directors at Apex and Zenith CSAs identified care coordinator turnover, with average stays of 18 months and two years plus, respectively, as their biggest problem. The "churning" of care coordinators means CSAs are frequently investing care coordinator time training in an evidenced based modality that is not taught in colleges. The majority of their newly-hired care coordinators do not meet the two years plus experience anticipated for someone to become proficient at high fidelity wraparound.

The longer time that Pinnacle CSA retains care coordinators—three plus years and growing—leads to higher skilled wraparound service, Tier 2 Certification, more experienced care coordinators who now are able to refresh wraparound skills and are able to enhance skills

with more advanced topics such as trauma-informed care, supporting a parent dealing with or surviving domestic violence, supporting parents with cognitive disabilities, and working with families with multigenerational mental health problems, or families dealing with grief and loss. Pinnacle has also been able to sustain additional projects for latency age and transitional age youth. Because hiring is anticipated, Pinnacle is able to have a greater choice among applicants for new or replacement positions.

Pinnacle has done a number of things differently that their care coordinators identified as motivating agents. Productivity goals are linked to both incentive pay and flexibility in schedules. Incentive pay ends up being higher than salary rate of pay for billed time beyond 15 hours. Care coordinators who bill for more than thirty hours in one week are paid in the same pay period as the hours are worked. Care coordinators are given the flexibility and the autonomy to determine which hours they work to accomplish 40 hours a week, and where they do their work. Pinnacle has used technology to make care coordinators more effective, to facilitate completing paperwork remotely, and to stay connected to families and peers when on the road, through email, phone, and texting on agency-provided iPhones. Pinnacle emphasizes that working at Pinnacle is a “career, not just a job” by promoting from within, offering transitions to work in other care modalities and with other populations, and preparing individual professional development plans with one’s supervisor to identify training and opportunities to facilitate growth on an individualized path. In this vein, Pinnacle offers a defined benefit pension plan after an initial period of employment. Pinnacle assures support from management, fair pay, acknowledgement for great work and creativity, autonomy, opportunities for growth, recognition that each staff is a unique person, as well as an employee, and events, big and small, in which to enjoy colleagues.

Chapter V

Discussion

Definitions of leadership

Rank and Hutchinson (2002) identified the qualities of social work leadership expressed by leaders in the Council on Social Work Education (CSWE) and the National Association of Social Workers (NASW) to include five common factors for defining leadership in social work: *Proaction, Values and Ethics, Empowerment, Vision, and Communication.*'

Proaction was further described as “to motivate, organize, take risks, facilitate change, mentor, display courage, innovate, and to be entrepreneurial and persistent” (p. 492). CSA personnel and agency executives exhibited courage, confidence, innovation, and creativity to facilitate the implementation of a care model in Massachusetts that hadn't been fully articulated. They needed to be flexible and trust that a workable system would eventually unfold. The agencies and program managers in this study had been involved in the few wraparound pilots that had been implemented in the commonwealth. Among the other 21 agencies, many had not had any experience with a wraparound model prior to submitting a bid. Parent agencies bidding for CSA contracts were accepting the risk that undefined demand for services might not emerge and whether they would be able to deliver high fidelity wraparound with a fee structure that was perceived to be only attractive to inexperienced college grads willing to work for low pay. Art, the Apex executive, related,

The model for high fidelity wraparound expected care coordinators to be masters level with two to three years experience... The state set the minimum [fee for service] rate. The insurers accepted that rate [as what they would pay]. This fee for service rate is considerably below the rate state agencies will pay for someone with two years experience.

The Apex executive has lobbied for a rate that includes a margin for training and for turnover, and a salary step increase for care coordinators with a masters degree and two or more years experience. The Zenith executive has recommended a day or case rate instead of fee-for-service. The Pinnacle executive admits, “Almost anything would be better than [fee for service in] fifteen minute increments.”

Clare, the Zenith executive, continues to participate in CBHI advisory boards. The roles of care coordinators are quite proscribed. She advocates for more explicit standards of practice for in-home therapists and therapeutic mentors, newer CBHI services.

The Values and Ethics (p. 492) refer to the NASW Code of Ethics. All of the CSAs embodied these ethics in their wraparound practice and within their CSAs.

Themes of Empowerment include: “instilling hope, confidence, accomplishment, collaboration, influence, and the ability to identify issues and concerns for policy makers” (p. 492). All of the CSAs included in this investigation strongly embrace the principles of wraparound, derived from the code of ethics, in directing their own processes and interactions and in their work with children, families, providers, and natural supports.

Vision was described as: “ [the] ability to translate a vision into goals and objectives and leading others to achieve them, understanding and forecasting future directions and leading the way, visualize goals which include the values of the profession (p. 492).” All of the executives

and program directors/managers, and some of the care coordinators contributed to the work that led to the Rosie D. v. Romney suit and the remedy embodied in CBHI and the CSAs. These professionals, with many others, translated the vision of in home care for children with SEDs, to a federal law suit, to a proposed remedy and implemented that remedy successfully. Daily, care coordinators in their roles with the care plan team facilitate the translation of the family's and child's vision into treatment goals, objective measurements, tasks, and measured outcomes selected by the family which form the shared treatment plan for all of the providers, family, child, and natural supports.

Communication was elaborated as “interpreting the mission of the profession to the public (Rank & Hutchinson, 2000, p. 493).” The group differentiated leadership in social work as being committed to the NASW Code of Ethics, with a ‘systems perspective’, using ‘participatory leadership’ to accomplish ‘altruism’ while promoting the ‘public image’ of social work (p. 491). Intensive Care Coordinators and Family Partners share the mission of the profession with families from the first interview. After the family has an opportunity to tell their story and explain their needs, the family is invited to participate in a process informed by the ten principles of wraparound. As the care coordinator and family partner explain strengths based, individualized, family voice and choice, culturally relevant, etc. they inform families, and later providers, and natural supports, of the mission and values of social work.

Social work ethics

The social work Code of Ethics is manifest in the ten principles of wraparound: family voice and choice, team based, natural supports, collaboration, community based, culturally relevant, individualized, strengths based, unconditional, and outcome based. All of the program managers interviewed expressed their desire to exemplify the ten principles of wraparound in the

culture of the interactions within their CSA, and believed that experiencing these principles in their relationships would lead to their care coordinators and family partners doing better work and higher fidelity wraparound in the field. No matter how complex the family scenario used in training, when interventions are being evaluated, the discussion comes back to how well does the intervention represent these ten principles.

Management by objectives

The three executives each spoke of clear missions, a principle of MBO, but the only concrete measurement of objectives, another principle of MBO, that was tracked from the CSAs to the executive level was the productivity numbers. Performance evaluations for employees throughout the agencies were formulated qualitatively around the employee's ability to accomplish their contribution to the mission in terms of the values and ethics of social work. Within the CSA, objectives included the numerous timelines dictated by CBHI and the insurers and the measurements of fidelity to wraparound, which were closely monitored, analyzed, and improved. While middle management might be cognizant of the status of these measurements, it was not essential to report them to higher management levels within the organization.

Transformational leadership

All of the care coordinators spontaneously praised their current and past program managers/directors in each of the qualities of a transformational leader. This model of leadership is highly syntonetic with the values of social work. Transformational leadership is based on the ability of a charismatic leader to generate enthusiasm for her vision, being an innovative problem-solver, knowing their team members, coaching and mentoring them, and providing opportunities for them to meet their personal goals, and the ability to instill confidence, belief in the cause, and high expectations through engagement, enthusiasm, and encouragement (Bass &

Avolio, 1994). Pinnacle's culture emphasized innovation, excellence, and career, individualized career planning, a policy of promoting from within, and of mobility within the agency. Together with the available time and resources to implement innovative support programs, Pinnacle most strongly supported its transformational leaders.

Learning organizations

Senge (1990) described learning organizations as employing five disciplines of thought: systems thinking, personal mastery, revealing mental models to prepare for change, a shared vision, and team learning. Many—if not most—social workers are already adept at systems thinking. Senge's idea of personal mastery is a way of addressing problems by using the energy engendered by the difference between our aspiration and the predicament of today, insight into the ways in which we each limit ourselves, and the ability to hold things lightly because all of the answers are not needed today. Social workers are trained to be adept at iteratively muddling over problems with ever-greater insight. Senge's Revealing mental models to prepare for change is another way to describing the social work phenomenon of introspection to reveal the 'unknown known', the mental models that we ascribe to, but do not hold consciously. As already addressed, shared vision is a characteristic of transformational leadership. Team learning employs three core capabilities: aspiration, reflective conversation, and understanding complex systems. The four levels of supervision, individual, group, dyadic, and case conference, employed consistently by all three CSAs, along with the seminar format and brainstorming which are common in social work training, all support an intrinsic model of team learning and the core learning capabilities. Learning organizations are thought to be highly generative, innovative, and highly adaptable to rapid change.

This investigation focused on the people responsible for three of the highest performing CSAs. Each of these organizations began with a core of a few people who were experienced in wraparound care coordination. This core knowledge on day one was not necessarily available to the other CSAs. A future study might interview staff from all of the CSAs and their executives. One might have extended the investigation to the attitudes of family partners or families receiving services. In addition, one might have asked what was the influence of the boards of directors for each agency. The study might have investigated the opinions of the executives of CBHI, the court monitor, or the Center for Public Representation regarding key decisions and hurdles yet to be overcome.

This researcher was surprised to find (1) how difficult it was for the CSAs to operate an effective business model using the current fee-for-service rates, (2) that only Pinnacle emphasized flexibility and individual career plans, and (3) that Pinnacle was alone in taking advantage of technology, which enhanced their care coordinators ability to perform at a high level.

The CBHI and the insurance providers need to revisit the compensation. If fee-for-service is inviolable, they need to strongly consider (1) raising the ICC bachelors and masters rates, (2) giving a nominal increase in rate for licensure, and most importantly, (3) establishing a fourth rate for care coordinators with a masters degree and two years experience. It is to CBHI's detriment that care coordinators are leaving for other state employment at the time when they are becoming truly experienced in providing the high fidelity wraparound services that CBHI is mandated by the court to provide.

Each of these organizations was very good at transformational leadership. Each program manager/director had a keen commitment to coaching and mentoring her staff. However, only

Pinnacle took knowing their team members, coaching and mentoring them, and providing opportunities for them to meet their personal goals to the level of formal individual career plans.

The investment in the tools to make care coordinators more effective is a testament to the value Pinnacle places on their employees' time, personal lives, and creativity in performing their jobs. Having the tools to do one's job effectively is not just a measure of respect, but is part of the employer-employee social contract.

CBHI has many milestones ahead. It has been heartwarming to realize how many people worked in their own ways for years to prepare for the Rosie D suit and the caliber of people who work daily to enact the remedy.

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APPENDIX A

Informed Consent Form

[Candidate's name]

I am a social work graduate student at Smith College School for Social Work. In my first internship I worked as an intensive care coordinator in a community service agency. The implementation of the Children's Behavioral Health Initiative accomplished a paradigm shift in the delivery of services for children with severe emotional disorders. I am doing research to learn more about the leadership and motivation of the professionals who successfully created the community service agencies and accomplished this feat. *[Name of CSA]* is one of the highest performing CSAs in Massachusetts. I would like to do a case study of you and your colleagues' experiences in birthing and bringing the CSA to its third anniversary. This study will be presented as a thesis and may be used later in presentations, publications, or dissertations.

Your participation is completely voluntary. You must be 21 years of age, English speaking, a mental health professional, and a program manager of a CSA, the hiring executive of the program manager, or an intensive care coordinator of the CSA. You must be employed by the CSA or its parent organizations. Program managers of a CSA must have been in that position from July 1, 2009-July 1, 2012. I am asking you to participate in one twenty minute to two hour audiotaped face-to-face interview. The length of the interview depends upon what you would like to report. I will first ask you for some general information about yourself and your mental health career. The remainder of the interview will be open-ended for you to tell your story of what factors, including leadership style, motivation, key hurdles and decisions, and systems of care, helped make you, your colleagues, and the agency successful. You may refuse

to answer any of my questions. The person who transcribes the tapes will have signed a confidentiality agreement..

It is conceivable that you might not like the case study as written. Because this is an appreciative inquiry regarding the strengths of the CSA and its members, I hope this will be unlikely. There will be no tangible reward for taking part in the study, but your participation will allow you to share your unique experiences in being part of paradigm shifting change in services and perhaps give you a new perspective on your accomplishments. It is my hope that these case studies will provide insight to local, state, and federal policy makers, social work educators, agency executives, program managers, and social workers interested in leadership roles. You may contribute in the development of understanding that might be helpful to those considering reducing the cost of health care, implementation of wraparound services, care for the seriously mental ill, the effects of teams in delivery of care, social work education, and successful social work leadership in times of rapid change.

Confidentiality will not be possible within the CSA, where your colleagues may know that you are being interviewed. However, confidentiality of the data will be protected: the agencies and individuals will be given code names; your informed consent agreement will be stored in a locked file; any tapes or printed data will be stored in a separate locked file; electronic data will be password protected. You will be cautioned not to mention any client names. Any persons who transcribe the tapes or assist in data analysis will have signed a confidentiality agreement. The transcripts will be immediately scrubbed of any identifying information. When the data is prepared for thesis, presentation, or publication, vignettes, short quotes, and any information which might identify the agency or the individual will be disguised. My research advisor will only have access after identifying information has been removed. Data and any

physical tapes will be kept for three years, or after three years until no longer needed. When no longer needed, the data will be destroyed.

Participation in the study is voluntary. If you choose to participate, you may withdraw before May 30, 2013, by emailing the investigator, unless the interviews have been completed and/or your withdrawal would invalidate the participation of the rest of the CSA's/agency's participants. If you withdraw all of your data will be destroyed immediately.

If you have any questions, please contact me at xxxxxxx@gmail.com or (nnn-nnn-nnnnn or you may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413)-585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please keep a copy of this form for your records. Thank you for your interest in my study.

Sincerely,

Researcher: _____ Date: _____

Participant: _____ Date: _____

APPENDIX B

HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 — F (413) 585-7994

March 1, 2013

Jacqueline Kinsley

Dear Jacqueline,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads 'Marsha Kline Pruett' followed by a flourish.

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Acting Chair, Human Subjects Review Committee

CC: Michael Murphy, Research Advisor

APPENDIX C

Interview Guide

Participants will be asked for limited demographic data including:

- Age,
- Self-identified gender,
- Race, and ethnicity,
- Highest degree attained,
- Professional license(s) held, and
- Years of experience in the mental health field.

The interview will be unstructured around the following themes:

- Leadership,
- Motivation, and
- Key hurdles and decisions,

with respect to

- Quality of service to clients,
- CSA mission and members,
- Cooperation and adequacy of the system of care, and
- Meeting insurance requirements.

Sample prompts include:

- Why did you apply for your position?
- What skills do you bring that you feel are important to your role? What skills have you had to develop?
- How would you describe your leadership style? How do you motivate yourself and your co-workers?
- How would you describe the culture in the parent agency? CSA/agency?

- How does your agency measure performance of the CSA? Of individuals?
- How does the CSA go about selecting and focusing on performance, change, or improvement of services? How are the uses of CSA resources determined? How does the CSA/agency determine subjects for training, quality improvement, etc.?
- What characteristics are important in clinical social workers as intensive care coordinators during times of rapid growth? Does that change during more stable growth?
- How do you work with the other agencies and systems in your catchment area? Can you give me examples of how the system of care has worked together to resolve an issue? How long does it take to fulfill referral requests? How long do children stay in ERs before going to CBAT? If there is a problem with wait times, what are you doing to affect the problem?
- How has the role of insurance affected your delivery of care? What have you been able to do to affect this problem, if any?
- What decisions have had the biggest impact for the CSA? What hurdles remain?