Achieving Greater Impact from the System of Care: Opportunities and Challenges

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Executive Summary

The purpose of this study was to assess the status of the system of care (SOC) for children, youth, and their families in Palm Beach County and to explore the feasibility of a new governance model. This model is consistent with emerging national trends in public health and based on shared resource stewardship, better management of the portfolio of investments in population health that is informed by data on investment yield for improved population health. In pursuit of these goals several existing planning and evaluation documents were reviewed, and interviews were conducted with 51 representatives from 29 child serving organizations and their funders. Population health was defined using the World Health Organization definition involving overall well-being beyond the absence of illness.

Findings

When asked to rate the population health of children and youth in PBC on a 10-point scale, almost all participants rated it 5 or 6 and described huge geographic and racial/ethnic disparities across the county. Respondents identified several strengths that promote population health including collective impact initiatives like Healthier Together and Bridges, Birth to 22: United for Brighter Futures, and new funding enabling improved school mental health services. Other facilitators included strong leadership and collaboration among key stakeholders. Several barriers to population health were noted including geographic and racial inequities, inadequate funding, categorical program silos that make access and service coordination difficult, non-interoperative data systems, workforce limitations, and poor communication.

The interviews also explored openness to a new system-level governance model that would include shared stewardship, portfolio management and an interoperable data system. Most respondents agreed with the construct of shared stewardship and many PBC examples of shared stewardship were noted. Challenges were also noted including need to meaningfully include the perspectives and self-identified needs of the community as well as those of the providers. The lack of data on long-term outcomes and limited mechanisms for data sharing across systems present further challenges.

While most believed that portfolio management made sense, implementation challenges were also noted such as the differential agility of funders to re-allocate funds and the lack of a forum where all relevant players, including community residents, could convene to manage the portfolio of investments. Challenges noted in developing an interoperable data system included significant concerns regarding real or perceived legal constraints on how data can be shared.

Opportunities and barriers to improving the existing system of care were also explored. There was consensus among interviewees that the existing leadership facilitates population health and is the strongest asset of its SOC. Some challenges also were identified in the leadership domain including the lack of involvement of either providers or community residents in leadership settings. Despite efforts to coordinate leadership, there is not one governance entity that is accountable for the population health of children and youth.

Many informants mentioned the dashboard for the Birth to 22 initiative as a useful set of metrics on child well-being including reports of differential health status at the zip code level. Regarding client-level information systems, many participants noted the constraints of their mandated data systems. Finally, many participants identified PHF's Healthier Together sites and CSC's Bridges sites as opportunities to promote community resident-driven initiatives that identify and build on community strengths and develop grass roots leaders.

Recommendations

Based on these findings, the report makes the following recommendations. In the short term, responding to the requirements of HB 945 provides important impetus for the development of a governance model premised on shared stewardship and the use of real-time data to inform portfolio management. As part of the planning process for HB 945, the governance entity should request regular reports from AHCA of Medicaid expenditures for behavioral health disaggregated by major service type. Second, the work of the Palm Beach County Portfolio Design Core Team should continue and include a communication plan that will broaden the discussion to a full range of stakeholders. Third, the exploration of data system integration should continue. A small working group should be established and staffed to develop a strategy for greater data interoperability. Finally, issues related to integrating the 211 Data System with Unite PBC should be explored.

In the intermediate term, collective impact investments such as Healthier Together and Bridges should be continued and expanded. These approaches can identify community assets and needs from residents' perspectives and may result in more durable and community relevant solutions. Second, the governance entity should investigate vendors who provide care coordination services**.**

In the longer term, Palm Health Foundation and other leaders in behavioral health should explore alternative models to better support pediatricians' ability to assess and appropriately treat the behavioral health needs of children and youth. Finally, a multi-pronged strategy should be used to target areas with the greatest health inequity with the goal of reducing these inequities.

Achieving Greater Impact from the System of Care: Opportunities and Challenges

Introduction

National Context

> "The US health system is both expensive and inefficient, producing less value at a higher cost than the health systems of most other developed countries while yielding strikingly large health disparities across population subgroups."[1(p2003)]

In this quotation, Neal Halfon and his colleagues summarize the major challenges that we face in reforming our health care system from one that emphasizes the delivery of medical care to one that focuses on the production of population health. As they further note, the contributors to health include resources from medical care, public health, genetics, behavior, social and environmental factors. These are the determinants of overall health. This observation is underlined by research comparing the United States to other developed nations and investigating the relationship between the ratio of GDP expenditures on social services compared to those for medical care. Bradley and colleagues[2] demonstrated that several measures of population health status are associated with a relatively greater investment in social services than in healthcare. They conclude that "…adequate investment in social services and public health, not just investments in health care, may be key to understanding variations in health outcomes…".[2(p767)] From an international perspective, the US has the lowest ratio of social services spending relative to health care of any Organization for Economic Co-operation and Development (OECD) nation and on average has the worst health care outcomes, partially explaining the American health care paradox – more spending, poorer outcomes.[3]

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Additionally, as the literature linking early childhood exposure to adversity with lifelong health consequences has continued to strengthen, we increasingly realize the importance of reducing childhood trauma and building resilience. A formidable literature[4] on the long-term benefits of early intervention activities has been developing throughout the last two decades. Behavioral health problems are among the earliest manifestations of unmitigated exposure to adversity. These problems precede the development of other chronic illnesses and are associated with increasing burden of disease and premature mortality. Long term laudatory effects of systematic universal prevention interventions, in contrast, demonstrate the lifelong value of investing in these types of programs. A powerful recent example[5] of these effects involved the 30-year follow-up of individuals who participated in the Seattle Social Development project. The experimental intervention, Raising Healthy Children, had teacher, parent, and student components and was based on a social learning paradigm. It was delivered from 1st to 6th grade. Thirty years later results indicated better overall health and well-being for individuals in the experimental condition relative to controls. Remarkably, assessment of the offspring born to adults who were in the original study,[6] indicated two generation effects. While likely the most

extensive and long-term demonstration of the effects of universal, school-based intervention, this study[7] joins several others demonstrating impacts over many years.

Findings like these regarding the determinants of health over a lifetime and the increasing realization of the poor overall health status and dramatic inequities among subgroups of the US population, have led to a focus on the role of public health in addressing these issues. In 2016 the US Assistant Secretary of Health[8] introduced the concept of Public Health 3.0. Public Health 3.0 is distinguished from earlier public health models in that it explicitly addresses the role of the multiple determinants of health and identifies core capacities that are needed to address these including cross sector community partnerships and actionable data with clear metrics. Expanding the conversation Bommersbach and colleagues[9] focused specifically on the role of and implications for the behavioral health system. They called for greater use of public health perspectives and methods in behavioral health and a much closer alignment between the behavioral health system, public health system, medical care and other human service sectors. Halfon and colleagues[1] propose a conceptually similar reform landscape as they identify the 3.0 version of a health transformation framework contrasting Version 1.0 which concentrated on treating acute illness, 2.0 focusing on chronic disease, and 3.0 that takes a life course developmental perspective to optimize health through the development of community accountable health development systems.

Consistent with the logic of Public Health 3.0 and growing out of his foundational work on population health, David Kindig and his colleague Bobby Milstein[10] have described an approach to evaluate and adjust the investment portfolio in overall health. Resonating to the findings regarding the association between health/social spending and health outcomes, they proposed a process through which communities can evaluate their overall portfolio of investments. They also emphasized that if partners across sectors[10(p581)] "…want to change the structures that drive system performance (such as governance, goal setting, prioritization, measurement and others) then they must develop a high level of maturity in… broad stewardship, sound strategy and sustainable financing." The work of fostering stewardship partnerships and balancing investment portfolios is being led by an organization called ReThink Health. A central conceptual framework for stewardship discussion involves a distinction between urgent needs and vital conditions. Vital conditions include everything that we need for health and well-being including healthy living, a process of lifetime learning, meaningful work and wealth, humane housing, a thriving natural world, reliable transportation, a sense of belonging in community, and civic muscle. Urgent needs are circumstances that require responses such as housing homeless individuals and serving people's urgent health and mental health needs. The challenge is to respond to the urgent needs effectively while continuing to promote the vital conditions that underwrite health and well-being. Balancing the portfolio involves continuing to meet urgent needs while developing a well-being economy that promotes inclusion and access to the vital conditions for well-being.

A consistent theme emerges from some of the leading thinkers in population health. We currently have a ratio of social services and supports which is not commensurate with improvement of population health and addressing health inequities. Achieving a more optimal ratio will require a mature governance function with access to timely accurate data about cross

sector investments and community needs. In this study we explore issues that can help to promote 3.0 activities in Palm Beach County.

Palm Beach County

Multiple local funders initiated BeWellPBC in January 2019 after the Parkland shootings, high-profile suicides, and community health assessments created a sense of urgency regarding addressing the behavioral health challenges in Palm Beach County (PBC). With Palm Health Foundation (PHF) serving as the backbone for this collective effort, the mission of BeWellPBC is to increase and improve interagency coordination, increase the alignment between public health, behavioral health services, and social services, and more widely engage community members in innovative solutions. In April 2019 BeWellPBC was selected by ReThink Health as one of four sites across the country to participate in a regional portfolio design project (PBC Portfolio Design Core Team) funded by the Robert Wood Johnson Foundation. The goals of this project were to assess the current portfolio of partnerships and investments in the behavioral health system in PBC, as well as to explore the possibility of a shared stewardship model to manage this portfolio more effectively. The PBC Portfolio Design Core Team was formed to advance the work. The Portfolio Core Design Team is composed of representatives from the Children's Services Council, Palm Health Foundation, BeWellPBC, Palm Beach County Community Services, and Youth Services Departments. As a next step, two consultants with considerable experience in the Florida system and national reform movements were asked to conduct a series of key informant interviews and review existing documents to advise Palm Health Foundation and BeWellPBC regarding enthusiasm for and concerns related to implementing a shared stewardship initiative (See Appendix A for bios of the two consultants). Central to these considerations was an assessment of the current infrastructure in the county that might support or frustrate such an effort and if and how Palm Health Foundation could best support such an effort.

The investigation focused on the system of care (SOC) for children and youth as an exemplar of the issues that may be involved in successfully implementing shared stewardship. House Bill (HB) 945, now codified in FS 2020-17, mandates a planning process that could support fundamental reforms in the SOC. The legislation requires managing entities to lead a planning process that promotes the development and effective implementation of a coordinated system of care including integrated service delivery approaches that facilitate access to care. Participants in the planning process must include children and adolescents with mental health needs and their families, behavioral health providers, child-serving entities, and Medicaid managed medical assistance plan. Plans must be initiated by 1/1/21 and implemented by 1/1/22.

As will be discussed in the methods section below, the consultants explicitly framed the discussion around a broad definition of health from the World Health Organization. "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[11(p1)] Consistent with the shared stewardship model and the work with ReThink Health, interviews were held with several key stakeholders representing funders, leaders, providers, and grass roots organizations. The consultants used the constructs and tools provided by ReThink Health to discuss the current allocation of resources. A related set of issues involves the potential development of an interoperable data system that will lead to a better understanding

of the functioning and integration of the SOC in the service of improving population health. Such a system could be used to better integrate treatment at the client level, evaluate the effectiveness of specific interventions, and map the capacity of the system.

The goals of the exercise are to assess the status of the current SOC and to explore the feasibility of a new governance model based on shared stewardship, portfolio management, and data on population health status.

Methods

Materials Reviewed

To better understand the Palm Beach County context, we began by reviewing a number of documents that reflected the needs of the community, planning documents and reflective evaluations. Among the documents reviewed were

- The 2019-20 Community Behavioral Health Needs Assessment for Palm Beach County completed by Ronik and Radlauer[12]
- Florida House Bill 945[13]
- The Community Health Improvement Plan,[14]
- The Palm Beach County Youth Master plan and related dashboards and documents,[15]
- Palm Beach County Zip Code Report,[16]
- The Third Interim Report of the Twentieth Grand Jury,[17]
- Mapping Behavioral Health in Palm Beach County, Florida: A Network Analysis for BeWellPBC,[18] and
- A Shared Purpose: Transforming Communities through Social Determinants - Lessons Learned from the First Five Years of the Healthier Together Initiative[19]

Additionally, we reviewed web content for most of the organizations from which the key informants were selected.

Key Informant Interviews

Respondents

Working in collaboration with Patrick McNamara at the Palm Health Foundation and Lauren Zuchman of BeWellPBC, a list of desired respondents was constructed. The list was intended to represent a broad range of perspectives on the SOC for the county and included the major organizations that are concerned with and/or serve children and youth in the county. The full list of respondents is included in Appendix B. The sample included funders, advocacy groups, county government, service providers and some grass roots organizations. Forty two interviews were completed from September to mid-December involving a total of 57 respondents who were interviewed either individually or in small groups from the same setting. Thirty-three organizations were represented with two or more interviews with five organizations.

Interview Protocol

An interview protocol was also developed in conjunction with Palm Health Foundation (See Appendix C). The protocol consisted of 11 questions addressing

- the population health status of children and youth in the county,
- facilitators of and barriers to optimal population health,
- respondent's role in the SOC,
- their strongest collaborators,
- characterization of the leadership in the county,
- evaluation of the shared stewardship concept,
- usefulness of data dashboards and of interoperable data systems,
- questions related to portfolio management, and
- a final general question asking respondents how they would change the system if they were operating without any constraints.

The protocol was used to guide the conversation with each respondent but was not rigidly administered in favor of a more free flowing discussion. Most interviews were conducted by both interviewers with a few completed only by one interviewer. Interviews typically lasted about one hour, and many were recorded for later reference.

Coding

Summaries of each interview's content were drafted by one of the interviewers and cross checked for completeness by the other interviewer, if two were involved in the interview. These summaries were subsequently coded and the responses to each of the major areas of the protocol were summarized. The findings are organized by the key domains and are presented below. It is important to note that these findings are our interpretations of the responses and, with few exceptions, have not been cross-checked with the respondents. Any errors or misinterpretation are ours.

Findings

The findings for this report are organized by the domains that were explored in the interviews with key informants that were conducted between September and December 2020. The findings also incorporate relevant data from the document reviews.

Population Health Status

The framing question for the interviews was: What is the population health status of children and youth in Palm Beach County? When asked to characterize the population health of children and youth in PBC on a scale of 1-10, almost all participants gave a ranking of 5 or 6 and described huge disparities across the county. On the one hand, an informant stated: "PBC is resource rich for some people." Strengths include a robust health care system with many access points and a culture that is supportive of education. Reportedly, the disparities

> The population health status of children and youth depends on where you live in PBC.

were related to geographic inequities and racial/ethnic disparities. For example, when discussing school readiness, one participant noted: "If you are poor, you are not ready. If parents are black or brown, you are not ready." Data indicate that Black children do much worse than White children when they enter kindergarten, even when both receive comparable early learning resources. In poorer areas such as Pahokee or the Glades, there is little trust in the health care system and limited access to care. In summary, the population health status of children and youth depends on where you live in PBC.

These interviewee perspectives conform with findings from the June 2020 revision to the PBC Health Improvement Plan. Both the infant death rate and the fetal death rate findings show health and racial inequities. The report identified 12 primary care health professional shortages including dental and mental health care. Multiple geographic health status disparities are also documented in the Palm Beach Zip Code Report.

Participants also were asked to enumerate the facilitators and challenges to population health in PBC.

Facilitators

Respondents identified several strengths in PBC that promote population health including initiatives of the Children's Services Council (CSC), PBC Youth Services, Southeast Florida Behavioral Health Network (SEFBHN), a successful referendum enabling the school district to increase mental health services in the schools, local community projects sponsored by CSC (Bridges) and PHF (Healthier Together), and collaboration among key stakeholders.

In an impressive effort to underwrite the population health of children in PBC, the CSC plans, funds, and evaluates evidence-based prevention and early intervention programs for children birth through five years of age. Healthy Beginnings, for example, has a strong family support component, Triple P promotes healthy relationships among parents and children, and the visiting nurse programs offer in-home services to low-income pregnant women and new mothers. CSC is also a primary funder of the Early Learning Coalition. Finally, CSC and Youth Services of PBC jointly support after school programming to keep youth on a healthy developmental trajectory.

After the Marjory Stoneman Douglas High School shooting incident in Broward County in 2018, voters in PBC approved an increase in the mil levy for the school district that resulted in major new funding for mental health services. The school district added 170 behavioral health positions with at least one position at every school campus. About 100 campuses now have on-site Tier 3 services. The district also developed four geographically located crisis assessment prevention teams. In addition, the judicial circuit has developed a School and Community Safety Taskforce to improve police and emergency response systems.

Community-driven projects in high-risk areas were also identified as a facilitator of population health including PHF's Healthier Together sites and CSC's Bridges initiative. One respondent noted that the Healthier Together projects are beginning to make a difference because peer to peer supports and resident driven initiatives equalize power —"We need equal voices at the table, and it has to be safe." Strengths of these communities were described as unity, spirituality, a sense of community and working together.

Community-driven projects in high-risk areas were also identified as a facilitator of population health including PHF's Healthier Together sites and CSC's Bridges initiative.

A final facilitator identified by many respondents is the high level of collaboration among key stakeholders--"System leaders do communicate." Respondents self-identified as good collaborators around initiatives such as Birth to 22 and the response to COVID-19.

Challenges

Several barriers to population health were noted by participants. These include geographic and racial inequities, inadequate funding, categorical program silos that make access and service coordination difficult, non-interoperative data systems, workforce limitations, and poor vertical communication.

As noted in the PBC Health Improvement Plan and Zip Code Report, structural health inequities are reflected in dramatic differences in health status outcomes that are sometimes found in adjacent zip codes. Differential access to healthy food, a safe environment, employment opportunities, and high-quality behavioral healthcare services are challenges. For children, content in early learning programs is premised on life experiences that are less likely to be experienced by children in impoverished zip codes. For low-income parents, even evidence-based practices can have components that may unintentionally discriminate.

Structural health inequities are reflected in dramatic differences in health status outcomes that are sometimes found in adjacent zip codes.

Funding issues identified include loss of insurance coverage, Florida's unwillingness to expand Medicaid, reductions in social services due to federal and state cuts and Medicaid's unwillingness to adequately fund evidence-based approaches. Finally, as was pointed out in the December 2020 Florida Grand Jury Report, the state of Florida provides less funding per capita than any other state for mental health care and treatment. The grand jury report also highlighted the lack of coordination across agencies and levels of government and a lack of a clear governance/accountability function.

Difficulties were also described in navigating the human service system due to funding silos, a confusing array of programs and access points, and lack of warm handoffs between service providers for youth and parents. Agency data systems represent one of the siloed components of the SOC with each sector or program initiative often having its own data system and reporting requirements that do not link with other sectors' systems.

Workforce limitations include a lack of highly skilled behavioral health staff, turnover, and an under-reliance on peer support specialists and paraprofessionals. One area that was identified by several respondents was the lack of integration of the behavioral health system with pediatric practices. One respondent, the Pediatric Society President, noted difficulty in effectively referring children in need of behavioral health care to community resources. In her group practice, she is using a collaborative care model and employing a psychiatric nurse practitioner and psychologist in the clinic to see children in need. An expert developmentalist also visits the clinic regularly to address special concerns with healthy development. The developmentalist is employed by another agency and bills through that agency for services. Both the psychologist and the nurse practitioner bill, when possible, for their services through the practice and are employees of the practice. This is an unusual model in PBC, likely reflecting some of the billing difficulties reported in the collaborative care practice. However, the pediatrician reported that problems with depression and anxiety are quite common and she feels as though co-locating services is an effective strategy to better address these issues. Given the difficulty in completing referrals and their reticence to identify problems that they cannot address, many pediatricians may not screen for behavioral health problems.

Finally, vertical communication challenges were noted between system leaders and both community residents and provider organizations, as well as, between system leaders and line staff. Concerns were expressed with the lack of structured avenues for bi-directional communication from the community to providers and funders. Reportedly, often communication happens after decisions are made by leaders and providers rather than listening to community residents first.

Receptivity to New Constructs

The interviews explored the informants' openness to moving toward a new system-level conceptual model that would include shared stewardship, portfolio management, and an interoperable data system.

Shared Stewardship

Shared stewardship was defined as a cooperative leadership model in which funders and other leaders from the community consider themselves stewards of the resources dedicated to promoting population health. Most respondents liked the construct of shared stewardship and many examples of shared stewardship in PBC were noted. One respondent commented that stewardship "is somewhat organically happening." For example, there is an agreement among PBC's major foundations that in times of crisis, such as COVID-19, strategies are in place to get funding out quickly. One such strategy is a common application form that 10 funders agreed to use. It was also noted that the PBC Portfolio Design Core Team, as part of the ReThink Health project, is moving forward with implementation of some shared stewardship strategies.

The 11 collective impact initiatives in PBC are another example of shared stewardship. Several informants identified Birth to 22 as a strong example of shared stewardship. Birth to 22 was developed in 2013 and supports the health, growth, development and education of children

and youth through young adulthood. CSC and PBC Youth Services provide the backbone support for Birth to 22; with over 300 organizations involved today.

Challenges were also noted in achieving full shared stewardship. In contrast to the examples cited earlier, one informant characterized this as "a radical shift" that funders would have to lead; another observed that "system change is massive and hard." Others commented that the perspectives and needs of the community and of providers would need to be represented—a change from what is happening currently. The grass-roots voice of the community needs to be amplified. Another barrier identified regards data.

Providers' responses to the shared stewardship construct highlighted several issues. First, there is competition among providers for resources and fears that a shared stewardship model could endanger existing programs. Some providers felt that investment decisions should be based on assessment of program impact and client outcomes and highlighted the importance of equitable resource distribution in relation to local community need. Providers also noted the importance of representing the real needs of communities in the process.

Portfolio Management

In portfolio management a distinction is made between resources dedicated to vital conditions and resources responding to urgent needs. The premise is that if more resources could be identified and used for vital conditions, such as housing, there would be less need over time to fund urgent needs, such as homelessness.

Many respondents appeared to have some difficultly breaking set to address root causes and continued to focus on service delivery for urgent needs. Others embraced the idea of portfolio management and expressed a wish to move more in this direction. For example, county respondents noted that the county has some flexibility in its investments and has shown a willingness to spin off certain programs. A recent example involved turning Head Start over to CSC and using resources that were made available to create the Youth Services Department. This change in investment reflected an assessment that other entities may be better situated to run Head Start than the county and freed resources to be effectively re-purposed.

Although there generally was conceptual agreement that portfolio management made sense, many respondents noted implementation challenges that are inherent in the funding constraints under which human service organizations in our country operate. One barrier is the differential agility of funders. Foundations can have great flexibility in shifting funds; CSC has more flexibility than entities funded by state or federal agencies. Agencies with public funds often have strict mandates regarding expenditure of funds for specific purposes. The county has greater flexibility than the state.

A second challenge is that currently there is not a forum in which all the relevant players can do portfolio analysis and management. The availability of data about system functioning is relevant here as well. To make informed investment decisions, data on long term outcomes would be required and is currently lacking. Useful data that is currently lacking was described by one informant as a convergence between research evidence, listening to the people receiving

services, and measured outcomes. Another data challenge is the limited mechanisms for data sharing across systems that could be used to increase the efficiency of system functioning and perhaps free resources for upstream investments.

A final challenge noted was power. "Who is going to relinquish power?" As documented in the reflections on the first five years of Healthier Together, issues of power and control sometimes impeded progress.

Interoperable Data Systems

During the interview process an interoperable data system was described as a client-level cross-agency data system in which a client's movement through the system could be observed. The system could be used both for clinical/service management purposes such as tracking client status, referrals, multiple system involvement, etc. Once again, respondents reported that such a system, if properly done, could be useful. But respondents had many concerns and issues regarding implementation. Most prominent among these concerns was issues regarding real or perceived legal constraints on how data can be shared. Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) restrictions were noted. Some reported that productive conversations among program staff often seemed to die when agency attorneys became involved since they felt that data sharing increased risk for their institution.

Ideally, the county would like access to data from the Department of Children and Families (DCF) and SEFBHN. Some data sharing agreements are in place with these entities, but their data systems do not link at this point. For example, if DCF's eligibility determination for Supplemental Nutrition Assistance Program (SNAP) benefits could be shared with the County data system, it would eliminate the need for duplicate efforts at determining eligibility by the county – thereby increasing efficiency.

The Health Care District (HCD) recently launched Unite PBC, an initiative that uses the Unite US social services platform. HCD selected Unite US to help their primary care clinics improve efficiencies and obtain feedback for social service referrals. Additionally, the system provides important data to assist the clinics with meeting Federally Qualified Health Center (FQHC) reporting requirements for social service referrals. The structure of the Unite Us platform enabled HCD to provide this tool to other non-profit community organizations at no cost. Unite PBC is currently recruiting agencies throughout the county to join the Unite PBC platform. The platform will be most effective by having the broadest set of participating agencies in the network. Unite PBC provides information on referrals to the referring agent and feedback regarding referral completion from the receiving agency. Unite PBC also includes some screens that can help to identify client needs with the capacity to share screening information to reduce duplicative data collection. It has potential to provide information on system functioning and capacity by mapping referral and completion patterns.

While it has attractive features, several respondents were concerned that it potentially will duplicate other client management systems and may cause participating agencies to use two or more data systems to integrate services for their clients. For Unite PBC to efficiently reach its potential it would have to interface with existing data systems for those agencies that are

represented in the 211 data base (about 1600) as well as those in the CSC, SEFBHN, DCF, County Community Services and Youth Services, among others. Interviewees noted that this integration might be possible using application program interfaces (APIs) with some of these systems but that this would likely not be quick, easy, or inexpensive to accomplish.

Another concern with potentially using the Unite PBC platform to support the functioning of the SOC is keeping information about system capacity current. The platform relies on referral completion rates as a measure of system capacity. Some respondents report that given the workload of many non-profits and their mixed incentives to accept new referrals, referral completion rates may not be a reliable capacity measure. The 211 system, for example, devotes a good deal of staff time actively reaching out to agencies to help assure accurate information. In addition, the Unite PBC system does not collect information regarding the types and volumes of services received or the outcomes that are accomplished. If the system could be integrated with other systems that record these data, if issues of accurate capacity measurement can be addressed, and if it is successfully deployed to a large number of agencies, Unite PBC may hold promise for producing a systemwide perspective on client movement, referral volume and system capacity. Arguably, this system wide perspective could also be attained by further analysis of the data from the 211 system. The 211 Counts dashboard currently provides real time information regarding requests for help across several categories as well as unmet need in each of the categories.

Status of System of Care

Another area of exploration was both opportunities and barriers in the existing system of care including leadership, dashboards of indicators at the system level, client level information systems, and promising programmatic initiatives.

Leadership

There was consensus among interviewees that leadership is a strong facilitator of population health in PBC and the strongest asset of its system of care. Various informants described leadership as "very strong; excellent leaders and elected officials", "helpful infrastructure of relationships among funders to rapidly respond to community needs", and "strong, passionate and well-informed." Many leaders have been in leadership roles for long periods and have experience working in several organizations and thereby have a broad perspective on the overall system. The system of care was rated highly in collaboration. Many informants identified the following organizations as strong collaborators: Southeast Florida Behavioral Health Network, Children's Services Council, the County Community and Youth Services Departments, Health Care District, Palm Health Foundation, Quantum Foundation, the School District, United Way of Palm Beach County, among others.

Leadership is the strongest asset of its system of care.

An example of collaboration noted by several participants is the conceptualization and implementation of Birth to 22 in 2013. Major collaborators came together to construct, fund, and implement Birth to 22 and develop its Youth Master Plan. It is informed by a life span developmental model through young adulthood with interventions at each life stage to promote

and/or reduce threats to healthy development. Indicators are also present to gauge population health status at each developmental point.

Despite its conceptual clarity and comprehensiveness, some current challenges with Birth to 22 were noted. First, perhaps related to its breadth, some respondents noted that organizational structure has become unclear and somewhat fragmented. Relatedly, while many indicators are tracked, there is not a clear relationship between intervention strategies and changes in these indicators. To the degree to which the interventions and outcomes are geographically specific, the effects of interventions may be swamped by reporting county wide data. Perhaps drilling down on more specific intervention-outcomes linkages could help to clarify the overall strategy of the Birth to 22 initiative. Again, likely related to breadth, some respondents noted that there are multiple Birth to 22 workgroups but little communication among the workgroups and not clear communication structures between the workgroups and the Birth to 22 funders group. "Sometimes you can be too busy to be productive." Another concern with the initiative is the degree to which it responds to the needs and progress of individuals with more severe and disabling conditions.

Other challenges also were identified in the leadership domain. First, many participants noted the lack of involvement of either providers or community residents in leadership settings. Grass roots leaders, community residents, and people with lived experience are not at the table. It was noted that this would mean a fundamental shift in the power structure; decision makers would have to agree to share power with community residents. Regarding providers, one comment was, "They hold a good deal of power and must be partners in executing the system." A second challenge is that despite efforts to coordinate leadership, there is not one governance entity that is accountable for population health for children and families. As a result, leadership efforts were described by one informant as "peripheral and disjointed" by another as "occurs through different avenues" and as "a semi-loosely connected system of activities." A related concern is that many new and innovative projects are initiated in PBC but not built upon or sustained over time.

Dashboards

One of the interview questions explored whether there were any dashboards of metrics on child and family population health linked to strategies for improving the metrics. In response to this question, many informants at both the leadership and the grass roots levels mentioned the dashboard for the Birth to 22 initiative as a useful set of metrics on child well-being. One Birth to 22 CSC report portrays differential health status at the zip code level. Hot spots can be identified to address issues such as infant mortality rates and equity issues. One concern is that it is generally deficit oriented rather than focusing on metrics of population health assets. Given the number of indicators, it can be a challenge "to make the data tell their story" for local communities and their residents, especially for county wide data.

Client-Level Information Systems

During the discussion about interoperable data systems, many participants noted their own mandated client-level data systems. The Health Care District, for example, uses

PRAPARE, a client-level data system that assesses all the social determinants (housing, hunger, safety, utilities, childcare access). ChildNet is required by the state to use Florida Safe Family Network (FSFN) as its client-level data system, and the Department of Health's (DOH) data system is a statewide requirement by FL DOH. As noted earlier, the PBC Community Services Department has several data systems including HMIS. Currently there are limited linkages across these systems.

Promising Initiatives

During the interviews, many participants identified PHF's Healthier Together sites, CSC's Bridges sites, and the PBC Portfolio Design Core Team as opportunities to promote shared stewardship, portfolio management, and resident-driven initiatives that identify and build on community strengths. These programs also are fostering resident leaders who are beginning to participate on agency boards and who bring the community's voice to leadership forums. While many of the other initiatives that were discussed in the interviews had proponents and detractors, only positive comments were shared regarding Healthier Together and Bridges, perhaps reflecting their strong linkage with 'the ground.'

Achieving Greater Impact

The final domain that was investigated during data collection was perspectives about new facilitative structures or initiatives that would be required to enhance population health using existing fiscal and human resources in PBC. Areas that were discussed include governance structures, dashboards of indicators, client level information systems and model programs.

Governance Structures

One finding from the study is the lack of a clear governance structure in PBC to enhance population health for children, youth, and families. Even at the leadership level, this structure does not exist. There are various entities, such as the Funders' Coalition and the leadership group for Birth to 22, but not one coherent governance entity. A related finding is that this governance entity needs to include providers and community residents. A potential opportunity to address the governance issues is the county's implementation of HB 945, which calls for explicit efforts to develop system of care implementation strategies such as an effective and inclusive governance structure.

Dashboards of Performance Indicators

Despite the challenges noted earlier about the Birth to 22 dashboard, it has many strengths that could be enhanced. There is a data workgroup chaired by CSC and the School District that is addressing these issues including the addition of population health assets. Second, Organizing Against Racism, a community organized initiative that is focused on racial/ethnic inequities, has the potential to develop a dashboard that focuses on inequities. During the discussion about common metrics, one informant noted that the Ages and Stages Questionnaire (ASQ) is used by CSC in its childcare centers, 211, Help Me Grow, and in some pediatric

clinics. A shared dataset and dashboard could be developed that would display the results and prevent duplicative administrations of the ASQ.

Client-Level Information Systems

Two solutions for future exploration emerged from the discussions on client-level information systems. The first solution, affirmed by many participants, is cross-system data sharing agreements on a "need to know" basis. These agreements could be used to address a particular issue or an at-risk target population. During the interviews, several existing data sharing agreements were identified. The school district, for example, has data sharing agreements with some organizations including Achievement Centers for Children and Families. This early childhood provider can pull data on a particular child served and look at the child's educational record over time. A different example is the data sharing agreement (Community Based Care Integrated Health - CBCIH) between ChildNet and the Sunshine Child Welfare Specialty Plan, the Medicaid Managed Care program for children in Florida's child welfare system. There is a daily integration of FSFN and Sunshine and daily exchanges of data between ChildNet and the Child Welfare Specialty Plan.

The second solution proposed by the PBC Community Services Department is to use APIs to build bridges between existing data systems. The Department has purchased a platform where this is possible and is currently linking its internal 12 data systems. Broward County uses the same platform and ChildNet already has an API with the platform in Broward. Another respondent agrees conceptually with the use of APIs but notes that these interfaces take time and funding on both sides; they are not "free".

Model Programs

Community-driven initiatives such as PHF's Healthier Together, CSC's Bridges sites, and Healthy Start Coalition's Healthy Beginnings are producing good results and should be expanded as a strategy to identify and support community strengths and engage community residents in system change. These programs also highlight the outcome variable of belonging to a community, feeling connected and supported. Finally, the PBC Portfolio Design Core Team has the resources and leadership to promote shared stewardship and portfolio management opportunities in PBC.

Summary

The findings identify many Palm Beach County strengths such as strong leadership and collaboration, rich resources in some sections of the county, dashboards that address population health indicators, and strong endorsement of and experience with collective impact strategies. Findings also indicate an openness to exploring new approaches such as shared stewardship and interoperable data systems. These themes are the framework for the report's recommendations.

Findings indicate an openness to exploring new approaches such as shared stewardship and interoperable data systems.

Discussion and Recommendations

Several consistent themes emerged from the interviews. First, the SOC is characterized by strong, competent leadership. Many of the system leaders have long tenure in PBC and have worked in various SOC roles over the years. This gives them a good grounding in the logic and rationale for the SOC and appreciation for others' roles and contributions. There is general agreement regarding the goals and mission of the SOC although there may be some disagreement about relative emphasis and some specific competencies – especially as relates to children with more complex needs.

Second, it was clear that there is a strong collaborative spirit among members of the SOC for children and youth in PBC. Individuals may not always agree with their system partners but universally they respect them and attribute positive motivation to them. Individuals realize that there is competition among providers for resources but nonetheless are committed to the overall success of the SOC as reflected in healthy, successful children and youth. Some specific collaborations like child welfare and juvenile justice are effective in addressing the needs of individuals on which they overlap but this reflects more of a case-by-case collaboration than full cross agency collaborative relationships.

Third, the strong leadership and cooperative spirit should support a shared stewardship/portfolio management approach. However, a good deal of work is yet to be completed to educate the broader community regarding the concepts of urgent need and vital conditions and to further elucidate the expected reduction in urgent needs because of investment in vital conditions. Greater targeting of investments toward specific population health improvements could begin to link investments in vital conditions with improvement in health and reduction of urgent needs.

Fourth, agencies and some funders within the SOC have good access to data that is used in system and clinical management. However, with some exceptions, the data systems are not integrated with one another. While there is near universal agreement that further integration would be helpful for both responding to individual's needs and better understanding the functioning of the SOC, there is great skepticism regarding the ultimate success in creating an interoperable system with information available at the client level across agencies or funding source.

Fifth, the current information environment does not include information on services funded through insurance – especially Medicaid. Nationally, Medicaid accounts for 24% of expenditures for behavioral health services as contrasted with about 16% from state and local sources[20] indicating that Medicaid accounts for 1.5 times more behavioral health services than state and local. Given the relatively rich funding environment in PBC, the ratio of state and local to Medicaid is likely closer to one. Information on general health expenditures is also important. Nonetheless, the portfolio analysis is significantly hampered without insurance information.

Sixth, a related concern involves the need to better integrate and support pediatricians in the system of care. While we were not able to pursue this issue in depth, an interview with a pediatric leader indicated a frustration among pediatricians with their ability to appropriately

screen and serve the behavioral health needs of children and youth, even though behavioral health problems are common in pediatric patients.

Finally, while most respondents rated the overall health and well-being of children and youth in PBC as about a five on a ten-point scale, many respondents highlighted the gaping disparities in their health status across the county. These inequities are strongly related to racial and ethnic groups. PHF's local analyses of the Child Opportunity Index[21] indicates that black children are nearly eight times more likely to live in low opportunity census tracts, Hispanics are 2.5 times more likely while white children are 3.6 times more likely to reside in high opportunity neighborhoods. Based on these findings, we recommend the following set of activities.

Responding to the requirements of HB 945 provides important impetus for SOC planning and the development of a governance model.

In the Short Term

Responding to the requirements of HB 945 provides important impetus for SOC planning and the development of a governance model. Strategic leadership and accountability should comprise the governance function as contrasted with a unified command and control function. In the 2nd edition of Building Systems of Care: A Primer, Pires[22] identifies several key requirements for governance entities. One issue is authority; the governing body needs to have an explicit authority to govern. Second, the governing body needs to be representative of those who have a stake in the system of care, including families, youth, and local community residents. Finally, the governing entity must have the capacity to govern, including staff and data management. Using the concepts of shared stewardship, the governance function should evaluate the effectiveness of the portfolio investments by reference to demonstrable effects on population health status outcomes. Research indicates[23] that strategic portfolio management by a governing entity must be supported by a real-time data system that assures an adequate return on investment. Outcome analysis can thus inform future investment strategies. It is important that the perspectives of communities with the most inequitable health status be integrally involved in governance. A communications plan should inform the broader community of the strategies that are being employed and results achieved. Clearly, the communication plan should inform the existing authorities (non-profit boards, government, etc.) since their continued support for an effective system is essential.

These recommendations are consistent both with the findings from the Community Behavioral Health Needs Assessment that highlighted the importance of collaboration across the system as well as the development of a shared language/taxonomy across the human service sectors to facilitate effective communication. The needs document also highlighted the importance of shared outcomes and data.

Reflections from the first five years of the Healthier Together initiative underscore the importance of effectively integrating the community members' perspective into the planning and implementation process. They also underscore the challenges of building trust with traditionally disenfranchised populations and promoting their empowerment to become full partners. The HB

945 planning process may provide an opportunity to include some community members from the Healthier Together and/or Bridges initiatives who have addressed behavioral health issues and become comfortable with their role and contributions in shared governance. The inclusion of peers in planning and service delivery, which has expanded during the last several years, is clearly consistent with expanding the voice of lived experience.

As part of the planning process for HB 945 request regular reports from AHCA of Medicaid expenditures for behavioral health disaggregated by major service type. The lack of these data significantly impacts the ability to characterize overall system investments. While aggregate data on expenditures by service type would be helpful, data on services provided at the client level would be most helpful. A pilot study could be initiated with ChildNet and the Sunshine Child Welfare Specialty Plan to investigate the possibility of generating regular data reports from CBCIH on expenditures for physical health and behavioral health services to PBC children in the child welfare system. Similar data should be sought from commercial insurers.

Work of the Palm Beach County Portfolio Design Core Team should continue. This initiative is in the vanguard of thinking regarding improvement of population health. The small group of system leaders who are participating in the exercise have an opportunity as one respondent put it to 'think deeply' about root causes of health problems and essential community strengths and assets that promote health and well-being. As part of their work, they should include a communication plan that will broaden the discussion to a full range of key stakeholders to develop a shared vocabulary across system sectors of key concepts such as the portfolio of vital conditions and urgent needs and, ultimately, a plan for true shared stewardship. The communication plan should attend to both horizontal communication to other agencies or actors who ultimately should be engaged in shared stewardship but also vertically within organizations and affected communities.

The exploration of data system integration should continue. Given the skepticism that exists in the community around the ability to accomplish full interoperability of the data systems and the considerable barriers, real and imagined, to such full integration, we recommend that a small working group be established and staffed to develop a strategy for greater interoperability. As a first step, reviewing the proposal that has been offered by PBC Community Services should be a primary task of the working group. The use of APIs to integrate functions between data systems on an as needed basis seems like a workable strategy that should be supported. As programmatically sensible linkages are formed, a network of data sharing arrangements should begin to emerge with each node in the network reflecting a particular integration task in the service of a particular program need. PHF has expressed willingness to provide resources to staff the workgroup and to support the development of APIs with the county, CSC, SEFBHN, DCF, ChildNet, and the School District as core participants.

Investigate the issues that would be involved in integrating the 211 Data System with Unite PBC. The perceived duplication of these two systems (as well as other systems operated by CSC and the county) and the lost opportunity for Unite PBC to profit from the extensive relationships supporting data quality that 211 has developed merits special attention. Resources should be devoted to integrating these two efforts. As recruitment of agencies into Unite PBC is underway, perhaps a global agreement between the Health Care District and 211

could greatly accelerate populating the Unite PBC platform. It also provides Unite PBC a 'front door' to the community through the calls that are received by 211. Both systems would be enhanced by such integration.

In the Intermediate Term

Collective impact investments such as Healthier Together and Bridges should be continued and expanded. As mentioned in the findings, there was universal praise for these initiatives as holding great promise for addressing some of the most significant challenges confronting marginalized communities. They use planning and implementation approaches that differ from the more prescriptive strategies used in less complex circumstances. They emphasize the meaningful involvement of community members in defining problems and designing solutions. These approaches can identify community assets and needs from resident's perspectives and may result in more durable and community relevant solutions. One consistent finding from the interviews related to the general need to meaningfully include community voice in stewardship activities. The Healthier Together and Bridges initiatives may help to develop and empower community voice which must be included in shared stewardship/portfolio management.

Meaningful involvement of community members in defining problems and designing solutions can identify community assets and needs from resident's perspectives and may result in more durable and community relevant solutions.

The Healthier Together initiatives also underscore the importance of informal support systems that naturally occur in communities. One instance of including informal supports is represented by the Wraparound model. While the notion of 'warm handoffs' typically refers to the integration of services across agencies, greater involvement of community members further suggests handoffs from formal services to informal supports. The community becomes an enduring asset that is integrated into the system of care.

Investigate vendors who provide care coordination services. Late in the process of developing this report, PHF was approached by a care coordination company that claims to have developed a sustainable business model for their services that could be an intriguing addition to the 211 and Unite PBC functions. The model relies on the cost savings that occur through improved care coordination to fund the coordination activities and employs individuals from impacted communities as care coordinators. It also can train and certify individuals as community health workers.

The community becomes an enduring asset that is integrated into the system of care.

In the Longer Term

Palm Health Foundation and other leaders in behavioral health should explore alternative models to better support pediatricians' ability to assess and appropriately treat the behavioral health needs of children and youth. The shortage of child psychiatrists is a national problem. Given the difficulty in obtaining the kinds of support needed, various models have been explored. One represented in this study involves the inclusion of mental health specialists in the pediatric practice. Another model, the National Network of Child Psychiatry Access Programs, with a program in Jacksonville, involves university collaboration to obtain access to child psychiatrists who are themselves supported by other behavioral health professionals. They can provide ongoing consultation and support to pediatricians for serving children in the primary care setting. Given the importance of primary care for children's healthy development, better supporting pediatricians in addressing behavioral health needs will improve the system of care.

Target areas with the greatest health inequality with the goal of reducing the inequities.

Target areas of the greatest health inequality with the goal of reducing the inequities. A multi-pronged strategy should be pursued to reduce the striking differences in health status across PBC zip codes. The Healthier Together and Bridges programs may be important first steps in this process. Deploying additional funding to neighborhood groups and grass roots organizations will help to strengthen the consumer base in these areas. Attention to structural barriers such as racism and discrimination should be an integral part of the conversation. Environmental quality, availability of affordable, nutritious food, safe places to recreate and relax, and safe affordable housing are all part of the mix that will take coordination across sectors to accomplish.

Summary

Almost all the elements that are needed to dramatically improve the population health of all children and youth are available in PBC. In the short term, work on the 945 plan and the related governance structure as well as the data collaborative workgroup can begin to build the infrastructure for longer term development. The 945 plan provides an opportunity to explicitly conceptualize the system of care profiting from the developmental model and measurement system of Birth to 22 and perhaps enhancing it to better address the needs of children with complex challenges. Initial exploration of the data collaborative also can help inform the conceptualization of the SOC in the short term and explore the opportunities that are provided by use of APIs to begin data integration. Hopefully, in the longer term, these individual agreements and API type technologies will allow greater integration and increased capabilities to fully model the functioning of the SOC. If synergies can be found between the Unite PBC platform and 211 as well as the other existing data systems, this too could help in mapping client flows throughout the SOC as well as improving service effectiveness. The continuing work of the PBC Portfolio Design Core Team can further develop thinking regarding the yield of the investment portfolio and, over time, broaden participation and incubate a model of shared stewardship that can form the basis for an effective governance model.

References

1. Halfon N, Long P, Chang DI, Hester J, Inkelas M, Rodgers A. Applying a 3.0 transformation framework to guide large-scale health system reform. *Health Affairs*. 2014;33(11):2003-2011. doi:10.1377/hlthaff.2014.0485.
2. Bradley EH, Canavan M, Rogan E, et al. Variation in health outcomes: The role of spending on social services, public health, and health care, 2000–09. *Health Affairs*. 2016;35(5):760-768. doi:10.1377/hlthaff.2015.0814.
3. Bradley EH, Sipsma H, Taylor LA. American health care paradox - high spending on health care and poor health. *Qjm*. 2016. doi:10.1093/qjmed/hcw187.
4. National Academies of Sciences, Engineering, and Medicine; Division of Behavioral and Social Sciences and Education; Board on Children, Youth, and Families; Committee on Fostering Healthy Mental, Emotional, and Behavioral Development Among Children and Youth. *Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda*. Washington (DC): National Academies Press (US); September 11, 2019.
5. Kosterman, R., Hawkins, J.D., Hill, K.G. et al. Effects of social development intervention in childhood on adult life at ages 30 to 39. *Prev Sci*. 2019;20:986–995. https://doi-org.ezproxy.lib.usf.edu/10.1007/s11121-019-01023-3.
6. Hill KG, Bailey JA, Steeger CM, et al. Outcomes of childhood preventive intervention across 2 generations: a nonrandomized controlled trial. *JAMA Pediatr*. 2020;174(8):764–771. doi:10.1001/jamapediatrics.2020.1310.
7. Shern DL, Blanch AK, Steverman SM. Toxic stress, behavioral health, and the next major era in public health. *American Journal of Orthopsychiatry*. 2016;86(2):109-123. doi:10.1037/ort0000120.
8. Desalvo KB, O'Carroll PW, Koo D, Auerbach JM, Monroe JA. Public health 3.0: Time for an upgrade. *American Journal of Public Health*. 2016;106(4):621-622. doi:10.2105/ajph.2016.303063.
9. Bommersbach T, Borger K, Steverman S, Manderscheid RW, Sharfstein J, Everett A. Behavioral health, local health department accreditation, and public health 3.0: Leveraging opportunities for collaboration. *American Journal of Public Health*. 2018;108(10),1334-1340. https://doi.org/10.2105/AJPH.2018.304533.
10. Kindig DA, Milstein B. A balanced investment portfolio for equitable health and well-being is an imperative, and within reach. *Health Affairs*. 2018;37(4):579-584. doi:10.1377/hlthaff.2017.1463.
11. World Health Organization. Frequently asked questions. World Health Organization. Accessed January 6, 2021. https://www.who.int/about/who-we-are/frequently-asked-questions.
12. Ronik-Radlauer Group. Palm Beach County Behavioral Health Needs Assessment 2019. Accessed January 6, 2021. https://discover.pbcgov.org/communityservices/SubstanceUseDisorders/Documents/Palm_Beach_Behavioral_Health_Needs_Assessment_Report_2020_Phase_2.pdf.
13. Florida House of Representatives. CS/CS/HB 945. Accessed January 6, 2021. https://www.flsenate.gov/Session/Bill/2020/945/BillText/er/PDF.
14. Stephenson-Royster A, Coore B, Valencia C, Chen M, Jaramillo R. Palm beach County community health improvement plan. Updated June 2020. Accessed January 6, 2021.

http://palmbeach.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/_documents/palm-beach-community-health-improvement-plan-updated-july-2020.pdf
15. Strengthening the steps to success: Youth master plan for Palm Beach County. Accessed January 6, 2021. http://pbcbirthto22.com/
16. Children's Services Council. Palm beach County Zip Code Report. 2017. Accessed January 6, 2021. http://pbcbirthto22.com/pdf/Palm_Beach_County_Zip_Code_Report.pdf
17. Twentieth Statewide grand Jury. Third interim report of the twentieth statewide grand jury. Accessed January 6, 2021. http://myfloridalegal.com/webfiles.nsf/WF/CPAL-BW6T2Q/$file/3rd+Interim+Report.pdf
18. Visible Network Labs. 2019. Organizational Network Analysis of the BeWellPBC Community Network: Time 1 Report. Available from BeWellPBC.
19. Palm health Foundation. A shared purpose: Transforming communities through social determinants - lessons learned from the first five years of the healthier together initiative. August 2020.
https://cdn.trustedtechexperts.com/docs/library/PalmHealthcareFoundation2016/Healthier%20Together/HT%20Five-Year%20Look-Back%20FINAL.pdf
20. Zur J, Musumeci MB, Garfield R. Medicaid's role in financing behavioral health services for low-income individuals. June 29, 2017. Accessed January 6, 2021.
https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/#:~:text=Medicaid%20accounted%20for%2025%25%20of,financing%20sources%20(Figure%206).
21. Kramer T. Mapping neighborhood opportunity to improve community health. July 31, 2019. Accessed January 6, 2021. https://www.trainthebrainpbc.org/mapping-neighborhood-opportunity-to-improve-community-health/
22. Pires SA. Building systems of care: A primer 2nd edition national technical assistance center for children's mental health. Georgetown University Center for Child and Human Development. 2010.
23. Armstrong MI, Milch H, Curtis P, Endress P. A business model for managing system change through strategic financing and performance indicators: A case study. *American Journal of Community Psychology*. 2012;49(3-4):517-525. doi:10.1007/s10464-012-9512-z.

Appendix A: Consultant Bio Sketches

Mary I. Armstrong, PhD

Specializing in state and local government evaluation and policy analysis, Dr. Armstrong is Associate Professor Emeritus, Department of Child and Family Studies, College of Behavioral and Community Sciences, University of South Florida. She is the former Executive Director of the Louis de la Parte Florida Mental Health Institute at USF. Dr. Armstrong's specific areas of interest include the impact of financing arrangements on at-risk children and families including Medicaid managed care health care reform, IV-E Waivers and child welfare privatization, and cross-system governance and financing of effective systems of care. Related topics include the integration of physical health and behavioral health (mental health and substance use), informal supports for caregivers of at-risk children, and the effectiveness of out of home settings for children, adolescents, and young adults with behavioral health needs.

Dr. Armstrong is a Governing Councilor for the American Public Health Association and an active member of the Mental Health Section. She is past President of the Global Alliance for Behavioral Health and Social Justice (formerly the American Orthopsychiatric Association). She is a member of the National Association of Social Workers and the American Evaluation Association; and is a frequent contributor to journals and books.

David L. Shern, PhD

From 2006 to 2012 Dr. Shern served as the President and CEO of Mental Health America (MHA), *formerly the National Mental Health Association* the nation's oldest and largest advocacy organization concerned with all aspects of mental health and illness. He returned on an interim basis in 2014 following the departure of his successor. After leaving MHA Shern joined the staff of the National Association of State Mental Health Program Directors as a Senior Public Health Advisor where he concentrated on the national implementation and financing of specialty programs serving people with first episode psychosis. He has a faculty appointment in the Department of Mental Health at the Bloomberg School of Public Health, Johns Hopkins University.

Prior to joining MHA, Dr. Shern served as professor and dean of the Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida, one of the largest research and training institutes in behavioral health services in the United States.

His work has spanned a variety of mental health services research topics including serving street dwelling individuals with SMI; epidemiological studies of the need for community services; the effects of differing organizational, financing and service delivery strategies on continuity of care and client outcome and the use of alternative service delivery strategies such as peer counseling and self-help on the outcomes of care.

Appendix B: Interview Respondents

Interview Summary Status (12/23/2020)

Organization	Date of Interview	Interviewees
Southeast Florida Behavioral Health Network	9/29	Ann Berner, Jill Sorensen, Becky Walker
Palm Beach County Administration	10/1	John Van Arnam, Nancy Bolton
Health Care District of PBC	10/6	Dr. Belma Andric, Dr. Courtney Rowling, Dr. Tom Cleare
PBC Youth Services / Community Services Departments	10/7	James Green, Tammy Fields, John Hulick, Taruna Malhotra
ChildNet	10/8	Larry Rein, Susan Eby
Children's Services Council	10/8	Dr. Lisa Williams-Taylor, Michelle Gross, Robert Kurimski, Tanya Palmer
United Way of PBC	10/09	Dr. Seth Bernstein
Student ACES	10/13	Krissy Webb
Community Partners	10/14	Dr. Jibby Ciric
JFK Medical Center – North	10/16	Sharon Tarlow, Beau Lynch
Department of Juvenile Justice	10/16	Shirlon St. Amour, Greg Starling
Families First of PBC	10/16	Andre Torres
Dept. of Children and Families	10/20	Elisa Cramer, Suzette Fleischman, Robert Shea
American Association of Caregiving Youth	10/21	Connie Siskowski
Inspire Youths	10/20	Devon Lewis-Buchanan
Suits for Seniors	10/21	Jervonte Edwards
15th Judicial Court	10/22	Judge James Martz
NAMI PBC	10/22	Marsha Martino, Katherine Murphy
Quantum Foundation	10/23	Randy Scheid
Early Learning Coalition	10/23	Aruna Gilbert
MHA PBC	10/28	Jeremy Morse
Eating Disorders Alliance	10/29	Liz Motta, Lisa Murano, Johanna Kandel
Federation of Families	10/29	Veree Jenkins
Department of Health PBC	11/02	Dr. Alina Alonso
PBC Community Services Dept. #3	11/03	Taruna Malhotra
Inner City Innovators	11/05	Ricky Aiken
PBC School District #1	11/06	Keith Oswald
PBC School District #2	11/06	Dr. Mary Claire Mucenic
UnitePBC/Health Care District	11/09	Dr. Tom Cleare
Achievement Centers for Children & Families	11/11	Stephanie Seibel
SEFBHN #2	11/13	Ann Berner, Jill Sorensen
BeWellPBC	11/16	Lauren Zuchman
Palm Health Foundation	11/18	Patrick McNamara
Sunshine CW Specialty Plan	11/20	Neiko Shea
CSC #2	11/23	Robert Kurimski

Care Coordination Systems	11/30	Bob Harnach and two colleagues
211	12/02	Sharon L'Herrou
Palm Beach Pediatrics	12/21	Dr. Shannon Fox-Levine, Kimberly Brennan

Appendix C: Interview Protocol

Palm Health Foundation Project
Interview Guide

Agency _____

Liaison _____

Time and Date of Interview _____

Thank you for agreeing to participate in this interview.

We'd like to present a little context for you regarding the project that we are doing for Patrick and the Palm Health Foundation. As I am sure you know, our nation and our communities are confronting serious challenges to our health and well-being. Several groups are trying to develop strategies to effectively confront our deteriorating health. One strategy that Palm Health Foundation has been exploring involves looking at our portfolio of investments in health comparing, for example, how much we are spending on housing and income supports (vital conditions) in contrast with how much we are spending on urgent needs like emergency care, homeless services. A related set of concerns involves how these resources are coordinated and managed to maximize the common good. Developing a coordinated, leadership function to steward these resources is something that may be necessary and desirable.

So today we would like to get your sense of the possibility of launching such an effort in Palm Beach County and how you would consider your organization's role in such an effort. We would like to focus on the population health of children and their families.

We promise that any information data that you share with us will be kept strictly confidential. In any written reports or verbal presentations that we make, whatever you say to us will be combined with data from the other interviews that we conduct. Without your permission we won't directly share information that could be attributed to you.

Definitions
System of Care – We are defining this term very broadly to encompass universal prevention and mental health promotion activities through deep end treatment.
Population Health –Using the World Health Organization's definition, health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
Population of Interest – The children and families that reside in Palm Beach County

1. Using a 10-point scale with10 being the best and 1 being worst, how would you rate the overall population health Palm Beach County youth.
2. Thinking of both treatment and prevention/promotion activities, what are some of the strongest facilitators of population health for children and youth?
3. What are the greatest barriers to promoting the health and well-being of these children?

4. How would you describe the primary and secondary roles that your organization plays in contributing to the system of care in PBC including the full spectrum of activities from primary prevention through treatment?
5. Who are your strongest collaborators is pursuing population health for children and families?
6. How would you characterize the status of leadership in the county to promote the population health of children and families?
7. Would it be helpful in PBC to move towards a stewardship model of shared leadership and governance, recognizing that all funding streams come with their own sets of constraints and need to be managed to maximize the common good?
8. Do you think that compiling a dashboard of metrics on child and family population health linked to strategies for improving the metrics would be helpful?
9. How helpful would it be to have an interoperable data system at the client level for managing the population health in PBC?
10. Portfolio management is one way to think about how resources are invested in promoting population health. In evaluating a portfolio of investments, the balance between investments in vital conditions and urgent concerns can be helpful. Safe housing, reliable transportation, and lifelong learning are examples of vital conditions while acute medical treatment, addiction services, unemployment benefits and homeless services are urgent. Given your organization's opportunities and constraints, how would you characterize your portfolio of investments?
    a. If you could adjust these investments, what would that entail?
11. If you could change one thing to improve the system of care for children and youth in Palm Beach County, what would that be?