Whole System Mapping

Context:
At the beginning of a multi-partner/multi-sector process that seeks to understand what the many contributors of services do for a shared target population.

Purpose:
Engage with stakeholders to understand all partners' contributions to service provision for a given population in order to see the current range of services and initiate next step system mapping. This process seeks to capture a full picture of current services provided, including where, by whom, and intensity of service. It positions stakeholders to see complementary system components and discuss how the parts (could) work together.

Status: New

Primary nature of group task: Convergent

Time:
Preparation time: 2 hours to plan data collection (and collect data in a meeting if all participants are present); more time to acquire and integrate input if data is collected through email/survey.

Time required during session: 30 minutes to discuss completed table, more if coupled with more advanced system mapping

Follow-up Time: Up to 2 hours (see questions below)

Materials needed:
Whole systems map table (MS Excel document is easiest for data entry)

Inputs:
Each partner/stakeholder fills out one row of table for a clearly identified target population, answering the following questions (each question is a column in the table):

1. What happens for this population in my agency?
2. For whom exactly do we provide these services?
3. Where are the services provided?
4. When? (What triggers entry, frequency, exit, etc.)
5. Who delivers the services?
6. What are the outcomes (both process-oriented such as action plans and for the service recipient such as improved health)?
7. Who funds this service?

Group may add new columns (or delete existing columns that are not relevant) in the table to tailor the responses desired. For example: What are Best Practice quality markers provided in this service?

Compiler should take all of these responses and compile them into one large table (see example below).

Outputs:
Whole system map approved by group.
Discussion for stakeholders to examine next steps.

Roles:
Compiler requests and compiles answers from each agency/stakeholder
Facilitator works with group to lead discussion about completed whole systems map, choosing from relevant discussion questions below, and/or using tailored discussion questions.

Possible Discussion Questions to Examine Results of a Completed Whole Systems Map:
The facilitator can use any of the following questions (based on the needs of the group and goals of the project) to guide discussion of the whole system map.

1. Do we need to collect quantitative information about anything in our map? For example, data on:
    a. Numbers of children, young people, or families accessing services
    b. Age, gender, ethnicity, and location of those accessing services
    c. Referral and/or access source/s to the service if appropriate
    d. Referral numbers to services by the source of referral where it is a referred service
    e. Average wait times for services where appropriate
    f. Rate of non-attendance
    g. Outcome indicators for services
    h. User evaluation measure/s for services
2. Do we need to move on to other types of system mapping? We may if the group answers "yes" to any of the following:
    a. Are we interested in understanding the pattern, type, distribution, or use of service resources across a continuum of need?
    b. Are we interested in understanding where the key service gaps and constraints are likely to be found?
    c. Are we interested in understanding where there may be duplication of services for the same target audience for the services?
    d. Are we interested in knowing more about the profile of service users – who they are and from where, how they use services, and what happens to them on leaving services?
3. Do we need to move on to costing exercises? We may if the group answers "yes" to any of the following:
    a. Do we need to perform a top-down costing of the whole system to understand where resources are currently being used and to enable us to make plans to move resources from one part of the system to another as well as making cuts to budgets?
    b. Do we need to perform a bottom up (case by case) costing to calculate the total cost of a service or a group of services for one person?
    c. Do we need to perform a service or system costing?
4. If we know how many children/women are accessing our services:
    a. Are there fewer children/women accessing our services than expected?
    b. Is there an under- or over-representation of some groups?
    c. Does the profile of those accessing services reflect local demographics, for example in relation to ethnicity and social disadvantage?
5. Where and how do users access the system?
6. Are there services or supports that are being duplicated across the system and potentially wasteful?
7. Who are the main referring agents across the system? Do patterns of referral and access activity change across the system? Are referrals to services more or less appropriate across the system?
8. Where are the conditions for access to the system most restrictive? Do these points correspond to the most significant waiting lists and service bottlenecks? What appears to be the impact of these constraints on whole system functioning?
9. Are their additional or alternative locations within the system where needs could be met in a more appropriate way (rather than simply fitting support needs into existing services)?
10. Does there appear to be an optimum distribution of staffing and associated resource commitments to needs across the system? What appear to be the main constraints on service development and transformation that derive from the current distribution of resources?
11. Where do the outcomes appear to be strongest within the system? Where do they need to be better?
12. Are services actually meeting the objectives or achieving the outcomes they say they do, or which users actually want?

Evaluation criteria:

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History: Used by X# of Cohort 1 states. Colorado example included below.

References: Whole System mapping & Design (Speech, language and communication needs). By Commissioning Support Programme, February 2011.

Example: Several agencies in Colorado used a whole system map to begin a long-term collaboration with goal of identifying gaps, reducing duplication and implementing policy changes to support care coordination service provision for children and youth with special healthcare needs. 2014.

What happens?	For whom?	Where?	When? (trigger to entry, frequency)	Who delivers?	Outcomes?	Who funds?
HCP Care Coordination (statewide)	All CYSHCN birth-21, no eligibility exclusion criteria based on income, insurance or diagnostic criteria	Resource and referral for CYSHCN offered through all LPHAs; full model of HCP care coordination offered through larger LPHAs (>$15K). Client contacts by phone, home-based and/or community-based	Self-referral; community-based organization referral; provider referral;	Nurse-led care coordination teams within LPHAs	Six-month action plan with family-driven goals	CDPHE contracts with LPHAs using MCH block grant and state general funds
TCHD HCP Care Coordination (Adams, Arapahoe and Douglas counties)	All CYSHCN birth-21, no eligibility exclusion criteria based on income, insurance or diagnostic criteria	Through home visits, health care provider visits, telephone, email and text	By referral from community based agency, self, provider, hospital, schools. Minimum of 1/month contact with client, frequency	Nurse-led care coordination team, includes RNs, RD, LSW and family coordinator	Six-month action plan with family driven goals. Program specifc outcomes: All children will have consistent PCP	CDPHE through MCH/HCP contract with TCHD; no additional funding sources

			based on client need		Families have needed services Familes are satisfied with services Familes provide developmentally age appropriate care	
EPSDT/Healthy Communities Care Coordination (statewide)	All children, youth and pregnant women enrolled in Medicaid and CHP+ - Clients may have secondary insurance to Medicaid (not CHP+) (While the vast majority of clients are on Medicaid and RCCOs don't coordinate care for CHP+, there are children with special health care needs on CHP+ because of the family's overall income level.)	LPHAs and/or local departments of human services; phone	Patient self-referral; RCCO referral; community-based referrals; HCPF new enrollment data/lists	Healthy Communities Family Health Coordinators (Competencies and background determined by the Healthy Communities site in accordance with program contract requirements)	(Family member/self) Identification of children with special health care needs, referral to medical and community resources, monitoring of case and assistance in finding providers, transportation; Educate and outreach to families who are newly enrolled in Medicaid	HCPF and varying matching agency funds
Tri-County Health Department Healthy Communities	Children and youth under age of 20, children enrolled in CHP+, and pregnant women who are eligible and enrolled in Medicaid or CHP Plus.	Tri-County Health Department	At any time. Self-referrals; other TCHD programs; community referrals; provider referrals; RCCO referrals; after approval for Medicaid/CHP Plus. (In many cases, referrals are made to families in the	Our Family Health Coordinators are hired based on their ability to fill our job description and receive training from HCPF on CBMS and Medicaid/CHP Plus application process.	Assure clients are established with a medical home; assist clients to get the most out of their health benefits and understand what their benefits can do for them; refer clients to appropriate community services and	HCPF and general funds from Tri-County Health Department

			process of applying for Medicaid or CHP+ via the Presumptive Eligibility or Certified Application Assistance process.)		other health care providers as needed	
RCCO Care Coordination (statewide)	All children, youth and adults enrolled in Medicaid AND enrolled in a RCCO	Practice-based; RCCO-based); and/or community-based (through contract with the RCCO)	Varies by RCCO region; no standardized process for identification of client with need for care coordination	1 - 3 delivery methods which varies by RCCO region: RCCO; Practice-based; Community based (no standardized competencies for care coordinator)	Reduce KPIs; increase PCMH utilization; connect members to appropriate resources	HCPF
RCCO 3 Colorado Access Care Coordination (Adams, Arapahoe and Douglas counties)	All children, youth and adults enrolled in Medicaid AND attributed to RCCO region 3		Health risk assessment (try to complete with 100% of clients); provider referral; claim case finding	Varies by setting;	Reduce KPIs; increase PCMH utilization; connect members to appropriate resources and reduce costs.	HCPF