Assessing for Interorganizational Collaborative Capacity:

Child-serving systems within Multnomah, Clackamas, and Washington County

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Executive Summary

Within the Tri-County region, there exists a wide range of agencies, organizations, and providers dedicated to serving the health, safety, and wellbeing of children, youth, and families. Under a shared vision of the Tri-County System of Care governance structure, child-serving organizations are being transformed from a diverse array of services into a unified system of care. This process involves building a shared capacity to engage in coordinated efforts between child-serving systems. This assessment focuses on the experience of collaborating between the multitude of child-serving systems throughout Multnomah, Clackamas, and Washington County. Child-serving system partners include providers and organizations related to mental health, addictions and substance abuse, Intellectual & Developmental Disabilities, Juvenile Justice, education, medical and dental, Child Welfare, and other support services. The assessment attempts to answer the question, *"How well are children's system of care partners within the Tri-County area able to collaborate throughout their local array of services and supports?"* This study is intended to generate knowledge about key factors for successful collaboration between organizations including information sharing, policy alignment, and support for collaborative efforts. Supporting organizations can use the information gained from this study to target investments toward enhancing or developing capacities critical to the performance of youth and family services and the system of care as a whole.

Findings depict a system of care driven by well-meaning individuals doing their best to collaborate despite a lack of coordinated infrastructure or metrics for collaboration. Recommendations include establishing clear guidelines for collaboration between child-serving entities and ensuring administrative support for these activities.

Keywords: *Systems Thinking, Interorganizational Collaborative Capacity, system of care, assessment research, cross-system collaboration, care coordination, child-serving systems*

Introduction

A 'system of care' is a spectrum of community-based services and supports for children, youth, and families that is organized into a coordinated network. It is designed to build meaningful partnerships with families in order to improve health and safety outcomes for multisystem involved youth (Stroul, Blau, & Friedman, 2010). The Tri-County System of Care (SOC) was created as a structure designed to provide "leadership, provide recommendations, and technical assistance to address system-level barriers and challenges" throughout the Clackamas, Multnomah, and Washington County System of Care networks (Systems of Care Institute, 2021).

Effective collaboration is essential when coordinating care for children, youth, and families who require an array of services and supports from multiple entities in order to avoid the reality of dedicated family members becoming primary medical managers (Berry et al, 2014), duplicative efforts, and unnecessary service utilization or system involvement (OHA & DHS, 2018). While the metric "collaborative capacity" is not widely used in practical applications, the framework is drawn from the literature and disciplines of community capacity (Beckley et al, 2008), cross-sector collaboration (Bryson, Crosby, & Middleton, 2006), community-based collaborative processes (Cheng & Sturtevant, 2011), and others.

The model and method utilized in the survey is provided by Jansen et al (2008), who define Interorganizational Collaborative Capacity (ICC) as "a system of processes by which organizations work together to accomplish common or complementary goals and objectives or a common mission." More broadly, collaborative capacity can be seen as the ability of a group to leverage assets within the context of their environment in order to achieve shared goals (Cheng & Sturtevant, 2011). The survey items were developed and tested over a period of years in order to provide "scales that have very good to excellent internal-consistency reliability and convergent validity," (Jansen et al, 2008), and correspond to an open systems model of organizations (Galbraith, 2002 as cited in Jansen et al, 2008).

One clear limitation of the examined frameworks, which will be expanded upon later, is their limited inclusion of service users in the collaborative process. The vision of the Tri-County System of Care is to support children, youth, and families "by a seamless, sustainable, comprehensive collaboration across systems and communities, which leads to generations of healthy adults. Services are youth-guided, family-driven, easily accessed, and culturally responsive," (System of Care, 2020). The SOC offers a strong foundation for improving quality of care, addressing enduring barriers, and they provide collaborative infrastructure for a diverse array of services and supports. However, fully realizing this vision will remain out of reach without clearly defining meaningful inclusions of service-users in the process.

Methods

In order to answer the guiding question, this study combines literature review, surveys, existing data, and individual interviews in order to gain a holistic perspective of our local collaborative capacity. The Qualtrics research platform was used to design and house the survey, and they were distributed throughout a network of connected individuals who self-identified as working within a child-serving system within Multnomah, Clackamas, or Washington County. Interview participants were selected via

networking and chosen with the intention of capturing diverse perspectives throughout the local array of services and supports.

The validated survey utilized in this study was developed by Jansen, Hocevar, Rendon, & Thomas of the Naval Postgraduate School (2008) and provided the basis for assessing Interorganizational Collaborative Capacity (ICC). Three additional demographic items and four local system of care specific survey items were included for further context. This anonymous survey was circulated throughout a network of individuals using the snowball method. Participants were self-identified as working within the Tri-County area within child-serving agencies or organizations which engage in coordination with other entities. This survey includes scales such as Resource Investment in Collaboration, Information Sharing, Collaborative Learning, and Barriers to Collaboration. Scale items were designed for their potential to reveal effective approaches when facing the challenges of building up ICC. Within this conceptual framework, collaborating organizations are seen as complex adaptive systems with a set of five subsystem domains represented by the points of the pentagon in Figure 1 (Galbraith, 2002, as cited in Jansen et al, 2008).

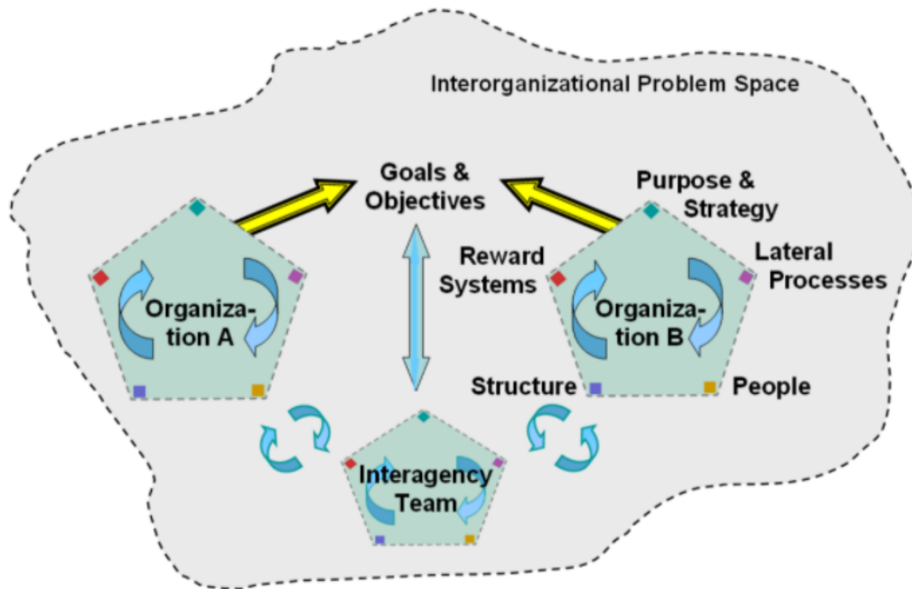

Figure 1. The Interorganizational Collaborative Capacity Model (Hocevar, Thomas, & Jansen, 2006)

Five semi-structured, one-to-one interviews were conducted on the Zoom virtual platform. They were recorded, transcribed, thoroughly analyzed for relevant and meaningful themes, and coded accordingly to identify possible any overlapping or nuanced emergence of related themes. Additionally, existing data from focus groups was analyzed and mined for supporting information.

Findings

The survey received a maximum of 30 responses, and an average response rate of 25.3 responses per survey item. Broken down by child-serving system, the Mental Health system accounted

for 20 participants, or 67% of the responses, Addictions and Substance Abuse = 1, Intellectual & Developmental Disabilities = 2, Juvenile Justice = 2, Medical & Dental = 1, Child Welfare = 3, Self Sufficiency or other = 0, and Early Childhood = 0. By County, Multnomah County = 22, Multiple or N/A = 8. By role type, Direct client service = 9 (30%), Executive leadership (Decision makers) = 10 (33.3%), Supervisor or Support of direct service = 8 (26.7%), and Administrative/Program support = 5 (16.7%).

The survey on Interorganizational Collaborative Capacity examines the overall ability of collaborating organizations to work effectively together toward shared goals. "All items used a 6-point Likert-type scale ranging from Strongly Disagree to Strongly Agree. Thus, 3.5 is the scale midpoint. Sample means higher than 3.5 indicate agreement, and a sample mean of 6 would indicate unanimous agreement," (Jansen et al, 2008).

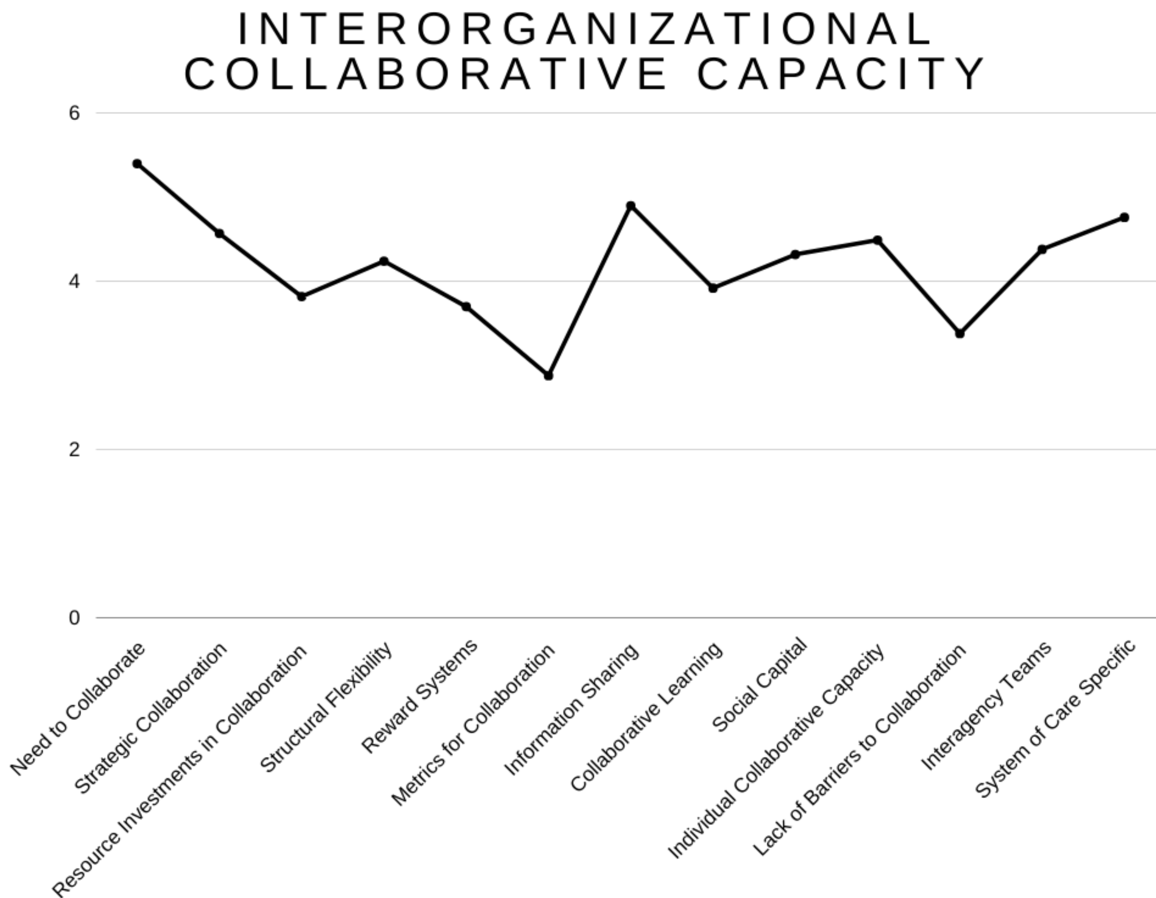

Figure 2. Profile of survey result means of children-serving system partners within Multnomah County.

Figure 2 displays the results of this survey found in Table 1, divided into the 12 verified scale categories and one additional local system of care-specific scale. Table 1 provides the numerical values of each section: the means, standard deviation, and average sample size. These depictions offer visualizations of the original guiding questions, and easily show places where respondents have the experience of being successful or lacking in certain domains. Overall, respondents rated their organizations highly in the scale of Need to Collaborate (5.4) and Information Sharing (4.9). The scales

with the lowest scores are Metrics for Collaboration (2.9) and Lack of Barriers to Collaboration (3.4). The main drawback of the current data is the overrepresentation of the Mental Health System within Multnomah County. Further discussion accounts for this limitation, however for the time being, the data primarily reflects the experiences of this demographic.

Table 1. *Means, Standard Deviation (S.D.), and Average Sample Size (n.) for children-serving system partners within the Multnomah County*

Scale	Mean	S.D	n.
Need to Collaborate	5.7	0.74	30
Strategic Collaboration	4.6	1.02	29
Resource Investment	3.8	1.28	28
Structural Flexibility	4.2	1.06	27
Reward Systems	3.7	1.56	25
Metrics for Collaboration	2.9	1.48	22
Social Capital	4.3	1.12	25
Information Sharing	4.9	0.82	25
Collaborative Learning	3.9	1.4	23
Individual Collaborative Capacity	4.5	0.95	24
Lack of Barriers to Collaboration (*1)	3.4	1.29	23
Interagency Teams	4.4	1.01	22
System of Care Specific (*2)	4.8	1.09	24

(*1) The Barriers to Collaboration scale is the only scale in which a higher value represents lower collaborative capacity. It is thus reversed so that it can be compared to other scales and relabeled "Lack of Barriers to Collaboration"

(*2) The four System of Care specific items were added which draw directly from the System of Care/Wraparound Initiative mission and vision, and should represent survey participants' sense that their home organizations meaningfully pursue these goals.

The individual interviews generated related and overlapping themes that can be mapped onto the ICC model, though for the purposes of coding for themes were given their own terms. These themes or parameters are *Do Your Job* (Following through on job expectations, returning calls, making referrals), *Individual Knowledge* (Understanding of the availability of services, expertise, aptitude), *Personal Characteristics* (Drive, effort, pride, biases, authenticity), *Self-Care* (Making time to prioritize one's own needs), *Reliance on Connections* (Knowing who to call, who you trust, who not to rely on, mentorship), *Collaborative Communication* (Educations/understanding systems, collaborative learning, information sharing), *Resources and Services* (Both use of funds or resources, and the availability of services), *Policies and Procedures* (Compliance mechanisms, information sharing allowances), "*Natural Balance*" (Natural balance of people who do and don't put effort into their job, the idea of "The System"), *Reflective Insight* (Learning from the past and engaging in reflection), *Support, Training, & Oversight* (Management, checks and balances, check-ins), and *Job Expectations* (Time pressures, explicit responsibilities). Associated domains relating survey scales and interview parameters can be found in Figure 3, where interview parameters are listed in italics.

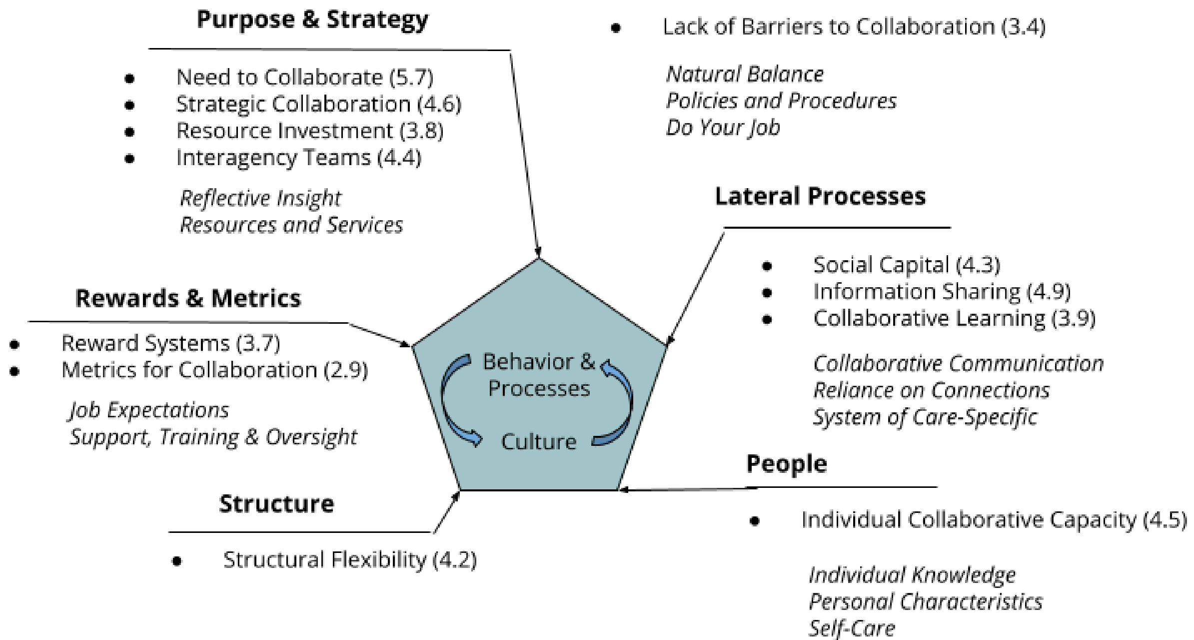

Figure 3. Survey Domains, their associated scales, and related interview parameters.

The Purpose and Strategy Domain.

Survey respondents reported overall positive perceptions in this domain. The “felt need”, or Need to Collaborate (mean: 5.4) was rated highly, which describes the motivational energy and effort needed to overcome challenges to collaboration. Having common goals and recognizing organizational interdependence (Strategic Collaboration mean: 4.6), while rated highly, was brought down significantly by item SC-1 (3.8): “We have clearly established goals for interorganizational collaboration,”. There seems to be a willingness to invest resources to accomplish shared goals, RI-2 (4.2), but overall Resources Investment in Collaboration (3.8), committing budget, resources and personnel, was felt to be low.

The interviews uncovered a similar, related theme of *Reflective Insight:* organizational practice of taking into account past successes or failures, conducting evaluations, and considering the system as a whole. Tied together with *Resources and Services*, a pattern surfaces of continually “revintening the wheel”. This involves funding new programs instead of supporting existing ones, or continuing to engage in processes that do not address the intended community need because efforts are not made to identify root causes, share information between organizations, or engage in collaborative learning. As one interviewee said, “To make system change, it’s imperative to be able to look inward.”

The Lateral Processes Domain.

Under this domain, a key limitation of the current data collection comes to light. The Information Sharing (mean: 4.9) scale was the second highest rated scale, and the items are framed from the point of view of one’s own organization, i.e. “My organization has strong norms that encourage sharing information with other organizations.” Given the main demographic of survey respondents (Multnomah

County Mental Health system), this scale should be read as the self-perception that this system shares information very well. Contrast this with the overwhelming sentiment that barriers to communication represent a key issue within the local system of care. All 5 interviewees cited this issue on multiple occasions, and aspects of the theme *Collaborative Communication* was most often cited as a barrier. Phrases that appeared often in relation to this theme are “siloed”, “fragmented”, or “fractured” infrastructure and systems, and a lack of “cohesion” and “transparency”. This theme will be drawn out more in the Lack of Barriers to Collaboration Domain, related to *Policies and Procedures*.

Collaborative Learning (mean: 3.9), or the degree to which organizations prioritize working with other entities to identify shared lessons or commit resources to training workers about other systems, was rated well and this was reflected in the interviews. People feel that there is overall good effort in this area. A common praise for their own or partnering organizations was when they committed time and resources to providing training, resources, and connections with other systems, citing this as “a really smart way to help solve [the] issue” of “navigating new systems” so that “engaging with folks won’t seem so foreign and different.”

Finally, the Social Capital (4.3) scale received high scores. Related broadly, this is the notion that interpersonal networks are associated with success, which involves people taking the initiative to build and maintain relationships across systems. The interviews also reflected a huge dependence on who you know, or *Reliance on Connections*. Knowing who to call, who to trust, and finding “people you can count on because they’re consistent.” This was most often cited as the way people succeed or survive in the system as it functions now, and improving relationships meant the ability to “connect with people in order to do the work better.” Lastly, one participant in the focus groups (Appendix D) stated succinctly that “If you don’t have someone you know, sometimes a lot of those questions just go unanswered or ignored. Sometimes things don’t get done.”

The Structure Domain.

Structural Flexibility bears on the ability of an organization to quickly form or modify policies, processes, and procedures in order to support collaborative efforts. The mean score of 4.2 represents moderate agreement, where survey respondents feel that their organization is somewhat able to do so. This is also reflected in the interviews, where interviewees feel that there is an overall shared value for collaboration throughout the children’s system of care.

The People Domain.

Individual Collaborative Capacity received a mean score of 4.5, again depicting the self-perception that individual Multnomah County Mental Health providers possess the necessary skills, expertise, knowledge of other organizations, and a willingness to engage in collaborative efforts. Three related themes from the interviews emerged: the value of *Individual Knowledge,* the importance of *Self-Care,* and an emphasis on the impact of individual *Personal Characteristics* on the success of collaboration and coordination. An overarching theme here is the notion that the success of the system of care is dependent on an individual's level of effort and dedication. To meet the needs of service users, despite the issues facing the system of care, one must diligently take care of themself, go above and beyond, and be able to account for the short-comings of others who apply themselves less. This makes sense in light of the findings in the previous section: where the pursuit of successful collaboration and

system navigation tends to fall on the responsibility of dedicated individuals willing to go the extra mile for the benefit of service users. One interview described the amount of extra work they needed to do in order to connect and collaborate with others in the field just to be able to get their job done. Like others, they relayed that it is often necessary to connect with “like-minded” people who are willing to go above and beyond in order to get care for service users, find the information they need, or set up additional structures of support for others in the field to be able to achieve these aims.

Lack of Barriers to Collaboration.

The scale “Barriers to Collaboration” is reverse scored to create a metric for Lack of Barriers (mean score: 3.4), with a *low* score indicating a perception that many factors impede effective collaboration, and a high score suggests less felt-barriers. This is one area where increased data collection from other systems and counties would give a more robust portrait of the issues being faced by agencies and organizations throughout the Tri-County area regarding successful collaboration. Here is a breakdown of the five items within the Lack of Barriers scale, listed from highest (desirable) to lowest (undesirable) mean score . [B-2 (3.9)] “People in my organization tend to be suspicious and distrustful of their counterparts in other organizations,” [B-5 (3.7)] “My organization’s unique requirements make collaboration difficult,” [B-3 (3.4)] “I face incompatible requirements or requests when working with other organizations,” [B-1 (3.0)] “A history of interorganizational conflict affects our interorganizational capability,” and [B-4 (2.9)] “Conflicting organizational policies make collaboration difficult.” These diverse items cover aspects of “history, individual collaborative capacity, role conflict, policies, and unique requirements,” (Jansen et al, 2008), all which represent key leverage points for improvement within organizations. These themes were evident within the interviews, and similar frustrations are commonly heard in everyday working conditions related to the difficulties of coordinating services for children.

Points associated with the *Do Your Job* parameter often related to frustrations about individuals in other organizations not following through, returning phone calls, and making appropriate referrals. This sentiment seems highly related to items B-1 and B-2: interorganizational distrust and conflict. Other statements characterized this tendency as a kind of *Natural Balance* within organizations related to the amount of workers who can be expected to follow through consistently, and of those that may not. When taking a look at *Policies and Procedures,* many pointed to conflicts associated with privacy and compliance. One interviewee captured this important characteristic, citing that:

> There are only incentives not to share information… there are all these legal barriers not to share. HIPAA, FERPA for school cases, rules from the Juvenile Justice or Child Welfare system, medical records, etcetera. All of those protect against sharing information: there are consequences if you share information you shouldn’t, and no benefits to sharing information that you should. The legal protections are really focused on “don’t share”… People share information when they want to, and they have a really strong wall to stand behind when they don’t want to or when they’re overwhelmed.

Additionally, the lack of centralized information presents as a unique barrier within the children’s system of care due to an inability to find what services are available, contact information for key workers within programs, or access to data necessary to make informed treatment decisions.

The Rewards and Metrics Domain.

This domain can be characterized as a continuation of the previous domain given that combined, they represent the three lowest scored scales, hindering effective interorganizational collaboration. Reward Systems (mean: 3.7) is the degree to which collaboration is rewarded, or the consequences of their behavior in terms of personal payoff. Metrics for Collaboration (mean: 2.9) are established criteria and standards for collaboration. These scales are complemented by the interview parameters *Job Expectations* and *Support, Training, & Oversight*. Taken into a larger context, these metrics can be seen as leadership recognizing the value of collaboration, building expectations around these activities into individual roles and responsibilities, and providing support for them. One individual relayed that:

> We have time built in for communication and collaboration with partners. [...] I feel like at my job they've really sheltered us from [being overworked]... so we really do have time to communicate and collaborate with folks. But I know with other professionals on my teams, they only have that one hour for our wraparound meeting and that's it, and they don't have extra time to give someone a call and make that extra two emails that have to happen to get something for someone. Really high caseloads impact workers' ability to connect. [...] When it's just left up to even the best intended care coordinator or worker, if you don't have time, then you just don't have the time unless it's something you have to do.

Another interviewee shared a similar sentiment, saying that:

> Every organization has people that want to do more. In organizations, some people you know may not follow through. That becomes a cancer in your organization if someone can collect the same check as you do by doing 60% [of the work]. So I can't, as a coworker, motivate people to change. I can do my work and continue to support. But that comes from on high about how you allow, or how you support, how you put policies into place [to encourage collaboration].

These passages reflect a central theme to emerge from this assessment, the lack of time workers can dedicate to collaborative efforts, whether due to unclear job expectations, feelings of frustration around limited accountability practices with partnering entities, or a lack of oversight and/or support when it comes to ensuring necessary coordination activities can be completed.

Analysis

Findings from this assessment depict a system run by dedicated individuals going above and beyond to ensure that youth and families are served with integrity. Desire for collaboration, positive regard, and strong connections seem to run deep throughout the array of child-serving services and supports within the Tri-County area. Reliance on connections represents a strength, a challenge, and possible leverage. Experienced individuals serve as repositories of historical knowledge which provide some measure of reflective insight that may not be sought after or generated by organizations on their own accord through evaluation, information-sharing, or collaborative learning. A quote from one interviewee summarizes this point:

> It's a huge loss when you cut the top off (e.g. someone with a lot of experience leaves or retires), and you lose all that historical knowledge... We're really repetitive with the way we come up with innovative ideas, so we'll try something until it doesn't work. And then, instead of saying "what didn't work and what's worked in the past," we stop it, and then five years later do the exact same thing... One of the ways that we succeed in this field is by building connections and nurturing or protecting that historical knowledge.

The value of relationship-building and mentorship is evident at the individual level. Investing in interorganizational collaborative learning and engagement could leverage this facet of the system of care in order to create positive outcomes by increasing both individual and organizational interconnectedness.

The story painted by the interviews is that of collaboration by necessity, often by exerting additional effort to self-organize into networks of "like-minded" people who make similar (extra) efforts to connect colleagues and community members with services and supports. Strong networks are fundamental within the current system, and success can often depend on knowing who to call. Effective collaboration across systems and between organizations is often left undefined, requiring dedicated efforts to foster and cultivate connections workers can rely on to get the job done. Making that extra phone call, completing additional referrals, or maintaining consistent lines of communication can easily fall off the back end when this is not built into one's roles and responsibilities. When time is a precious commodity, effective collaboration loses focus because the labor required to navigate a fractured multitude of incongruous operating processes is disincentivised, under-valued, or unclear.

In the pursuit of safe and healthy children, families, and communities, effective and streamlined collaboration between child-serving entities is essential. Collaborative efforts are prevalent throughout the local array of children-serving systems. They are not uniformly established or incorporated, however, leading these efforts to vary greatly in degree, quality, and alignment. This can cause workers to point a finger outward in search of ways to understand the frustrating reality. Scientist and author of *The Limits to Growth*, Donella Meadows provides invaluable insight into understanding complex systems in her final work, *Thinking in Systems: A Primer*. She describes that it's "almost irresistible to blame something or someone else," but "No one deliberately creates those problems, no one wants them to persist, but they persist nonetheless. That is because they are intrinsically system problems— undesirable behavior characteristics of the system structures that produce them," (2008). Strengthening and promoting an effective system of care will require agencies and organizations to ensure collaboration is an embedded operational process, one not left up to good intentions. This means identifying community-facing employees, establishing definitive criteria for activities related to coordination and collaboration, and assuring this work can be carried out by providing adequate time and support for these tasks.

In understanding and defining the nature of communication throughout child-serving systems, four factors emerged which impact information flows, both positively and negatively. Barriers to communication, or negatively impacted information flows, were often cited as the main issue facing the system of care as a whole. All of the following factors represent possible points of leverage for agencies and organizations to target in order to improve the overall collaborative capacity of their team, and should contribute to interorganizational capacity as well if such practices are shared throughout the Interorganizational Problem Space. When targeting improvements to collaborative capacity, it is essential to step outside of the framework of individual deficit that plague the field of social services.

Complex systems require complex explanations that do not rely on changing the behavior of individuals; and in understanding the problem, we define the solutions.

Job Expectations & Rewards.

Are tasks related to coordination and collaboration clearly defined within the roles and responsibilities, or do these end up becoming “additional” work? Given the normal constraints related to completing other job expectations, a lack of time or information required to complete these tasks: does going above and beyond to achieve these tasks (as is often required) reflect on performance or impact employee compensation? Is collaboration rewarded or recognized? When workers need to go above and beyond and put in extra effort because there isn’t time or ability to successfully navigate complicated systems of care, a lack of support or incentives to do so means that many may not go the extra mile if this is what’s required to find care. This disparity between those that will go above and beyond and those that don’t builds resentment among workers and between organizations perceived as doing less.

Support, Training & Oversight.

Is there enough time built in for tasks related to collaboration and coordination? Does leadership and administration value this necessary component of a complex system of care and ensure that workers have the support, training, and oversight required to complete these tasks as a means for accountability? Is there regular training and opportunities to learn more about other systems or services? When mining existing data from focus groups, many workers report receiving large amounts of information during the initial training period for which they had little context. Therefore, it was difficult to recall or put to use on the job (Appendix D). Despite being told that most learning happens on the job, and that it takes upwards of a year of ‘hands-on’ experience to become proficient, this process is not often supported as an ongoing, continual learning process. Workers may not be given opportunities on the job to make new connections and learn about other systems in a supported capacity, they are expected to learn these things on their own.

Access to Information & Reliance on Connections.

Navigating a diverse array of services and supports spread across multiple systems requires an immense amount of informational resources. Many workers report needing to rely on binders full of resource lists, contact information, and local services. These paper copies quickly go out of date and become obsolete, though remain within the stack to become distracting clutter. Knowing who to call to find necessary information is a major barrier for new and experienced workers alike. A reliance on connections means that networks of cooperative relationships operate as a stand-in for accessible information. For individuals lacking confidence or experience in building and maintaining a strong network of support, reaching out can be intimidating. One interviewee shared that the smartest way her team supports collaborative success is by building in regular opportunities to meet and greet colleagues in other systems. Ongoing, collaborative learning supports the health of a functioning system of care by creating strong networks of positive working relationships. A persistent call for a centralized database of information, resources, and contact information for services throughout the county and state continues to go unanswered. Having easy access to accurate and updated information that supports coordinated care is an essential component of a successful system of care.

Policies & Procedures.

"It's so hard for medical care and mental health care staff to talk to each other. We work the same hours. We don't take lunches. HIPAA makes it hard— too many steps for parents," said one participant in the focus groups. Statements such as this illustrate clearly that these issues are not characteristics of an individual deficit or lack of follow-through from workers. Unique organizational requirements, policies and procedures, especially those relating to compliance and privacy, contribute greatly to the structural environment or Interorganizational Problem Space in which cross-collaboration exists. Therefore our conception of the problems within this space must take on an equally holistic view of their antecedents.

Conclusion & Recommendations

An effective system of care enables the coordination of necessary services and supports for children, youth and families. Agencies and organizations that share an overarching goal of promoting the safety, health, and wellbeing of service users exist within a common Interorganizational Problem Space. This is the environment within which child-serving systems of Multnomah, Clackamas, and Washington County provide crucial services for a large population with complex needs. Collaborating within this space is no longer optional: transferring critical healthcare information and coordinating care is an integral process that varies greatly by degrees of success. The ability of the system as a whole (including agencies and organizations as key structures) to successfully carry out tasks related to care coordination is framed as *Interorganizational Collaborative Capacity*. In order to fully understand and articulate the local ICC, this study examined the fundamental elements of collaboration between organizations with shared goals or objectives.

Findings uncover the extent to which negatively impacted flows of information affect workers ability to engage in coordination and collaboration. Limited time, large caseloads, hindersome and complicated compliance procedures, and siloed infrastructure all contribute to negative health outcomes for service users, burnout, and wasted resources. "Missing information flows is one of the most common causes of system malfunction. Adding or restoring information can be a powerful intervention, usually much easier and cheaper than rebuilding physical infrastructure," (Meadows, 2008). In the face of an underfunded social services sector and a competition of limited resources, local leaders can focus on increasing the *ability* of child-serving agencies and organizations to collaborate effectively given current structures, assets, and resources. Thoughtful and targeted improvements can bolster already-existing strategies, or address key aspects of effective care coordination. Following are specific recommendations for expanding collaborative capacity throughout child-serving systems.

1. Child-serving agencies and organizations develop collective guidelines and practices for information sharing, coordination, and cross-system collaborative efforts at both the individual and organizational level. Collective guidelines acknowledge collaboration as an essential process that requires buy-in and accountability from all parties, including support from administration to ensure workers have adequate time and resources to achieve these tasks.
2. Organizations incorporate clear metrics for collaboration and coordination within the roles and responsibilities of employees who are tasked with coordinating care or transmitting information, and those supporting or overseeing workers in these roles. Metrics for collaboration include the

importance of continuous and on-going collaborative learning and engagement opportunities between systems.

3. Oregon Health Authority establishes a centralized database containing contact information, eligibility requirements, referral processes, and program details for services and supports within the state which is accessible to workers engaged in care coordination. Local leaders can contribute to this goal by continuing to advocate for this essential service, and ensuring that this information is currently available in a clear and accessible format.

Limitations & Future Research.

Some of the limitations of this assessment include the scope of data collection that was achieved, and the novelty of the Interorganizational Collaborative Capacity assessment model. Increased efforts should be made to expand data collection within Clackamas and Washington Counties, and throughout partnering systems that were underrepresented. Additionally, more research should be done on “how to diagnose or audit the collaborative capacity of organizations that are expected to be in effective collaborative relationships,” (Hocevar, Thomas, & Jansen, 2006, cited by Jansen et al 2008).

There exists considerable room for improvement regarding the inclusion of service-users in an equitable collaborative process. The vision of the Tri-County System of Care governance structure is to support children, youth, and families “by a seamless, sustainable, comprehensive collaboration across systems and communities, which leads to generations of healthy adults. Services are youth-guided, family-driven, easily accessed, and culturally responsive,” (System of Care, 2020). The SOC offers a strong foundation for improving quality of care, addressing enduring barriers, and they impose a structure of order and alignment between and across a diverse array of services. However, the fidelity of this vision cannot be realized metrics defining the accomplishment of ‘youth-guided’ and ‘family-driven’ services. In this pursuit, it will be essential to consider what is important, not necessarily what is quantifiable. In their article *Citizens Differ from Organizations: Modeling a Specific Citizen-Centered Collaborative Capacity,* Aschhoff (2018) points out that organizations utilize collaboration to achieve their mission or shared goals, leveraging a range of resources. In contrast, the goals of ‘citizens’ (or service-users) may be different or at odds with those of the organization: individuals act on their own accord, in the pursuit of individual wellbeing. Given this imbalance of resources, power, and priorities, it is the task of the organization to actively engage service-users in order to enable genuine partnership. Child-serving agencies and organizations should develop and incorporate explicit guidelines for the inclusion of service-users in treatment planning, service provision, and program design to ensure that services are youth-guided, family-driven, easily accessed, and culturally responsive.

Further assessment is required to expand our understanding of the local collaborative capacity. Insights gained throughout this process can be shared between communities to further develop the success of care coordination and enhance the benefits therein. Organizations must dedicate time and resources to evaluating the progress of these endeavors, using clearly developed guidelines as metrics for success.

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Appendices

Appendix A - Survey Results as of February 27, 2021

Appendix B - Interorganizational Collaborative Capacity Survey Questions

Appendix C - Individual Interview Questions

Appendix D - Cross-System Collaboration Committee: Focus Group Task Force Report

Appendix A - Survey Results as of February 27, 2021

Finis	RecordedDa	Q54	D1	D2	D3	N1	N2	N3	SC1	SC2	SC3	SC4	SC5	RI1	RI2	RI3	SF1	SF2	SF3	SF4	RS1	RS2	RS3	RS4	M1	M2	IS1	IS2	IS3	CL1	CL2	CL3	SO1	SO2	IC1	IC2	IC3	IC4	IC5	IC6	IC7	B1	B2	B3	B4	B5	IT1	IT2	SS1	SS2	SS3	SS4
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1	2/4/2021 12:	1	1	4	2	1	1	1	2	1	1	1	1	1	1	2		2	2	1	1	1	1	1			1	1	1	1	1	1	1	1	2	1	2	2	3	2	2	6	6	6	6	6	3	2	2	2	3	2
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1	2/4/2021 15:	1	1	1	1	1	1	2	2	3	2	1	2	1	3	3	3	2	2	1		3	3		6	5	2	2	2	2	2	3	3	2	2	3	1	1	2		3	5	4	5		5	2	2	2	1	1	2
1	2/4/2021 15:	1	1	1	2	2	1	2	4	3	4	3	3	4	3	3	5	3	3	3	5	4	3	5	6	5	4	2	3	4	4	3	4	3	2	3	3	3	3	3	3	3	4	4	3	3	3	4	3	2	2	3
1	2/4/2021 17:	1	1	1	3	1	1	1	5	1	3	2	3	3	3	3	4	3	3	5	5	6	6	6	5	5	1	1	1	3	1	5	2	2	5	3	2	1	4	2	1	5	3	4	3	5	5		5	1	1	1
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1	2/5/2021 16:	1	1	6	3	1	1	1	3	1	1	1	1	3		3		3	1	1		2	2				1	2	1	2	1	1	1	1	1	1	1	1	1	1	1	5	5	5	5	5	2	2	1	1	1	1
1	2/10/2021 9:	1	1	7	4	2	2	2	3	1	3	3	3	4	2	4	4	4	3	4	2	4	3	5	3	4	2	3	2	2	3	4	3	2	4	4	3	3	3	3	3	2	2	3	2	2	3	2	3	3	3	3
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1	2/24/2021 8:	1	1	1	3	1	1	1	2	1	1	2	2	3		3	2	2	3	3	2	1	2	2			2		2	3			3	2	2	3	2	3	2	2	2		5	2	3				3	2	2	2
1	2/24/2021 8:	1	1	1	2	1	3	2	4	3	3	3	4	6	4	5	3	3	2	5	4	4	4	4	4	5	3	3	3	5	4	5	5	2	2	2	3	2	2	2	4	3	3	4	4	3	1	2	2	1	1	3
1	2/24/2021 17	1	1	1	2	1	1	3	3	2	2	2	3	3	3	4	4	2	2	2	3	3	3	1	4	4	3	3	2	2	2	2	3	2	2	3	2	2	2	3	3	2	3	3	2	2	3	3	2	1	2	2
1	2/26/2021 11	1	2	1	1	1	1	1	2	1	1	2	3	2	2	2	2	4	2	3	1	2	2	2	2	3	2	2	1	2	2	1	1	2	3	2	2	2	2	2	2	2	3	4	3	3	3	3	3	2	2	1
	mean					**1.57**	**1.53**	**1.7**	**3.24**	**1.97**	**2**	**2.28**	**2.67**	**3.29**	**2.77**	**3.41**	**3.3**	**2.86**	**2.21**	**2.66**	**2.92**	**3.46**	**3.44**	**3.35**	**4.1**	**4.14**	**2.19**	**2.12**	**1.96**	**3.29**	**2.82**	**3.14**	**3.08**	**2.28**	**2.58**	**2.8**	**2.36**	**2.44**	**2.46**	**2.35**	**2.6**	**3**	**3.88**	**3.38**	**2.91**	**3.74**	**2.65**	**2.6**	**2.67**	**2**	**2.13**	**2.17**
	st. dev					**0.72**	**0.76**	**0.74**	**1.19**	**1**	**1.05**	**0.87**	**0.98**	**1.41**	**1.15**	**1.27**	**1.2**	**1.03**	**0.66**	**1.35**	**1.47**	**1.69**	**1.5**	**1.6**	**1.54**	**1.42**	**1.12**	**0.65**	**0.69**	**1.46**	**1.43**	**1.32**	**1.2**	**1.04**	**1.04**	**1.02**	**0.74**	**0.98**	**0.87**	**0.98**	**1.02**	**1.48**	**1.13**	**1.41**	**1.21**	**1.22**	**1**	**1.02**	**1.21**	**1.12**	**1.01**	**1.03**
	translated Mean					**5.43**	**5.47**	**5.3**	**3.76**	**5.03**	**5**	**4.72**	**4.33**	**3.71**	**4.23**	**3.51**	**3.7**	**4.14**	**4.79**	**4.34**	**4.08**	**3.54**	**3.56**	**3.65**	**2.9**	**2.86**	**4.81**	**4.88**	**5.04**	**3.71**	**4.18**	**3.86**	**3.92**	**4.72**	**4.42**	**4.2**	**4.64**	**4.56**	**4.54**	**4.65**	**4.4**						**4.35**	**4.4**	**4.33**	**5**	**4.87**	**4.83**
	Total responses					30	30	30	29	29	29	29	27	28	26	29	23	28	29	29	25	26	25	23	21	22	27	25	27	24	22	22	25	25	24	25	25	25	24	23	25	22	24	24	23	23	23	20	24	24	24	24
							Ntm	5.4			**SCtn**	4.57			**RItm**	3.816(			**SFtn**	4.24:			**RStr**	3.707	**Mtm**	2.88		**IStm**	4.91		**CLtn**	3.916	**SOtr**	4.32						**ICtm**	4.487				**Btm**	3.38:	**ITtm**	4.375			**SStn**	4.757
							Ntsd	0.74			**SCts**	1.02			**RIts(**	1.276(			**SFts**	1.06			**RSts**	1.56!	**Mtsd**	1.48		**IStsc**	0.82		**CLts**	1.403	**SOts**	1.12						**ICtsc**	0.95				**Btsd**	1.29	**ITtsd**	1.01			**SSts**	1.09:

Appendix B - Interorganizational Collaborative Capacity Survey Questions

	Demographic Information
D-1	Which county do you mostly work in?
D-2	What area of the Children's System of Care is most applicable to your work?
D-3	Which option best describes your role?
	Need to Collaborate
N-1	Interorganizational collaboration is a high priority for my organization.
N-2	My organization recognizes the importance of working with other agencies to achieve its mission.
N-3	People in my organization understand the benefits of collaborating with other organizations.
	Strategic Collaboration
SC-1	We have clearly established goals for interorganizational collaboration.
SC-2	The leaders of my organization emphasize the importance of collaboration.
SC-3	My organization is willing to address interorganizational goals.
SC-4	My organization's leaders meet and confer with the leaders of other organizations about mutual collaboration.
SC-5	My organization considers the interests of other agencies in its planning.
	Resource Investment in Collaboration
RI-1	My organization has committed adequate time, budget, and personnel to interorganizational collaboration.
RI-2	My organization is willing to invest resources to accomplish cross-agency goals.
RI-3	My organization has assigned adequate personnel to the work required for effective interorganizational collaboration.
	Structural Flexibility
SF-1	My organization invests significant time and energy to deconflict existing policies and processes that impede collaboration.
SF-2	My organization is flexible in adapting its procedures to better fit with those organizations with which we work or might work.
SF-3	My organization is responsive to the requirements of other organizations with which we work.
SF-4	My organization can quickly form or modify partnerships as requirements change.
	Reward Systems

RS-1	Engaging in interagency activities at work is important to career advancement in this organization.
RS-2	My organization rewards employees for investing time and energy in building collaborative relationships.
RS-3	My organization rewards members for their IA collaborative activities.
RS-4	Collaborative talents and achievements are considered when people are reviewed for promotion.
	Metrics for Collaboration
M-1	My organization has identified measurement criteria to evaluate interorganizational efforts.
M-2	My organization has established clear performance standards regarding interorganizational work.
	Information Sharing
IS-1	My organization has strong norms that encourage sharing information with other organizations.
IS-2	My organization provides other organizations adequate access to information we have that is relevant to their work.
IS-3	People in my organization share information with other organizations.
	Collaborative Learning
CL-1	My organization commits adequate human and financial resources to training with other organizations.
CL-2	My organization has strong norms for learning from other organizations.
CL-3	My organization works with other organizations to identify lessons learned for improved collaboration.
	Social Capital
SO-1	Our employees know who to contact in other agencies for information or decisions.
SO-2	Members of my organization take the initiative to build relationships with their counterparts in other organizations.
	Individual Collaborative Capacity
IC-1	Our employees have the collaborative skills (e.g., conflict management and team process skills) needed to work effectively with other agencies.
IC-2	Members of my organization are aware of the services and capabilities of other organizations with which we have to work.
IC-3	Members of my organization respect the expertise of those in other organizations with

	whom we work.
IC-4	Members of my organization understand how our work relates to the work of other organizations with whom we need to collaborate.
IC-5	Members of my organization are able to appreciate another organization's perspective on a problem or course of action.
IC-6	Members of my organization are willing to engage in a shared decision-making process with other organizations when addressing interorganizational issues.
IC-7	People in my organization seek input from other organizations.
	Barriers to Collaboration
B-1	A history of interorganizational conflict affects our interorganizational capability.
B-2	People in my organization tend to be suspicious and distrustful of their counterparts in other organizations.
B-3	I face incompatible requirements or requests when working with other organizations.
B-4	Conflicting organizational policies make collaboration difficult.
B-5	My organization's unique requirements make collaboration difficult.
	Interagency Teams
IT-1	My organization gives members of special project teams adequate authority to speak on behalf of the organization.
IT-2	My organization supports the decisions and recommendations of the special project teams.
	SOC Specific
SS-1	My organization actively seeks out input or participation from service users.
SS-2	My organization respects and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family and their community.
SS-3	My organization prioritizes the perspectives of family and youth, and planning is grounded in providing options and choices such that it reflects family values and preferences.
SS-4	My organization implements services and supports that take place in the most inclusive and accessible way, that safely promote child and family integration into home and community life.

Appendix C - Individual Interview Questions

Collaborative Capacity Interview

Name, Role, Organization, Date

1. What is the current nature of collaborative efforts within the children's system of care? How would you describe the capacity of individuals and organizations to collaborate?
2. What does successful/effective collaboration look like among organizations? How would you define a successful system of care?
3. What do you think is the main issue facing the system of care? Or what are some key issues?
4. Why is this an enduring issue despite knowing what some of the problems are?
5. What is already working? How do people succeed or survive in the system as it functions now?
6. How would this issue look from the viewpoint of senior decision-makers? What factors or components will that level see? How do they think about the issue?
7. What is something your organization could do to improve effective collaboration?

Appendix D - Cross-System Collaboration Committee: Focus Group Task Force Report

System of Care
Cross-System Collaboration Committee
Focus Group Task Force Report

Purpose: Focus groups were held to help identify the training needs of line level staff when it comes to navigating different systems on behalf of the families and children they serve.

Methodology: Focus groups are a qualitative research methodology that allows the researcher to gain in-depth descriptive information about a particular subject. Participants are guided by a facilitator through a series of pre-determined questions. Focus groups provide qualitative data on a topic as it pertains to a specific group (not the general population).

A task force of six agency staff designed a structured discussion guide pertaining to the research topic and implemented the focus groups:

- Adam Peterson, Wraparound Supervisor, Clackamas County Behavioral Health · Travis Tarpo, Wraparound Coordinator, Clackamas County
- Pam Rivers, Wraparound Coordinator, Clackamas County
- Brian Whitmer, System of Care Program Coordinator, Washington County · Clarissa McGee, Family Partner, Oregon Family Support Network
- Selby Stebbins, System of Care and Behavioral Health Coordinator, Health Share of Oregon.

Pam and Travis served as focus group moderators. The remaining participants were note takers. Data coding, analysis, and the final report were prepared by Selby, Brian, and Adam.

One focus group per county was conducted in Multnomah, Clackamas and Washington counties (three focus groups total). There were twenty-one participants representing ten different systems:

Department of Human Services (DHS) Developmental Disabilities Juvenile Justice

County mental health
Education
Peer services
Community mental health providers
Early Learning
Community Navigator
Primary Care.

Participants were recruited via the professional networks of current System of Care (SOC) members. The majority of participants had been in their current positions for 6 months to one year, however a few participants were either more recently hired or had been in their positions longer than one year. Participants were informed as to the purpose of the focus group and encouraged to answer questions based on their training and work experience for their current position only. Participants were assured of confidentiality in their answers and were offered copies of the final report (upon completion).

KEY FINDINGS

By way of introduction, it likely comes as no surprise that when asked which systems they access and why, participants listed dozens of different systems and agencies and a multitude of different reasons (for a complete list of both these topics, please see appendices A and B).

In brief, however, it can be noted that the systems most frequently referenced by name were the educational system (schools and special education services), the legal system (juvenile and criminal justice, courts, local sheriff), mental health providers, Wraparound services and DHS.
Key reasons participants identified for accessing other systems were to support care coordination efforts to assure a "seamless" process for their families; to avoid redundancy of services and wasting time. The second most cited reason was the need to advocate on behalf of the families who find system navigation daunting for any number of reasons (language challenges, simply not comfortable, family anger directed toward the system).

All participants recognized the absolute necessity of cross-system collaboration and the impact it had on their work:

- *"If I wasn't collaborating with other systems, I wouldn't have a team...Each shop knows what their shop does well, but we don't. We can't meet all the needs of that family. So, that collaboration is vital."*
- *"I need all these systems in order to make sure children are safe and especially to build on family strengths."*

Participants were able to identify both strengths and deficiencies regarding their employer provided training on how to access and navigate other systems.

A common theme in all three focus groups was the value and power of learning direct from another person. Participants valued face-to-face learning opportunities and several self identified as experiential learners. Ways in which participants engaged in face-to-face learning included:

- Shadowing a co-worker or being shadowed
- Guest presenters from other organizations coming to their office and providing information
- Direct training from a supervisor or co-worker
- Receiving a general overview or broad stroke training from a supervisor or co-worker
- Visiting other agencies, seeing the site, and engaging their personnel.

Participants also mentioned other training resources such as on-line trainings, information binders, and handbooks. These resources were usually described as being difficult to use or understand and often outdated. Multiple participants stated that there were assumptions on the part of their agencies regarding their level of knowledge around local resources or system navigation upon hiring. This assumption may have caused agencies to offer less

training to those personnel. Several staff also spoke to receiving large amounts of information in the first several weeks for which they had no context and therefore later it was hard to remember and use this information.

A majority of participants described their training process as being a 'trial by fire' or 'trial and error' experience. Example descriptions include:

- *"...it was a crash course before the supervisor left. It was her last week and a new supervisor was not yet hired."*
- *"I had a check-list but no one to help me even know who to talk to, everyone [is] so busy and to have the burden to be on me to make all these connections was awful."* · *"My supervisor said 'we're going to take tours of places and learn the referral processes' but it never happened. It would have been helpful and trauma-informed to have that information to share with people."*
- *"When I was first trained it was set up – 'these are the systems you have to learn to navigate'- but it was just presented as a check list. And, then to learn there was a person I could actually collaborate with, and help the family together, but that switch didn't come until about six months."*

Three participants recognized the challenging nature of training:

- *"I was told from the get-go that a lot of the learning about systems comes from experience. They cannot teach to every situation that might come up."*
- *"I was told it would take some hands-on, year-long learning."*
- *"[I was presented with] a general overview of systems' purposes, specifics may not have been useful because the needs of each client are so unique."*

Participants noted that training content was primarily specific to their own systems or to their unique role. For example, one participant stated: *"I was taught how to make the phone calls for [this activity], that's really important to my role, but other than that, I wasn't really taught how to navigate any of the systems in a formal way."*

When asked what would have been helpful to learn, participant responses were universal across all three groups. All responses related to different aspects of interacting with systems outside their own. Information was requested on:

- Identifying the different systems and who they serve
- Role parameters (what people can/cannot help with)
- Information for different systems on their application process and eligibility requirements
- How to access/make referrals to different systems and programs including knowing who to contact and what forms are needed.

Multiple participants requested that this information be presented face-to-face versus "reading and reading." One participant commented "*We have resource guides but they are not laid out well or easy to navigate so something even more simple; the nuts and bolts of the services described in plain English. It is annoying to have to look around in three different policy guides. Have someone come in and describe services in plain language. [It is] clunky to review policy manuals, [need] something more concise and easy to navigate.*"

After the initial employer-provided trainings, participants used multiple strategies on their own to learn how to successfully navigate other systems.

Once hired, participants used three primary methods to access information on other systems. These methods were consistent across all three counties. However, while each method was successfully employed, the challenges of each method were also noted.

1. Person-to-person contact: This was frequently mentioned as a standard way to learn about accessing and navigating other systems. Supervisors and co-workers provide important information through resource sharing, coaching, and case consultations. One participant mentioned learning about resources from the families themselves. Most participants also grew their own list of contacts at different agencies over time. This network was seen as very useful. A few participants mentioned the high usefulness of having designated agency staff serve as resource navigators and/or having staff from another agency embedded in their office a few hours each week.

- *"We have two resource coordinators. I don't know how it works, but they have a pulse on what is happening in the community, a human resource bank, and they are essential."*
- *"We do have a service matrix and that comes from a resource person. That person is in my office frequently so I go and ask her questions all the time."*

The Wraparound process was mentioned by participants in all three counties as being highly useful beyond case coordination and instead serving as an actual learning venue to find out about other systems and how to access them. As one participant stated: "*Wrap is huge.*"

While information received from this method was useful, it could also be somewhat happenstance (not timely). Additional challenges included the ability to access people when needed, knowing who can help, and feeling comfortable enough to approach them.

- *"If you don't have someone you know, sometimes a lot of those questions just go unanswered or ignored. Sometimes things don't get done..."*

2. On-line resources: As one respondent said "*Google is my friend.*" Participants repeatedly mentioned their reliance on internet search engines to find the information they needed. Only one participant referenced the 211 App as another digital resource.

Participants universally also expressed frustration at the time required to complete this research and determine if the information found was useful or not.

- *"We get asked the same questions but each case worker is doing the same research over and over."*

3. Hard Copy information: Despite heavy use of internet search engines, printed materials stored in binders or even a file cabinet were still referenced in all three groups. While there were comments regarding how easily outdated or unorganized the content of the binders could become, they were still seen as handy-format for a go-to resource and one that could be transported to a client's home.

- *"My supervisor sends out information every two weeks with information she finds. Also, we have a group e-mail so we can share resources or ask questions to get resources for a specific case. All the advocates print out all those resources and keep them in a binder, organized, so you can use it with families on the spot at home visits and can just hand it to them. It is faster."*
- *"I like having a binder of resources, otherwise you just have to remember in your head."*

Lack of efficient communication between agencies was referenced repeatedly as a barrier to cross-system collaboration in all three focus groups.

Participants emphasized over and over a need for better communication between agencies. Here are a few sample

statements:

- *"Counselors won't send you notes unless you ask them to. I thought they would just send updates but they don't…I had no idea. I just thought there was a system set up where everyone shared info."*
- *"It's so hard for medical care and mental health care staff to talk to each other. We work the same hours. We don't take lunches. HIPAA makes it hard – too many steps for parents."*
- *"[We] get information on kids when cases are closed. Information comes in when no longer needed. Even I am terrible about sharing information due to lack of time…"*
- *"Seems like DHS, child welfare, self-sufficiency, OHP should have a better way to communicate with each other. I don't want to be on hold for 45 minutes or have to figure out who in my office knows the answer. It seems unreasonably hard to connect to things everyone is using."*
- *"My young people are not getting the information they need from people on their teams. People have no idea what is going on. Different people get different documentations."*
- *"It would be nice if we all had updated systems, our on-line systems and our forms, and if they were connected…the systems we use for information themselves…are not user friendly or connected to each other. [It] took me four people to ask and find out who my kid's DD caseworker was, and that was after having googled [this] county's DD services, and had to talk to the receptionist and she had to find someone to call me back. Why so hard and long?"*

PARTICIPANT RECOMMENDATIONS

Participants were able to successfully describe the tools needed to aid them in cross-system navigation.

When asked to brainstorm ideal resources for cross-system navigation, participants had many creative ideas, such as:

- Easier access to multidisciplinary teams
- Opportunities to shadow other providers
- Resource books, binders or pamphlets
- Give a binder to families and help them fill it
- "All Staff" meetings where everyone is brought together to learn what else happens in their own system or division
- Be provided samples of blank forms and examples of completed ones from different systems
- More timely and frequent information sharing between agencies

After the brainstorming activity, participants in each county were asked to rank their top three choices for a systems navigation aid.

The top choices can be placed in two categories:

1. Face-to-Face meetings.

    a. Suggestions included 'summits' (large groups of people brought together around a common theme), agency open houses, or mixers.

    b. Access to key point people. This could be either a staff person at their own agency with specific topical knowledge or staff from another agency embedded in their office.

    c. "Systems 101." There was a high level of interest in having guest presenters come to their agencies and of receiving presentations from other departments within their own systems, and that these presentations be rotating amongst a variety of presenters.

2. Systems Information Resource. This idea took two forms:

- A searchable on-line systems map which could help determine which services a client is eligible for as well as how to access the services.
- A hard copy directory, potentially in binder form, which lists resources and systems information (services, how to access, eligibility) for each county in the tri-county region.

Honorable Mentions

Although not voted as a top choice, the idea of a “video tour” of other systems/supports was suggested in all three focus groups. Partners were interested in being able to access recorded presentations from other systems not only for their own learning but also to share with families. Also, two of the three focus groups requested “contact sheets” of 1-2 pages in length which would identify major systems, how to access them, and who/what position to contact.

It is also worth keeping in mind the frequency with which the Wraparound process was mentioned not only as a support for families but also as a way for staff to learn about other systems and to meet contacts.

TASK FORCE COMMITTEE CONCLUSIONS

These focus groups elucidate the challenges of cross-system collaboration and highlight the many ways that staff attempt to cope with these challenges. Just as staff employ multiple strategies in order to navigate multiple systems, managers likely need to employ multiple supports for employees. While some suggested supports are potentially expensive and difficult to maintain, other ideas could be more easily incorporated into the daily experience of staff. For a complete list of options, please see appendix E.

The Task Force Committee recommends that System of Care (SOC) Executives act on three primary recommendations:

1. Training Brochures: Develop short and sweet training brochures about each agency that are available on a web platform that can be updated and shared regularly.

2. Annual All-Staff Training: Form a regional training group made up of all staff in agency training roles and task them with development and implementation of a cross-system training plan, including an annual all-staff training. Training plan must ensure all staff of all agencies are provided training about each system annually. Training shall be hosted by the Tri-County SOC.

3. Case Consultation: Formalize opportunities for improved case consultation via expanding the DHS Preventive Staffing Group to Clackamas and Multnomah Counties and by expanding the use of in-office system liaisons.