

FEASIBILITY ASSESSMENT OF THE SERVICE DELIVERY MODEL

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Abstract: In this component of the evaluation, the Circles of Care grantees assessed the feasibility of their model systems of care. The goal of the Feasibility Assessment was to assure that each model system of care was well designed with careful consideration of project goals, community resources and readiness, cultural competence and measurable outcomes.

The Feasibility Assessment was designed to answer the following questions: Are the needs for services in the community matched with model systems of care? Are there adequate human and other resources to bring the plan to fruition? Is the management system appropriate to the service system design? Is the service system design financially sound? Is it economically justified?

Assessing the Feasibility of the Strategic Plan

Grantee Methodologies

One of the final steps required to accomplish the goals and objectives identified in the Circles of Care (CoC) Guidance for Applicants (GFA) was to complete an assessment of the feasibility of the new models. The GFA stated, "In order to add greater reliability to the service system design, grantees will perform a feasibility assessment of their preliminary design and complete the final design by making revisions consistent with the assessment." Prior to the implementation of a new System of Care, it is essential to determine if the system is fiscally and programmatically feasible, as noted from one grantee:

This feasibility study and subsequent report is important to the program because it allows the project staff and evaluators to consider the question of cost effective programming. Determining if there are more efficient ways to accomplish the same outcome is part of fiscal responsibility. In addition, cost efficiency allows more youth and families to be served with available resources.

In order to guide them through this process, the Circles of Care Evaluation Technical Assistance Center (CoCETAC) conducted an orientation to feasibility assessments and provided the grantees with a comprehensive CoC Program Feasibility Assessment Checklist. This checklist included a number of components critical to conducting a feasibility assessment including a description of the strategic plan, their community needs assessment, as well as descriptions of human resources and material inputs, and management, financial, and economic analyses.

The overall goal of the CoC project was to plan the design of a family-focused, community-based, wrap-around service delivery model that is culturally appropriate *and* cost-effective for youth who are struggling with Serious Emotional Disturbances (SED). One of the steps in the strategic planning of any new service delivery model is to gather information about the feasibility (in terms of cost outlay) of developing certain programs currently missing in each community. The feasibility discussion among the grantees was framed by Wolff's (1998) "economic evaluation for measuring societal costs" (p. 385). Wolff noted, "...as policy makers have struggled to get the most out of each public dollar, economic evaluations of public-sector investments have become more important" (p. 386). A common form of such evaluation is the cost analysis study. The Government Accounting Office is increasingly using cost analysis to support public spending on children's programs (Wolff, 1998). The Substance Abuse and Mental Health Services Administration (SAMHSA) has now established well-specified "cost-bands" for the residential, intensive outpatient and regular outpatient services that its grants fund (S. M. Manson, personal communication, November 3, 2003).

A cost analysis worksheet was subsequently developed to provide the grantees with a standard procedure for calculating specific projections of costs related to proposed projects that emerged from their systems of care planning. Specifically, one grantee (in collaboration with community members and service providers) identified community-based residential treatment as a high programmatic need. It was noted that youth in this community needed the intensive services that residential treatment can provide, as well as on-going extended family support and readily accessible traditional healing services. As an illustrative example, a number of costs were identified by the grantee and plans were developed to address them in

the System of Care model (see Table 1). As asserted by Wolff (1998) and indicated in Table 1, cost analysis should include specific cost categories and provide a calculation of average cost per youth served.

Table 1
Cost Analysis Worksheet for Community Youth and Family Service Providers Source: Designing Economic Evaluations to Measure Societal Costs (Wolff, 1998)

EXAMPLE – Proposed ADOLESCENT RESIDENTIAL TREATMENT FACILITY
Cost categories (annual) and cost (in dollars)

1.	<u>Total On- Budget Costs</u> - including:	
	a. salaries, wages, benefits	500,000
	b. supplies (e.g., paper, cleaning, copying)	70,000
	c. equipment (e.g., new computers, new copier)	100,000
	d. utilities (heat, phone, electricity)	50,000
	e. building space (no rent; high maintenance)	100,000
	f. other (specify – vehicle maintenance)	40,000
	g. other (specify- horse maintenance)	10,000
	h. other (specify - food, kitchen maintenance)	20,000
	i. other (specify- school books, supplies)	10,000
2.	<u>Total Off-Budget Costs</u> - resources paid (fully or partially by other agencies)	
	a. grant funding (sources – State, Federal)	60,000
	b. foundation funding (source – Casey Foundation)	20,000
	c. donated labor (300 hours at \$20 per hour)	6,000
	d. equipment (2 vehicles, 2 computers, 1 copier)	25,000
	e. land	- 0-
	f. building (one building)	- 0-
	g. administrative services (specify)	- 0-
	h. other off-budget funding?	- 0-
	TOTAL GROSS RESOURCE COSTS (1 + 2) =	\$1,011,000
3.	<u>Deducting Unrelated Costs</u>	
	a. non-client services (estimated labor, transportation & materials)	
	research	10,000
	community education	30,000
	training activities	30,000
	b. contracted-out specialized services (charity)	50,000
	(involves money transfer only)	
	c. unrelated services	- 0 -
	(services not to adolescent/families)_____	

NET RESOURCE COSTS = (1 + 2) – 3 = 1,011,000 - 120,000 = \$891,000

Net resource costs divided by number served = Average Costs per person

891,000/400 = \$2,227.50 per year (\$185.62 per month)

CoCETAC suggested that grantees focus on assessing the feasibility of adding new services or programs included in their models as well as for any modifications of existing services or programs instead of trying to assess the feasibility of the entire plan. Much of this effort was completed among the program staff; however, several of the grantees indicated they brought the models back to the communities for review and comment. One grantee asked questions about the programmatic and fiscal feasibility of their model during meetings with leaders, Elders, community members, school professionals, and health care and special education providers.

Key Findings

Need for Services

In developing their Systems of Care, one of the primary tasks was to identify services or programs missing in the current service system and identified by the communities as something that they would like to see addressed in any new system. The grantees used their completed needs assessment and service system descriptions to determine what these components might include. Based on the needs that were identified by the communities, grantees included new services or modifications to existing services or programs and addressed these in their model. Overall, grantee communities observed a lack of mental health services or observed that existing services are under-funded and inadequate. A number of needs were identified by the grantees and plans were developed to address them in their System of Care model. Several examples serve to illustrate (and are included in Table 2). For instance, one of the grantees identified several needs in their current system as: (a) the need for trained, credentialed American Indian and Alaska Native (AI/AN) service providers with advanced degrees; (b) coordination or integration between certain sectors (e.g., substance abuse and mental health services); and (c) to address the isolation, burnout, and high turnover among service system staff. These needs were addressed by incorporating a new training model that included continuing education/training for providers in their System of Care. Another grantee addressed barriers to services, such as lack of access to funds, transportation, telephone, and physical access to services, by the development of satellite clinics in a number of their communities. Other grantees identified the need to involve the family and community support systems more formally into their service models and addressed this by including such things as a Family Support Circle and extended family (e.g., *Tiospaye*) support system.

Table 2
Selected Needs and Model in Four Circles of Care Communities

Grantee	Identified Need	Model Component
Cheyenne River Sioux Tribe	Barriers to services - lack of access to funds, transportation, telephone, physical access to services	Development of satellite clinics in communities
Fairbanks Native Association	Trained, credentialed AI/AN service providers & AI/AN providers with advanced degrees; coordination or integration between service sectors; isolation, burnout & high turnover among service system staff	Ch'eghutsen' training model - continuing education/training for all Ch'eghutsen' providers
Inter-Tribal Council of Michigan	Parent and family support	Family Support (F.S.) Services, with F.S. Coordinator, F.S. Circle, and Independent F.S. Organization
Oglala Lakota Nation	Community way of life patterned by Lakota rules	Tiospaye support system

Available Resources

Another component in the assessment of the feasibility of their service systems was an analysis of the resources each grantee community has available to them, including human and other material resources. One of the primary considerations was the availability and adequacy of human resources. All of the grantees indicated that they would need to hire additional staff in order to implement their new service systems. They identified specific positions with the desired educational level and experience in their Feasibility Assessment reports. As noted in their service system descriptions, the grantees concluded that these human resources are scarce. In particular, grantees residing in rural settings reported a lack of AI/AN providers who either possessed appropriate training and credentialing or had advanced degrees. In contrast, grantees located in urban settings noted that, while individuals with the desired background were more readily available, they often lacked cultural competence, and AI/AN professionals are not readily available. In spite of this, several grantee communities identified staff members from their CoC programs to assume a number of the identified positions within their Systems of Care.

Through the course of the grant, material needs were identified and budgeted by each grant community, including building space, office supplies, informational systems (e.g., computers, software), and utilities. This process allowed each grantee the opportunity to engage in specific planning so such material needs could be clearly articulated, as grant writing and other funding opportunities became available. Table 3 provides an illustration of needs for material supplies and utilities.

Table 3
Material Inputs/Supplies and Utilities

Cost categories (annual) and costs (in dollars)

1. Total Material Inputs/Supplies and Utilities - including:

a. supplies (e.g., paper – 3000, cleaning – 5000, copying – 7000)	15,000
b. equipment (e.g., computers, upgrades – 15,000, new copier, upgrades – 15,000)	30,000
c. utilities (heat – 3,500, phone – 8,000, electricity – 3,500)	15,000
d. building space (rented – 15,000; and maintenance – 5,000)	<u>20,000</u>
Total	\$80,000

Management System

Another essential element of the grantee feasibility assessments was an analysis of the local management system. As one might expect, the ownership and legal framework of the new Systems of Care range from tribal oversight to oversight by private non-profit organizations, with Executive Boards that have tribal, family, community, and/or service provider representation. One of the grantee communities planned a small program that would depend heavily upon other programs that currently exist to provide a new System of Care. Another grantee community expressed concern about the governance of their project, after a decrease in anticipated funding made it necessary to develop a scaled-back version of their model, which would be implemented in fewer communities. Because they hope eventually to fully implement the model, the grantee community identified the importance of outreach to these communities for their continued input and collaboration.

Justification for the System of Care

Other components of the grantee communities' assessment of the feasibility of their new service systems included financial and economic analyses. In general, the majority of grantees reported that their programs

were considered “financially feasible” (see Table 4) given that expected revenues were equal to or greater than expenses. However, a problem was identified in that most of the grantee communities were relying on local, state, and/or federal grant monies to fund a significant portion, if not all, of their programs, and they recognized that they would have to replace these funds when they completed these grants. As a result, several of the grantees acknowledged the need to investigate other funding options that would provide longevity for their programs. As one grantee noted, “The system of care needs to aggressively seek funding sources beyond federal grants to create a system that can be sustained over time. In addition to private foundations, Medicaid and third party reimbursement needs to be explored”. Another option identified by one of the grantees was to have some of the costs absorbed by member agencies.

Table 4
Financial Feasibility Analysis

Source: Designing Economic Evaluations to Measure Societal Costs (Wolff, 1998).

Annual Estimates (in dollars)

1. Total <u>Investment Estimates</u> - including:	
a. donated labor and matching funds (see Appendix A)	30,000
b. Volunteer services (extended families)	<u>80,000</u>
Total investment estimates	\$120,000
2. Total <u>Revenue Estimates</u> – including:	
a. grant funding (source –Federal)	<u>600,000</u>
Total: investments and revenue	\$720,000
3. Total <u>Operating Cost</u> Estimates – including:	
a. salaries, wages, benefits	300,000
b. supplies (e.g., paper, cleaning, copying)	15,000
c. equipment (e.g., new computers, new copier)	30,000
d. utilities (heat, phone, electricity)	15,000
e. building space (rented; and maintenance)	20,000
f. other (specify – community, staff and service provider training –e.g., wraparound model, Cultural Mental Health training)	40,000
g. other (specify- travel)	<u>80,000</u>
Total operating costs	\$500,000

Financial Feasibility =

Total investments and revenue (720,000) less total operating costs (500,000) = \$220,000

The financial feasibility for this program is adequate given that revenue is greater than costs. However, the federal grant subsidy will end in 2005. It will be important to begin now to cultivate more potential sponsors/donors for the continued viability of the program.

Wolff (1998) indicates that financial feasibility which addresses annual investments (e.g., volunteer, donated service) and revenue related to costs can provide sound justification to policy makers for continuing community-based children's services. Table 4 provides an example of a financial feasibility analysis used by one grantee to solicit additional funding from policy makers in their community and state. The cost effective focus on community-based, family-focused volunteer services enabled this grantee to successfully lobby its state and federal representatives for additional funding.

Cultural Competence and Community Readiness

All grantees worked in diverse tribal cultural settings. Given these contexts, a critical ethical and process element of the feasibility assessment was to determine if the plans were culturally appropriate and acceptable to the communities. Historically, either or both Indian Health Service (IHS) and state mental health units had served each of the communities. Needs assessments revealed that services were often delivered using personnel and methods that were alien to the communities. For example, the Alaska service system exported large numbers of children with SED to out-of-state placements in which their cultural background was not acknowledged, and aftercare considerations (often returning to a very remote and small village) were not part of the treatment modalities. Additionally, grantees discovered that communities associated SED with stigmatization and there was a reluctance to identify children early. Again historically many AI/AN children had been diagnosed (and misdiagnosed) with learning disabilities and placed in special education programs. In many grantee communities, this led to suspicion and distrust of mental health professionals and programs. For example, in Alaska and South Dakota, such diagnoses have led AI/AN parents to believe that the state might take their children from them. Given these considerations, grantees had to assess the attitudes and awareness of the community for engaging in the programs that were developed.

Grantees dealt with this issue in a variety of ways but with some significant commonality. First, grantees involved the community in the development of the system of care models. Focus group methodology was utilized to elicit input on what the model should include. Significant for many of the grantees' process was the inclusion of Elders and Traditional Healers to insure that the model was grounded in the culture. Examples of how this shaped the program models were the culturally grounded definitions of SED. One program, in California, continued informing the community and providers throughout their process through a regular newsletter. This newsletter informed communities and developed awareness. Second, two of the grantees utilized the Community Readiness model developed at Colorado State University to structure their planning. One program in Oklahoma structured their entire planning process using this model while another program in

Alaska used it in the final stage of planning to assist in implementation of pilot projects. Third, at least one of the grantees returned to each community assessed during the needs assessment process to garner feedback related to the question of whether the assessment was feasible and culturally grounded. Many grantees held trainings and provider meetings to garner feedback on the models. Finally, this feedback from diverse sources was used to continually revise the systems of care models.

Conclusions

The feasibility assessment was reported to have a positive impact on the CoC planning process, as it proved to be quite valuable for practical planning. The most frequently reported challenges were related to getting accurate information, and the opportunities most mentioned were related to discovering new ways to make sustainability more of a reality. Ethical concerns consistently revolved around respect, cultural competence, and community ownership. However, in the end, all grantees reported high degrees of ethical practice related to feasibility assessment as outlined in the CoC GFA. Indeed, grantees overwhelmingly noted that evaluators and policy makers should make note of the process used in feasibility assessment (and other aspects of the CoC process) and use it as a participatory model for federal government and AI/AN collaboration. This issue is particularly important given the recent development of federal “cost-band” specifications for mental health (S. M. Manson, personal communication, November 3, 2003).

In conclusion, the CoC grantees considered a number of essential elements for feasibility assessment, including the needs of their communities, the resources available to them, the management system necessary for implementation, the financial and economic soundness of their plans, and cultural competence and community readiness in developing their Systems of Care. While optimistic that they would be able to successfully implement their systems with the revenues available to them, they were also realistic in acknowledging that they need to identify other funding options for the sustainability of their programs.

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