Coordinated System of Care

A Communications Plan

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Overview

The Coordinated System of Care (CSoC) is an initiative of the Louisiana Governor's Office, involving the State's four child-serving agencies, along with families, youth and other partners, to better streamline and coordinate public behavioral health services for children who are either in or at risk of being in out-of-home placement (e.g. foster homes, groups homes, juvenile detention facilities, residential treatment centers).

The four State agencies that participate in CSoC are the Louisiana Department of Health and Hospitals, which serves as the lead implementing agency for this initiative, the Louisiana Department of Education, the Louisiana Department of Children and Family Services and the Louisiana Office of Juvenile Justice. One aspect of CSoC that can be confusing to the key publics and stakeholders involved in the initiative is that CSoC is a very specialized part of a larger initiative, the Louisiana Behavioral Health Partnership. The partnership is a coordination of all publicly funded behavioral health care services through a central entity, called a State Management Organization (SMO), which will consolidate, administer and provide payment for all behavioral health services from these four agencies. CSoC preceded the Louisiana Behavioral Health Partnership, and served as the basis of inspiration for it. CSoC also provides services through the SMO, but while the partnership serves anyone trying to access public behavioral health services, CSoC is strictly for children and youth who are involved with multiple child-serving systems and are in or at-risk of being in out-of-home placements, who will be identified as needing specialized services to treat complex behavioral health needs.

What is CSoC?

CSoC is a new approach and philosophy to delivering and financing behavioral health services for Louisiana's children and adults through a fully integrated, single-point-of-entry system. The CSoC adheres to several core values that guide its activities. Effective systems of care fundamentally address this philosophy, which serves as the foundation for all activities. CSoC promotes an enhanced array of services, has mechanisms to finance these services and the infrastructure to support and emphasize accountability on multiple levels (of families, of providers, of state agencies) as well as continuous quality improvement. The values that serve as the foundation are:

- Family-Driven
- Youth Guided
- Home and Community-based
- Strength-Based and Individualized
- Culturally & Linguistically Competent
- Integrated Across Systems
- Connected to Natural Helping Networks
- Data Driven and Outcomes Oriented

CSoC will fundamentally transform the way behavioral health services are provided to children and families, enhancing the available service array to offer a spectrum of effective, community-based services and supports for children and youth with or youth with significant behavioral health challenges who are in or at risk of out-of-home placement and their families, which is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs to help them function better at home, in school, in the community and throughout life. To be successful, coordinated systems of care require a

commitment to trying, reflecting, revising and adapting to ensure the system is continuously improving.

CSoC will initially be implemented in five regions of the state – Capital Area, Northwest Louisiana, Northeast Louisiana, Central Louisiana and Jefferson Parish (which is separate from Greater New Orleans Area to administer these types of systems per the Act 1225 regions as reflected in the CSoC Community Application). The first CSoC services are scheduled to be offered beginning March 1, 2012. The children who are already involved with state agencies will be screened using a Louisiana version of the Child and Adolescent Needs and Strengths (CANS) assessment to identify those eligible for CSoC services. The State estimates that there are 2,400 children in Louisiana who will qualify for CSoC services, based on their current data. Once a child is in CSoC, two critical components of service delivery are the Family Support Organizations (FSO) and Wraparound Agencies (WAA), which are being formed and staffed in each of the implementing regions. The WAAs will be responsible for facilitating an individualized care planning process called a Child and Family Team, which results in a plan of care. This plan of care contains services and supports that will address the family's priority needs. Within CSoC, the FSOs will be service providers, and will offer some of the services that CSoC youth are eligible for to meet their complex behavioral health needs. Covered services that the FSOs will provide include parent support and training, and youth support and training. Within this system of care, a child identified as having complex behavioral health needs who is also in an out-of-home placement or at risk of being in an out-of-home placement will undergo the identification process to see if he or she qualifies for CSoC services. If the child is determined CSoC eligible (this screening process is still in development, but will be determined by the agency staff involved in conjunction with the SMO), that child will have his or her care

managed through the SMO to ensure he or she is not receiving duplicative services from different agencies. The child's family will then be referred for a comprehensive assessment and concurrently to the WAA, which will work with the family to develop an individualized care plan for the child, and the FSO, which will provide some of the services needed to address the child's behavioral health needs. The ultimate goal is to reduce the State's reliance on institutional and residential care for children with complex behavioral health needs. Through the enhanced array of services that will be available in the regions, families will be better equipped to handle their children's behavioral health needs, which will reduce their risk of being placed in out-of-home options.

Finally, there is a preventive element to CSoC. If children who have complex behavioral health needs are identified and treated early in their lives, they are less likely to have serious behavioral health needs as adults, less likely to be in the adult criminal justice system and more likely to complete school successfully.

To get an overview of CSoC and the factors involved, I conducted primary and secondary research.

Primary Research

For primary research, I conducted interviews with the members of the CSoC Governance Board, which represent the different agencies involved, along with advocate groups, and the CSoC State Team, who are staff designated from each partnering agency to support the implementation efforts being led by DHH and the CSoC director. I also interviewed the CSoC director and DHH Office of Behavioral Health Interim Assistant Secretary. In total, my interview subjects consisted of:

- Office of Juvenile Justice staff (CSoC Governance Board – Mary Livers)
- Mental Health America Louisiana staff (CSoC Governance Board – Mark Thomas)
- Office the Governor (CSoC Governance Board – Kristy Nichols and Anne Cassity)
- Department of Children and Family Services (CSoC Governance Board – Ruth Johnson)
- Department of Education (CSoC Governance Board – Donna Nola-Ganey)
- Family Advocate – Peggy Kirby
- Parent Advocate – Sherri Houin
- Staff to the CSoC Governance Board – Shannon Robshaw
- Department of Health and Hospitals (CSoC Governance Board – Kathy Kliebert)
    - CSoC Director Jody Levison-Johnson
    - Office of Behavioral Health Interim Assistant Secretary Anthony Speier
    - CSoC State Team
    - WAAs and FSOs representatives from the five implementing regions

Overall, the interviews revealed several common findings about the benefits and challenges of the CSoC initiative.

Benefits:

- The agencies will truly be working together in a more coordinated fashion than occurs in the current system, so there will be less duplication of services, and the services will be better targeted and more effective. Several agency staff gave examples of children who they found were receiving the same service from two different systems, and the treatment wasn't working effectively in either system. But, the two agencies had no knowledge of each other, and were therefore unable to coordinate care.

- Better case management and client record tracking – because the SMO will be administering the services, all youth and family records and treatment history will be stored in a single location, accessible to all systems involved with appropriate consents. In addition to care management, universal data management also will help ensure less duplication of services.
- The main benefit everyone noted was the potential to exponentially improve the lives of children who have complex behavioral health needs. All agreed inpatient and/or out-of-home treatment is not an ideal option for children, and that it will be better to help children stay in their homes. Also, because Medicaid service expansion is a major factor in this initiative, there will be more providers available than there have been before. This will increase access to and opportunities for Medicaid-funded behavioral health services, and will make available an enhanced array of services to treat the children, youth and families who qualify for CSoC, regardless of whether they are Medicaid eligible.
- This model will allow all agencies to use their available funding and services provided more effectively. The SMO, acting as a universal care management entity, will decrease incidences of duplicative services, which will save costs in those areas, and these funds can be applied toward offering expanded services to children who need them through the FSOs and other behavioral health services now available through the Medicaid expansion.

Challenges

While all interview subjects agreed CSoC is an improvement over the current system, they did note some challenges that will need to be addressed through communications planning as this initiative moves forward.

- The name “Coordinated System of Care” was an issue with most, but not all, interview subjects. In addition to the name, branding CSoC as an initiative and as its own entity was an issue. People find it very confusing to distinguish between the Louisiana Behavioral Health Partnership and CSoC, which are related but separate. Also, CSoC is very similar to the name of another major effort under way through the Department of Health and Hospitals, Coordinated Care Networks. That initiative is an effort to coordinate physical health care in Medicaid through managed care, so not only are the names very similar, the purpose is. Several interview participants noted that it is very hard for people to tell these apart, which is a hindrance to getting others to understand and support CSoC.
- The Legislature is another area people mentioned as a challenge. Legislators in the previous year’s session did not understand the difference between CSoC and Coordinated Care Networks, and often used the two interchangeably. The interview subjects emphasized that it is very important, in preparation for next year’s session, to make sure the Legislature knows what CSoC is and why/how it is working, or the funding will be in jeopardy.
- Also, several participants noted that a critical factor in Legislative understanding is provider engagement. Providers talk to the Legislature, and it is crucial to CSoC’s success that providers are engaged and participate as needed, not only for Legislative awareness, but also so that adequate numbers of providers will embrace CSoC and offer its services.
- Family engagement is a challenge for this initiative. While all interview subjects agreed this is a major CSoC goal, all noted it is a hard goal to achieve. In dealing with

families who have children in different systems, interview subjects noted the parents often are not used to being heard or having a voice in the process. This change will be difficult for them to truly embrace at first. This sentiment is also true of field staff who work with the families. The move to a system that is family-driven and youth guided will be challenging, as professionals and staff have different perspectives of families and can appear or engage in more blaming and shaming ways. These staff also have seen numerous programmatic changes or attempted changes. All parties will likely have a wait-and-see attitude to determine if CSoC will work as intended before fully embracing the system.

Secondary Research

The major component of my secondary research toward this communications initiative was a communications audit to see what materials were readily available for CSoC. At this point in the initiative, there is not a lot of available communications material. I did note a scattered web presence for the initiative. There is a CSoC page on the Department of Children and Family Services website, and a CSoC section of a Louisiana Behavioral Health Partnership website that is part of the overall Department of Health and Hospitals website. There is one brief webpage about CSoC on the Department of Education website, and there is no CSoC presence that I could find on Office of Juvenile Justice's website. Of these, the most comprehensive CSoC overview is on the webpage that is part of the Department of Children and Family Services website. That page contains all information relating to CSoC, including State and Legislative documents, facts, contact information, a timeline and history of the efforts to develop CSoC and links to the limited media materials that are available. But, the layout is not very interactive or user-friendly, and because it is a page and not a full

subhome-style layout, there is a lot of vertical scrolling required to view all of the information. For the Department of Health and Hospitals and Department of Education websites, there is just a scant overview of CSoC, with some facts highlighted. Neither of these webpages gives a lot of comprehensive information or full details about CSoC, though; they function more as a quick overview. In all three cases, the CSoC pages were not easily accessible from the homepage (I found them all through using the "Search" feature from the department homepages), nor did any have user-friendly URL names that would make it easy for visitors to find the site. Also, while the Department of Education site pointed to the Department of Children and Family Services site as the CSoC website, there was no evident collaboration or coordination among the three different agency sites related to this initiative, and the fourth agency did not have any discernible web presence for it.

As part of the communications audit, I looked at news releases that had been issued pertaining to CSoC. In this instance, the Department of Health and Hospitals had the majority of news releases issued, which mostly involved the Request for Proposals process the State used to select the SMO. Also, there were news releases about regional conferences and training sessions for CSoC. The Department of Children and Family Services had one news release I found on CSoC, which was about the Governor's announcement of the initiative's formation. Much like the websites, there was no obvious coordination among the different news releases, although the releases did each mention all agencies involved in CSoC. Since DHH had so many releases comparatively, it appeared these are just issued through and displayed on the DHH website, not simultaneously displayed on or with news from the other agencies.

A final piece of the communications audit was reviewing some of the internal materials that the different agencies prepared to address CSoC with internal staff. These materials were developed as needed for specific audiences to describe what CSoC is and does. Both Department of Education and Department of Health and Hospitals provided some of this information, which had been created for their staff. While these pieces were not comprehensive, they provided a good overview for an internal audience, and could be used as a basis to develop more, broader-reaching internal communication materials.

A probable cause for the limited communications materials on CSoC is that the public communication function for this initiative is not clearly defined and is a bit complex. While each of the agencies participating has a communications director or other top public relations professional, and while CSoC has a staff, none of the agency PR professionals are the designated person to coordinate and supervise all CSoC communication. Additionally, when the SMO begins operations in Louisiana, it will have its own communication staff and will operate under its own communications plan, although any messages from the SMO must be approved by the DHH communications director prior to issuance. It appears that at this time, CSoC communication methods are handled by the respective agencies as appropriate, but there is not a broader, coordinated approach. This is an issue the communications plan attempts to resolve, with objectives and tactics suggested to better streamline the communication.

For supplemental secondary research toward this communications plan, the Covalent staff also compiled a list of advocacy groups that should be considered partners in this initiative. This list, which is attached as an appendix to the communications plan, overviews groups that should be targeted for outreach as providers and advocates within the communications

plan. These groups all have prior experience with the State's behavioral health system, and will be able to engage with the staff at the partner state agencies who are implementing CSoC.

Finally, we conducted research to look at how initiatives similar to Coordinated System of Care were implemented in other states. Covalent looked generally at other states, and particularly at the other states where Magellan, which is the selected SMO for Louisiana, operates these systems. Additionally, we reviewed best practices and guidelines from Substance Abuse and Mental Health Services Administration (SAMHSA) and other behavioral health policy groups to see how these systems should operate. Overall, the evidence from these prior systems shows that when these systems are implemented appropriately and effectively, they reduce costs while maximizing accountability between the different governmental agencies involved and delivering better outcomes for children. Institutional and/or residential care as currently used for children with complex needs is not effective as a stabilizer or a shorter-term intervention. When care is better managed and focused outcomes are applied, residential care is a targeted, important part of the service array in a system of care. Nationally, states that have adopted a coordinated approach have begun seeing drastic improvements for youth with severe behavioral health disorders, e.g. better services referrals, fewer out-of-home placements and reduced time in institutional settings, and more children completing or attending school. Magellan has adopted some innovative approaches to engage youth in other states, notably in Arizona with the MY LIFE initiative. The research into similar systems of care in other states supports that Louisiana has built a behavioral health care treatment services array based on evidence-based approaches and best practices, and that CSoC is part of a national trend to reduce reliance on institutional

care for children to improve long-term outcomes and lessen incidences of children in juvenile justice systems winding up in the correctional system as adults.

Issues, Challenges, Problems and Opportunities

The major opportunities for gaining stakeholder support for this initiative are that CSoC is using an abundance of evidence-based and promising approaches for treating children who have complex behavioral health needs. CSoC is based on existing initiatives and policies that other states developed, which led to better outcomes for children. Another advantage is that people appear to be universally frustrated with the current system of providing behavioral health services to children. I did not talk to anyone during the interviews who felt the current system is effective, and several interview subjects noted a common complaint from everyone throughout the years is that not enough work is done to coordinate services among the different agencies, making it too hard for families to navigate the system. CSoC is a solution to address the lack of inter-agency coordination, and so it appears people will be at least initially receptive to it as a positive alternative to the current method of treatment. But, the staff involved must be cautious, as this advantage can be easily lost if people do not perceive improvements once CSoC is in place.

Some challenges that exist to CSoC's successful implementation are a lack of internal understanding and general lack of public awareness. The staff who work at the different child-serving agencies do not appear to fully understand what CSoC is or how it will operate, and they do not seem clear on what their roles will be in this system. This is difficult to resolve at this time because while CSoC aims to create a universal access point for services, there is not a universal access point for information, especially internal information. A lot of

this is because the implementing regions are just setting up services, and the State's contract with the SMO is still being finalized, which makes them unavailable to participate in planning discussions with staff now. Staff from Magellan and the state agencies involved met in a first communications summit on Dec. 2, 2011, to begin working through some of these issues.

Name confusion is an issue that contributes to the above challenge – it is too difficult for people to distinguish between CSoC and Louisiana Behavioral Health Partnership, and between CSoC and Coordinated Care Networks. These are all major state initiatives that involve the same agencies, and in many cases, the same service recipients, and it is very confusing for people to tell them apart and to determine for which services they are eligible and where to get them. This name similarity causes confusion over which initiative is which, and especially contributes to the general lack of public awareness about what is taking place. Such lack of awareness is a deterrent for effective communication because if not enough people know about and embrace CSoC, there will be reduced opportunities for cyclical communication, where audiences can act as ambassadors to other audiences. Cyclical communication will set CSoC up for a cascade effect, in which messages flow down from one audience to another, which is highly effective for information dissemination, particularly about large and complex public health endeavors.

Finally, a major issue is the general fear of change that accompanies any state-level programmatic change. Even though people seem universally dissatisfied with the current system, they are not going to quickly embrace a completely new way of operating behavioral health services in state. This is a fear that must be recognized and assuaged through effective communication at the onset of this initiative.

Situation Analysis and Problem Statement

The two key components of a successful communications plan for any public policy initiative are targeted media relations and clear, consistent public information. At this time, CSoC is progressing toward implementation, and needs adequate name recognition, acceptance and understanding to build support for CSoC. To ensure success, the Coordinated System of Care implementation staff must adopt a comprehensive, effective communications plan that will educate a variety of stakeholder audiences about the initiative and engage them to participate appropriately during implementation and beyond as this fundamental behavioral health service transformation occurs.

Planning and Programming

The CSoC implementation staff need a comprehensive communications plan that builds on the work the planning committee members have done for the past three years to create this initiative, and creates more opportunities for them to engage with key publics as this system takes effect. Through effective communication, the staff working directly to implement this initiative can provide more information to key publics and challenge misperceptions others may have about the initiative.

There are two primary goals of this communications plan:

Goal 1: Create awareness and recognition for CSoC, building support and helping people better distinguish it from other, similar initiatives.

Goal 2: Educate and activate affected groups, empowering them to take action at the correct times.

These two goals will help the CSoC implementation team reach its key publics and target audiences, which include:

- *Staff* of all agencies involved in CSoC. Employees are the best ambassadors for any initiative, and it is important that staff who will be on the front line, interacting with consumers and representing that agency, know what is happening and how they should participate so they can better advocate for CSoC.
- *Providers*, who will need to enroll with the SMO to offer services to CSoC children. Because of the Medicaid expansion to offer CSoC, there will now be providers who

have never worked with Medicaid before and have never worked in a behavioral health managed care environment, who will be part of the system. In order to engage these participants, it is critical to outline the steps they must take to enroll and receive payment.

- *The FSOs and WAAs in the implementing regions*. These groups are the people who will be directly communicating to and working together with the families to help them access services appropriately. Because of this, these staff represent a specialized internal audience, and they in many ways function as the end consumers of the communication cascade for this project.
- *Current recipients and the implementing regions*. It is important for selected participants to be aware of what is happening. This is particularly important for the implementing regions, which must also be aware of the available services.
- *Prospective recipients and the future regions*. The additional five regions that remain to implement CSoC services will be looking to the first implementing regions for a greater understanding, and recipients in these regions will be hearing from people they know in other regions. It is very important that providers, consumers and staff in the implementing regions are informed and prepared to advocate positively to this audience.
- *Families/Foster Families*, who will be caring for children in CSoC and will need to know how to access services. They will also need to understand CSoC so they will not be afraid to participate in these services for their children. This audience is not looked at as the end consumer for this particular initiative because of the method of identifying CSoC children. The initial cohort of enrollees (the first several hundred

enrollees, who will be identified by efforts among the partner State agencies) will be primarily selected based on agency identification of children in the existing system. Parents and families should be aware that there are behavioral health services available, and that they can call the SMO and be screened to determine those services for which they are applicable. Those services may or may not include CSoC. For this reason, the end consumers for this phase of the communication are considered the FSOs and WAAs, who will work with the identified children to help them access the services. Families would benefit from communications regarding the Louisiana Behavioral Health Partnership, which allows for anyone to call and be referred for services based on level of need, which may or may not include CSoC services. Progressing forward, as families call the SMO and are screened for services, anyone deemed eligible for CSoC will receive those services. For this reason, it is important that families do have a basic understanding of the initiative in the beginning phases.

- *Advocates and community stakeholders*, who are very protective of people in the current system, and will be watching to ensure children in CSoC really are provided more effective services that offer better results, as promised.
- *Judges* are a specialized audience because they are often the determiners of when children are placed in State departmental custody and/or out-of-home care. Because they have the power to assign children to systems, it is critical that they understand CSoC and how it will operate, so they will be more trusting of agency staff's recommendations for whether children should be placed in CSoC or not.
- *The SMO, which is Magellan Health Services, Inc.*, set to operate in Louisiana. Because the SMO will have front-line interactions with providers and consumers, and

will enact its own communications plan, it is critical that the SMO staff in Louisiana are clear on efforts taking place at the state level, to ensure a consistent flow of information.

- *The Legislature and executive branch of State government*, which have the power to direct funding for CSoC. Also, the Governor created CSoC under executive order, so it is imperative that the executive branch is aware of how it is performing. Additionally, the Legislature has passed a resolution seeking annual performance reports on CSoC, so it is best to be proactive and make sure they are aware on a regular basis how CSoC is performing.
- *The media*, who are in a unique position to help others understand CSoC. Media coverage regarding CSoC has been minimal this far, especially in comparison to the Coordinated Care Networks initiative. If CSoC implementers can get select media to understand the initiative and provide thorough coverage, this could increase general awareness and understanding.
- *Taxpayers and general public*. This group funds the State behavioral health services and needs to know the best and most appropriate action is being taken to make responsible use of their tax dollars.

Goal 1: Create awareness and recognition for CSoC, building support and helping people better distinguish it from other, similar initiatives.

1. Objective: Create communication pieces/opportunities that help affected audiences better separate CSoC from the Coordinated Care Network initiative, and further distinguish CSoC from the overall Louisiana Behavioral Health Partnership.

a. Tactic: Create a provider resource guide that gives a thorough overview of what the Louisiana Behavioral Health Partnership is, with a separate CSoC section that describes how it functions in relation to Medicaid, specifying that CSoC is for children regardless of Medicaid eligibility, describes how they can enroll as Louisiana Behavioral Health Partnership services providers and be paid for their services, and provides a distinction between what providers need to do for the behavioral health component as opposed to what they need to do for Coordinated Care Network enrollment, which will be occurring simultaneously. NOTE: As provider relations are a specified part of Magellan's contract with the State to operate the SMO, the contractor will serve in an advisory capacity, and Magellan should actually create this outreach piece. *Timeframe:* First quarter 2012.

b. Tactic: Schedule a series of provider calls to discuss the issue of provider recruitment. Magellan's Louisiana operation has already begun contacting providers, and they are confused about what is happening and whether they need to enroll. This should be handled with a process similar to the effort DHH undertook for the Coordinated Care Networks provider recruitment calls, where a medical director with this initiative gave a thorough overview of provider recruitment, and took providers' questions. Legislators should be aware of and invited to participate in these calls, alongside providers from their districts. NOTE: The Department of Health and Hospitals has scheduled a series of provider and community forums to discuss the Louisiana Behavioral Health Partnership during December 2011, which may eliminate the need for or change the structure of these calls. *Timeframe:* First quarter 2012.

c. Tactic: Develop a compare/contrast-style fact sheet to distribute internally to staff, which distinguishes between CSoC and Coordinated Care Networks, and further separates CSoC from the overall Louisiana Behavioral Health Partnership. This will be designed to help staff better understand the differences, which will help them better direct consumer calls, and will help staff acting as spokespeople for CSoc to communicate effectively with media. If appropriate, this sheet could be shared with external audiences and possibly featured on the webpage for this initiative. *Timeframe:* First quarter 2012.

d. Tactic: Produce a Legislative-specific communication that thoroughly explains CSoC and gives an overview, to be delivered while they are not in session. This will help them get a better overview of CSoC in real-time, to better assist their constituents. *Timeframe:* First quarter 2012.

e. Tactic: If appropriate, schedule a presentation on CSoC for a non-session meeting of the joint Health and Welfare Committees to describe CSoC and meet with legislators during their off time to help them better understand the initiative. *Timeframe:* Second quarter 2012.

Justification: Each of these audiences will play a very special role in a particular part of CSoC as it progresses toward implementation. It is very important that each of them know what to do and when to do it, so things stay on schedule, and so people are not overwhelmed with the change. Additionally, these tactics set the communication plan up to achieve a functional cascade system, in which audiences that take action early know and understand, and later trickle this information down to secondary audiences at different times. This style of communication is ideal because

it allows for personal opinion leaders to influence others, and helps the CSoC implementation team gain traction without having to directly engage everyone.

2. Objective: Take existing web presence for CSoC, and use this as a basis to create a site that is more accessible, more user friendly and better conveys information about the initiative. This should be handled in a manner similar to the universal website DHH created to house all information relating to the Coordinated Care Networks initiative, which worked effectively for disseminating all information from one online source. *Timeframe:* This objective has an overall timeframe of having the website work completed by the end of first quarter 2012.
    a. Tactic: Instead of webpages, which are all that are currently available, use a subhome-style approach to develop a true website for CSoC, which can house multiple items in different pages, instead of placing everything on one page.
    b. Tactic: Create this site centrally within the website of one of the partner agencies (Department of Health and Hospitals is recommended to host this as the implementing agency), and create a user-friendly URL for the site that the other agencies can all share on their websites and point back to the same site. This will ensure that when users search for "CSoC" or "Coordinated System of Care" on any of the agency websites, they will find the same site each time. Logos from each of the partner agencies should be prominently displayed on the front of the CSoC website, so it will be obvious that this is an initiative touching each of those agencies.

c. Tactic: Within the site, create audience portals for Regions, Providers and Families to better segment the information and help users selectively find items that apply to them.
d. Tactic: Create separate sections of the website to house all resources related to CSoC, an RFP library to consolidate that information, CSoC Governance Board items as part of public records and a calendar to show current events. On the current Department of Children and Family Services site about CSoC, the information is too intertwined, and on both this and the Department of Health and Hospitals site, the main information relates to the RFP process, which is old at this point. These resources are helpful, but don't need to be right on the homepage for CSoC.
e. Tactic: Display news releases about CSoC on the CSoC site, so these can be easily found together. The news should be shown or featured on the front page of the CSoC website.
f. Tactic: Display the news releases on each of the departments' websites, with links back to the new CSoC site.

Justification: Since one of the most positive aspects of CSoC is that the State's different child-serving agencies are finally coming together, the web presence for the initiative needs to enhance cohesion. The current web presence is not at all coordinated, and is split inconsistently among the different agencies. A streamlined approach would better reflect the CSoC goals, and would also make it easier on the different audiences affected to find information from a single location. Technically, this is quite feasible because both Department of Health and Hospitals and

Department of Children and Family Services use websites that were designed and are hosted by Covalent Logic, so staff at both agencies are familiar with the Content Management System to update information. As part of the communications planning, Covalent could work with appropriate staff at both agencies to develop one consistent site for CSoC that could be shared among all agencies.

3. Objective: Engage media to improve coverage of CSoC.
    a. Tactic: A designated communications staff member from one of the partner agencies should approach capital bureau reporters to help them work on a feature-style story about the changes, which would involve connecting them with an identified advocate/FSO member/WAA member from an implementing region and, if possible, a family willing to share their story. *Timeframe:* Second quarter 2012.
    b. Tactic: The CSoC State Team, each of whom are assigned a primary implementing region to serve as the liaison for, should work with the communications staff at the agencies and the FSOs in the implementing regions to identify family advocates in each region, as well as family success stories, where possible. This will help gain localized coverage in each of the implementing regions as CSoC gets under way. *Timeframe:* Third quarter 2012.
    c. Tactic: The CSoC Governance Board should engage the communications staff at each of their respective agencies, so that there can be a coordinated approach to communication about this initiative, and so the public information staff at the agencies can participate in the planning and advise the Governance Board accordingly. *Timeframe:* First quarter 2012.

d. Tactic: Have the CSoC Governance Board chair sign a Letter to the Editor that is sent to the major newspaper in each of the implementing regions, touting the benefits of the system and explaining how it will work. This letter should be co-signed by the family representative of the CSoC Governance Board to emphasize the system's values. *Timeframe:* First quarter 2012.

Justification: While there are many positives to CSoC, the story has not been communicated as effectively as possible because of a lack of external communication about it. Media are in a unique position to help with the cascade model of communications planning because they can inform other key publics of what is happening, and to report on the initiative. Because of their unique role in this plan, media should be targeted and informed to help better inform others. Also, if media are clear at the onset, this will result in clear and better-focused coverage for CSoC during implementation and beyond, as more regions come online with the CSoC model. This in turn provides better communication for all target audiences and key publics. Accommodating the media at the onset of this initiative will be effective throughout CSoC's lifespan at getting the message out.

4. Objective: Develop episodic communication practices to help educate people about CSoC, encouraging them to get involved.
    a. Tactic: Develop an electronic newsletter that communicates the latest information about CSoC, and build up a distribution list that includes members of each of the key publics, to better inform and engage them. This tactic worked quite successfully for the Coordinated Care Networks initiative. The newsletter should be issued on a regular, frequent basis, e.g. twice monthly, monthly, so that all

audiences will become accustomed to receiving regular information and updates. The newsletter should be structured in a way that it is sent from one place (ideally, from the system used to update and maintain the CSoC website), but makes it obvious that all agencies are partners on this initiative. *Timeframe:* First quarter 2012.

b. Tactic: Create a series of social media messages, for both Facebook and Twitter, and share these among the different partner agencies to feature through their social media channels. This way, each agency can still have communication channels unique to that agency, but are sharing consistent information with their followers. *Timeframe:* First quarter 2012.

c. Tactic: Develop a standard boilerplate, CSoC template and news release format for CSoC items, and share this among all partner agencies. This will ensure that any time a news release about CSoC is issued, it has a consistent look and feel. People will be better able to recognize the initiative if consistent messaging is used in agency news releases relating to it. *Timeframe:* First quarter 2012.

d. Tactic: Share news releases among the partner agencies, and place all on the central CSoC website. This will ensure all CSoC information is available in one place, and better coordinates the communication efforts among the different agencies. *Timeframe:* ongoing.

e. Tactic: Create a print piece, such as a post card or flier, to reach people who do not have emails. This piece should also be about the general Louisiana Behavioral Health Partnership, as many people will need to refer anyone, not only the CSoC audience, for behavioral health services. Magellan should produce this piece in

keeping with their contract, with CSoC providing input specific to that section. *Timeframe:* Third quarter 2012.

Justification: Much like the web presence, the communications to date about CSoC vary widely from agency to agency. If the messages about CSoC are better streamlined and coordinated, this will help people better distinguish CSoC and recognize it. Also, this will help the public information staff at each of the partner agencies to participate, as it reduces the burden on them to come up with original messaging or collaborate separately with each other.

Goal 2: Educate and activate affected groups, empowering them to take action at the correct times.

1. Objective: Help consumers better understand and be prepared to navigate CSoC and access services.
    a. Tactic: Develop an internal communications piece, either a resource guide or simple booklet, to distribute to the FSOs and WAAs in each of the implementing regions, which will clearly point them to how they can help families, what resources are available to them and gives them tips for interacting with the families. This can also include a checklist for the FSOs and WAAs to share with families upon referral, so both parties will know what to expect from the process. Magellan should produce this piece in keeping with their contract, with CSoC providing input specific to that section. *Timeframe:* Second quarter 2012.

b. Tactic: Repeat the series of public forums that took place prior to the RFP being issued for CSoC, to allow any interested parties to engage with the CSoC Governance Board and other implementing staff, asking questions and learning more about the initiative. *Timeframe:* Second quarter 2012.

c. Tactic: Create a resource guide for advocate groups and referral sources, e.g. hospital emergency rooms, day cares and other places that might see children who appear to need behavioral health services, which lets them know about what is available and how to find help. NOTE: This particular piece will probably reference the overall Louisiana Behavioral Health Partnership to give people a general number to call for help. Magellan should produce this piece in keeping with their contract, with CSoC providing input specific to that section. *Timeframe:* Third quarter 2012.

d. Tactic: Produce an instructional communications piece that can be shared during the planned trainings for internal agency staff, which will show them how people can navigate the system, walks them step-by-step through how people will get services and lets them see how they can point consumers in the correct direction. This activity should occur in conjunction with the SMO, Magellan, as this is a deliverable area of their communications plan that is part of their contract with the State. *Timeframe:* First quarter 2012.

e. Tactic: Establish a frequent or even weekly communication between the CSoC State Team and the implementing regions' community teams, to give them updates on timeline, SMO implementation and other important aspects of the

process, so they can better inform recipients in their communities. *Timeframe:* First quarter 2012.

f. Tactic: Identify community advocates who can speak on behalf of CSoC, either at the forums referenced above, or generally, who can better assist families locally. The FSOs in the implementing regions can assist with identifying appropriate advocates to accomplish this. *Timeframe:* First quarter 2012.

g. Tactic: As needed and as possible, schedule individual meetings with provider groups (e.g. the Mental Health Rehab Providers organization) to explicitly detail changes and plans to them, and help them be better prepared to enroll and provide services. This activity should occur in conjunction with the SMO, Magellan, as this is a deliverable area of their communications plan that is part of their contract with the State. NOTE: The need for and structure of these individual meetings may change depending on the outcome of the regional Louisiana Behavioral Health Partnership meetings taking place in December 2011. *Timeframe:* First quarter 2012; ongoing.

h. Tactic: Hold an advocates summit for the first five implementing regions, to help engage advocates in those areas and have them be prepared to assist with implementation. This should include all FSOs and WAAs, but also community advocates who will be interacting with them and available to assist. If this is successful, this can be repeated with the later implementing regions, and advocates from the first summit can participate in the planning. *Timeframe:* Second quarter 2012.

i. Tactic: Hold regular meetings with internal staff so everyone can share and discuss their communications issues and challenges. These meetings should take place within each agency, but then these concerns should be shared at larger meetings of all agencies to identify universal problems. *Timeframe:* First quarter 2012; ongoing.

j. Tactic: Create an Intranet site or other portal where staff working on CSoC at the different agencies can exchange information internally, and share solutions with each other. Covalent will be happy to advise on software or open-source programs that could serve this purpose, if none are available internally. *Timeframe:* First quarter 2012; ongoing.

Justification: As with earlier mentions of the cascade model, it is imperative that any key public that will have direct interaction with families be extremely well informed, to help guide families and point them in the right direction. Their understanding is critical to the overall success of CSoC.

2. Objective: Increase youth involvement in CSoC implementation, to help those affected better advocate for their peers, and to advise the CSoC Governance Board on planning.

    a. Tactic: Encourage early success stories from the first round of CSoC children to speak on behalf of the initiative, helping their peers who might need these services. These stories could also be featured on the CSoC website. *Timeframe:* Third quarter 2012; ongoing.

b. Tactic: Develop a CSoC focused activity for youth empowerment that coincides with Children's Mental Health Awareness Day in May. *Timeframe:* Second quarter 2012.

c. Tactic: Work together with the SMO to provide some kind of program or effort that gets youth involved. This could be a contest, fun run, rally or some other type of fun, interesting promotion, but should be aimed directly at youth. NOTE: Magellan should advise on and take the lead on implementing such an activity in Louisiana, based on the success of its MY LIFE initiative in other states. *Timeframe:* Third quarter 2012.

d. Tactic: Hold special forums/listening sessions in the implementing regions just for youth and their families. Given the sensitive nature of this, it would not be possible to do this as a public meeting. But, this could be a good way to communicate internally with children and to get ideas that would be effective at improving CSoC for later implementations. These forums should be administered as a joint effort between the CSoC Governing Board and Magellan. *Timeframe:* Third quarter 2012.

Justification: During the interviews and at the CSoC Governance Board meetings, several members mentioned a lack of youth involvement, and said they wanted to get more youth involved. This would be an appropriate and constructive way to engage youth, making them more likely to want to participate and share success.

Implementation/Strategy

Covalent Logic is available to assist with implementation of all objectives and tactics outlined above, pursuant to the communications contract in place with CSoC. Assistance will occur upon approval of these items by the contract monitor for this work.

Covalent will work with the CSoC director and other partners to develop a promotional slogan or tagline to help brand the initiative and make it more appealing to consumers. This would be used in all marketing and communication pieces concurrent with the initiative, to help people better understand and relate to the changes. Overall, the main points to emphasize throughout the CSoC messaging are that this is a family and youth-driven effort, in which families will be given a voice as never before, and also that where the youth involved have been is not as important as where they are going – they now have the power to shape their future. Some suggested slogans for the initiative are:

- CSoC: Supporting families. Building strengths.
- CSoC: Empowering families. Achieving outcomes.
- CSoC: Your choice, your future.
- CSoC: Supporting families as they build the future.
- CSoC: Strengthening families and communities.
- CSoC: Connecting communities, finding futures.
- CSoC: Partnering for a better future.

These names are subject to review and input from the CSoC stakeholders before any are used in a communications plan for the initiative.

Some common message elements and concepts that will be emphasized in all communications regarding CSoC include:

- This system is designed to provide better care for children. If it works ideally, children will get better services earlier, which will reduce their likelihood of needing intense behavioral health care throughout their lives.
- This creates a single point of entry for all services.
- All players are at the table, so families do not have to go from agency to agency to find services.
- This system makes better use of what's available to help each child get the best health care for him/for her.

Evaluation

This communication plan is a flexible document that should be re-evaluated at least monthly leading up to CSoC implementation. The contract monitor and public information staff at the partner agencies can add, delete or alter goals as necessary to ensure that effective communication is ongoing.

The following are some outcomes CSoC can look for as part of its ongoing environmental scanning processes and consider indicators of progress or success with the communications plan:

1. Increased and better-focused media coverage of the CSoC initiative.
2. More visitors to the to-be-developed CSoC website, with visitors using fewer clicks to get to the desired information. (If Covalent is approved to make the website modifications mentioned in the plan, Covalent can provide monitoring and reporting for this metric.)
3. Increased social media traffic regarding CSoC, with followers responding to the information.
4. Robust attendance at public forums in different regions of the state leading up to CSoC implementation. CSoC should aim to have at least 1,000 total participants statewide.
5. Successful return rate on provider recruitment, where at least 70 percent of the providers who receive the communications pieces enroll or request to enroll to participate in CSoC and offer services.
6. Better and more focused responses from the regions regarding CSoC implementation, with better direction to the families with whom they interact.

7. Coordinated issuance and dissemination of CSoC-focused news releases, with all of the partner agencies consistently distributing and sharing this information from their sites. Ideally, there would be at least one CSoC-specific news release issued per month, shared among each agency.

If the communications plan results in at least four of the seven progress indicators outlined above, the CSoC director can consider this plan and its strategies successful.

APPENDIX A: CSoC Advocacy Groups

Providers

- MHAL
    - Works closely with Behavioral Health (formerly the Office of Mental Health) and DHH
    - Deals with children and adults with mental health issues
    - Spearheaded the formation of the Mental Health Reform Coalition in 1996
        - Now known as the Louisiana Behavioral Health Coalition
        - Purpose: "Move Louisiana's mental health system away from its current over-reliance on institutional care and toward the establishment of a comprehensive, community-based, person-centered system of care for adults and children with serious mental disorders."

- RTC Providers, Inc.
    - Based in New Orleans and certified by DHH

- National Alliance on Mental Illness (NAMI)

- State Mental Health Agency
    - Based in Baton Rouge and certified by DHH

- State Protection & Advocacy Agency
    - Based in New Orleans

- Center for Mental Health Services
    - Based in Shreveport

- Louisiana Association for Behavioral Health
    - Based in Napoleonville, LA

- Quality Start
    - Child Care Rating System
    - Provides mental health consultation at the child care center level
    - A program in DCFS

School Counselor Organizations

- Louisiana School Counselors Association
    - Based in Lafayette
    - Purpose: "To foster a close and professional relationship amongst school counselors across the state."
    - This group could be a big one to target, as they seem to be able to represent the interests of many at the Legislature

- Louisiana Counseling Association
    - Partnered with the National Guard
    - Have a presence at the Legislature but don't usually have their hands in too many bills

Occupational Therapists

- Louisiana Occupational Therapy Association
    - The Louisiana chapter of the American Occupational Therapy Association
    - Have three permanent legislative/government relations staff
    - Seem to have a smaller membership, and are engaging in grassroots efforts to increase its member base

Social Workers

- Louisiana Association of Clinical Social Workers
    - A professional organization for clinical social workers in either administrative or clinical roles who function in diverse settings in both the private and public sectors, which include:
        - Medical hospitals

        - Nursing homes
        - Psychiatric hospitals
        - Outpatient clinics
        - School systems
        - Private practices

    - National Association of Social Workers, Louisiana Chapter
        - Sanctioned by DOE
        - Purpose: “To promote quality, integrity, unification and effectiveness of the Social Work profession while supporting social workers in their mission to serve diverse populations, and to ensure justice, equality and opportunity for all citizens of the state.”