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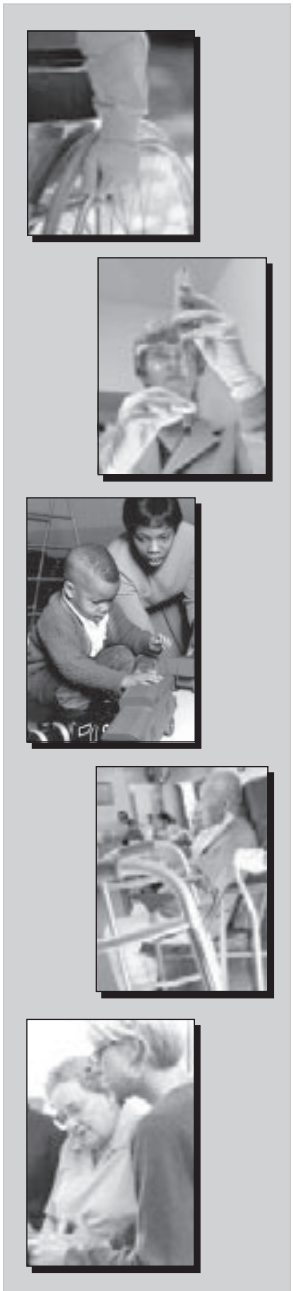
RATIONALIZING HEALTH AND HUMAN SERVICES



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ACKNOWLEDGMENTS

When Steve Adams and Jim Stergios approached me last summer about writing a paper on Health and Human Services for Pioneer, my initial reaction was not to do it. I had my opportunity to work in EOHHS, and it seemed inappropriate for me to take another look at it. But the more I thought about it, the more I thought it would be worth initiating debate about strategy and structure. The fiscal crisis was real and not going away, I did have some thoughts on how EOHHS might be re-made, there would be a new Governor in January 2003—no matter who won—and it seemed like a good time to think a bit outside the box. Nonetheless, I'm sure some who read this paper will wish I had stuck to my original inclination.

Once I agreed to work on an essay, I asked Jim for help, and he and Emily Chaisson gave me a great deal of time, information, and data to help me think through my case. Without the two of them, there would be no paper. Thank you both for your help and assistance.

I also talked to some of my former colleagues on both the public and private sector side of this issue to hear their views on what might be done, and to test some thoughts of my own. Three in particular—former DSS Commissioner Linda Carlisle, former EOHHS Secretary Bill O'Leary, and Paul Cote of Greater Lynn Mental Health—gave me a great deal of time and insight. Thanks to all three.

Thanks also to Senator Susan Tucker for her thoughts and encouragement to put some of the conversations she and I have had about this issue down on paper. In particular, her ideas about taking a more coordinated approach to managing local and regional activities (and office space) across EOHHS were very helpful.

And many thanks to Kathryn Ciffolillo for her thoughts and her work on editing and design. She remains a sharp, focused editor, and a terrific information arranger.

I realize, because I've been there, how dramatic the proposal I make in this paper will look and feel to people who either have worked or do work within the system. It is intentionally dramatic. Many organizations throughout this Commonwealth have re-made themselves over the course of the past decade, primarily due to the capabilities and benefits of integrated information technology and administrative simplicity. Many were far more complex than EOHHS.

In most cases, these people pursued an aggressive change agenda because they felt the status quo underserved their clients. If they didn't change the way they operated, they would lose their clients to someone else who was better prepared to meet their needs. In the case of EOHHS, most of its clients have no alternatives. This makes changing the status quo far more difficult. In fact, many will argue that any change is bad for the

people served by EOHHS. This is simply untrue. Change that integrates information, reduces duplication and fragmentation, and puts the needs of EOHHS clients over the needs of other EOHHS constituencies is positive change and should be diligently pursued.

In this time of budget constraints and high expectations, senior leaders within the EOHHS community must be willing to think differently about what they do, how they organize it, and how they measure their performance. Systems and information integration opportunities exist, but only if people are willing to do the difficult and complicated business process re-design and IT development work that such an effort will require. If done well, it can produce a service delivery and finance system for clients and for staff that far exceeds the one we work with today and can do so without busting the budget.

So when our leaders take on this debate, propose some new ideas, and seek a new course for EOHHS, instead of simply squashing the thought because it's not the same as last week's same-old, same-old, let's engage it, and see where it goes. It may be a bumpy ride, but the destination—for staff, for caregivers, and for clients—will be worth the trip.

—Charlie Baker

PREFACE

It is not often that someone previously involved in running a large public service system makes the time to reflect on lessons learned and present a vision of what could be. Such reflection is especially welcome regarding the human services where state managers are so often in crisis mode and where the secretary is caught up in the dizzying day-to-day tasks of managing a $9.5 billion system that embraces medical care and assistance to the poor, care for those with age-related, mental health and retardation, substance, and other challenges.

This paper is opportune for two additional reasons. First, it comes at a time of fiscal difficulties that will put increasing downward pressure on human services funding over the next few years. How to deliver services more effectively will stand squarely in the middle of these debates, as we seek to avoid lessening services to the vulnerable. The other reason is that the reflections are those of a former public servant with vast experience who, while Secretary of Health and Human Services and of Administration and Finance, advanced and successfully brought to completion significant reforms to the human services—including but not limited to consolidations, rendering the information technology and many oversight processes uniform, and welfare reform.

What Baker does in this paper is consider the next logical steps in the system's evolution. Setting systemwide strategic objectives and making the most of productivity-advancing tools and ideas that have proven successful in meeting other service needs might seem exceedingly hard tasks given the current institutional cultures within the human services agencies. Those familiar with the system will immediately realize, however, that many of the actions undertaken during Baker's time as Secretary were arguably even more difficult. Given the manner in which he is proposing them—calibrated to assess the impact of reform along the way and to allow for mid-course corrections—these reforms are hardly radical.

These reforms, in fact, are only the right *first* step in reforming the purchase of service system. Meeting the needs of the state's historic commitment to the vulnerable will require—and we should not be shy in seeking—further reforms.

—Peter Nessen

Peter Nessen is a former Massachusetts Secretary of Administration and Finance.

EXECUTIVE SUMMARY

Over the course of the past decade, thousands of organizations have used business process redesign and information technology to get to know their customers well, and they have used that information to do a better job of meeting their customers' needs. Five years ago, anyone who had a checking account, a mortgage, an auto loan, and a credit card with the same financial institution might as well have been dealing with four different companies. Today, more often than not, that individual gets one statement each month that consolidates his or her entire relationship with that financial institution. The bank knows the extent of its relationship with each customer, and its customers can manage their accounts and loans in a unified, coordinated manner.

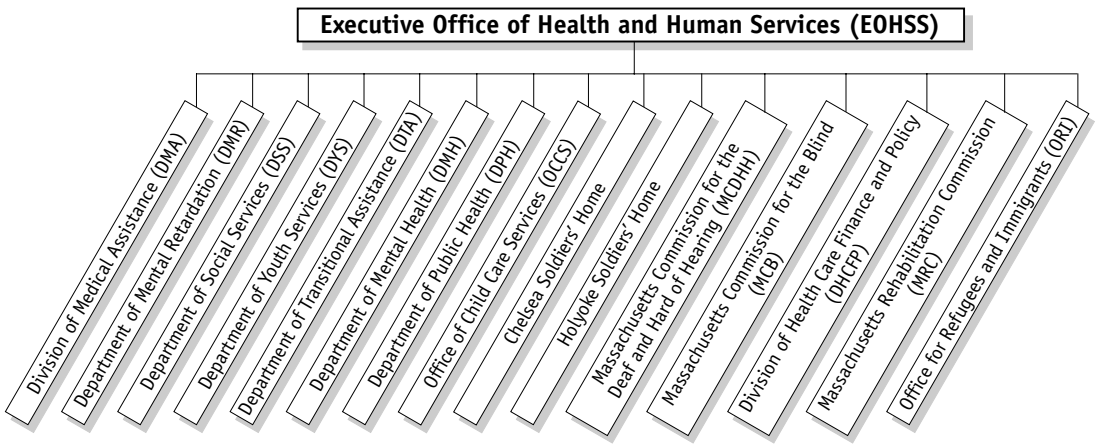
The client-centered approach to information management has not made much headway in the public sector, but that may be about to change. Most states, including the Commonwealth of Massachusetts, are facing very challenging fiscal situations. Despite several hundred million dollars in spending cuts and over $1 billion in tax increases in FY 2003, Massachusetts will face intense financial pressure on its operating budget for at least the next few years. The size of the budget gap facing state legislators and the next governor in FY 2003 and 2004 may exceed $1 billion. Some analysts, including those at the Massachusetts Taxpayers Foundation, think the deficit may be as high as $2 billion in FY 2004. Integrating data and consolidating functions across government agencies offer an opportunity to improve service delivery and save taxpayer dollars.

Integrating data and consolidating functions across agencies of the Executive Office of Health and Human Services (EOHHS) offer an opportunity to improve service delivery and save taxpayer dollars.

EOHHS and "Product Line" Organization

The Massachusetts Executive Office of Health and Human Services is organized by category, or in business terms, by "product lines." The Secretariat, the largest in Massachusetts, is responsible for providing leadership and oversight to 15 member agencies, which manage the delivery of health care, rehabilitation, social, juvenile justice, and family services to the citizens of the Commonwealth.

Figure 1. EOHHS "Product Line" Structure



Each agency employs its own lawyers, investigators, case managers, IT managers, etc. Each agency keeps track of its own client base, and each uses, for the most part, different ID numbers to do so.

Historical, categorical approaches to managing departments and clients no longer make sense—different EOHHS agencies serve many of the same people, but do so in isolation.

Experiments in aggregating data in many states, including Massachusetts, are beginning to demonstrate that historical, categorical approaches to managing departments and clients no longer make sense. Recently, EOHHS has had some success aggregating data from multiple agencies using its MassCARES program. Using client identification and aggregation technology, MassCARES has confirmed what most people assumed—that different EOHHS agencies serve many of the same people, but do so in isolation.

As of yet, no one has tried to use this new tool to build budgets, generate additional federal revenue, target program initiatives, allocate resources, structure EOHHS agency offices, or rethink the way EOHHS operates. No one has tried to take the information MassCARES has made available to develop an integration and coordination strategy for EOHHS.

Given the magnitude of the Commonwealth's fiscal problems, the roughly $500 million EOHHS and its agencies spend on managing their activities, and the opportunity data aggregation and aggressive coordination hold for the Secretariat and its clients, it is clearly time to consider something different.

A Proposal

As long as the budget offices, legal operations, investigative apparatus, case management functions, area operations, policy shops, IT and systems shops, human resource activities, regulatory authority, and advocacy roles rest within the departments, health and human services will never be able to coordinate or integrate its strategy, its activities, or its objectives.

This proposal to rationalize health and human services presumes that EOHHS would eliminate its existing operating agencies over time and replace them with an integrated Secretariat organized along functional lines.

The proposal to rationalize health and human services presumes that EOHHS would eliminate its existing operating agencies over time and replace them with an integrated Secretariat organized along functional, rather than product, lines.

In this model, each operating division would be led by a commissioner, who would report directly to the Secretary of Health and Human Services. The implementation process would happen one commissioner consolidation at a time and would take place over at least a two-year period. Each one would involve the development and submission to the legislature (and presumably to the public) of a timetable for consolidation, a set of deliverables as the process unfolded (staffing, resources, responsibilities, key interfaces), and a set of metrics on which each commissioner would expect to be measured going forward.

The seven commissioners would have the following responsibilities: information technology, licensing, investigations, purchased services, administrative and financial operations, case management, and transitional assistance.

Restructuring Goals

The division-specific goals would be as follows:

1. Organize IT investments and business processes to ensure that program and financial information are shared and managed on a client-by-client basis.
2. Create a single licensing operation and hold it accountable for licensing and re-licensing all organizations and individuals doing business with EOHHS.
3. Consolidate and coordinate all abuse investigations on a statewide basis.
4. Create a single purchased services unit, managed and administered by EOHHS at the highest level of the Secretariat.
5. Consolidate into single units the dozens of legal, budget, human resource, and other administrative operations within the Secretariat.
6. Create a single point of accountability for case management activities. This will give EOHHS the capacity to organize its case management efforts to maximize effectiveness and complement what private providers are already doing in this area.

Under this reorganization scheme, cash assistance for targeted populations and access to job training, MassHealth coverage, child-care services, and other purchased services would remain mostly intact. The shelter programs, which have been funded through Transitional Assistance for years, would be funded out of purchased services.

The Office of the Secretary would employ subject matter experts who can coordinate policy and serve as key points of accountability on certain issues. These individuals would work closely with each of the commissioners to ensure that the over-arching objectives of the Secretariat in each of these key areas are understood and being pursued.

Any approach to re-organizing EOHHS will raise a myriad of operational, logistical, and financial questions that demand to be answered.

Conclusion

Given the stakes and risks involved, the initiative needs to begin with some well-defined principles:

- This change cannot be done all at once and will require an incremental approach. A gradual, open process would provide opportunities for stakeholders to contribute their ideas and insights.
- The legislature and the public need to be informed on a regular basis as the plan moves forward.
- The stated overall goals have to be less administration, less duplication, and better service provision—it can't be viewed as just another way to cut the budget.
- The commitment to integration and reform has to be sustained throughout the process—otherwise nothing will change.

Any approach to reorganizing EOHHS will raise a myriad of operational, logistical, and financial questions that demand to be answered. They should be raised, and they need to be answered—to the extent possible. The tendency in the past has been to deny the debate over the "what if" questions, instead of acknowledging the importance of the debate itself, and the possibilities for improvement it presents.

EOHHS needs to take a different approach to serving its staff, its provider partners, and its clients if it wishes to enhance its support for the Commonwealth's most vulnerable citizens in the future.

Is there ever a good time to consider a significant change in the way EOHHS and its operating agencies do business? The answer is, "YES." Any time is a good time to consider whether or not the structure that is in place today suits the strategies, objectives, and capabilities of the Secretariat and its operating agencies going forward.

The fiscal situation, with or without any significant changes in the revenue picture during the next 18 to 24 months, will be very difficult, and it will put enormous pressure on EOHHS, its agencies, and its constituents. An integrated approach may discover huge opportunities to generate additional federal matching funds that remain unnoticed and unaccounted for under the current structure. A 10 to 20 percent improvement in federal financial assistance would be worth a huge sum of money—close to $100 million—at a point in time when the Commonwealth desperately needs the help.

Given the profound fiscal difficulties facing the Commonwealth over the course of the next several years, the advances in information technology and data-sharing made possible by data aggregation tools like MassCARES, and the increasingly inter-related nature of the work done by the agencies within the Secretariat, now is, in fact, as good a time as any to think completely outside the existing framework. EOHHS needs to take a different approach to serving its staff, its provider partners, and its clients if it wishes to enhance its support for the Commonwealth's most vulnerable citizens in the future.

RATIONALIZING HEALTH AND HUMAN SERVICES

Charles D. Baker, Jr.

INTRODUCTION

About two years ago, I bought a suit at a men's clothing store. At the time, I thought nothing more about it than that. A few months later, I received a mailing letting me know that new suits in my size made by the same manufacturer would be arriving at the store in about two weeks. Shortly after that, I got a phone message at home reminding me that they were receiving a shipment of suits I might be interested in.

Suppliers and retailers need to know their customers, and they need to serve them well to succeed.

So I went back—and bought another suit. This time, I also bought a pair of shoes and some ties. Since then, this store, using mail, e-mail, and phone messages, has done a wonderful job of keeping me informed about what's going on in the store that, given my shopping tastes and habits, might be of interest to me. It's not pushy or aggressive, simply informative and personal. And they have demonstrated, over and over again, that they know what I've purchased, how I had it altered, and who served me when I was there. In short, they have demonstrated to me that they know me, and they know my interests and my tastes.

Over the course of the past decade, thousands of organizations have used business process redesign and information technology to get to know their customers well, and they have used that information to do a better job of meeting their customers' needs. Five years ago, anyone who had a checking account, a mortgage, an auto loan, and a credit card with the same financial institution might as well have been dealing with four different companies. Today, more often than not, that individual gets one statement each month that consolidates his or her entire relationship with that financial institution. The bank knows the extent of its relationship with each customer, and its customers can manage their accounts and loans in a unified, coordinated manner.

The client-centered approach to information management has not made much headway in the public sector, but that may be about to change.

Whether you call it Customer Relations Management or something else, it is the gospel for goods and services suppliers—you must know how, when, and where your customers interact with you if you want to meet their needs and hold onto their business. These days, consumers have many, many choices and access to lots of third-party information to help them make purchasing decisions. Suppliers and retailers need to know their customers, and they need to serve them well to succeed.

While this holistic approach to managing client relationships is relatively new, it has been reworked and refined in numerous private sector settings. People know a great deal about how to make it work, and how to measure its success. In fact, most of its leading practitioners would argue that it is a far more cost-effective, and ultimately superior, way to manage clients and/or customers, for several reasons:

Extreme budget cycles and tough times inevitably and negatively affect the Massachusetts Executive Office of Health and Human Services (EOHHS), its operating agencies, and its clients.

- First, such businesses know more about their clients and can use that knowledge to manage the relationship and to perform better when clients interact with them.
- Second, they eliminate an enormous amount of administrative duplication and data fragmentation, because they are managing the whole relationship through one lens with one data set, rather than trying to reconcile multiple sources of unconnected information through multiple channels.
- Third, they can use the information they generate to pursue corporate-wide approaches to managing issues and solving problems, because they have a better understanding of how the organization functions as a whole.

This consolidation and integration is happening every day throughout our economy. The client-centered approach to information management has not made much headway in the public sector, but that may be about to change. Most states, including the Commonwealth of Massachusetts, are facing very challenging fiscal situations. Despite several hundred million dollars in spending cuts and over $1 billion in tax increases in FY 2003, Massachusetts will face intense financial pressure on its operating budget for at least the next few years. The size of the budget gap facing state legislators and the next governor in FY 2003 and 2004 may exceed $1 billion. Some analysts, including those at the Massachusetts Taxpayers Foundation, think the deficit may be as high as $2 billion in FY 2004. Integrating data and consolidating functions across government agencies offer an opportunity to improve service delivery and save taxpayer dollars.

THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Across-the-board cuts fail to consider how agencies relate to one another or provide services. The result could be a more fragmented, less satisfying hodge-podge of agencies and activities than we have.

History shows that extreme budget cycles and tough times inevitably and negatively affect the Massachusetts Executive Office of Health and Human Services (EOHHS), its operating agencies, and its clients, because they represent such a large portion of the Commonwealth's operations and spending. Just as important, an organization and delivery system that today looks and feels very complicated—to the people who work in it and try to manage it *and* to the folks who seek services from it—will almost certainly become more so if the Commonwealth's fiscal condition continues to deteriorate. As has been done in the past, across-the-board cuts will be made that fail to consider how agencies relate to one another or provide services.

The result could be a more fragmented, less satisfying hodge-podge of agencies and activities than we have today. This, combined with a general sense that the Secretariat is not living up to its potential, could leave the EOHHS and its clients in an even more difficult political, operational, and financial position than they are in today.

The time has come to reconsider the status quo at EOHHS. Obviously, the current arrangement, with all its fragmentation, is initially less worrisome than something new, but in an era of very limited resources, it seems extremely unfair to the poor and disabled to ignore an opportunity to improve coordination, streamline operations, and maximize

customer satisfaction. With that in mind, this paper will try to "think big" about the way we manage services to our most vulnerable populations, and to propose both a process and goal for utilizing tools from the private sector to reshape EOHHS.

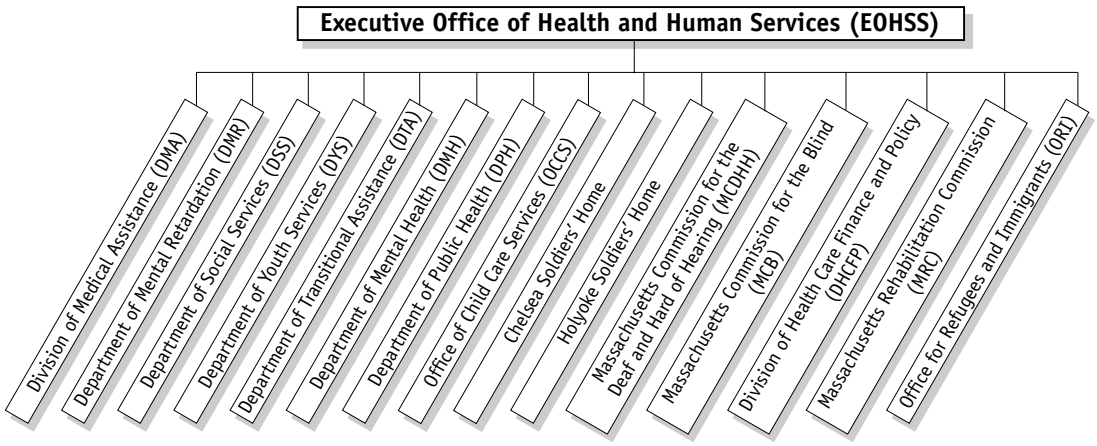
"Product Line" Organization

EOHHS, the largest secretariat in Massachusetts, is responsible for providing leadership and oversight to 15 member agencies, which manage the delivery of health care, rehabilitation, social, juvenile justice, and family services to the citizens of the Commonwealth.

Organized using a traditional "product line" approach, EOHHS comprises 15 agencies that manage the delivery of health care, rehabilitation, social, juvenile justice, and family services to the citizens of the Commonwealth.

With some modest name changes and incremental adjustments along the way, figure 1 represents how the Secretariat has been structured for many, many years.

Figure 1. EOHHS "Product Line" Structure



The Secretariat is organized using a traditional product line approach. While many public and private entities still organize themselves around product lines, many others have taken more integrated approaches to organizational structure, data generation, and customer relations. The technology to aggregate information across product lines has become increasingly user friendly. And more importantly, many organizations have discovered that the product line approach has negatively affected their capacity to serve their customers fully. The right hand not knowing what the left hand is up to is an old cliché, to be sure, but many organizations are responding to that age-old nostrum by consolidating and simplifying operations and integrating data to create more effective and more efficient relationships with their customers.

Many organizations have discovered that the product line approach has negatively affected their capacity to serve their customers fully.

The Executive Office within the EOHHS Secretariat has a staff of 30—divided among 11 units, including the Health Services Unit and the Human Services Unit. However, the Secretary of EOHHS does not have line authority over its 15 component agencies. The creation of the executive-level Secretariat did not give the Secretary the capacity to coordinate and manage the agencies under its jurisdiction. The staff, the resources, and most of the statutory authority reside with the departments and their commissioners. Much of the time, the departments do not view themselves as beholden to or even part of a larger Secretariat. In many cases, agency employees consider the Secretariat a problem to be managed and not a convener, coordinator, or decision-maker.

There are no EOHHS standards that cross agencies concerning area boundaries, service coordination, unique client identification numbers, service codes, staff positions, or provider contract terms. The Secretariat is there to submit a budget, but the programming and the resources within the Secretariat are located at the agency level and are driven by agency-specific concerns. As a result, inter-agency coordination and integration is very limited.

The Secretary is not authorized to issue regulations, the lifeblood of any operating agency. For the most part, the Secretariat's real authority rests in the role it plays in selecting each agency commissioner and signing off on each agency's budget. The rest of the Secretary's power is a matter of influence and persuasion. The limited authority at the top constrains the Executive Office's ability to perform its job effectively.

The McGovern Report, published in 1986, noted, "Contracting for social and rehabilitative services (and for services generally) has not been fully recognized as an administrative and policy problem. Administration of the provider system has developed in a piecemeal, contradictory, and duplicative fashion, with primary care decisions left to contracting agencies, and the system has not benefited from the kind of consistent and coordinated central oversight which is necessary to ensure effectiveness and long-term viability."[1]

The Secretary of EOHHS does not have line authority over its 15 component agencies. The limited authority at the top constrains the Executive Office's ability to perform its job effectively.

While this analysis is more than 15 years old, it is as true today as it was when it was written. As long as the budget offices, legal operations, investigative apparatus, case management functions, area operations, policy shops, IT and systems shops, human resource activities, regulatory authority, and advocacy roles rest within the departments, health and human services will never be able to coordinate or integrate its strategy, its activities, or its objectives.

The Scope of EOHHS Activities

In FY 2002, the total appropriation figure for all the EOHHS agencies was $9.54 billion, nominally totaling about 40 percent of state government's total budget.[2] Since EOHHS generates a tremendous amount of federal revenue, either through categorical aid or matching grant programs (MassHealth/Medicaid, SSI, AFDC, etc.), the Secretariat's actual draw on state tax dollars is closer to 30 percent.

Seven of the 15 EOHHS agencies make up the vast majority of the dollars, manpower, and activities of the Secretariat:

- Division of Medical Assistance (DMA)
- Department of Mental Retardation (DMR)
- Department of Social Services (DSS)
- Department of Youth Services (DYS)
- Department of Transitional Assistance (DTA)
- Department of Mental Health (DMH)
- Department of Public Health (DPH).

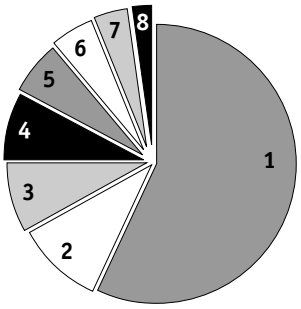
These are also the agencies that most people associate with the Secretariat. They handle and pay for most of the health care, children's services, and disability programming offered by EOHHS. The other agencies within the Secretariat also do important work (the Office of Child Care Services licenses and funds an enormous child care service system, for example), but they are less well known than the seven mentioned above.

[1] Senator Patricia McGovern, *Purchase of Service: Protecting the Promise of Community Based Care* (1986), pp. 4-5.

[2] Source: FY 2002 state budget.

Figures 2 and 3 depict FY 2002 EOHHS appropriations by category and by agency.

Figure 2. EOHHS Spending by Category, FY 2002

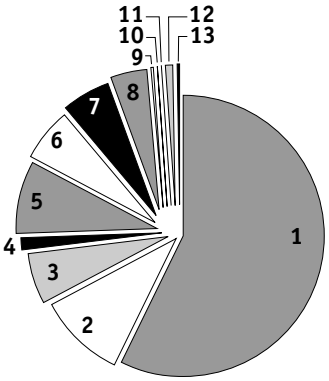


1.	Medicaid	57%	$5,376m
2.	Mental Retardation	10%	$964m
3.	Services to Children	8%	$758m
4.	Cash Assistance	8%	$713m
5.	Mental Health	6%	$608m
6.	Public Health	5%	$516m
7.	Day Care Services	4%	$393m
8.	Housing Assistance	2%	$144m

Total appropriations for all the EOHHS agencies was $9.54 billion in fiscal year 2002.

Data: Appropriation categories and figures from Glen Tepke at the Massachusetts Taxpayers Foundation (MTF).
Note: Salary reserve ($5 million) not included.

Figure 3. EOHHS Spending by Agency



1.	Division of Medical Assistance	58%	$5,482m
2.	Department of Mental Retardation	11%	$931m
3.	Department of Social Services	6%	$569m
4.	Department of Youth Services	1%	$124m
5.	Department of Transitional Assistance	8%	$803m
6.	Department of Mental Health	6%	$591m
7.	Department of Public Health	5%	$516m
8.	Office of Child Care Services	4%	$395m
9.	Chelsea Soldiers' Home	<1%	$23m
10.	Holyoke Soldiers' Home	<1%	$17m
11.	Massachusetts Commission for the Deaf and Hard of Hearing	<1%	$5m
12.	Massachusetts Commission for the Blind	1%	$69m
13.	Division of Health Care Finance and Policy	<1%	$10m
	Total		**$9.5b**

Source: Appropriation figures from the FY 2002 budget.

The Limits of Data Collection

The Secretariat does not generate much information that deals with overall EOHHS activities. There is no standard set of data definitions or standard process for generating and disseminating program information across the Secretariat. For example, the Departments of Social Services, Transitional Assistance, and Medical Assistance all serve pretty much the same clients, and all have invested tens of millions of dollars in client identification and tracking systems over the past decade. None of these systems talk to one another.

The Departments of Social Services, Transitional Assistance, and Medical Assistance, which all serve pretty much the same clients, all have client identification and tracking systems, none of which talk to one another.

The EOHHS agency data that are available tend to be financial. Budget data are available on an agency-by-agency basis, but generally the data points are defined by and the data collated by the Commonwealth's accounting and personnel administration

systems. Thus, the data are useful in answering queries concerning pre-defined categories of spending, but remain very hard to manipulate for purposes and analyses specific to EOHHS. As a result, the Secretariat continues to have trouble answering basic questions:

- How many people are served by the Secretariat?
- How much does EOHHS spend on general administration?
- How much does EOHHS spend on program administration?
- How many people are served by more than one EOHHS agency?
- How many people are served by more than two EOHHS agencies?
- How many people have EOHHS agency case managers?
- How many people have cases being managed by more than one EOHHS agency?
- How many private service providers are licensed or regulated by more than one entity within the Secretariat?
- How many phone calls did EOHHS agencies receive from clients last month?
- What issues represented the largest categories of calls fielded by EOHHS agencies?
- How many times last month did any one client of any one EOHHS agency come in contact with or seek services from or through more than one agency?

This data block has been partially mitigated over the last year or so using client identification and aggregation technology developed by the Executive Office called MassCARES. MassCARES has confirmed what most people assumed—that different EOHHS agencies serve many of the same people, but do so in isolation.

The fact that we now know how many case managers in various EOHHS agencies serve the same family hasn't translated into a more coordinated or organized approach to case management.

Counting Clients

MassCARES estimates that EOHHS and its agencies serve about 1,260,000 people. The capability of MassCARES to generate a figure approximating an unduplicated count of EOHHS clients is a big step forward for EOHHS. That it can show, by zip code, where these people reside, is equally important.

Each agency keeps track of its own client base, and each uses, for the most part, different ID numbers to do so. They also have different ways of tracking clients served. Some track individuals, some track "visits" or "encounters" or "beds," and some simply rely on estimates from the caregivers with whom they do business.

The fact that we now know how many case managers in various EOHHS agencies serve the same family hasn't translated into a more coordinated or organized approach to case management. No one has tried to use this new tool to build budgets, generate additional federal revenue, target program initiatives, allocate resources, structure EOHHS agency offices, or rethink the way EOHHS operates. No one has tried to take the information MassCARES has made available to develop an integration and coordination strategy for EOHHS.

The Origins of Health and Human Services in Massachusetts

The origins of the Massachusetts social services system can be traced back to the Elizabethan Poor Law of 1601, which took the view that local communities, especially local churches, should care for the poor and disabled. The first American almshouse was opened in Boston in 1662, while many smaller communities boarded the poor and otherwise needy in private homes.

As the late eighteenth and the early nineteenth century brought an increasing number of immigrants to Massachusetts, more formal assistance was needed, and state- and county-administered almshouses began to replace local, largely informal arrangements. It didn't take long for these almshouses, which housed the physically and mentally ill, criminal, vagrant, orphan, indigent, and elderly populations together, to become overcrowded. The notion that distinct populations had differing needs led to the creation of specialized urban hospitals supported mainly through private philanthropy. In 1863, the legislature created the Massachusetts Board of State Charities to gather data, define issues, and articulate public policy. Three years later, the State Board of Health was established.

The early twentieth century brought more impoverished immigrants, and pressure grew on state government to centralize and consolidate the hodge-podge of local and county public assistance programs. At the same time, private charities emerged and played an increasing role in assisting poor and needy children and, later, adults. State departments were renamed and reorganized several times, but by 1920 the Massachusetts Departments of Public Health, Mental Diseases, and Public Welfare (including the Division of Juvenile Training that oversaw state reform schools) and the Massachusetts Commission for the Blind were all up and running.

The federal government entered the social service arena with the New Deal. Although federal involvement at this time was limited to cash assistance entitlements to the needy, the Social Security Act of 1935 gave the federal government the enlarged role in human services that it has even today.

The Depression and World War II left state institutions overcrowded, filthy, and in deplorable condition. The development of new medications and methods of treatment and behavior modification, together with the new view that institutionalization was inhumane, were the underpinning for the movement to deinstitutionalize the mentally ill and retarded and, instead, to care for them in community settings.

In 1962, the "Service Amendments" committed the federal government to a new role in funding social services for the poor: state welfare agencies were authorized for the first time to purchase services from "sister" public agencies, paving the way for state agencies to purchase services from private agencies.

Massachusetts was among the first states to deinstitutionalize and move toward the provision of community-based services in the late 1960s. Deinstitutionalization accelerated after the 1970 Mental Health Reform Act imposed limits on new admissions to state mental hospitals. The newly created Department of Youth Services began dismantling the state's training schools and detention centers in 1972.

The state began contracting with private agencies, and soon its role in human services had evolved from primarily a direct service provider to a purchaser as a well as a provider.[3] In 1971, the Sargent administration created the Executive Office of the Secretary of Human Services to provide, in theory, CEO-style leadership and oversight to the various agencies. By 1986, 11 agencies within the human services secretariat funded contracts for social and rehabilitative services. In FY 1975, DMH had targeted 84 percent of its direct services budget to hospitals and state schools—only 54 percent went to these same facilities by FY 1986, and by FY 2002, it was less than 30 percent.

The proliferation of state social service agencies in the 1980s was due either to a loud, public outcry concerning a particular act or incident, aggressive interest group advocacy, or the recent arrival of federal funding to support a particular program. The Department of Social Services was created in response to a series of tragedies involving children under the care and supervision of the Department of Public Welfare. Later on, the Massachusetts Office for Refugees and Immigrants was created to carry out the state's refugee resettlement program under the federal Refugee Act of 1980. The Massachusetts Commission for the Deaf and Hard of Hearing became independent from the Massachusetts Rehabilitation Commission (which was itself established in 1955) in 1986 in response to intensive lobbying efforts to create more state services particularly oriented toward the deaf and hard of hearing. The Department of Mental Retardation separated out from the Department of Mental Health in 1987, due in large part to aggressive advocacy for a separate agency.

The Division of Medical Assistance was separated from the Department of Public Welfare once its programming expanded beyond its original mission to provide health care coverage to AFDC and SSI recipients. The Division of Health Care Finance and Policy was created in 1996 through the consolidation of two other departments (the Rate Setting Commission and the Department of Medical Security). The Office of Child Care Services was created in 1997 by consolidating the licensing functions of the Office for Children with the child care purchasing activities of various EOHHS agencies.

[3] Senator Patricia McGovern, *Purchase of Service: Protecting the Promise of Community Based Care* (1986). Historical overview, Anna Schuleit, **www.1856.org.**

THE PRIVATE PROVIDER PERSPECTIVE

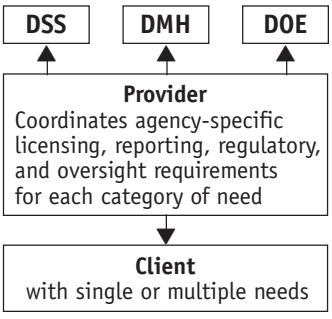
Most state agencies that operate as part of the EOHHS Secretariat measure and monitor their financial and operating performance using their own financial and operating metrics. They do this despite the fact that every single day, they and their counterparts throughout the Secretariat make decisions that directly affect the financial and operating performance of other EOHHS agencies. When they change eligibility standards, provider reporting requirements, case management policies, provider payment policies and/or amounts, or licensing requirements, they have an often unintended impact on other agencies within the Secretariat, on the clients and customers the agencies serve, and on the private organizations that provide care.

For those who work in private organizations that interact with EOHHS agencies, the lack of coordination is a source of continual frustration.

For those who work in private organizations that interact with EOHHS agencies, the lack of coordination is a badge of honor, a price of entry, and a source of continual frustration. For some, the difficulties associated with doing work for and business with more than one EOHHS agency is simply the price they pay to participate in the system. They acknowledge the duplication of effort, the fragmentation of information, the multiple layers of case management and program oversight, but express no real confidence that it will ever change. Those who have participated in licensing processes involving more than one agency tell tales about 200-page applications, multiple application resubmissions over many months, agency staff changes that require starting the application process over, and the gathering of virtually the same information for submission in different formats to various agencies.

Others talk about inspectors, licensors, service coordinators, and other regulatory personnel from different EOHHS agencies conducting program and financial reviews at different times and under different terms throughout the course of the year. In some cases, compliance with one agency is non-compliance with another. Provider organizations working with special needs children often need to comply with financial and program regulations from DSS, DMH, and the Department of Education, all of which are different, but all of which reflect on the same children, their progress, and their well-being. The state agencies focus on—and are fragmented according to—particular categories of need, while the provider organizations seek to deliver services to specific clients, many of whom have multiple needs.

Figure 4. The Burden of Coordinating Services



The documentation required by each agency varies, and those providers that contract with multiple agencies must fulfill the requirements of each agency with which they interact, including the provision of board minutes, policy manuals, forms and questionnaires, and inspection reports. There is a uniform financial report that is used by all of the EOHHS agencies, but not a uniform reporting requirement. As a result, many agencies have staff who spend all their time preparing quantitative compliance reports.[4] Each agency also has its own method to be used in treatment plans and assessments, and the fact that different data-gathering tools are required by each agency causes the process to be "inefficient, duplicative, and a waste of…time."[5]

[4] Interview with Paul Cote, Chief Executive Officer, Greater Lynn Mental Health & Retardation Association, Inc., June 17, 2002.

[5] Joe Loconte, *Seducing the Samaritan*, Pioneer Institute, 1996, 12.

Many EOHHS providers end up becoming, by default, care coordinators for EOHHS clients. In some cases, Commonworks being perhaps the best example (see page 17), they are contracted to coordinate and manage complex cases across multiple agencies, but most of the time, the coordination is their contribution to the system, and not something that's either recognized or funded.

Ironically, while this rule-based, agency-specific approach to performance gives the provider community headaches concerning "compliance," the agencies financing the provision of service aren't sure the providers are being properly regulated.

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Different Providers, Same Issues

La Alianza is a small contractor on the spectrum of EOHHS providers, but has played a significant part in the rebirth of the Dudley Square area. The agency has been in existence for 33 years and has built up a network of youth and family services, with seven departments and 22 service areas, including education, employment and training, elder services, youth development, and mentor and counseling programs, making it the largest Latino services organization in Boston, programmatically. La Alianza employs 50 people from 10 different cultures.

Justice Resource Institute has been in business for almost 30 years and is now one of the largest human service providers in the Commonwealth. A staff of more than 900 runs 22 different programs in several states, including the management of a health center and mental health clinic; street youth outreach; court and probation services; residential schools for mentally ill, cognitively limited, developmentally disabled, and behaviorally challenging youngsters; comprehensive services for developmentally disabled adults; and adult offender services.

Not surprisingly, dealing with multiple EOHHS agencies is more difficult for the smaller agency than it is for the larger one. La Alianza is more concerned about licensing, reporting, and regulatory issues than JRI, in part because JRI has the staff and the experience to manage multiple formats and complex reporting requirements.

Licensing and Reporting

La Alianza's frustrations with licensing practices were exemplified by interactions with DPH and DMH with regard to its Latino Family Counseling Center, which has contracts with both state agencies. DPH requires that all substance abuse programs be licensed and that the license be renewed every two years. The initial application for the DPH substance abuse license is around 200 pages long (including information on the program's history, menu of services, but also encompassing building inspections, etc.). After spending two years trying to get licensed, during which it resubmitted materials five times and saw a change in inspectors, La Alianza staff have still not been notified as to what more they need to do to obtain the license. La Alianza must also be licensed by DMH, which is 10 years behind on performing site visits. As a result, La Alianza's license, which was up for review in 1992, is considered valid until DMH has a chance to do the inspection.

There is no clear, statewide approach to licensing, paying for, and programming community-based, privately delivered services in Massachusetts.

Reporting can also be difficult, especially when programs are funded by multiple state agencies. La Alianza's program to reduce infant mortality rates in the Latino community receives funding from DPH and the Boston Public Health Commission, which in turn receive federal funding. La Alianza must therefore follow city, state, and federal regulations and reporting requirements. La Alianza's work with Chapter 766-approved schools requires the agency to report to DSS, DMH, and the Department of Education. Each agency wants different information, and each wants it in a different IT format (because they all have different computer systems).

To add to the confusion, some agencies do their contracting, licensing, and performance reviews at the area or regional level, and others do some or all of it centrally. There is no clear, statewide approach to licensing, paying for, and programming community-based, privately delivered services in Massachusetts.

Regulations

This situation is further clouded by the fact that state regulations are constantly changing, with one state agency having made at least three sets of changes in its program regulations over the last two years. Staff at La Alianza voiced the view that the system "is very convoluted" and that "when you're dealing with regulations required by state agencies, it can take months to get something simple done."[6] La Alianza has two lawyers on staff to interpret regulations and their implications for the agency. Senior staff noted that flexibility and discretion are needed if they are to serve clients effectively and that regulations restrict such flexibility.

'The amount of paperwork, and the time it takes to get processed and finalized, affects the amount of time that we can spend providing direct services,' says one EOHHS provider.

The impact on resources is considerable and a source of frustration for La Alianza. No one disputes the importance of licensing and reporting, because "there has to be some sort of control, some guidelines." But in many cases, "the amount of paperwork, and the time it takes to get processed and finalized, affects the amount of time that we can spend providing direct services." At a minimum, La Alianza staff believe that EOHHS in particular and state government in general need to do a better job of coordinating its reporting and regulatory activities.

Justice Resource Institute staff expressed similar concerns about agency coordination and simplification, but were equally concerned about the impact of regulatory activity on the delivery of high-quality care. Too many regulations represent agency responses to one-time events, so that regulations that apply to everyone are based on single incidents; in many cases, regulations work to replace human judgment.[7]

EOHHS policies also make it more difficult to attract and retain qualified direct care staff. Staff turnover is generally driven by three issues: stagnant provider reimbursement rates (reflected in low pay for these positions), complex and conflicting EOHHS agency regulatory policies (which most caregivers, particularly the good ones, will say are demoralizing and nonsensical), and little support for creative, unusual approaches to care delivery and care management. By limiting yearly adjustments in provider reimbursements and adding rules and regulatory requirements with each passing season, EOHHS and its agencies make it less attractive for good provider staff to stick with their organizations and their clients over time.

[6] Interview with William Rodriguez, Liliana Mantilla, and Tito Fuster of La Alianza Ispana, August 29, 2002.

[7] Interview with Susan Wayne and Andrew Pond of the Justice Resource Institute, September 3, 2002.

THE CLIENT PERSPECTIVE

During my tenure at EOHHS in the 1990s, I met with clients of EOHHS agencies and their families on numerous occasions. Their views and concerns about care delivery and bureaucracy ranged from very positive to profoundly negative. Recent discussions with EOHHS agency clients and their families confirm that the love/hate relationship that many of these people had with state government when I was there has not changed much in recent years. There are several themes that come through in their comments that are worth bearing in mind.

Quality of Care

Many clients and their families—particularly those who are served by the disability agencies—believe that providers and caregivers worry more about program compliance and time and activity reporting than they do about the actual care they provide. They find little to cheer about in the reporting they are privy to and do not believe that complying with state regulations necessarily translates into quality care or service for their family members. Many believe the rules lead to an institutional approach to community-based care and would prefer a less detailed, but more substantive, approach to oversight.

Caregivers who know and understand their clients get more done with less effort than those who are working with little knowledge of the clients they are expected to serve.

For example, many families believe that the connection their loved one has with the people he or she lives with and the people who oversee their daily activities is more important than many of the state's regulations. And yet this issue—whether the people who live and work together like one another and get along—is generally not considered an important part of the review process. Time and activity records, more than almost anything else, dominate the reporting requirements put forth by EOHHS agencies. And while this information can be helpful, it hardly represents a quality of life. Many family members believe the best caregivers care primarily about making a connection with the people they work with and serve, and the current reporting environment puts little or no emphasis on this critical element of excellence.

Staffing

Most families would prefer to see a lot less paperwork and far more focus on how well the family member relates to the people he or she sees every day. Staff turnover is a huge problem for many direct care programs. Connections among clients and caregivers don't happen overnight, and any client who loses a caregiver he or she enjoys as a result of turnover is less likely to engage the next person who comes along, for fear that person will soon depart as well. Others indicated that if there were more emphasis on the connection between caregivers and clients, there would be less concern over staffing levels, time and activity reporting, and the like. Caregivers who know and understand their clients get more done with less effort than those who are working with little knowledge of the clients they are expected to serve. Trust and comradeship can be powerful, positive forces for success, but neither is deemed useful or important by most agency rule-makers.

Trust and comradeship can be powerful, positive forces for success, but neither is deemed useful or important by most agency rule-makers.

Agency classification and payment policies can have the perverse effect of accentuating difficult client behavior. Since almost any outburst requires a variety of structured, defined responses, it is very difficult for caregivers to work through or downplay any conflict with their clients. In addition, some clients, many in fact, can be and are re-classified if they behave badly, which generates a higher rate of reimbursement for the organization taking

care of them. Some families believe these rules make it harder for caregivers to "normalize" their relationships with clients and make it all too obvious that residential care is more about rules and employment than it is about caregiver/client relationships.

Lack of Coordination

Families served by more than one EOHHS agency have complained for years about the difficulties associated with stitching together coordinated programs for themselves and members of their family if they need to involve more than one agency. Data get lost, information isn't shared, funding is categorical or programmatic and doesn't support inter-agency cooperation. Most of the time, someone who is served by one EOHHS agency and wants to learn something about another is better off pursuing that information independently than seeking it through anyone at the first agency. Staff at any given EOHHS agency are unlikely to know much about the roles and capabilities of another agency, don't have ready access to this information, and frequently don't consider this knowledge important or necessary.

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A PROPOSAL: RATIONALIZE HEALTH AND HUMAN SERVICES

When I became Undersecretary for Health within Health and Human Services in 1991, I joined an administration that was committed to making a number of significant changes at EOHHS. Our plan was not very complicated and was well covered in the media and in policy debates through the first several years of the administration. It had a number of components, but really came down to five key goals:

1. Consolidate the EOHHS facility system, which was far larger than it needed to be, given the advent of Medicaid and significant changes in the way we served people with disabilities.
2. Bring a managed care approach to MassHealth (then called Medicaid), emphasizing community-based services and prospective payment systems.
3. Significantly reduce administrative and operational headcount throughout EOHHS.
4. Enhance and coordinate efforts to pursue federal matching funds for EOHHS services.
5. Reform welfare by using a work-first approach to support low-income populations, thereby encouraging recipients to seek and hold onto productive employment.

While this approach wasn't universally embraced then nor is it now, it was an articulated strategy for dealing with the fiscal realities we faced at the time and was based on solid policy analysis. Over time, we achieved most of our policy objectives:

1. We right-sized the state's facility system, made capital investments in our remaining institutions, and allocated significant dollars to community-based services.
2. We reduced the increase in Medicaid/MassHealth spending for the better part of 10 years (which made the expansion that was later enacted far more achievable).
3. Our headcount dropped significantly.
4. We dramatically enhanced federal revenue collections throughout EOHHS (although there is more that can be done in this area).
5. We implemented significant changes in the state's AFDC and General Relief programs.

Ten years later, state government generally, and EOHHS in particular, is facing another financial crisis. It is time to change the model that has guided EOHHS operations for the past 40 years. The strategies that were pursued 10 years ago made sense then, before the integration and consolidation of information became an everyday occurrence. Today, when so many EOHHS constituents are served by multiple state agencies through numerous sources of funding, the notion that every agency should stand alone from every other makes much less sense.

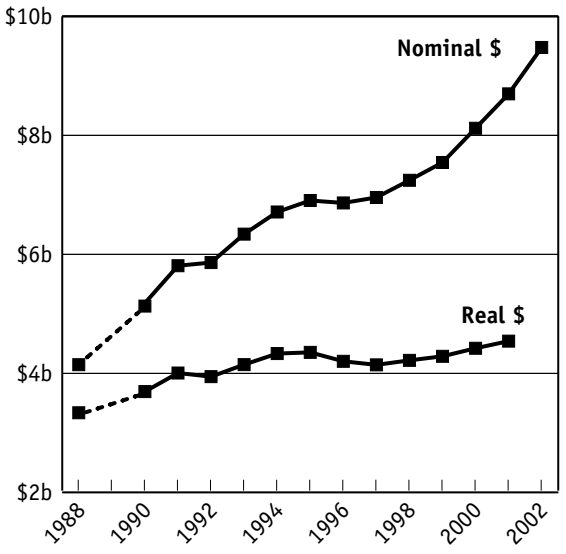
Growth in Spending on Health and Human Services in Massachusetts

Spending on human services in Massachusetts has shown large nominal increases in recent years that translate into real-dollar increases overall. As figure 5 shows, spending increased from 1988 to 2001 in nominal terms by 110 percent. From 1988 to 2002, spending rose in nominal terms by 129 percent. In real terms, the increase from 1988 to 2001 was approximately 36 percent.

Over the past decade (1992-2001), total EOHHS spending grew by 61.7 percent, which is slower than the growth in overall state spending during this same period of time (75 percent).[8] On an annualized basis, spending by EOHHS agencies rose by about 4.9 percent per year on average, which is again slower than the 5.8 percent average annual increases in state government spending. During that same period, cumulative inflation was more than 30 percent, meaning that in real dollars, spending rose by an average 1.6 percent annually, compared to an approximately 3 percent average annual increase in real total state spending.

Much of the increase in total EOHHS spending was due to a jump in Medicaid spending. The increase in Medicaid spending can in great part be attributed to several program expansions, the expense of long-term care, and general health care inflation. The cost of expanding Medicaid (which then became MassHealth) eligibility was partially offset by increases in cigarette taxes and federal revenue.

Figure 5. Total EOHHS spending, nominal and real, 1988-2002



Source: Appropriation figures are from the FY 2002 budget.
Note: Inflation rates for 2002 are not yet available.

Principles for Change

Every journey has to start somewhere, and this one, given the stakes and risks involved, needs to begin with some well-defined principles:

- This change cannot be done all at once and will require an incremental approach.
- The legislature and the public need to be informed on a regular basis as the plan moves forward.
- The stated goals have to be less administration, less duplication, and better service provision—it can't be viewed as just another way to cut the budget.
- The commitment to integration and reform has to be sustained throughout the process—otherwise nothing will change.

[8] Including Medicaid, Cash Assistance, Day Care Services, Housing Assistance, Mental Health, Mental Retardation, Public Health, Services to Children and the Salary Reserve, the FY 2002 appropriation number was $9.48 billion, which represents an increase of 61.7 percent from total spending in 1992, which was $5.86 billion. Source: Glen Tepke, MTF. Total state appropriations in FY 2002 were $23.69 billion, while in 1992 the total state *spending* was $13.54 billion, an increase of 75 percent. Source: Glen Tepke, MTF.

Most of the major policy and operational changes that took place within EOHHS in the 1990s were done with the support of the legislature. There are several ways to engage legislators in this discussion as well. One is to seek legislation calling for the administration to submit a plan to the legislature to integrate EOHHS and its activities over some period of time. Another is to sign an Executive Order to develop a plan and to require submission of the plan to the legislature upon its completion for review and comment. The second approach would move more quickly and would give the legislature the opportunity to analyze the proposal and conduct public hearings on it once it has been developed.

Consolidating, organizing, streamlining, and/or simplifying EOHHS have been discussed in policy circles for years.

The proposal, no matter what it looks like, will generate disagreement and controversy, but will not necessarily present a new idea. Consolidating, organizing, streamlining, and/or simplifying EOHHS have been discussed in policy circles for years. Numerous academics and professionals have proposed varying approaches. Some have proposed consolidating all health care agencies and activities; others have proposed creating a single agency for serving children. Still others have proposed consolidating all the disability agencies into either a single disability agency or a single social and rehabilitative services agency. In addition, some legislators and advocates have proposed consolidating all agency investigation personnel and activity, and others have proposed a single structure for performing case management services.

Figure 6. Common Functions across EOHHS Agencies

	Deputy Commissioner	Assistant Commissioner	General Counsel	Information Technology	Civil Rights	Financial	Public Affairs	Human Resources
DMA	■	*	■	■	■	■	■	■
DMR	■	*	■	■	■	■	■	■
DSS	*	*	■	■	■	■	■	■
DYS	■	*	■	■	■	■	■	■
DTA	■	*	■	■	■	■	■	■
DMH	*	*	■	■	■	■	■	■
DPH	■	*	■	■	■	■	■	■
OCCS	■	*	■	■		■	■	■
MCDHH	*		■	■	■	■	■	■
MCB	*		■	■		■	■	■
MRC	*	*	■	■	■	■		■

* *Deputy Commissioners*: **DSS**: Operations A&F. **DMH**: Management and Budget, MH services, Clinical/Professional Services. **MCDHH**: Policy and Programs. **MCB**: Finance and Administration, Services, Organizational Management. **MRC**: Disability Determination, Independent Living, Vocational Rehabilitation, Administration and Finance. (Note: There may be some redundancies between Financial and Deputy Commissioners.)

* *Assistant Commissioners*: **DMA**: Long term care services, Member services, Acute/ambulatory care services. **DMR**: Quality Management, Field Operations, Management and Finance, Policy Planning and Children's Services, Systems Integration Management. **DSS**: Quality Assurance, Adoption and Foster Care, Clinical Services and Intergovernmental Affairs, IT, HR/employee relations. **DYS**: A&F. **DTA**: A&F, Field Ops., Policy and Program Management, Management IS. **DMH**: A&F, Applied IT, HR, Child/Adolescent Services, Forensic Services, Program Operations, Clinical/Professional Services. **DPH**: Management and Resources, Program and Prevention (Associate Commissioner), Bureau of Environmental Health Assessment, Bureau of Family and Community Health, Bureau of Health Quality Management. **OCCS**: Admin and Finance, IS. **DHCFP**: 2 Assistant Commissioners. **MRC**: Administration, Case Processing East, Case Processing West.

Note: MORI and DHCFP are not included in the chart. MORI has recently reduced staffing to 14 people; consistent information for DHCFP is unavailable.
Data: Phone survey, agency organizational charts and organizational charts in the *Political Almanac, 2002*.

And yet EOHHS remains a Secretariat comprised of mostly categorically defined agencies with limited missions. Any attempt to pursue consolidation must begin by recognizing the emotion and the history that each agency and its advocates will bring to the discussion. It should presume that the only process that will permit this kind of reform to move forward will be incremental, time-consuming, and open. The status quo has in some cases stood its ground for 100 years. There is a deep organizational commitment to the role or mission of some agencies. For some constituents, the loss of an independent agency will imply a loss of stature, importance, and ultimately, legislative support for its programs and its objectives. The arguments from agency supporters for maintaining each one will be well articulated and passionately delivered.

Any attempt to pursue consolidation must recognize the emotion and the history that each agency and its advocates will bring to the discussion, and should presume that the only process permitting this kind of reform to move forward will be incremental, time-consuming, and open.

One way to initiate the discussion is to propose a new structure for EOHHS. The proposal presented here presumes that EOHHS would eliminate its existing operating agencies over time and replace them with an integrated Secretariat comprised of distinct operating divisions. The standard term for this would be to organize along functional lines.

In this model, each operating division would be led by a commissioner, who would report directly to the Secretary of Health and Human Services. The implementation process would happen one commissioner consolidation at a time and would take place over at least a two-year period. Each one would involve the development and submission to the legislature (and presumably to the public) of a timetable for consolidation, a set of deliverables as the process unfolded (staffing, resources, responsibilities, key interfaces), and a set of metrics on which each commissioner would expect to be measured going forward.

The seven commissioners would have the following responsibilities:

- Information Technology
- Licensing
- Investigations
- Purchased Services
- Administrative and Financial Operations
- Case Management
- Transitional Assistance.

This approach is by no means the only possible way to consolidate by function. There are literally dozens of structures and tactics that can be applied once there is basic agreement on the objective. This plan starts with one fundamental assumption: EOHHS needs to understand its interactions with its vendors and constituents better than it does now. Getting there will require a comprehensive re-thinking of how it organizes and manages its day-to-day activities, and how it generates and uses information. Functional organizations tend to be flexible, which is important, but more importantly, they tend to be more integrated than product line organizations.

This plan starts with one fundamental assumption: EOHHS needs to understand its interactions with its vendors and constituents better than it does now.

Functional Operating Divisions

Information Technology

The Goal: **Organize IT investments and business processes to ensure that program data and financial information are shared and managed on a client-by-client basis.**

To begin, EOHHS must develop one primary database that can identify and track EOHHS clients over time. Whether EOHHS chooses to use MassCARES, which is a data aggregator, or something like the MassHealth database—which could serve as a default for the others—doesn't really matter. The larger issue is committing to a single source for client information, and the inevitable change that would follow such a commitment.

If we truly believe in integrated care, service, and support for poor and disabled populations, we have to begin with a single, unified identification system that gives EOHHS the capacity to understand how, when, and where these clients interact with the system.

The MassHealth database already carries the vast majority of EOHHS clients as its own beneficiaries, which makes it an ideal default database. While its principal function is providing enrollment information for MassHealth program managers, recipients, and providers, it could serve as the primary source of basic information concerning all EOHHS clients, and its swipe-card technology is already in use throughout the Commonwealth's healthcare delivery system.

The notion of using the MassHealth system as the single identification system for all EOHHS clients will surely draw outrage and criticism from those agency heads who think their ID system should be the primary source record for EOHHS clients. It will also draw negative reactions from those who oppose the notion of any single source of information on EOHHS clients. This issue needs to be discussed, processed, and resolved. But in the end, if we truly believe in integrated care, service, and support for poor and disabled populations, we have to begin with a single, unified identification system that gives EOHHS the capacity to understand how, when, and where these clients interact with the system.

Under the current structure, which involves multiple systems across multiple agencies, EOHHS staff cannot access information across departments without making special, almost Herculean, efforts to do so. In limited instances, if they know how to look for it, they can find it, but not generally when they need it most. Providers have the same problem. This negatively affects decision-making at every level of the Secretariat. To remedy this problem, one individual, who is accountable to the Secretary, needs to be responsible for consolidating and integrating program data.

Licensing

The Goal: **Create a single licensing operation and hold it accountable for licensing and re-licensing all organizations and individuals doing business with EOHHS.**

Every agency with licensing responsibilities inside EOHHS believes its licensing operation is doing a great job. The truth is there are many licensing functions throughout EOHHS all doing something, and more often than not, doing it without any serious regard or appreciation for what their colleagues in other agencies are doing. There are pockets of recognition and coordination, but it is the exception rather than the rule.

The licensing operation should consider using national accreditation standards as its de facto standards for provider organizations. This would not prohibit licensing personnel from doing field work or desk audits of its contracted provider organizations, but it would give providers much more predictable compliance standards than the ones they have now.

Investigations

The Goal: **Consolidate and coordinate all abuse investigations on a statewide basis.**

Every couple of years, someone in the legislature attempts to consolidate the abuse investigation operations that are spread throughout EOHHS agencies. The agencies respond by arguing that if they don't manage their own investigations, they cannot remedy the problems that are identified. Some fall back on statutory requirements, and all resist this idea with energy and passion.

Dividing the investigations operation into separate units—children, disabled adults, short-term, long-term, etc.—should be done to ensure expertise and subject matter familiarity, but the function itself should be statewide and consolidated. In addition, the information generated by the investigative operation needs to be incorporated into the ongoing activities being managed by the EOHHS purchasing, case management, and licensing divisions.

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Purchased Services

The Goal: **Create a single purchased services unit, managed and administered by EOHHS at the highest level of the Secretariat.**

EOHHS agencies buy an enormous amount of purchased services—close to $3 billion annually. If one includes MassHealth, the number approaches $8 billion. For the most part, these purchases are not coordinated—financially or programmatically—between or among existing agencies. And while many agencies buy many of the same kinds of services—residential services, day treatment services, case management services, rehab services, health care services, etc.—from many of the same vendors, there is little attempt to coordinate purchasing, revenue maximization, outcome measurement, or oversight.

The Commonworks Model

The Massachusetts Commonworks Program is a partnership among the DSS, six not-for-profit "lead agency" human service providers, and the ValueOptions/Commonworks Service Center, which serves some of the most difficult kids in the DSS system. Many of the youths have significant mental health, behavioral, and social problems, which have resulted in multiple placements in foster care, residential treatment, and psychiatric facilities.

Within each of the six DSS regions, a private not-for-profit organization serves as lead agency under contract with DSS to provide care coordination for DSS-referred youth. Each lead agency is responsible for determining the level of care necessary to meet the youth's needs. In conjunction with the DSS social worker, the lead agency determines when the youth no longer requires placement services and may be transitioned with supportive aftercare services to a permanency placement or to living independently in the community. The lead agency is responsible for sub-contracting with residential providers to provide placement services; working with providers to develop individualized treatment plans; monitoring outcomes; and informing DSS of client progress.

The Commonworks Service Center, under contract to DSS, provides administrative and quality improvement services for the department and the lead agencies. These services include management of financial processes; training and technical assistance; data analysis and reporting; identification and dissemination of best practices; and tracking and monitoring critical incidents, quality indicators, and outcomes.

In southeastern Massachusetts, Justice Resource Institute is the lead agency. Institute president Susan Wayne cites three reasons Commonworks has been more effective than the state was in providing case management services for these clients. First, private providers had a hand in defining and putting Commonworks together—a level of input rarely seen at the state level. Second, there is a good deal of flexibility in program structuring, implementation, and spending. Unlike traditional state contracts, Commonworks provides "flex money" for meeting client needs. Finally, the data that Commonworks collects on demographics, lengths of stay, diagnosis, treatment plans, and outcomes are turned into useful knowledge about treatment effectiveness and, therefore, have a direct application to practitioners and clients.

Imagine an environment in which the Commonworks approach to purchasing services and tracking performance were the rule rather than the exception. Under the current structure, Commonworks stands out not just because it works, but because it is so significantly different. First, its operation is data-driven, and there is general agreement among participants about what data need to be collected, and why it is important. Second, its financing structure is case-based, so provider organizations aren't tied to the more detailed, categorical, inflexible financing arrangements found throughout the rest of EOHHS. Third, it forces provider staff and state staff to collaborate by focusing on the clients, not on the rules or the requirements of the contract. Fourth, it offers quality incentives and performance bonuses to providers who outperform established benchmarks. Finally, it brings disparate arms of government together around a common set of objectives that are tied to the client and not the rules of any one particular agency.

The opportunity to simplify rule making and enhance programmatic coordination throughout EOHHS is profound, but so are the risks.

The purchasing division would also have the option to purchase inpatient, day treatment, rehab, long-term care, and other institutional services from state-owned and state-operated facilities. This would exert some discipline over the state's own operations and would require the Commonwealth to consider the capital and revenue-generating capabilities of its own provider organizations more carefully.

The opportunity to simplify rule making and enhance programmatic coordination throughout EOHHS is profound, but so are the risks. A consolidated purchasing operation could become an obstacle to high performance, instead of an enabler. In fact, a consolidated purchasing operation, if done poorly, could make it harder, rather than easier, to institute programs modeled on Commonworks. That may be one reason purchasing activities have been delegated and fragmented. For this operation to be successful, it must serve the needs and expectations of several key constituencies, but should focus its primary efforts on meeting the needs of the client, working closely with the EOHHS case management operation. It should also coordinate its activities with the licensing and investigative operations, thereby ensuring that the Secretariat speaks to the provider community with one voice on most administrative issues.

Administrative and Financial Operations

The Goal: **Consolidate into single units the dozens of legal, budget, human resource, and other administrative operations within the Secretariat.**

This would make it possible to allocate human capital within the Secretariat far more effectively; to organize and manage federal reporting requirements; to coordinate revenue maximization efforts, which currently operate with little or no statewide coordination; and to build and manage budgets on an integrated basis. This would lead, without a doubt, to a reduction in administrative spending and an improvement in data precision and coordination.

For example, EOHHS agencies occupy more than 200 sites statewide, some of which are owned space, but most of which are leased. There is no single inventory on how this space is used or organized, and none of it is currently tied to the client files generated by MassCARES. The Division of Capital Asset Management and Maintenance may have some general ideas on how the leased space is occupied, but its mission is to manage transactions in conjunction with EOHHS agencies on leased space and to manage owned space, not to determine if EOHHS agencies are located, staffed, and operated in ways that maximize the Secretariat's capacity to meet its clients' needs. DCAMM does not develop or track space management plans for EOHHS overall. EOHHS agencies spend more than $70 million on leased space, not counting the state office space it occupies or the state institutional space it oversees. Is the space used well or properly coordinated between and among agencies? Are the offices where they belong, given the locations of EOHHS clients? No one knows.

Going forward, EOHHS should have a single space use plan for the entire Secretariat. The plan should be driven by MassCARES data—or some other source of client information—and should be under continuous review. EOHHS funds and supports services that are delivered locally, but does not have a coordinated, data-driven approach to siting consolidated area or regional offices. If it did, its ability to maximize both its presence and its effectiveness—and to target activities to those areas and neighborhoods that need particular interventions—would be dramatically enhanced.

For starters, one could argue that EOHHS should have five to eight regional offices that house the departments managed under the Secretariat's jurisdiction and some number of area offices within that regional structure that work the same way. This should make it possible to reduce both space utilization and local and regional information fragmentation. It would also make the interactions between EOHHS staff and its constituents far less complex.

EOHHS agencies also build separate budgets with little or no regard for how the behavior, goals, objectives, and rules of the other agencies affect their own spending or revenue. Given the enormous amount of federal revenue generated by EOHHS agencies already—roughly $5 billion annually—the lack of a coordinated approach to managing this source of funding is a significant problem. An integrated approach may discover huge opportunities to generate additional federal matching funds that remain unnoticed and unaccounted for under the current structure. A 10 to 20 percent improvement in federal financial assistance would be worth a huge sum of money—close to $100 million—at a point in time when the Commonwealth desperately needs the help.

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Distribution of EOHHS Agency Offices across Massachusetts

Agency employees perform a variety of service, administrative, regulatory, and monitoring functions in 201 offices across the Commonwealth. (DMA and DHCFP offices are not included.) There are 152 area, 32 regional, and 16 main offices. The City of Boston has a total of 36 offices (14 area, 7 regional, and 15 state offices in addition to 8 dual-use offices). Springfield has 12 offices (7 area, 5 regional, and 2 dual-use), Worcester has 10 (6 area, 4 regional, and 3 dual-use), New Bedford has 7 (6 area, 1 regional, and 1 dual-use), Brockton has 6 (5 area, 1 regional, and 1 dual-use), Fall River

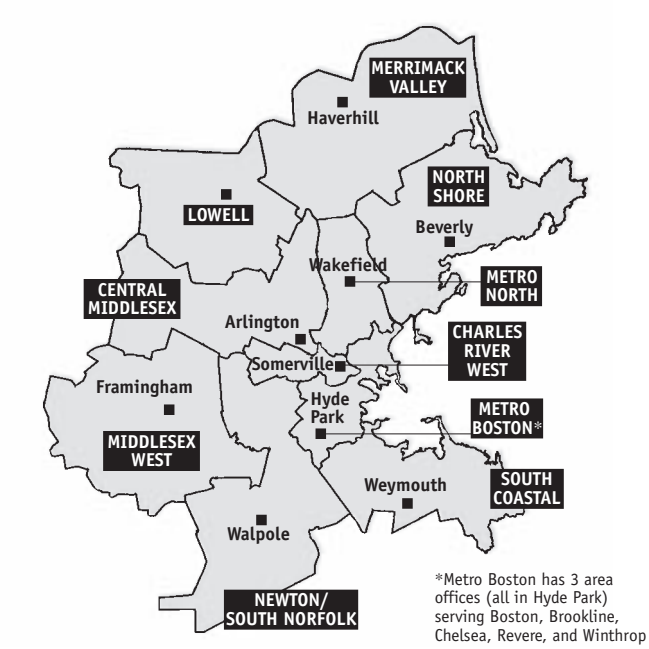
Figure 7. Metro Boston and Northeastern Massachusetts Area Offices and Geographic Areas Served, DMH, DMR, and MRC

■ - designates an agency area office location.

Borders demarcate surrounding geographic area served by each office.

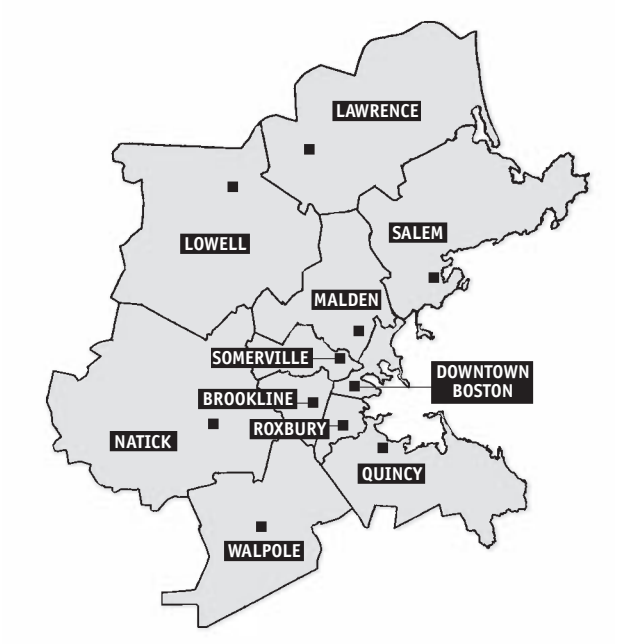
Area name used by agency shown in black box.

Department of Mental Health



*Metro Boston has 3 area offices (all in Hyde Park) serving Boston, Brookline, Chelsea, Revere, and Winthrop

Department of Mental Retardation



Massachusetts Rehabilitation Commission

has 5 (5 area and 1 dual-use), as does Holyoke, Lowell, and Pittsfield (all area offices). Plymouth also has 5 offices (4 area and 1 regional offices).[9]

If one were to superimpose a map containing area and regional boundaries and the offices that support them for all EOHHS agencies over a map of Massachusetts, it would be impossible to determine how local agency officials could possibly work with one another. Even in western Massachusetts, which is the least populous region of the Commonwealth, the regional boundaries and areas of responsibility are blurred. The Departments of Mental Health and Mental Retardation, which until very recently were within the same agency, have no common way of doing business in the western part of the state. Statewide, DMH has 30 area offices and 6 regional offices, while DMR has 27 area offices and 5 regional offices. This problem gets dramatically worse as one travels east. The system of regional and area offices of all EOHHS agencies east of Worcester, where most of the state's population resides, is virtually incomprehensible.

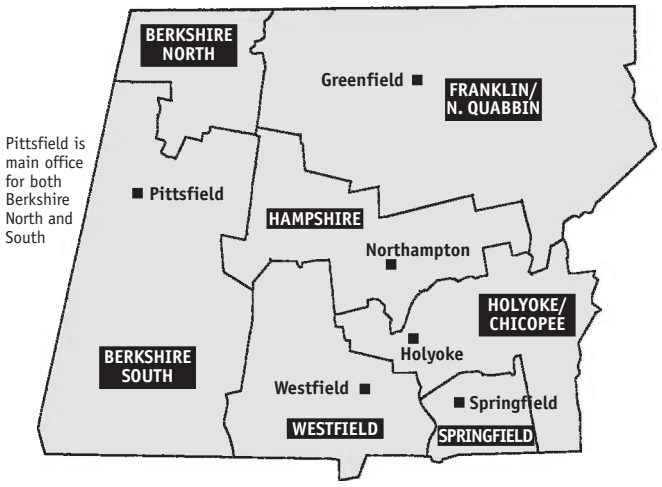
For more than 20 years, EOHHS Secretaries have tried to pursue a contiguous area boundary structure for EOHHS agencies to enhance regional and local coordination and cooperation. Some have talked about using the county lines as the template for structuring regional agency activity and operations. To date, no progress has been made in pursuing this agenda.

Figure 8. Western Massachusetts Area Offices and Geographic Areas Served, DMH, DMR, and MRC

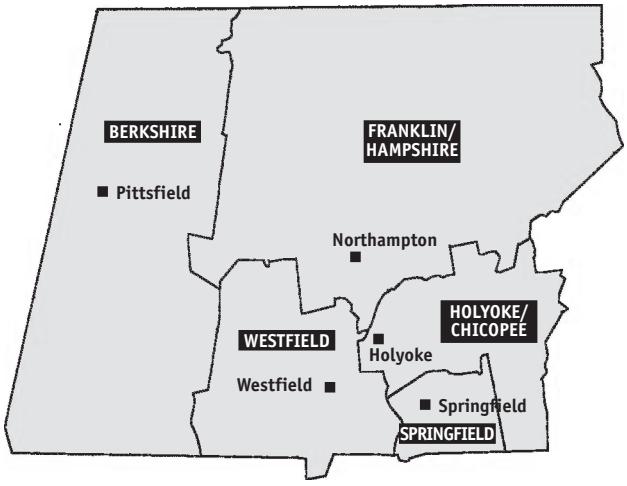
■ - designates an agency area office location.

Borders demarcate surrounding geographic area served by each office.

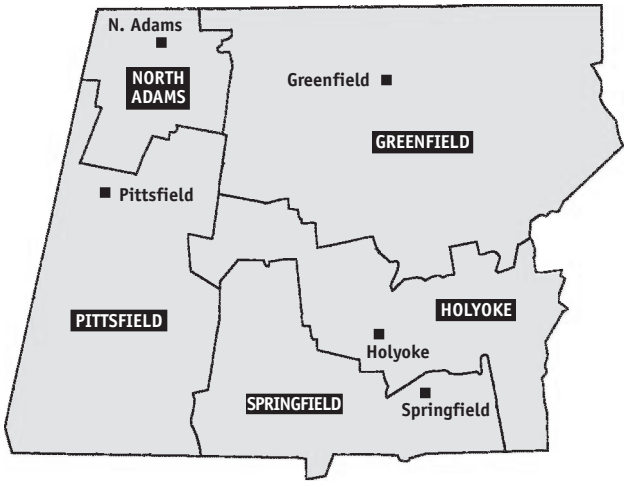
Area name used by agency shown in black box.



Department of Mental Health



Department of Mental Retardation



Massachusetts Rehabilitation Commission

[9] Information provided by the Office of State Senator Susan Tucker.

Case Management

The Goal: **Create a single point of accountability for case management activities. This will give EOHHS the capacity to organize its case management efforts to maximize effectiveness and complement what private providers are already doing in this area.**

Case management carries a number of names and designations in EOHHS agencies, including service coordination and outcomes management. The simple fact is EOHHS does not have a solid handle on how agency case managers interact with one another, with case managers in private programs, or with its client population.

Consolidating case management activities might make it easier to generate programmatic information that can, over time, inform and enhance the way the Commonwealth serves vulnerable populations.

A single case management operation could coordinate something that EOHHS needs to do more of—family conferences. It should be standard procedure to call a family conference within a short period of time (48 to 72 hours) after an EOHHS case manager opens up a new case. This would be easier to do with a unified approach to office location, purchased services, care coordination, and case management, and it needs to be part of how EOHHS relates to its clients under care and to their families. While some will say this is unreasonable, New York City has already established family conference requirements for all of its child protection activities, as well as periodic follow-ups during the time a child is under the care and supervision of the city. This could dramatically improve the role of the family in the care of kids and adults under the care or supervision of the Commonwealth and bring a more productive dynamic to these interactions.

This could also help EOHHS deal with the so-called "stuck child" issue, which involves children (and in many cases adults) who languish in the wrong level of care, primarily because the categorical and departmental approach the Commonwealth takes to funding services and managing cases leaves no room for coordination, flexible funding, or shared decision-making.

Finally, consolidating case management activities might make it easier to generate programmatic information that can, over time, inform and enhance the way the Commonwealth serves vulnerable populations. For example, EOHHS does not know how many children currently in residential settings are on psychotropic medications, how they are managed, or how their meds are reviewed. A more comprehensive approach to case management and data generation would give caregivers and providers (as well as EOHHS case managers) a set of predictors for specific outcomes in a particular population. Because the Commonworks program does collect data, its staff know when and under what circumstances children are most likely to run away, for example. Most other programs do not have that kind of information.

Transitional Assistance

Under this reorganization scheme, cash assistance for targeted populations and access to job training, MassHealth coverage, child-care services, and other purchased services would remain mostly intact. The shelter programs, which have been funded through Transitional Assistance for years, would be funded out of purchased services.

Office of the Secretary

The Office of the Secretary should employ subject matter experts who can coordinate policy and serve as key points of accountability on certain issues. Having Assistant Secretaries with specific responsibility for health policy, disability policy, and children's policy would seem to make sense. These individuals would work closely with each of the commissioners to ensure that the over-arching objectives of the Secretariat in each of these key areas are understood and being pursued. The Secretariat currently has a small, but increasingly effective, program management office. In a more integrated operation, the role and importance of this activity would increase significantly.

Maintaining client privacy is a problem to be solved, not a reason for continuing the status quo.

CONCLUSION

Any approach to reorganizing EOHHS will raise a myriad of operational, logistical, and financial questions that demand to be answered. They should be raised, and they need to be answered—to the extent possible. The tendency in the past has been to deny the debate over the "what if" questions, instead of acknowledging the importance of the debate itself, and the possibilities for improvement it presents.

Several people have questioned the value of employing a single data source, for example, arguing it could look like a "Big Brother" approach to managing EOHHS, and that this could be detrimental to many disadvantaged populations, such as recent immigrants, refugees, or undocumented immigrants.

There is an undeniable perception of "Big Brother" associated with managing EOHHS clients through a single database. Certainly client privacy issues would have to be addressed. However, the Secretariat's capacity to improve services for disadvantaged populations under this approach outweighs the downside of integrated information. There are privacy standards for managing information that are fully integrated into many aspects of American government—including law enforcement, health care, and immigration. Maintaining client privacy is a problem to be solved, not a reason for continuing the status quo.

Relying on one database to drive decision-making and to support client interactions with state agencies and private providers also raises the possibility of getting it wrong once and having it wrong throughout the Secretariat. The best way to manage this issue is to develop processes to correct problems as they are discovered. Under the current structure, someone dealing with multiple agencies might have to deal with the same data or eligibility problem many, many times under different circumstances to get it corrected. In an integrated environment, one must only solve a problem once to solve it completely.

Under the current structure, someone dealing with multiple agencies might have to deal with the same data or eligibility problem many, many times under different circumstances to get it corrected. In an integrated environment, one must only solve a problem once to solve it completely.

Would implementing this proposal be difficult? Yes. Would it be complicated? Yes. Would it represent uncertainty? Of course. But it would also force people to look more closely at the obvious deficiencies we've built into the infrastructure over the past 40 years, and to consider, perhaps for the first time, how a different approach to meeting the needs of our most vulnerable citizens might provide an opportunity to raise their expectations, as well as our performance.

There are a tremendous number of really good people who work, under difficult conditions, every day throughout EOHHS to try to make the system, such as it is, work for the clients of the Commonwealth. Whether they work directly for the Commonwealth of Massachusetts or with one of the many provider organizations, these people often succeed in spite of the fragmented systems. They deserve a chance to help state leaders re-think the way EOHHS is organized and operated, instead of simply being ordered to do more of the same with shrinking resources. An incremental, open process would provide opportunities for stakeholders to contribute their ideas and insights.

Given the profound fiscal difficulties facing the Commonwealth, the advances in information technology, and the increasingly inter-related nature of the work done by the agencies within EOHHS, now is as good a time as any to think completely outside the existing framework.

Is there ever a good time to consider a significant change in the way EOHHS and its operating agencies do business? The answer is, "YES." Any time is a good time to consider whether or not the structure that is in place today suits the strategies, objectives, and capabilities of the Secretariat and its operating agencies going forward. The fiscal situation, with or without any significant changes in the revenue picture during the next 18 to 24 months, will be very difficult, and it will put enormous pressure on EOHHS, its agencies, and its constituents. Given the profound fiscal difficulties facing the Commonwealth over the course of the next several years, the advances in information technology and data-sharing made possible by data aggregation tools like MassCARES, and the increasingly inter-related nature of the work done by the agencies within the Secretariat, now is, in fact, as good a time as any to think completely outside the existing framework.

Finally, I am well aware of the risks and difficulties associated with this sort of undertaking. I do not mean to imply that it would be easy, or without disruption. Nonetheless, EOHHS needs to take a different approach to serving its staff, its provider partners, and its clients if it wishes to enhance its support for the Commonwealth's most vulnerable citizens in the future. Deciding to do less and less within the same structure because it is an easier and less risky route to travel intellectually, politically, or operationally does nothing for them.

Engaging this debate, sustaining it over several years, and seeking an integrated, coordinated, client-focused Secretariat is a worthy objective. Let's hope that's enough to overcome the political and policy inertia that will surely stand in its way.

ABOUT THE AUTHOR

Charles D. Baker, Jr., is President and CEO of Harvard Pilgrim Health Care, Inc. Previously, Mr. Baker was President and CEO of Harvard Vanguard Medical Associates and, before that, served as Secretary of Administration and Finance and Secretary of Health and Human Services during the Weld and Cellucci administrations. In these posts, Mr. Baker planned and implemented major changes in public policy that reaped hundreds of millions of dollars in taxpayer savings while expanding health care coverage and services. Among his many achievements, he is credited with reforming the Massachusetts Medicaid program and overseeing a major overhaul of the Commonwealth's regulatory and purchasing functions. Mr. Baker currently serves on the Massachusetts Board of Education and on the boards of The Kenneth B. Schwartz Center, Pioneer Institute, Big Brother Association, Massachusetts Taxpayers Foundation, and American Association of Health Plans. He chairs the Massachusetts Association of Health Plans.