Department of Housing & Human Services

Housing Office: 2525 13th Street, Suite 204 • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax: 720.564.2283
Human Services: Boulder Office • 3460 Broadway • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax 303.441.1523
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BOULDER COUNTY HOUSING & HUMAN SERVICES

DHHS Advisory Committee
MONTHLY MEETING
Tuesday, February 23, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Agenda

1) **Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)**

2) **Review and approval of minutes from January 26, 2016 DHHS Advisory Committee with Board of County Commissioners meeting (3:33 p.m. – 3:35 p.m.)**

3) **Discussion Item—2016 Community of Hope Report and Committee's opportunities for support of outreach —Jim Williams (3:35 p.m. – 3:55 p.m.)**

4) **Discussion Item—Debrief from the meeting with the Board of County Commissioners—Angela Lanci-Macris (3:55 p.m. – 4:15 p.m.)**
   i. Reflections from the Committee members
   ii. Working toward a July 2016 follow up meeting, start to discuss how we move toward specific budget priorities for DHHS in our project areas/strategic focus as a committee.

**What do we want to accomplish as a committee in the next 4 months?

   a) Affordable Housing Crisis—**Betsey Martens and Robin Bohannan**
      i. 10 Year Plan to Address Homelessness alignment
      ii. Dream Big collective impact

   b) Early childhood supports—**Bobbie Watson**

   c) Family Resource Model—**Suzanne Crawford**

d) Integrated Health Care Supports/Community Health and Well-Being—**Jeff Zayach, Simon Smith, Laura Kinder**
   i. Community work with hospitals and clinics
   ii. Medicaid service expansion
   iii. Public Health Improvement Plan and DHHS priority alignment

e) Inclusivity—**Elvira Ramos and Dalia Dorta**

5) Deeper Dives into the project areas (4:15 p.m. – 4:45 p.m.)—Angela

a) Committee members to provide updates and discuss the next level of work and progress needed in these areas

i. **Family Resource Model—Suzanne Crawford, Melissa Frank-Williams (30 minutes)**

6) Committee recruitment (4:45 p.m. – 4:55 p.m.)—Chris Campbell

a) Follow up from email and thoughts about additional members

7) Upcoming Meetings—

a) **March Agenda Items:**
   a. Deeper dives into:
      (a) Early Childhood work
      (b) Integrated Health Care Supports/Community Health and Wellbeing

Next Meeting is Tuesday, March 29, 2015, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder.

8) Adjourn

Access to current and past packets for the Boulder County Housing Authority Board, the Boulder County Human Services Board, and the Housing & Human Services Advisory Committee can be found by clicking on the links below:
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Boulder County Human Services Board Packets

Housing & Human Services Advisory Committee Packets

**Note that full DHHS financials are in the associated links to the board packets above.

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BOULDER COUNTY HOUSING & HUMAN SERVICES

Human Services Board/Housing Authority Board/
DHHS Advisory Committee
JOINT MEETING
Tuesday, January 26, 2016, 3:00 – 4:15 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Commissioners Jones, Gardner, and Domenico Present

Members Present: Laura Kinder, Jeff Zayach, Robin Bohannan, Pat Heinz-Pribyl, Dalia Dorta, Betsey Martens, Simon Smith, Elvira Ramos

Staff Present: Frank Alexander, Angela Lanci-Macris, Susan Grutzmacher, Daphne McCabe, Melissa Frank-Williams, Jim Williams, Maggie Crosswy

Committee Action Items:

1. **Action Item—The next joint meeting between the Commissioners and the Advisory Committee will be scheduled for July 2016**

Detailed Minutes

1. **Call to order—Elise Jones, Chair, Boulder County Board of County Commissioners (3:00 p.m. – 3:03 p.m.)**

2. **Review and approval of today's agenda (3:03 p.m. – 3:05 p.m.)**

Approved as written

3. **Recognition of Dan Thomas and his 13 years of service and impact to the Boulder County Department of Housing and Human Services and the Boulder County community—Chair Jones, (3:05 p.m. – 3:10 p.m.)**

4. **Discussion Item:** How can the Advisory Committee, working with the County Commissioners, most effectively help actualize and align the community's and the DHHS's Vision/Mission? **Advisory Committee Members and the Board of County Commissioners (3:10 p.m. – 4:15 p.m.)**

Setting the stage for the conversation—Jeff Zayach, Public Health Director and Committee Member (3:10-3:15)

- Collective work between the Public Health, Community Services, Housing & Human Services and Community-based partners, its impact, and its future
- Impact of the Committee's work on the community and the Community of Hope Framework

Jeff Zayach—there is a significant and serious commitment from this Committee to support our community. I want to thank the Commissioners for their support in all of this group's work. We are working together in a very deep way and are working toward a vision for the community.

The graphic projected before you tells the tale of where we are at as a committee. Intersecting circles overlap in the pillars of self-sufficiency and the social determinants of health. You will hear of examples of directly where we work together, and were we intersect in our work in our community. The DHHS/CS/PH BHAG is a significant goal that we are working toward:

"Within 10 years, we will transform the health and well-being of our community by shifting programming and funding upstream into prevention oriented and consumer driven cross-sector solutions that improve outcomes across the lifespan and significantly reduce high-cost institutional interventions within a social determinants of health framework."

<u>Discussion Topics</u>

a) Affordable Housing Crisis—**Betsey Martens and Robin Bohannan (3:15-3:25)**
   i. 10 Year Plan to Address Homelessness alignment
   ii. Dream Big collective impact

Betsey Martens—housing stability, can already see the potential for this group to work together to transform how we approach the housing crisis. We are really in a pickle in Boulder County. Projects are getting harder and harder to pencil and the demand is growing by the quarter—increases of rent are going up quarterly.

Now is the time to lay down the silos between municipalities, focus on strong regional effort. What will be the glue to hold this effort together? We have some nice overlap in the housing arena (10 year plan board, HOME consortium, housing authorities).

We've come to realize that there is strong expertise within the county and we plan to leverage this expertise to come up with a regional plan. 10 Year Plan Board is a strong model for the larger, regional plan—strong strategic plan, goals and outcomes on the table.

Results of the Lee Hill project—90% retention rate after the first year. Number of complaints from the neighborhood is zero after the first year! 6 folks from the neighborhood group have offered to help guide the next project on the horizon.

We will look to the Commissioners to champion the plan. Community engagement has become very difficult—has come to a peak. Should spend some money to go back to the hard fought projects and survey the neighbors for their input. How do we use the contentious projects to support future projects.

Dream Big—How do we support a child outside of school, in the time that they are in the community and with their family?

Robin B—the community committee represents DHHS vision to be connected with community and to, in essence, turn the agency over to the community. This has accelerated the coordination of services—meaningful alignment between the HS Departments (Public Health, Community Services, Public Health), our community partners, and our clients.

b) Early childhood supports—**Bobbie Watson (3:25-3:35)**

This Committee provides the key opportunity for strong collaboration, connection, and aligned strategic planning for the community.

I. Collaboration with DHHS

Common Vision: That Boulder County has the highest quality childcare in Colorado

Common Goals

- strengthen community safety net
- design/implement a robust early childhood plan
- improve access to high quality affordable childcare

Shared outcomes

- Increase childcare capacity
- Increase quality of childcare programs
- Increase % of early childhood professionals with enhanced teaching credentials
- Decreased rate of child maltreatment
- Increase access to services to promote family stability and self-sufficiency

Common Strategies

- ITQA—infant/toddler quality availability for childcare
- Prof Dev
- Collective Impact
- Members of the Advisory Council

II. Collaboration with Public Health

- ABCD project—identify learning barriers very early on and keep kiddos out of the special ED type programs (early intervention type approach).
- ROA—Raising of America Project
- Founding members of the AC
- Jeff Zayach to join the ECCBC Board of Directors

Collaboration with Dream Big

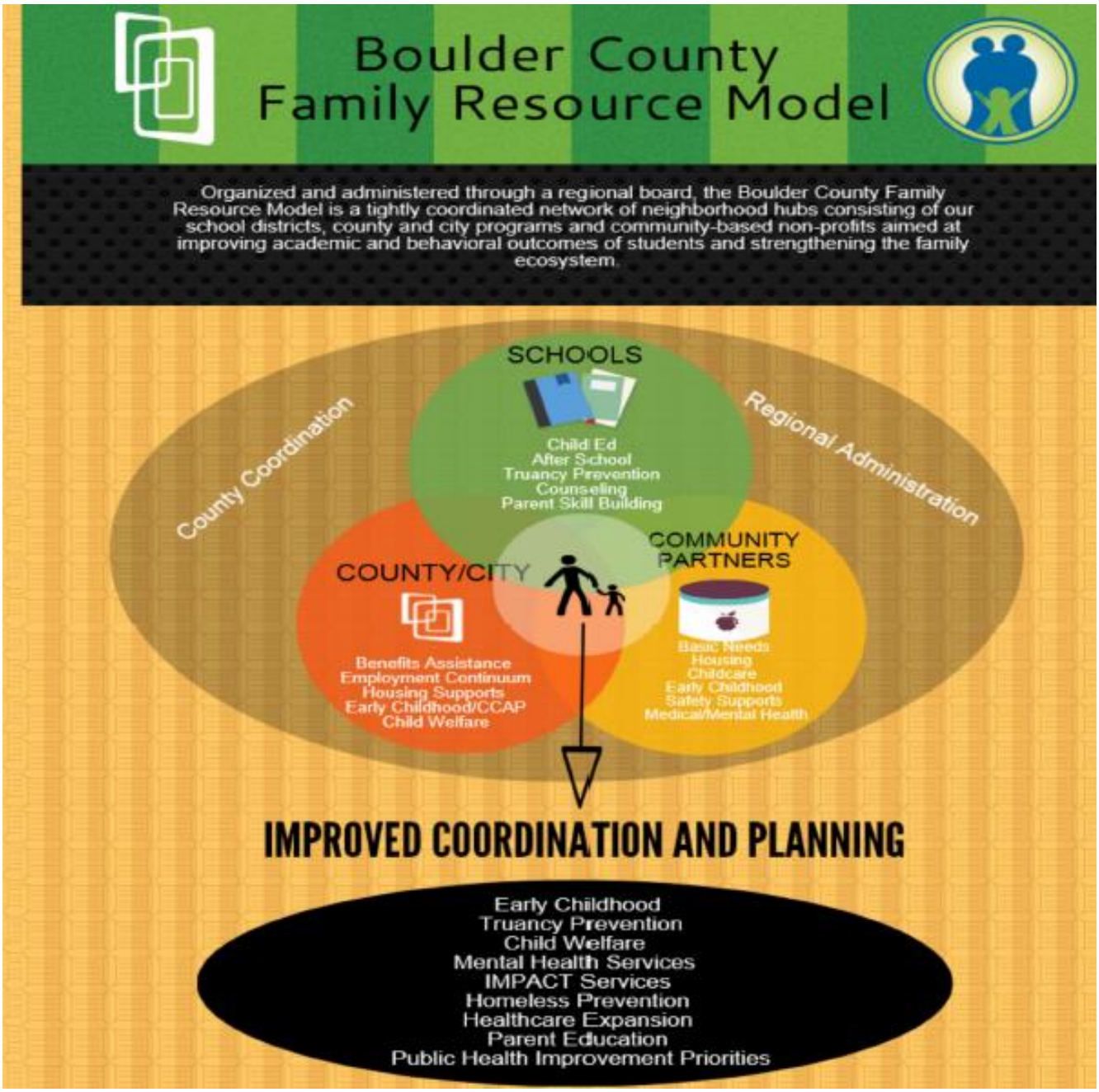
- Use of ECCBC Advisory Council for technical assistance
- Implement strategies to 'move the needle' on school readiness
- Employ current programs

c) Family Resource Model—**Melissa Frank-Williams (3:35-3:45)**

Developing progressive and visionary programming has been a huge asset in the community. Thanks to the Commissioners for this support.

The Family Resource Model represents a comprehensive model for holistic family supports

Frank—The key to the committee work and the community work in general has been how we learn from each other across the systems to knit a seamless framework (common framework).


Boulder County
Family Resource Model
Organized and administered through a regional board, the Boulder County Family Resource Model is a tightly coordinated network of neighborhood hubs consisting of our school districts, county and city programs and community-based non-profits aimed at improving academic and behavioral outcomes of students and strengthening the family ecosystem.
SCHOOLS
Child Ed
After School
Truancy Prevention
Counseling
Parent Skill Building
County Coordination
Regional Administration
COUNTY/CITY
Benefits Assistance
Employment Continuum
Housing Supports
Early Childhood/CCAP
Child Welfare
COMMUNITY PARTNERS
Basic Needs
Housing
Childcare
Early Childhood
Safety Supports
Medical/Mental Health
IMPROVED COORDINATION AND PLANNING
Early Childhood
Truancy Prevention
Child Welfare
Mental Health Services
IMPACT Services
Homeless Prevention
Healthcare Expansion
Parent Education
Public Health Improvement Priorities

d) Integrated Health Care Supports/Community Health and Well-Being—**Jeff Zayach, Simon Smith, Laura Kinder (3:45-3:55)**
   i. Community work with hospitals and clinics
   ii. Medicaid service expansion
   iii. Public Health Improvement Plan and DHHS priority alignment

Laura Kinder—My perspective comes from working at Longmont United Hospital (LUH) and working closely with the community on the Medicaid expansion. Working with DHHS staff, we've worked hard to enroll folks in healthcare coverage. LUH has seen a big impact from the enrollment (60% of patients are federally insured and 20% are charity care). According to the American Hospital Association US hospitals provided $42.8 Billion in uncompensated care in 2014 compared to $46 Billion in 2013. Increase saw the effects of ACA. Access to care is a signification goal for the safety net hospitals.

Simon Smith—the safety net and the providers are truly strong and inspiring. The County has really led the way in this area along with the community partners—investments, partnerships.

Goal has been to truly align strategies for targeting populations and specialty care. Mental health care, substance abuse has been an area of focus. Deep integration work has been a focus—early intervention type approach. Future work: targeted data sharing, targeting interventions, all focused on the Social Determinants of Health—innovative work and audacious goals. Speaks toward a longer-term strategy alignment for payment reform and systems integration—upstream investment yielding downstream savings.

Jeff Zayach—we are the only in the state that have looked at connecting health services to the social determinants of health. PHIP—how do we make sure that we are leveraging and supporting each other's work across departments—Famer's market and School District connections.

e) Inclusivity—**Elvira Ramos and Dalia Dorta (3:55-4:05)**

Elvira Ramos—One of our roles on the committee is to keep inclusivity at the forefront of discussions. Issue of staff retention, promotion and recruitment of folks of color, folks who speak multiple languages, and folks who are from underrepresented populations is a significant one across the community. How do we recruit and promote these folks here. The Community Foundation has taken the lead in this area. Hallmark in our community—Leadership Fellows Program—5 years into the program and 30 fellows that have gone through the program. Commissioners have supported this work, graciously.

Shifting gears, looking at the community from a prevention lens, how do we engage communities in early interventions to ensure their wellbeing? We are working with the single homeless population through collaborative—2 years into the homeless collaboration. Also working with the homeless veterans community.

Dalia—My goal as a Latina is to look at the Latino(a) community as the solution—we need to continue to work on being a welcoming community.

5. **Questions and reflections from the Commissioners and next steps (4:05 p.m. - 4:15 p.m.)**

Cindy—seen the evolution of the Committee and the community work. The outcomes of this shared has been amazing.

Deb—this kind of update is really valuable—I would recommend that we meet as a joint committee more often. Inclusivity should be included as a lens in the pillars/community of hope. Additionally, would like to see where community justice system fits into the pillars/strategic work by the department.

Elise—how do we circle back and talk to folks about successes. How do we get more ripples across the state in the incredible, cutting-edge work in this community?

Frank—Follow up meeting, specific asks in the regional planning framework.

6. **Adjourn**

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Business Resolutions:

BCHA Resolution No. 2015-23: Resolution for the purpose of approving the 2016 Annual Plan mandated by the United States Department of Housing and Urban Development (HUD) for Boulder County Housing Authority

BCHA Resolution No. 2015-24: A Resolution of the Board of Commissioners of the Housing Authority of the County of Boulder, Colorado (the "Authority") authorizing the execution and delivery of its multifamily housing revenue note (kestrel project) series 2016 (the "Note") in a principal amount not to exceed $60,000,000; ratifying certain actions heretofore taken; approving the forms and authorizing the execution and delivery by the Authority of the Note, a borrower loan agreement, a funding loan agreement, an assignment of deed of trust and loan documents and a tax regulatory agreement; authorizing the execution and delivery by the Authority of any and all necessary closing documents; repealing action heretofore taken in conflict herewith; and authorizing officials of the authority to do all other things necessary or advisable to complete the transaction authorized in this Resolution.

BCHA Resolution No. 2015-25: A Resolution summarizing expenditures and revenues, adopting a Resolution to approve the Budget for the Boulder County Housing Authority for the Calendar Year beginning the 1st day of January 2016, and ending the last day of December 2016.

BCHA Resolution No. 2015-26: A Resolution summarizing capital expenditures. Adopting a Resolution to approve the Budget for the Boulder County Housing Authority, for the calendar year beginning the 1st day of January 2016, and ending the last day of December 2016.

BCHA Resolution No. 2016-01: A Resolution concerning Project Based Vouchers in the Kestrel Affordable Housing Development in Louisville, CO.

BCHA Resolution No. 2016-02: A Resolution Amending the Boulder County Housing Authority Section 8 Administrative Plan.

BCHA Resolution No. 2016-03: Resolutions of the Housing Authority of the County of Boulder, Colorado, a Public Body, Corporate and Politic, concerning the Kestrel Development at 245 N. 96th Street in Louisville, CO (the "Sponsor Consent")

BCHA Executed Contracts
November 30, 2015 - January 19, 2016

Date Executed	Contractor Name	Description	Contract Amount (*not to exceed)	
11/30/15	Group14 Engineering	meter reading training at JC	$ 1,320.00	
12/01/15	Community Food Share	food for Casa de la Esperanza and Family Self-Sufficiency	$ 250.00	
12/03/15	Colorado Hazard Control, LLC	Weatherization/Rehab/Maintenance	$ 250,000.00	*
12/03/15	Eide Bailly	BCHA audit services	$ 70,350.00	
12/03/15	Freedom Fire Protection	Weatherization/Rehab/Maintenance	$ 250,000.00	*

12/03/15	H&M Mechanical	Weatherization/Rehab/Maintenance	$ 250,000.00	*
12/03/15	Jim Black Construction	Weatherization/Rehab/Maintenance	$ 250,000.00	*
12/03/15	Stonebridge Builders, LLC	Weatherization/Rehab/Maintenance	$ 250,000.00	*
12/08/15	DH Pace Company, Inc.	Provide and Install Locksets, Deadbolts, Latches, and Cores at Regal Square and Hillside (RFP 6340-15)	$ 36,176.38	
12/08/15	MAC Electric	Weatherization/Rehab/Maintenance	$ 250,000.00	*
12/08/15	Morrow Holdings LLC dba Risk Removal LLC	Weatherization/Rehab/Maintenance	$ 250,000.00	*
12/08/15	Sullivan Septic, LLC	Weatherization/Rehab/Maintenance	$ 250,000.00	*
12/10/15	AA Plumbing	Weatherization/Rehab/Maintenance	$ 250,000.00	*
12/10/15	Goldsmith Painting	Weatherization/Rehab/Maintenance	$ 250,000.00	*
12/17/15	BCHA	Revenue: Housing Stabilization Program (BCHA & HHS IGA) third amendment/renewal	$ 3,500,000.00	*
12/17/15	BCHA	Revenue: EnergySmart Plus IGA	$ 224,000.00	*
12/17/15	Gapter Septic Systems & Excavating, LLC	Weatherization/Rehab/Maintenance	$ 250,000.00	*
12/17/15	RITECorp	Weatherization/Rehab/Maintenance	$ 250,000.00	*
12/17/15	Sprague Pest Solutions	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/05/16	Accent Painting	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/05/16	Bradley Stedman	financial consulting	$ 10,000.00	
01/05/16	Excel Electric	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/05/16	Glenn Allen Carpets dba Fashion Carpet & Tile	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/05/16	Humphries Poli Architects	Add service to Kestrel contract	$ 57,835.00	
01/05/16	KJ Builders	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/05/16	Lakewood Plumbing	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/05/16	Mike's Specialties	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/05/16	RapidDry	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/05/16	The Little Guy Carpet and Upholstery Cleaner	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/07/16	A&H Roofing LLC	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/07/16	Colorado Energy Office	Revenue: Contract Amendment: Weatherization Assistance Program	$ 2,055,530.55	
01/07/16	Innovate Electric, Inc.	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/12/16	A-Ability Glass	glass repair (SOQ 6349-15)	$ 100,000.00	*
01/12/16	B&M Roofing	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/12/16	Beverly Hills Glass	glass repair (SOQ 6349-15)	$ 100,000.00	*
01/12/16	Columbine Appliances	appliance repair (SOQ 6351-15)	$ 100,000.00	*
01/12/16	Hillcrest Glass	glass repair (SOQ 6349-15)	$ 100,000.00	*
01/12/16	Hudson Integrative	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/12/16	RDS Environmental, Inc.	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/12/16	SERVPRO	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/13/16	Colorado Housing and Finance Authority (CHFA)	Revenue: NFMC Round 9 Grant Extension (from 12/31/15 to 6/30/16)	$ 10,550.00	
01/14/16	AAA Electric	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/14/16	Colorado Thermal Coatings	Weatherization/Rehab/Maintenance	$ 250,000.00	*

01/14/16	New Windows for America	Weatherization/Rehab/Maintenance	$ 250,000.00	*
01/19/16	Advanced Restaurant Solutions	Josephine Commons commercial kitchen quarterly maintenance	$ 2,999.00	*

Human Services Executed Contracts
November 30, 2015 - January 19, 2016

Date Executed	Contractor Name	Description	Contract Amount (*not to exceed)	
11/30/15	Margaret (Maggie) Tibbetts	home studies for foster/kin certification	$ 24,999.00	*
12/03/15	Boulder County AIDS Project (BCAP)	Task Order 2016-01: General Operating	$ 61,800.00	
12/03/15	Beth Risdon	Contract Amendment: home studies for foster/kin certification ($7001 increase)	$ 32,000.00	*
12/03/15	HOPE	2016 General Operating award	$ 5,150.00	
12/03/15	TLC Learning Center	2016 General Operating award	$ 50,000.00	
12/03/15	Wild Plum Center	2016 General Operating award	$ 63,036.00	
12/05/15	Aspen Grove Community Preschool	2016 General Operating award	$ 10,000.00	
12/08/15	Blue Sky Bridge	Task Order 2016-01: General Operating	$ 32,960.00	
12/08/15	Sister Carmen Community Center	Task Order 2015-04: Amendment to extend CCR contract from 6/30/15 to 12/31/15 and to increase contract by $13,266 (total contract of $50,066)	$ 13,266.00	
12/08/15	Sister Carmen Community Center	Task Order 2016-03: Family Resource Center	$ 200,327.00	
12/08/15	Sister Carmen Community Center	Task Order 2016-04: Nurturing Parenting classes for Lafayette-area and CCR referred families	$ 50,000.00	
12/08/15	SPAN	Task Order 2016-02: General Operating	$ 154,500.00	
12/09/15	Agape Family Services	2016 General Operating award	$ 10,000.00	
12/09/15	Lyons Emergency Assistance Fund (CNDC fiscal agent)	2016 General Operating award	$ 10,000.00	
12/10/15	Attention Homes	Task Order 2016-01: General Operating	$ 45,320.00	
12/10/15	Sister Carmen Community Center	Task Order 2016-01: General Operating	$ 65,000.00	
12/13/15	Roland Process Service & Investigations, LLC	process service	$ 14,999.00	*
12/16/15	Llynnette Osorio	home studies for foster/kin certification	$ 24,999.00	*
12/17/15	Acorn School	2016 General Operating award	$ 25,000.00	
12/17/15	Animal Assisted Therapy Programs of Colorado (AATPC)	therapeutic services (Core)	$ 50,000.00	*
12/17/15	BCHA	Housing Stabilization Program (BCHA & HHS IGA) third amendment/renewal	$ 3,500,000.00	*
12/17/15	BCHA	EnergySmart Plus IGA	$ 224,000.00	*
12/17/15	Boulder Day Nursery	Task Order 2016-01: General Operating	$ 37,080.00	
12/17/15	Boulder Shelter for the Homeless	Task Order 2016-01: General Operating ($200k) Task Order 2016-02: Emergency Services ($75k) Task Order 2016-03: Benefits Acquisition ($50k)	$ 325,000.00	
12/17/15	City of Boulder	Revenue: Child Care Resource & Referral program	$ 15,000.00	
12/17/15	Community Food Share	Task Order 2016-01: General Operating	$ 74,160.00	
12/17/15	Dental Aid	Task Order 2016-01: General Operating	$ 186,574.00	

12/17/15	SPAN	Task Order 2016-01: HSP ($45k) Task Order 2016-03: Emerg Svcs ($40k)	$ 85,000.00	*
12/17/15	Youth Villages	residential treatment services (Tennessee)	$ 94,000.00	*
12/20/15	Children's House Preschool	2016 General Operating award	$ 12,500.00	
12/22/15	Tennyson Center for Children	Community-Based Services	$ 2,999.00	*
12/24/15	Regina Gray (Reggie Gray)	Clinical Supervision groups for CMCO and CS case managers(TANF)	$ 14,550.00	*
12/25/15	Corporate Psychological Services	psychological services (monthly support and learning groups for staff)	$ 4,999.00	*
01/04/16	Deloitte Consulting	Contract Amendment & Extension: increase $15,550 for support services	$ 15,550.00	
01/05/16	Beth Risdon	home studies for foster/kin certification	$ 24,999.00	*
01/05/16	Center for People with Disabilities	Task Order 2016-01: General Operating	$ 181,023.00	
01/05/16	City of Longmont	2016 Nurturing Parenting and Abriendo Puertas services	$ 70,200.00	
01/05/16	EFAA	Task Order 2016-01: Housing Stabilization Program ($95,000) Task Order 2016-02: General Operating (HSF) ($125,000)	$ 220,000.00	*
01/05/16	Mental Health Partners	Task Order 2016-03: Senior Reach	$ 90,000.00	*
01/05/16	OUR Center	Task Order 2016-01: HSP ($95,000); Task Order 2016-02: General Op ($160,000)	$ 255,000.00	*
01/05/16	Safe Shelter of St. Vrain Valley	Task Order 2016-01: General Operating	$ 100,940.00	
01/05/16	Sister Carmen Community Center	Task Order 2016-02: HSP	$ 95,000.00	*
01/05/16	Voices for Children - CASA	2016 General Operating award	$ 31,930.00	
01/05/16	YWCA	Task Order 2016-01: General Operating	$ 159,650.00	
01/06/16	Community Services/Community Justice Services	JAC Coordinator	$ 23,500.00	
01/07/16	BOHO	Master Contract; Task Order 2016-01: General Operating ($10,000); Task Order 2016-02 ($20,00)	$ 30,000.00	
01/07/16	Bridge House	Master Contract and Task Order 2016-01 HSP	$ 30,000.00	*
01/07/16	Children First of the Rockies	2016 General Operating award	$ 70,994.00	
01/07/16	Mother House	2016 General Operating award	$ 10,000.00	
01/07/16	Patrice Langan	foster care training assistance	$ 6,000.00	
01/07/16	Safe Shelter of St. Vrain Valley	Task Order 2016-02: Housing Stabilization Program	$ 45,000.00	
01/07/16	Victor H. Cordero	evaluation services (Core)	$ 20,000.00	*
01/12/16	Centers of Medicare and Medicaid Services	Grant Application: Connecting Kids to Coverage	$ 997,369.83	
01/12/16	ECCBC	Task Order 2016-02: General Operating	$ 80,000.00	
01/14/16	Mental Health Partners	Task Order 2016-02: Community-Based Services	$ 224,526.00	

Department of Housing & Human Services

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BOULDER COUNTY HOUSING & HUMAN SERVICES

DHHS Advisory Committee
MONTHLY MEETING
Tuesday, March 29, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Agenda

1) **Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)**

2) **Review and approval of minutes from February 23, 2016 DHHS Advisory Committee Meeting (3:33 p.m. – 3:35 p.m.)**

3) **Discussion of 2016-2017 DHHS Strategic initiatives and linkages to the Committee's work plan—Frank Alexander and Angela Lanci-Macris (3:33 p.m. – 3:55 p.m.)**
   a) 2016 DHHS Strategic Initiatives
      a. Lens: DHHS Service Continuum
         (a) Continue to move programming and funding upstream to prevention oriented solutions
         (b) Focus on early engagement and assessment linked to preventative services and supportive care
         (c) Integrated Services Continuum
            (i) Low Risk, Low Involvement

      b. 4 core priority areas for 2016
         (a) Integrated Services Delivery Model of Care (ISDMC)
         (b) Kestrel Development Project
         (c) Staffing, Retention and Development
         (d) Integrated Data

      c. Key linkages to HHSAC Priorities and narrowing of HHSAC priorities

(a) Family Resource Model
    (i) Early Childhood Space
(b) Affordable Housing Initiatives
(c) Integrated Health Care Supports/Community Health and Wellbeing
(d) Inclusivity

4) Deeper Dives into the project areas (3:55 p.m. – 4:35 p.m.)

a) Committee members to provide updates and discuss the next level of work and progress needed in these areas

i. **Early Childhood Work—Bobbie Watson and Susan Grutzmacher (40 minutes)**

5) Discussion—Process for the next few months for focusing on narrowed priority areas and linkages to DHHS strategic work—Frank (4:35 – 5:00 p.m.)

6) Upcoming Meetings—

a) **April Agenda Items:**

a. Deeper dives into:

(a) Integrated Health Care Supports/Community Health and Wellbeing

Next Meeting is Tuesday, April 26, 2015, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder.

7) Adjourn

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DHHS Advisory Committee
MONTHLY MEETING
Tuesday, February 23, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Committee Members Present: Pat Heinz-Pribyl, Laura Kinder, Suzanne Crawford, Bobbie Watson, Jeff Zayach, Dalia Dorta, Betsey Martens

DHHS Staff Present: Angela Lanci-Macris, Whitney Wilcox, Melissa Frank-Williams, Jim Williams, Maggie Crosswy, Chris Campbell

Committee Action Items

1. **Action Item: Community of Hope report presentation/roadshow**—The DHHS Communications team will work to schedule these with our partners in the coming months, including agencies represented in the Committee—ECCBC, Longmont United, Community Foundation, Boulder Housing Partners

2. **Action Item**: Boulder County Legislative Agenda update from the Commissioner's office. Megan Davis, of the Policy Team will present at the March 2016 meeting on the 2016 legislative agenda.

3. **Action Item: Additional areas of focus/work for the next 4 months**—Committee members will send additional thoughts and ideas to Chris Campbell for compilation (see minutes for details).

4. **Action Item: Committee Recruitment**—members will send additional ideas on recruitment to Chris Campbell for compilation.

Detailed Minutes

1) Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)

Approved as written

2) Review and approval of minutes from January 26, 2016 DHHS Advisory Committee with Board of County Commissioners meeting (3:33 p.m. – 3:35 p.m.)

Approved as written

3) Discussion Item—2016 Community of Hope Report and Committee's opportunities for support of outreach —Jim Williams (3:35 p.m. – 3:55 p.m.)

Jim Williams—this document evolved much more into a community report as we went. We are grateful for the committee's input in shaping report.

The interlocking circles diagram: this forms the basis of the community report. The concept is that all of the pillars intersect in many ways and we are starting to look at how we are providing services across the traditional boundaries.

Photos are of our client families. Lots of data and research have gone into the report along with community partner snapshots. Integrated service delivery, prevention focus and key partnerships in the community are key areas of focus for each of the pillar areas.

It should be noted that environmental health will now be added to the circle graphic—key pillar for the community. We are developing an executive summary around 10 pages for the report and translating that to Spanish.

Bobbie—Could you do something similar TRENDS Report roadshow? You would get wonderful community participation in those presentations. Will DHHS be doing this? Jim—yes, that is the plan—this takes the TRENDS report a step further discussing what we are doing in the community.

4) Discussion Item—Debrief from the meeting with the Board of County Commissioners—Angela Lanci-Macris (3:55 p.m. – 4:15 p.m.)

Angela—on behalf of Frank and the staff, thank you for the incredible meeting the past month.

i. Reflections from the Committee members

Betsey—went well. There has been great follow up since the meeting. In the affordable housing arena, there has been some strong follow up from the Commissioners—evidence-driven, after action study for

example. They reached out to Betsey to get this information. Frank and I presented to the Consortium of Cities and the group was very engaged. Every elected body in the county now wants this presentation.

Pat—as a new member, it was very helpful for information and it is very obvious that these agencies work together. They are very receptive of the information and saw the integrated nature of the work.

Angela—the meeting really connected of the dots between the work that we are doing and the face of the work. Also, the coordination and integration came to the forefront. We should look for more of these opportunities.

Laura—validation on all levels and the opportunity to provide input to policy makers was very important.

ii. Working toward a July 2016 follow up meeting, start to discuss how we move toward specific budget priorities for DHHS in our project areas/strategic focus as a committee.

**What do we want to accomplish as a committee in the next 4 months?

What are areas we can focus on, strategic focus for our committee? What would we want to work toward between now and July?

Betsey—Worthy Cause is do up soon. We should focus on that area.

Bobbie—one thing that will impact ECCBC, huge expansion of federal dollars that will come to an end. Focused on quality. December of 2017 post race to the top money will sunset. How do we maintain that presence?

Betsey—Regional Housing Strategy draft around this time—Work that is kicking off with the key housing partners in the county.

Suzanne—support of the FRM framework pilot and model moving forward.

Jeff—LARC (Long Acting Reversible Contraception) funding is pretty set but the legislature has to approve it in the long bill. Should have plenty information by then. There will be a funding shortage in this area. ABCD work and support from Public Health and ECCBC could be a focus as well.

Jeff—partnership with SVVSD, looking toward a family resource center model. Longmont FRC model should have significant progress. Working with OUR Center, City of Longmont, and SVVSD.

Betsey—integrated plan and where are the risks. Existing service delivery and where there funding gaps are starting to appear.

Bobbie—minimum wage/living wage issue. Do we want to look at this? BOCC supports expanded parental leave, would they want to focus on wages?

Laura—would like to shift the conversation to healthcare access now that health coverage has been addressed. Hospital provider fee support at the state/legislative level. Would like to ask for support here.

Jim W—inclusivity—there is a lot of interest in making sure that we are looking at cultural competency in services and our own staffing model. Next steps here is to identify key staff to lead this project.

Angela—in preparation for this, what should we focus on?:

- Community of Hope Roadshows
- Affordable housing issue and support for the Twin Lakes project
- Betsey: We should have Mark Ruzzin and Megan Davis come to the next meeting and present the legislative agenda.

Committee members will send additional thoughts on areas that we can focus on for working with the County Commissioners. They will be collected and added to the minutes and for the next meeting.

a) Affordable Housing Crisis—**Betsey Martens and Robin Bohannan**
   i. 10 Year Plan to Address Homelessness alignment
   ii. Dream Big collective impact

b) Early childhood supports—**Bobbie Watson**

c) Family Resource Model—**Suzanne Crawford**

d) Integrated Health Care Supports/Community Health and Well-Being—**Jeff Zayach, Simon Smith, Laura Kinder**
   i. Community work with hospitals and clinics
   ii. Medicaid service expansion
   iii. Public Health Improvement Plan and DHHS priority alignment

e) Inclusivity—**Elvira Ramos and Dalia Dorta**

5) Deeper Dives into the project areas (4:15 p.m. – 4:45 p.m.)—Angela

a) Committee members to provide updates and discuss the next level of work and progress needed in these areas
   i. **Family Resource Model—Suzanne Crawford, Melissa Frank-Williams (30 minutes)**

Melissa Frank-Williams: How can we best leverage resources to see stronger outcomes? How can we best use the robust data that we are collecting to achieve better outcomes. These are some questions that the committee should consider.

A vision was created in 2010 when the Temporary Human Services Safety Net was passed –vision: "create a coordinated, county-wide system that strengthens families and communities."

Suzanne—Sister Carmen's evolution: when I first started in 2005, we were doing 3 boxes of food per year, to providing millions of dollars in resources to families in the community. We wanted to truly help folks versus a band aid approach. 2007/2008 how can we best support families. Looked into the Family

Resource Center model. Piloted a case management model in this area and started expanding that. Then focused on strengths-based case management model and then went toward family development type model. Looked at other models in California (site visits) and really saw how the model can work well. The model that we have in Boulder County is one that they are doing statewide.

Betsey—family resource center versus family resource school? What is the difference? Melissa—we have worked with the City of Boulder Family Resource School. These models are very similar and complementary. Coordination between the two is part of the continued work and what has brought the Family Resource Model to the fore.

Given the overlap in our FRC and FRS models, combined with opportunities to further strengthen linkages to our public schools and community based service providers, Boulder County Housing and Human Services (BCDHHS), proposes a Boulder County Family Resource Model which provides a holistic framework by which to organize key resources, programs, and stakeholders in achieving optimal family and child outcomes.

Angela—the concept of this family resource model is now ready to be shared with the Community. We've met with the Dream Big Committee and are meeting with the SVVSD and the City of Boulder. Folks will be hearing more about this in the coming months about how we are going to actualize this model. The conversations will start deepening around the regional steering committee, the local area collaboratives, etc.

Comments from the Committee:
Laura—who are the staff? Are they social workers, who are the people on the ground? Suzanne—yes, they are social workers and are credentialed in this work. We are exploring qualifications but the model is flexible to meet the need.

Bobbie—What percent of Suzanne's staff are bi-lingual and bi-cultural? Whitney, we are leveraging inclusive services from across the county to meet the need—strength of the model.

Dalia—in general, how do we measure outcomes and quality of service? Self-sufficiency matrix, survey data, and quality standards are all outcome measurement tools.

Betsey—from a Dream Big perspective, give us an example of how this would work on the ground? Whitney, they would fold in under this umbrella and continue their work. I have a dream model has an extensive, long-term focus and this is unique. We would need to ensure that we are not duplicating and ensure coordination—complementary services. Dream Big could cover some folks and other resources could be applied to other children and families.

Jeff—where would these conversations happen? Melissa—Regional board would agree to some absolutes and then look at how to best ensure coordination working with the local area collaborative.

6) **Committee recruitment (4:45 p.m. – 4:55 p.m.)—Chris Campbell**
   a) Follow up from email and thoughts about additional members

Bobbie—what is the charge and the goal of the committee? This could inform membership. Jim—Frank has said this before, we hope to continue to move the administration of the department more to the community-at the community-level, across the spectrum.

Jeff—Safety Pillar? Don't see a lot of representation here. Community Justice Safety Board presentation could be helpful.

Action Item: Committee Recruitment—members will send additional ideas on recruitment to Chris Campbell for compilation.

7) Upcoming Meetings—

a) **March Agenda Items:**

a. Deeper dives into:
   (a) Early Childhood work
   (b) Integrated Health Care Supports/Community Health and Wellbeing
b. Legislative agenda update from Megan Davis, Policy Analyst with the Commissioner's office

Next Meeting is Tuesday, March 29, 2015, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder.

8) Adjourn

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BOULDER COUNTY HOUSING & HUMAN SERVICES

DHHS Advisory Committee
MONTHLY MEETING
Tuesday, April 26, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Agenda

1) **Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)**

2) **Review and approval of minutes from February 23, 2016 DHHS Advisory Committee Meeting (3:33 p.m. – 3:35 p.m.)**

3) **Update from APHSA Local Council Retreat and National Cohort work with DHHS staff—Frank Alexander (3:35 p.m. – 3:45 p.m.)**
   a) Uma Ahluwalia, Montgomery County, MD presentation
   b) Dakota County partnership

4) **Human Services Financial Update—Will Kugel, DHHS Finance Director (3:45 p.m. – 4:15 p.m.)**
   a) 2016 Finances to Date
   b) 2017 Budget Process and Timeline
      i. Colorado Child Care Assistance Program Update
      ii. Child Welfare positions with State Budget

5) **Facilitated Discussion and Feedback on Budget Priorities and Timelines for 2017—and balance of 2016—Frank (4:15 p.m. - 5:00 p.m.)**
   a) Housing and Homelessness
   b) Family Resource Partnerships
   c) Child Care Assistance Program
   d) Contract Partnership priorities

6) **BCDHHS All Staff meeting on June 5th (8:00 a.m. – 3:30 p.m., Plaza Conference Center, Longmont)**
   a) **Members are welcome to attend: additional information to follow

7) **Upcoming Meetings—**
   a) **May 31, 2016, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder**
      i. **Agenda Items: Data presentation from Jason McRoy, Business Operations and Systems Support Division Director**
         a. What are the needs and desires of the Committee?
            (a) Overview of Systems Architecture
            (b) Review of Dashboards

         b. **Eligibility and Enrollment system update—Susan Grutzmacher, Community Support Division Director, Patrick Kelly, Project Director, Case Management and Community Outreach Division**
            (a) Community Support update
            (b) Open Enrollment 3
            (c) New partnership alignments

   b) **June 28th, 2016, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder**
      i. **Agenda Items:**
         a. **Equity survey update—Chris Campbell, Jim Williams, Dalia Dorta, Elvira Ramos**
            (a) Recommendations for next steps and feedback from HHSAC

         b. **Family Resource Partnership Governance update**—Angela Lanci-Macris, Melissa Frank-Williams

   c) **July 26th, 2016, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder**
      i. **Agenda Items:**
         a. Suggestions from Committee Members:

   d) **August 30th, 2016, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder**
      i. **Agenda Items:**
         a. Suggestions from Committee Members:

8) **Adjourn**

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DHHS Advisory Committee
MONTHLY MEETING
Tuesday, March 29, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Detailed Minutes

In attendance:

Committee Members—Pat Heinz Pribyl, Elivira Ramos, Simon Smith, Bobbie Watson, Laura Kinder, Betsey Martens, Jeff Zayach, Suzanne Crawford

DHHS Staff: Frank Alexander, Angela Lanci-Macris, Susan Grutzmacher, Melissa Frank-Williams, Maggie Crosswy, Chris Campbell

1) **Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)**

   Approved as written

2) **Review and approval of minutes from February 23, 2016 DHHS Advisory Committee Meeting (3:33 p.m. – 3:35 p.m.)**

   Approved as written

3) **Discussion of 2016-2017 DHHS Strategic initiatives and linkages to the Committee's work plan—Frank Alexander and Angela Lanci-Macris (3:33 p.m. – 3:55 p.m.)**
   a) 2016 DHHS Strategic Initiatives
      a. Lens: DHHS Service Continuum
         (a) Continue to move programming and funding upstream to prevention oriented solutions

(b) Focus on early engagement and assessment linked to preventative services and supportive care
(c) Integrated Services Continuum
(i) Low Risk, Low Involvement

b. 4 core priority areas for 2016
(a) Integrated Services Delivery Model of Care (ISDMC)
(b) Kestrel Development Project
(c) Staffing, Retention and Development
(d) Integrated Data

c. Key linkages to HHSAC Priorities and narrowing of HHSAC priorities
(a) Family Resource Model
(i) Early Childhood Space
(b) Affordable Housing Initiatives
(c) Integrated Health Care Supports/Community Health and Wellbeing
(d) Inclusivity

See the posted presentation.

DHHS BHAG: the reason we are bringing back up to the committee is we need to continue focus real solutions on how we are going to drive services upstream in to cost effective, low risk, low involvement interventions to reach our collective goals.

Review of the generative model and the Human Service Value Curve: As an agency, it continues to be a challenge to get out of the regulative area and move up the value curve to a more generative approach. Working with our community partners in a more seamless manner is key to moving up the value curve. This is a challenge to this Committee.

Our top DHHS priority is our integrated services delivery model of care and we seek the committee's input on the sectors within this model—healthcare, housing, work supports, etc. How do we create a decentralized continuum of practice that works at all entry points in the community—providing services without creating barriers.

We touched 86,000 individuals with some type of services in 2015. Need to ensure that those are efficient touches. Focusing on client empowered services—client portals, resources are readily available.

Betsey—how is high involvement defined? Frank—multi-agency involvement or multi-touch involvement. We have mapped some individuals who touch us 30 times in a couple month window and who are penetrating multiple systems. These are high risk, high involvement.

We want all of our partners to be financially strong—thus, we need to work together most efficiency as possible. We should use federal dollars first for example versus general fund for foundation funds for example.

Data and Technology Priority—key is the development of a shared infrastructure with our community partners. Case management platforms, client engagement portals, and data analytics are areas of focus for 2016. Client engagement portal is at its early stages but will empower clients to help themselves—self-service, choice of services, sign up for benefits. Much less administrative time is the goal—automated and self-service.

Family resource model in relation to our strategic approach—Angela: we are coordinating safety net services in a much more strategic way—this is the main goal of the family resource framework/model. Outcomes of the framework: a way for us to organize our organizations in a much more cohesive way.

Question for the committee to ponder is how do we best coordinate across our agencies, how do we make sure that our safety net is linked and efficient? See the proposed governance structure in the presentation. Many conversations are happening in many services areas and with key partners—School Districts, Workforce Boulder County, Clinics and Hospitals,

We would like to hear from the Committee on how to better organize and coordinate across the system:

Frank—are there current groups that you are in that can we can better coordinate with?

4) Deeper Dives into the project areas (3:55 p.m. – 4:35 p.m.)

a) Committee members to provide updates and discuss the next level of work and progress needed in these areas

i. **Early Childhood Work—Bobbie Watson and Susan Grutzmacher (40 minutes)**

Bobbie—we took the work plan format and put an early childhood frame.

Current and ongoing funding and collaboration with BoCo DHHS:

1) *ECCBC Operating support*: Boulder County commissioners have supported ECCBC as the backbone organization for the BoCo Early Childhood Collective Impact since 2011. The goal of the CI is to ensure that all young children across BoCo are healthy, valued and thriving and arrive at school ready to learn. In support of this, ECCBC ensures that the CI partners work in mutually reinforcing ways to reduce duplication, competition and inefficiencies across the early childhood system. We hold ourselves accountable to the BoCo community by producing the Early Childhood Indicators Report every 3 years (the next will be in FY 2016).

2) *ECCBC Professional Development*: BoCo DHHS recognizes the critical importance that high quality teachers play in the successful preparation of young children to enter school and be successful in life. To this end, BoCo DHHS matches funds from The Temple Hoyne Buell Foundation to provide financial incentives to early childhood teachers who are taking college coursework to enhance their teaching effectiveness.

3) *Infant Toddler Quality and Availability Grant*: In 2013, ECCBC and BoCo Childcare Assistance Program staff were invited to apply for a pilot program with 3 goals: improve the quality of licensed centers and homes who accept CCAP infants and toddlers; 2) increase the capacity of high quality centers and homes who accept CCAP infants and toddlers and 3) pilot a program to link increased CCAP reimbursement to improved quality. Since 2011, this collaboration has brought over $600,000 of quality and expansion money into Boulder County.

4) Pay for Success: ECCBC in partnership with DHHS and MHP are developing cost models to determine the feasibility of funding an expansion of the Community Infant Project through a pay for success loan.

Expanded collaboration model FY 2016 - 2017

Goal 1: The goal of the Boulder County Early Childhood Model is to have the highest quality licensed childcare available, accessible, and affordable to all families with young children across Boulder County

Objective	Activities + Timeline	People Responsible	Target Completion Date	Deliverables	Notes:
1 Create sustainable Quality Improvement Program leveraging RTTT and ITQA funds	a) Allocate funds for 10 hrs/week for client services manager b) Begin pre-licensing outreach	Bobbie Watson Susan Grutzmacher Danielle Butler	2/1/16 ongoing	0.25FTE Pre-licensing Interface with licensed childcare centers and homes	funding from BoCo and City of Boulder it is hoped that in FY 2017, we can obtain funding (OEC + BoCo) to increase to 1 FTE as this is critical to the recruitment and training of licensed family childcare- many of whom would serve CCAP families
2 Maintenance of childcare data and information	Jan – Dec 2016 This is the kind of supply/capacity data that is needed from this database: ✓ Licensed capacity of all 400 licensed centers and homes ✓ 'real time' slots filled and open ✓ Providers who accept CCAP ✓ # EC providers in BoCo by city (i.e. Boulder, Longmont, unincorporated BoCo) ✓ EC centers and homes reported by licensing level (i.e. 1, 2, 3, 4, 5) ✓ # EC providers by credentials ✓ # EC providers who are bilingual/bicultural ✓ # EC providers who are able to provide care for special needs children ✓ Wages for EC providers by professional level, i.e.	Susan Grutzmacher and team	ongoing	Conversion to Colorado Shines DB ECCBC team working to increase the number of providers on CO Shines	This data is crucial to the ECCBC Indicators Report as well as providing the 'supply' side of the supply-demand model

	directors, Asst Director/Program Director, Infant Nursery Supervisor, Early Childhood teacher, Ass't EC teacher, staff aide ✓ Annual retention rate ✓ % EC staff who receive benefits by position (i.e. free/reduced childcare, health ins, paid vacation, retirement plan, disability ins				
3 Convene a Task Force to look into the wages of early childhood professionals which impacts ability to recruit/retain quality EC staff	Oct 2016: convene an initial working group to: a) Develop a charge to this task force b) Determine membership Feb 2017: convene Wages Task Force a) Develop goals b) Develop work plan Dec 2017: release interim report	Bobbie Watson Susan Grutzmacher	6/30/17	Strategies to recruit, retain high qualified EC work force	Estimated $15,000 to provide support, research and data analysis The Women's Foundation is interested at the $5K level Other funders might include: Rose Community, Temple Hoyne Buell, The Chambers Fund
4 Develop ECE supply demand model	Dec 2016: convene working group to develop ECE supply-demand model Jan 2017 – Apr 2017: assess <u>demand</u> a) develop RFP b) contract for needs assessment c) conduct needs assessment June 2017: assess <u>supply</u>	Bobbie Watson Danielle Butler Susan Grutzmacher and CCR&R staff	12/31/17	Data quantifying: # EC slots (supply) Parent preferences (demand for childcare) Identification of gaps Recommendations to address shortfall	This task force will be staffed by Danielle Butler, the ECCBC Associate Director, who was responsible for the development and maintenance of this data for the government of Australia
Objective	**Activities + Timeline**	**People Responsible**	**Target Completion Date**	**Deliverables**	**Notes:**

5 Improve measures: # of children in high quality EC environs	Ongoing Quality work through RTTT Ongoing CCAP recruitment and support	Bobbie Watson and the ECCBC Quality team Susan Grutzmacher and the CCAP team	ongoing	Increase # of high quality centers and homes Increase # of CCAP providers Increase number of EC professional credentials by level Increase CCAP children in L2 or higher programs Increase L1 to L2 or higher Increase L2 to L3 or higher Pilot contracting for CCAP slots	Funding for Quality work through RTTT ends Dec 2017 DHHS/OEC looking for replacement funding to support ongoing work Would hope that Boulder County would increase their funding support for the ECCBC Quality work begun under the RTTT federal program

Goal 2: Parents of young children in Boulder County will have access to high quality parenting skills workshops

Objective	Activities and Timeline	People Responsible	Target Completion	Deliverables	Notes
1 Increase offerings of workshops and presentation which increase a parents' feeling of competency and understanding of early childhood development	a) brown bag presentations b) Touchpoints training	Bobbie Watson Suzanne Crawford Betsey Martens Julie Van Domelen	ongoing	Presentations will be given to clients and staff to increase their understanding of the importance of the first 5 years in determining a child's life success trajectory	Foundation funding may be available to help support this effort Will look to blend/braid funding with community partners

Bobbie—when I talk about the population I work with, are birth to 5 years, not all at risk/high needs. Families in Boulder County need support to pay for childcare—those who make up to $100k per year often struggle with the cost of child care.

Laura Kinder: when we talk about the providers, who are they. Bobbie: formal licensed childcare and informal childcare. Formal: Licensed centers, head starts, school districts programs. Informal: are nanny's, child care providers.

Betsey: how many kiddos are in childcare? Bobbie/Susan G: this is a data point that is elusive currently. We would like to assess that number in the coming year.

Bobbie: if you look at the pay scales with providers, the lower end (teachers aids) get paid minimum wage. This leads to constant turnover. Issue that is challenging. How do we look at creative ways to recruit and retain high-level staff in this area.

Bobbie: supply/demand model. We have a partial handle on the supply side for child care. What we don't have is a sense of the demand side. Susan G—we do know that most providers have waitlists, so we do have sense on the supply side (not enough).

Frank—when you look at this model, in a sense it similar to housing models, will you be looking at creative solutions that include the capital investment side that would allow for more resources in quality/retention/wages, etc. The market isn't going to respond, so we only have so many tools to respond.

Suzanne—loved the idea of perhaps buying some space and leasing back. Then what happens to the business owners who have to compete?

Jeff—think the task force is a good place to start the conversation on how to get at the affordability and availability issues.

Susan G—Working on success measures/outcomes measures around quality. How can we measure that we are moving children into quality child care centers and how do we support centers/providers to improve quality? Also, with CCAP providers, we are working in increasing the number of providers that accept CCAP. We are looking at other models to improve this.

Betsey—what is CSTAT and CO Shines: CO Shines is a rating system for quality. Rated licensing system. You get a higher level license if you are able to show higher quality—used to use Qualistar rating. Some is business process, quality of staff. CSTAT: was implemented 3 years ago at the State Level. Look at key indicators that they try to hit target wise at the state level and work with the counties to achieve goals.

5) Discussion—Process for the next few months for focusing on narrowed priority areas and linkages to DHHS strategic work—Frank (4:35 – 5:00 p.m.)

Betsey—systems question—how does a child move through out community from cradle to career? With the 0-5 population, how does it better transition to K-12. Seamless handoff. How are systems better weaved together? Frank—any level of case management oriented program, they are all mid-tier. You have a mid-level cost. The system challenge, that programs and services are built to serve a segment of the population and cannot carry a huge population base. If you look at population level support, where the expertise of the mid-level is accessible to all—through processes, through self-service, through new scaling models that are based on predictive factors—single parent, how old were you when you had your child, etc.

Elvira—what is the influence on the school systems in this model? How do we better work with them? Frank—we are working with them now. What they need from us is to be more seamless and more coordinated. If we can all stay together and sit at the right tables and come to the table with a coherent approach with the school districts, we can work with them in a way that will work.

Jeff—this is something to highlight—there has been a ton of work with the school systems on data sharing.

Frank—we know that there will be different programs and services, but if we all have common frameworks around these and governing in a common way. All of the shared learning will help us with progress.

Betsey—work I am doing is to blow open the funding system—healthy start voucher for example. Frank—in the meantime, if we use the federal dollars and use local funding to bridge gaps in services.

Betsey—Feedback on the Early Childhood work—put Parents first in the work plan and then providers.

Frank—this is doable if we keep talking. When we are talking, we should discuss, scaling, risk and provision at the right levels when we can.

Jeff—coming back with some more specific data on the correlations and how we can work on better handoffs and coordination between systems. This could help the group discussion.

Bobbie—have a child almost at birth, have a child have a common identifier with the school districts—follow kiddos through the systems.

Angela—where do you think the regional board for the Family Resource Framework Regional Board should land? Consider this between now and next meeting. Could be here or some hybrid of here.

Frank—there are good projects going that have great characteristics that could be better coordinated. The learning environment is right to tie these projects together.

Jeff—trying to really ground ourselves in the right focal points that need better coordination. Then we can decide where to focus our energies.

Action Item: send questions or thoughts to Frank and Chris in this area for compilation

6) Upcoming Meetings—

a) **April Agenda Items:**

a. Deeper dives into:

(a) Integrated Health Care Supports/Community Health and Wellbeing

Next Meeting is Tuesday, April 26, 2015, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder.

7) Adjourn

Access to current and past packets for the Boulder County Housing Authority Board, the Boulder County Human Services Board, and the Housing & Human Services Advisory Committee can be found by clicking on the links below:
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Department of Housing & Human Services

Housing Office: 2525 13th Street, Suite 204 • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax: 720.564.2283
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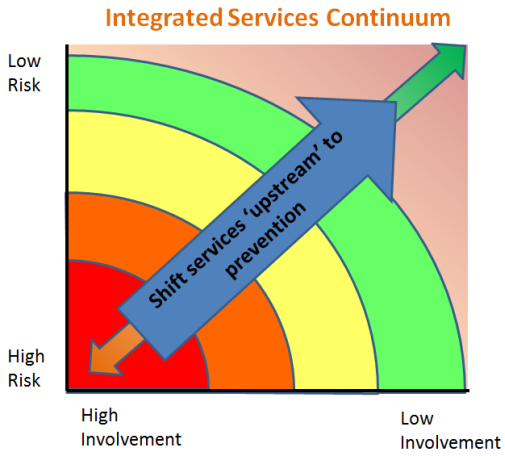
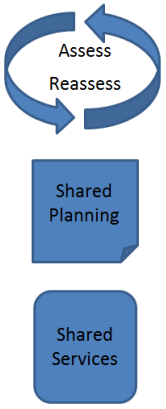
DHHS Advisory Committee Meeting Agenda
Tuesday, May 31, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

About the HHSAC: Committee members provide advice and guidance to the Department of Housing & Human Services (BCDHHS) staff and leadership in their efforts to most effectively serve the community. Committee members strive to actualize the vision of the agency and to ensure that the vision is aligned with the identified needs of the Boulder County community. Committee members provide substantive recommendations on improving the organizational effectiveness based on community input and personal experience.





1) **Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)**

2) **Review and approval of minutes from April 26, 2016 DHHS Advisory Committee Meeting (3:33 – 3:35 p.m.)**

3) **Game of Life client simulation—Daphne McCabe, HSP and Special Projects Coordinator, CM/CO Division DHHS (3:35 – 4:05 p.m.)**

4) **Data presentation from Jason McRoy, Business Operations and Systems Support Division Director (4:05 – 4:35 p.m.)**
   a. Overview of Systems Architecture and progress on BCDHHS IT Roadmap
   b. Review of dashboards and indicators; how we are using data to evaluate programs and services
   c. What data/information is most useful for the committee?

5) **All Staff Conference Preview – Jim Williams, Maggie Crosswy, Frank Alexander (4:35 – 4:45 p.m.)**

6) **Highlight Early Childhood Integration Work Example – Bobbie Watson (4:45 – 5:00 p.m.)**

7) **Upcoming Meetings—**

a) **June 15, DHHS All Staff Conference—8 a.m. – 3:30 p.m. at the Plaza Conference Center, 1850 Industrial Cir, Longmont, CO 80501

b) **HHSAC - June 28th, 2016, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder**

i. **Agenda Items:**

a. **All Staff Conference Summary – Opening presentation, takeaways**

b. **Revisit HHSAC Project List**

c. **Eligibility and Enrollment system update—Susan Grutzmacher, Community Support Division Director, Patrick Kelly, Project Director, Case Management and Community Outreach Division**

(a) Community Support update

(b) Open Enrollment 3

(c) New partnership alignments

c) **July 26th, 2016, 2:00 p.m., 2525 13th Street, Large Conference Room, Boulder**

i. **Agenda Items:**

a. **Family Resource Partnership Governance update**—Angela Lanci-Macris, Melissa Frank-Williams

d) **August 30th, 2016, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder**

****Note: potential joint meeting with HS/HA Board**

i. **Agenda Items:**

a. **Equity survey update—Chris Campbell, Jim Williams, Dalia Dorta, Elvira Ramos**

(a) Recommendations for next steps and feedback from HHSAC

8) **Adjourn**

Current and past packets for the Boulder County Housing Authority Board, the Boulder County Human Services Board, and the Housing & Human Services Advisory Committee can be accessed at the links below:
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BOULDER COUNTY HOUSING & HUMAN SERVICES

DHHS Advisory Committee
MONTHLY MEETING
Tuesday, April 26, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Committee Members in Attendance: Laura Kinder, Dalia Dorta, Betsey Martens, Simon Smith, Jeff Zayach, Pat Heinz-Pribyl, Suzanne Crawford

Staff in Attendance: Frank Alexander, Will Kugel, Whitney Wilcox, Daphne McCabe, Melissa Frank-Williams, Susan Grutzmacher, Jim Williams

Minutes

1) Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)

Frank: what we want to accomplish today is to look at some of the constraints with the 2017 budget early this year. We'd like to hear from you on how to balance competing factors and priorities for the 2017 budget. CCAP program, homelessness programs, community investments are areas where we want to hear from committee members.

2) Review and approval of minutes from March 29, 2016 DHHS Advisory Committee Meeting (3:33 p.m. – 3:35 p.m.)

3) Update from APHSA Local Council Retreat and National Cohort work with DHHS staff—Frank Alexander (3:35 p.m. – 3:45 p.m.)
a) Uma Ahluwalia, Montgomery County, MD presentation
b) Dakota County partnership

APHSA has adopted the generative framework/value curve view of business change. The locals group comprised of 26 counties who meet in a summit type meeting this past week.

Since we had experts in town for this event, Uma Ahluwalia gave a presentation to key Boulder County stakeholders about integrated planning, social determinants framework, and the inherent market-based structural challenges for communities. Laura: enjoyed that the focus on being more integrated as providers, seeing folks from Area Agency on Aging for example. Also, reaffirmed that the issues are broad and focused on the

Simon: reinforced what Boulder County is working toward—issues are very similar in Montgomery County as to Boulder County—wealthy, healthy county, yet there is significant areas that need support to help the community thrive.

Jeff—Aligning strategies and goals among health care providers is inspiring. Need to have more of these forums. Frank—need to figure out a mechanism to keep the conversation moving forward. Is there good way to take another step in the social determinants lens.

Frank—Additionally, building on work with our cohort partners, we met with a leadership team from Dakota County, MN. Focused on integrated services, front end prevention work.

HUD visit: Deputy Secretary of HUD visited Aspinwall (need to add notes here).

IBM Smarter Cities initiative to Denver: looking at the Denver Homeless Services support. Comprehensive assessment of the pipeline of homelessness in Denver. Goal is recommendations of integrating systems platforms/data.

4) Human Services Financial Update—Will Kugel, DHHS Finance Director (3:45 p.m. – 4:15 p.m.)

a) 2016 Finances to Date
b) 2017 Budget Process and Timeline
   i. Colorado Child Care Assistance Program Update
   ii. Child Welfare positions with State Budget

See the posted PowerPoint from Will Kugel. Will—discuss the high-level framework/lens for developing our 2017 budget. Opportunity for investments across the community based on the constraints and opportunities. Goal is to have collaborative conversations with our partners to direct our investments in the most impactful areas.

<u>Key Inputs to 2017 Investments:</u>

- County Commissioners
- Community Inputs
- Fund Balance Levels
- Human Services Safety Net Allocations
- Community Contracts
- Developmental Disability Levy Funds (new for 2016): now running through DHHS budget. Ballot does define where investments must be spent

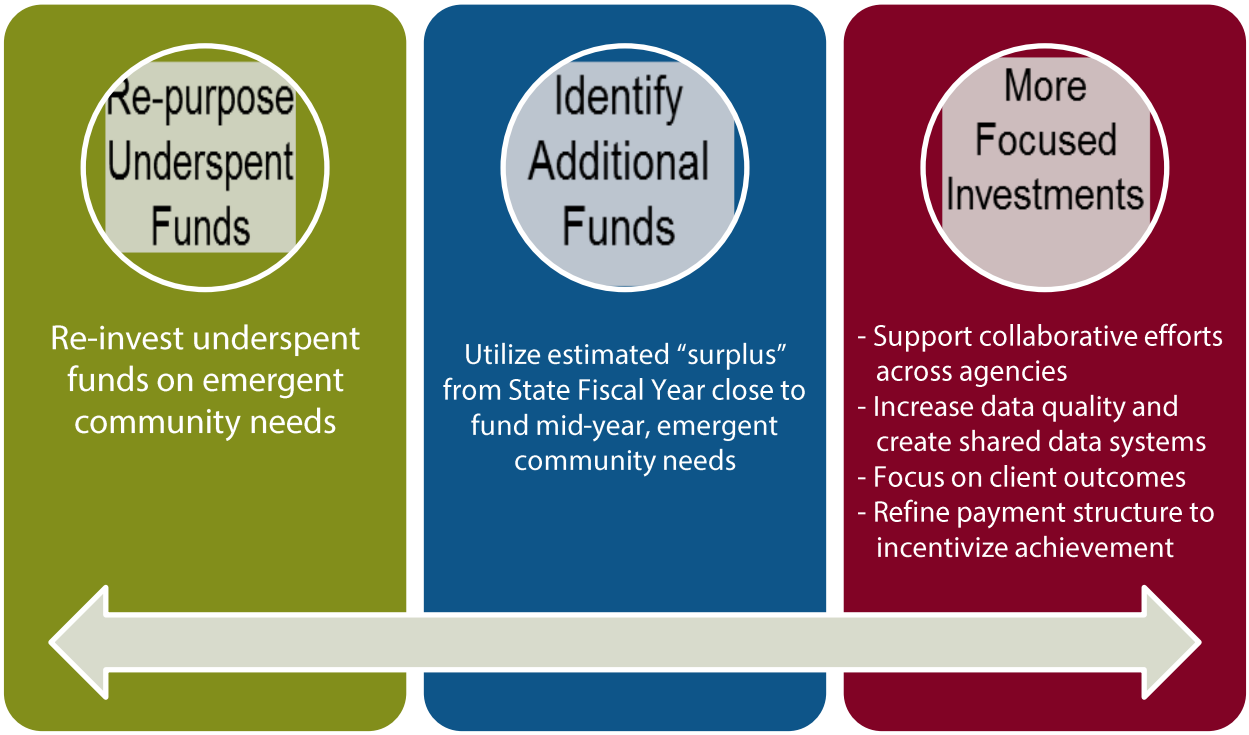
Frank—as we move through the rest of the year, as you've seen, the focus has been for DHHS to be a strong business partner to the safety net structure to better integrate the safety net and

align where our dollars go. Where are the edges, priorities that will help further develop the system moving forward? Will—need to think about what we are really investing in and are they having the highest impact from a social determinants of health lens.

Strategic Items for 2017 Budgeting

- State Allocation Levels
- Prioritization and Decision Making on Community Contract and HSSN Funding
- HHS TERM FTE Discussion
- New rate structure Child Care Assistance Program (Effective September 15, 2016)
- End of CDBG-DR Flood Work
- Revenue Changes (Increase and/or Decrease)
    - e.g., Healthy kids grant

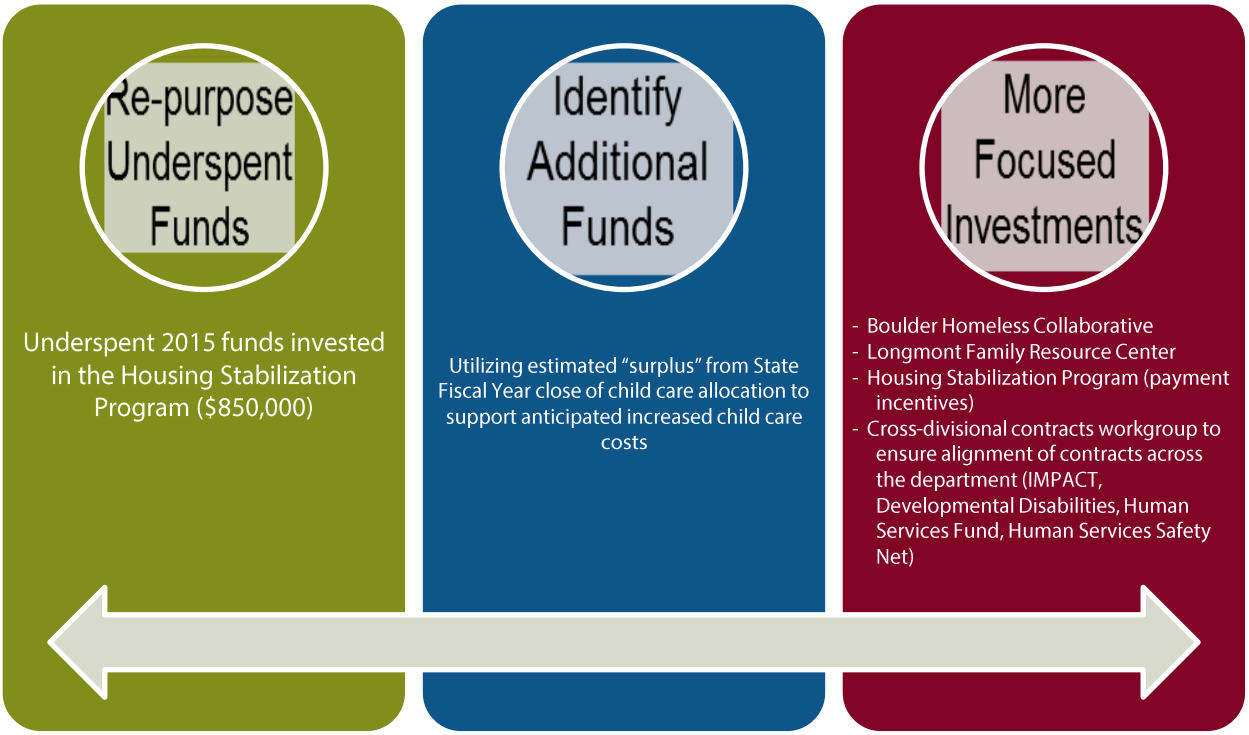
Leveraging of Community Resources (one budget strategy):



2016 Progress to Date:

2016 Progress to Date:

Frank—One example is that we were able to reinvest in the Genesis/Genesister program with Public health and then we started to look at strategies for more long term funding strategies. We've built the system within DHHS to repeat this pattern year after year. We then have additional resources to invest in high-impact areas.



Betsey: where does the Social Impact Bond strategy come into play to this strategy? Frank—we've spoken to a lot of investors that the bonds are a measure to get us to where DHHS already is: generating savings through wise investments to be reinvested in high-impact areas. Betsey: look at messaging value capture investment type language.

Jeff: Fund balance question--$8.7 million is undesignated? Will—that is correct.

CCAP discussion: has a community decision and impact—building in the right incentives and investing the right amount of dollars in the childcare assistance program. Over the next few months, we'd like this board to chime in on these decisions points. Where do we put the basic rate levels and how does this impact the number of CCAP slots. As the quality of the providers increase, this then equals

additional funding for the providers. Frank—need to look at the long view as well—5-10 year cycle. What does it mean for money that needs to be brought to the table—fact based conversations.

Bobbie—we have a large low income population in Lafayette. Need is very difficult to meet. Need to look at investments in the Lafayette schools and help to meet these needs.

5) **Facilitated Discussion and Feedback on Budget Priorities and Timelines for 2017—and balance of 2016—Frank (4:15 p.m. - 5:00 p.m.)**
   a) Housing and Homelessness
   b) Family Resource Partnerships
   c) Child Care Assistance Program
   d) Contract Partnership priorities

Frank—start to map out the next several months with the committee with the work we've started and the financial frame.

Jeff—the way you develop your strategic investments is very smart—not siloed and strategic way. Question about the pillars—do you see obvious areas where we need to focus on as a board/committee? Frank—few edges that we are intent on pushing. Believers in the value curve—we are in the collaborative space, not to the integrative space. Building these now and it is very difficult. Data driven system decisions. Our contracting processes connect funding and investments to an integrative systems approach. How do we integrate data, how do we provide seamless access to services with our homeless services partners for example? Jeff—the connection of the systems together is huge.

Betsey: First thought—big investment in data sharing and metrics is a strong need. Also, has DHHS looked at Housing First model—economic investment model. Disrupt poverty, wrap services around.

Second, as an advisory council, tough to follow some of the areas like CCAP for example. To some extent, we are siloed here as a committee. Some more education needed in the areas so we can start to become experts in areas. Frank—this is a continual community challenge. Does take a lot of time and investment. We need to discuss areas where we'd like to most focus to help the committee to be able to start to weigh in on key decision points and investment areas?

Dalia: lens, concerned about the community. Some of the talk that we'd have a diverse community, I hope that this thread continues. Where does this land in the strategic lens and planning?

Daphne: would it be useful to hear stories or cases where we've stabilized families? Child care assistance family for example.

Simon: the mapping of the overlap, complex patients, multiple chronic needs. We are looking to better integrate data. We met recently about the DHHS Client Portal and Clinica gave examples of how we work with complex patient (through data analytics and best practices). Could we have each member give a strategic plan presentation, small strategic presentations? We could then look at overlaps. Betsey: we are in the collaborative space on the curve, this is how the group works.

Frank: we could narrow a bit more to a specific population or program. In a container like the Family Resource Model for example. Betsey: someone describes a really complex case and we can look for overlap.

Frank—one area that we see is to think about cross-sector solutions with a focus on young parents with young children. You can carry the thread through—single moms with young kids are disproportionally penetrating the systems. It is about bridging the sectors. Carrying out some of these population examples.

Daphne: we could circulate stories to this group to consider. Simon: home visit program, home visit team writes stories about the environment, the home, etc. Frank—we could tie out some of the data examples as well.

Jim—like the idea of looking at the data across the data from a family or individual. Frank—could dig into the predictive analytics and then look at a real-life example.

Betsey: my suggestion about a case study, spend an hour on the data side and then look at the case study.

6) **BCDHHS All Staff meeting on June 15th (8:00 a.m. – 3:30 p.m., Plaza Conference Center, Longmont)**
   a) **Members are welcome to attend: additional information to follow

7) **Upcoming Meetings—**
   a) **May 31, 2016, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder**
      i. **Agenda Items: Data presentation from Jason McRoy, Business Operations and Systems Support Division Director**
         a. What are the needs and desires of the Committee?
            (a) Overview of Systems Architecture
            (b) Review of Dashboards

         b. **Eligibility and Enrollment system update—Susan Grutzmacher, Community Support Division Director, Patrick Kelly, Project Director, Case Management and Community Outreach Division**
            (a) Community Support update
            (b) Open Enrollment 3
            (c) New partnership alignments

   b) **June 28th, 2016, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder**
      i. **Agenda Items:**
         a. **Equity survey update—Chris Campbell, Jim Williams, Dalia Dorta, Elvira Ramos**
            (a) Recommendations for next steps and feedback from HHSAC

         b. **Family Resource Partnership Governance update**—Angela Lanci-Macris, Melissa Frank-Williams

c) **July 26th, 2016, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder**

i. **Agenda Items:**

a. Suggestions from Committee Members:

d) **August 30th, 2016, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder**

i. **Agenda Items:**

a. Suggestions from Committee Members:

8) Adjourn

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Client Stories for Game of Life Simulation at HHSAC Meeting 5/31/16

RD, Age 41.

I first met her in 2009, at SPAN during my outreach work shift. She was anxious and depressed, recently recovering from a bout of heavy drinking and physical abuse. MHP records show she first began as a client there in 2007, had early contact with the ARC, and her children were active patients with People's prior to our first meeting. In other words, she's been well connected to various agencies and over the years. At her best, she is always one small step away from hospitalization or incarceration.

I saw her intermittently throughout the years, typically during periods when she was on probation and needing regular checkups for liver function monitoring.. When off probation her spiral was always downward, succumbing to her battle with alcohol, and then drugs. In 2014 she had a cancer in situ diagnosis, but it took many months and intense behavioral health involvement prior to her completion of the hysterectomy. Luckily the cancer did not invade further tissue during those months.

She came to me at Alpine, on 5/4 of this year, distraught over her current situation. The remorse blankets her story. Her daughter was graduating high school but didn't want her to attend. "She's given up on me." She was scheduled to leave the half-way house on 5/15 and had no housing plan in place. Her first appt. with a housing specialist wasn't until 5/18 and knowing well her previous history, she knew she wasn't likely to stay clean without a place to live. "I can't go to the shelter, too many people from my past there." And though generally alcohol was her downfall, she said she had started to use meth after being homeless. "You know, I don't even like Meth – never did. But every time I was sleeping, men would mess with me. I needed something to keep me awake."

I was able to arrange for her to meet with the housing resource counselor at Alpine after she finished her appointment with me. But there was no magic answer. Her best option will be to go to Emergency Psychiatric Services the moment she is released from the half-way house. If she is lucky, her pathology appearing severe enough and space being available, she might get a mental health respite bed for a little while.

It's easy to say that this is an outlier, an individual whom we can't impact. After all, she isn't really ready to stop drinking and using. But she isn't some recent transplant to Boulder, and like many others with dual diagnosis of mental health problems and substance abuse, they wander in and out of various service agencies without any long term stabilization.

AA, Age 43

I met this patient at her house for the first time last Friday. I've been to this trailer park before, one of the poorest in Boulder County, on S Public Road between Baseline and South Boulder. The trailers are small, and dilapidated. In the poorly lit room, this 300 pound patient appears to be one with the love seat she is lying on—the edges of the couch being hidden by her rolls of flesh. Her husband welcomes us and squeezes in a small chair beside her before falling asleep against the wall. He has been working nights, caring for her in the day and catching what sleep he can in-between. They have been in this country for 17 years, have work permits and were both working full time, though the stroke he had last year prevented him from keeping a second job like he had in the past. She was a personal care attendant before becoming ill last December. She shows me a picture on her cell phone of herself in a coma, intubated and swollen. "This can't be me she says, her eyes tearing up." She has recently been released from a rehab hospital after nearly a 4 week hospitalization for systemic infection and organ failure. Unable to return to work she has lost her Kaiser insurance. She was scheduled with a f/u appointment at Kaiser and then was called the night before and told she could not be seen as she was no longer eligible. They are behind on their rent and using the sister Carmen food bank for food supplement. They have one daughter in California, and a son in Colorado who tries to help but is working and going to school and is not able to provide much support. Without her income, they do not know how they will survive.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

American Academy of Pediatrics Recommends Pediatricians Screen for Poverty at Check-ups and Help Eliminate its Toxic Health Effects

3/9/2016

With nearly half of young children in the United States living in or near poverty-- tied to a range of lasting medical harms—the AAP launches new anti-poverty initiative

ELK GROVE VILLAGE, IL – (March 9, 2016) Identifying poverty as one of the most widespread and persistent health risks facing children, the American Academy of Pediatrics (AAP) today issued new recommendations urging doctors to ask at all well-child visits whether families are able to make ends meet.

The new policy statement in the April 2016 issue of Pediatrics, "Poverty and Child Health in the United States" and an accompanying technical report (both published online March 9), describe the pervasive ways poverty harms children's health and development. The AAP calls on pediatricians to commit to helping the 1 in 5 U.S. children who live in poverty access the resources they need to thrive. A single question, "Do you have difficulty making ends meet at the end of the month?" can help identify families who would benefit from community resources.

"Pediatricians are dedicated to preventing illness in children and intervening early when there is a problem," said James Duffee, MD, MPH, FAAP, one of the authors of the policy statement. "Because poverty so strongly influences children's health and development, pediatricians are asking about poverty-related stress so we can connect families to resources in their communities."

Research shows that living in deep and persistent poverty can cause severe, lifelong health problems, including infant mortality, poor language development, higher rates of asthma and obesity, and an increased risk of injuries. A growing body of research links child poverty with toxic stress that can alter gene expression and brain function and contributes to chronic cardiovascular, immune, and psychiatric disorders, as well as behavioral difficulties.

"We know that poverty-related conditions can take a significant and lasting toll," said John M. Pascoe, MD, MPH, FAAP, a lead author of the technical report. "But we also know there are effective interventions to help buffer these effects, like promoting strong family relationships, which cause positive changes in the body's stress response system and the architecture of the developing brain."

Progress has been made to reduce child poverty in the U.S., but the rates remain stubbornly high. According to 2014 U.S. census data, 1 in 5 U.S. children (15.5 million) under age 18 live in poverty. When households designated as poor, near poor or low-income are included, the number of children living in poverty rises to 43 percent (more than 31.5 million).

While urban and rural areas continue to have high rates of poverty, the suburbs have experienced the largest and fastest increases in poverty since the 2008 recession. Pediatricians in every community need to understand the health risks of poverty and how to connect families to a network of local support programs.

"Poverty is everywhere. It affects children of all backgrounds and in all communities," said AAP President Benard P. Dreyer, MD, FAAP. "Pediatricians want to improve the health and well-being of every child, and helping families deal with poverty-related issues is essential to achieving that goal. Fortunately, we have realistic solutions that we know will work. This is a problem that can be solved, and it's well within our reach."

The AAP calls for support and expansion of state and federal anti-poverty and safety net programs, health care, early childhood education, affordable housing, home visiting programs, and critical nutrition support programs like WIC, SNAP, and the school lunch program. The AAP also recognizes the unique programs pediatricians around the country have already adopted in their practices to help low-income and poor families access the resources and skills they need to lift their families out of poverty, and urges pediatricians in every community to take simple steps in their own practices. The AAP is offering pediatric practices tools and resources to get started.

Among the Academy's recommendations for pediatricians:

- Screen for poverty-related health risk factors during well-child visits by asking about basic needs such as food, housing and heat, and refer families who need help to community resources.

- Identify and build on protective factors within families, such as cohesion, humor, support networks, skills, and spiritual and cultural beliefs. Programs integrated into the medical home have been proven to help parents build resilience in their children.

- Advocate for public policies to support all children and mitigate the effects of poverty on child health, including initiatives that increase access to healthcare, healthy food, and safe and affordable housing.

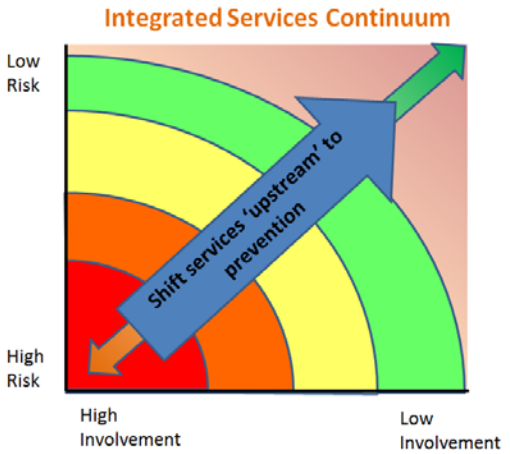
"Fifty years ago, the U.S. came together and nearly eliminated poverty in the elderly," said Dr. Dreyer. "It's time to do the same for children."

###

The American Academy of Pediatrics is an organization of 64,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults. For more information, visit www.aap.org and follow us on Twitter @AmerAcadPeds.

- See more at: https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/American-Academy-of-Pediatrics-Recommends-Pediatricians-Screen-for-Poverty-at-Check-ups-and-Help-Eliminate-its-Toxic-Health.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR:+No+local+token#sthash.DBlxgiVb.dpuf

BCDHHS Strengthening Families
2016 Conference (All Staff)
June 15, 2016
8:00 a.m. – 3:30 p.m.
Plaza Convention Center,
Longmont, CO



Integrating the Continuum through Prevention-Oriented, Family-Centered Shared Planning, Services, and Vision

BCDHHS Big Hairy Audacious Goal: Within 10 years, BCDHHS will transform the health and the well-being of our community by shifting programming and funding upstream into prevention oriented and consumer driven cross-sector solutions that improve outcomes across the lifespan and significantly reduce high-cost institutional interventions within a social determinants of health framework.

Conference Vision

Moving our community toward and through a more integrative and ultimately generative state in which all partners **work together utilizing common measures and language** (i.e., the Self-Sufficiency Matrix) **to collectively identify the right mix of resources at the right time** to help an individual or family move toward lower risk and lower institutional involvement.

Conference Goals

Building on past conference successes, discuss:

- **How can we work together better or more closely** to ensure a client is progressing through the Self Sufficiency Matrix toward thriving? **What resources do you deliver to clients** to help ensure they are transitioning up the matrix? **What data do you have** that show client movement up the matrix (i.e., wage improvements, food security, etc.)?
- **How can we work toward speaking a common language** across agencies and with our shared clients?
- **What can we be sharing with each other** (information, data, outreach planning, etc.) that will help us better serve our common clients and measure improvements in community-wide indicators and outcomes?
- At all levels of the agency, **how does this vision inform our everyday work** and what additional internal supports do we need to help meet this vision?

Draft Agenda

Time	Event	Session Lead(s)	DHHS Staff Leads	Location	Attendance
8:00-8:15	Networking, get coffee, find seats			Summit Ballroom	450
8:15-9:00	**Opening Session: BHAG/Integrating our Services Continuum/ISDMC, Social Determinants of Health and Grounding the Day in Common Self-Sufficiency Measures (SSM)**	Frank Alexander, Jason McRoy, Susan Caskey (ISDMC)		Summit Ballroom	450
	**** Discussion Sessions**** **"Shared Planning, Services, and Vision"**				
9:10-10:25 ***Confirmed***	**Discussion Session 1a: Sister Carmen Community Center Discussion**	**Suzanne Crawford, Marc Cowell and Andrea Ostroy**	**Melissa Frank-Williams**	**Silverthorne room**	75
Confirmed	**Discussion Session 1b: Mental Health Partners (MHP) Discussion**	**Matt Meyer**	**Susan Caskey, Sara Boylan**	**Summit Ballroom**	75
Confirmed	**Discussion Session 1c: Community Services Discussion—Community Action Program**	**Eliberto Mendoza, Robin Bohannan**	**Theresa Kullen, Lupe Abeyta**	**South Fairview room**	75
Confirmed	**Staff Development Session 1d: Lominger Competency Discussion—Practical applications for all staff**	**Megan Rymski**, Jim Hayen	**n/a**	**Front Range Theater**	75
Confirmed	**Discussion Session 1e: Public Health Discussion—*Community Health Programs*: GENESIS/GENESISTER, Prevention & Intervention program, Community Substance Abuse program (CSAP)**	**Heath Harmon, Andrea Poniers,** Jody Scanlon	**Alison Brisnehan, Patrick Kelly**	**Apache group**	75
Confirmed	**Discussion Session 1f: Integrated Services Delivery Model of Care (ISDMC), What does it mean to me?**	Susan Caskey, Kit Thompson	**n/a**	**Arapahoe group**	75
10:25-10:40	Break			All locations	
10:40-11:55 ***Confirmed***	**Discussion Session 2a: Boulder County Connect (client portal)/HHSCv2.0 Discussion**	John Green, Jason McRoy, Stefanie Kenny	**n/a**	**Silverthorne room**	75

Confirmed	**Discussion Session 2b: Emergency Family Assistance Assocation (EFAA) Discussion**	**Julie Van Domelen, Elizabeth Freedman**, and Audrey DeBroux	**Frank Alexander, Susan Grutzmacher, Sarah Reynolds**	**Summit Ballroom**	75
Confirmed	**Discussion Session 2c: Public Health Discussion—*Family Health Programs*: Nurse Family Partnership (NFP), Women, Infants, Children (WIC)**	**Heath Harmon**, Melinda Morris, Jane McKinley	**Angela Lanci-Macris**	**Front Range Theatre**	75
	Staff Development Session 2d: Having Difficult Conversations	Mountain States		**South Fairview room**	75
Confirmed	**Discussion Session 2e: Community Services Discussion—Area Agency on Aging**	**Sherry Leach, Robin Bohannan (APS)**	**Karen Hoover, Tonia Elliot, Kris Durso**	**Apache group**	75
Confirmed	**Discussion Session 2f: Housing Collaborative Discussion**	**Greg Harms** and program staff [expanded to Bridge House, SPAN—DM]	**Daphne McCabe**	**Arapahoe group**	75
11:55-12:15	Break			All locations	
12:15-1:15	**Lunch & Client Story Presentation: "Success in Prevention-Based Services Integration"**	Jim Williams, Chris Campbell, Maggie Crosswy	**Ann Baldwin, Wendy Ingham, Jenny Zuetell**	Summit Ballroom	450
1:15-1:25	Break				
1:25-2:40 ***Confirmed***	**Discussion Session 3a: Workforce Boulder County Discussion**	**Erin Jones**, Tonja Ahijevych	**Jessie Hancox, Angela Lanci-Macris**	**Silverthorne room**	75
	Discussion Session 3c: St. Vrain Valley (SVVD) and Boulder Valley School District (BVSD) Panel Discussion	McKinney Vento Liaisons **– MFW? Mollie Faughnan, Luis Chavez (SVVSD), Ema Lyman (BVSD)**	**Melissa Frank-Williams, Mollie Faughnan?**	**South Fairview room**	
Confirmed	**Discussion Session 1d: Supportive Housing Continuum/Housing Panel**	Amanda Guthrie, Sarah Buss	**n/a**	**Summit Ballroom**	75
Confirmed	**Discussion Session 3d: Outreach United Resource (OUR) Center Discussion**	**Edwina Salazar**, Veronica Orona, and Angela Garcia	**Angela Lanci-Macris**	**Front Range Theatre**	75

Confirmed	**Staff Development Session 3e: Getting the Right Services to Clients: What to Look for in a Home**	**Todd Rewoldt, Wade Branstetter, Bruce Ganter/LPEC, Gary Boyer/LPEC**	**n/a**	**Apache group**	75
Confirmed	**Discussion Session 3f: Removing Transportation Barriers for Vulnerable People**	**Angel Bond**	**Karen Hoover, Tonia Elliot, CASA staff?**	**Arapahoe group**	75
2:40-2:50	Break			All locations	
2:50-3:30	**Closing Session (Breakouts by Division):** "Based on all I've learned today, **how can I help** create a truly integrated services continuum in our community?" "**Where are the gaps** in our ability to work with partners/have partners work with us to be sure we're collectively identifying solutions for our clients?"				
	Family and Children Services Division (FCS)			**Summit Ballroom**	
	Community Support Division (CS)			**South Fairview room**	
	Case Management & Community Outreach Division (CM/CO)			**Silverthorne room**	
	Finance Division			**Front Range Theatre**	
	Housing Division			**Apache group**	
	IMPACT Care Management Division			**Arapahoe**	
	Business Operations & Systems Support Division (BOSS)			**Pawnee & Navajo**	

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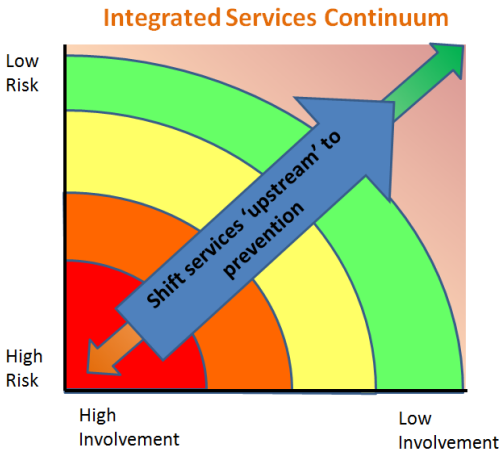
DHHS Advisory Committee
MONTHLY MEETING
Tuesday, June 28, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder



Agenda

1) **Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)**

2) **Review and approval of minutes from April 26, 2016 DHHS Advisory Committee Meeting (3:33 p.m. – 3:35 p.m.)**

3) **All Staff Conference Summary – Takeaways and Experiences – Jim Williams, Maggie Crosswy, Frank Alexander (3:35 – 3:45 p.m.)**

4) **Data presentation from Jason McRoy, Business Operations and Systems Support Division Director (3:45 – 4:15 p.m.)**
   a. Overview of Systems Architecture and progress on BCDHHS IT Roadmap
   b. Review of dashboards and indicators; how we are using data to evaluate programs and services
   c. What data/information is most useful for the committee?

5) **Eligibility and Enrollment system update—Susan Grutzmacher, Community Support Division Director, Patrick Kelly, Project Director, Case Management and Community Outreach Division (4:15 – 4:45 p.m.)**
   (a) Community Support update
   (b) Open Enrollment 3, Plans for OE 4

(c) New partnership alignments

6) Highlight Early Childhood Integration Work Example – Bobbie Watson (4:45 – 5:00 p.m.)

Upcoming Meetings:

a) **July 26th, 2016, 3:30 p.m., 2525 13th Street, Large Conference Room, Boulder**

i. **Agenda Items:**

a. **Game of Life client simulation—Daphne McCabe, HSP and Special Projects Coordinator, CM/CO Division DHHS**

b. **Revisit HHSAC Project List**

c. **Family Resource Partnership Governance update**—Angela Lanci-Macris, Melissa Frank-Williams

d. **Discussion of potential agenda for joint meeting with HS/HA Boards (Commissioners)**

b) **August 30th, 2016, 2:00 p.m., 2525 13th Street, Large Conference Room, Boulder**

****Note: potential joint meeting with HS/HA Board**

i. **Agenda Items:**

a. **Updates from the BOCC and from Committee members**

c) **September 27, 2016, 3:30 p.m., 2525 13th Street, Large Conference Room, Boulder**

i. **Agenda Items:**

7) Adjourn

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DHHS Advisory Committee
MONTHLY MEETING
Tuesday, April 26, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Committee Members in Attendance: Laura Kinder, Dalia Dorta, Betsey Martens, Simon Smith, Jeff Zayach, Pat Heinz-Pribyl, Suzanne Crawford

Staff in Attendance: Frank Alexander, Will Kugel, Whitney Wilcox, Daphne McCabe, Melissa Frank-Williams, Susan Grutzmacher, Jim Williams

Minutes

1) Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)

Frank: what we want to accomplish today is to look at some of the constraints with the 2017 budget early this year. We'd like to hear from you on how to balance competing factors and priorities for the 2017 budget. CCAP program, homelessness programs, community investments are areas where we want to hear from committee members.

2) Review and approval of minutes from March 29, 2016 DHHS Advisory Committee Meeting (3:33 p.m. – 3:35 p.m.)

3) Update from APHSA Local Council Retreat and National Cohort work with DHHS staff—Frank Alexander (3:35 p.m. – 3:45 p.m.)
   a) Uma Ahluwalia, Montgomery County, MD presentation
   b) Dakota County partnership

APHSA has adopted the generative framework/value curve view of business change. The locals group comprised of 26 counties who meet in a summit type meeting this past week.

Since we had experts in town for this event, Uma Ahluwalia gave a presentation to key Boulder County stakeholders about integrated planning, social determinants framework, and the inherent market-based structural challenges for communities. Laura: enjoyed that the focus on being more integrated as providers, seeing folks from Area Agency on Aging for example. Also, reaffirmed that the issues are broad and focused on the

Simon: reinforced what Boulder County is working toward—issues are very similar in Montgomery County as to Boulder County—wealthy, healthy county, yet there is significant areas that need support to help the community thrive.

Jeff—Aligning strategies and goals among health care providers is inspiring. Need to have more of these forums. Frank—need to figure out a mechanism to keep the conversation moving forward. Is there good way to take another step in the social determinants lens.

Frank—Additionally, building on work with our cohort partners, we met with a leadership team from Dakota County, MN. Focused on integrated services, front end prevention work.

HUD visit: Deputy Secretary of HUD visited Aspinwall (need to add notes here).

IBM Smarter Cities initiative to Denver: looking at the Denver Homeless Services support. Comprehensive assessment of the pipeline of homelessness in Denver. Goal is recommendations of integrating systems platforms/data.

4) Human Services Financial Update—Will Kugel, DHHS Finance Director (3:45 p.m. – 4:15 p.m.)

a) 2016 Finances to Date
b) 2017 Budget Process and Timeline
   i. Colorado Child Care Assistance Program Update
   ii. Child Welfare positions with State Budget

See the posted PowerPoint from Will Kugel. Will—discuss the high-level framework/lens for developing our 2017 budget. Opportunity for investments across the community based on the constraints and opportunities. Goal is to have collaborative conversations with our partners to direct our investments in the most impactful areas.

<u>Key Inputs to 2017 Investments:</u>

- County Commissioners
- Community Inputs
- Fund Balance Levels
- Human Services Safety Net Allocations
- Community Contracts
- Developmental Disability Levy Funds (new for 2016): now running through DHHS budget. Ballot does define where investments must be spent

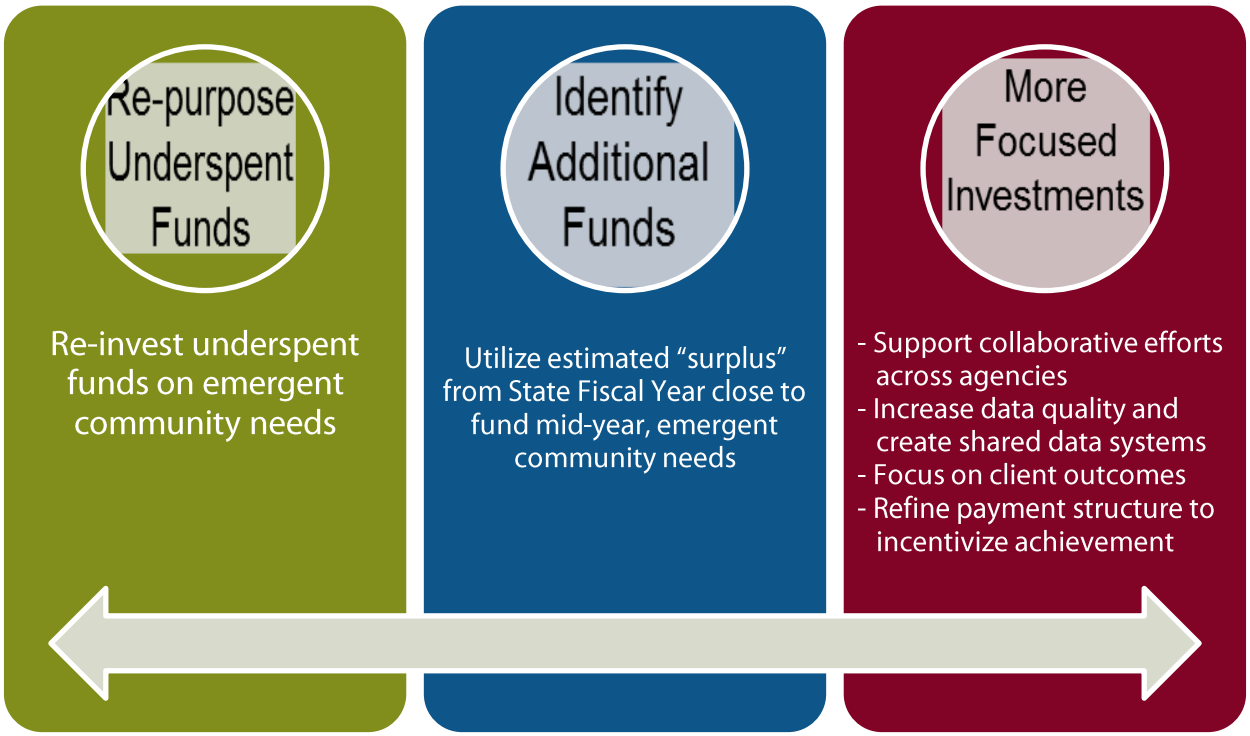
Frank—as we move through the rest of the year, as you've seen, the focus has been for DHHS to be a strong business partner to the safety net structure to better integrate the safety net and

align where our dollars go. Where are the edges, priorities that will help further develop the system moving forward? Will—need to think about what we are really investing in and are they having the highest impact from a social determinants of health lens.

Strategic Items for 2017 Budgeting

- State Allocation Levels
- Prioritization and Decision Making on Community Contract and HSSN Funding
- HHS TERM FTE Discussion
- New rate structure Child Care Assistance Program (Effective September 15, 2016)
- End of CDBG-DR Flood Work
- Revenue Changes (Increase and/or Decrease)
    - e.g., Healthy kids grant

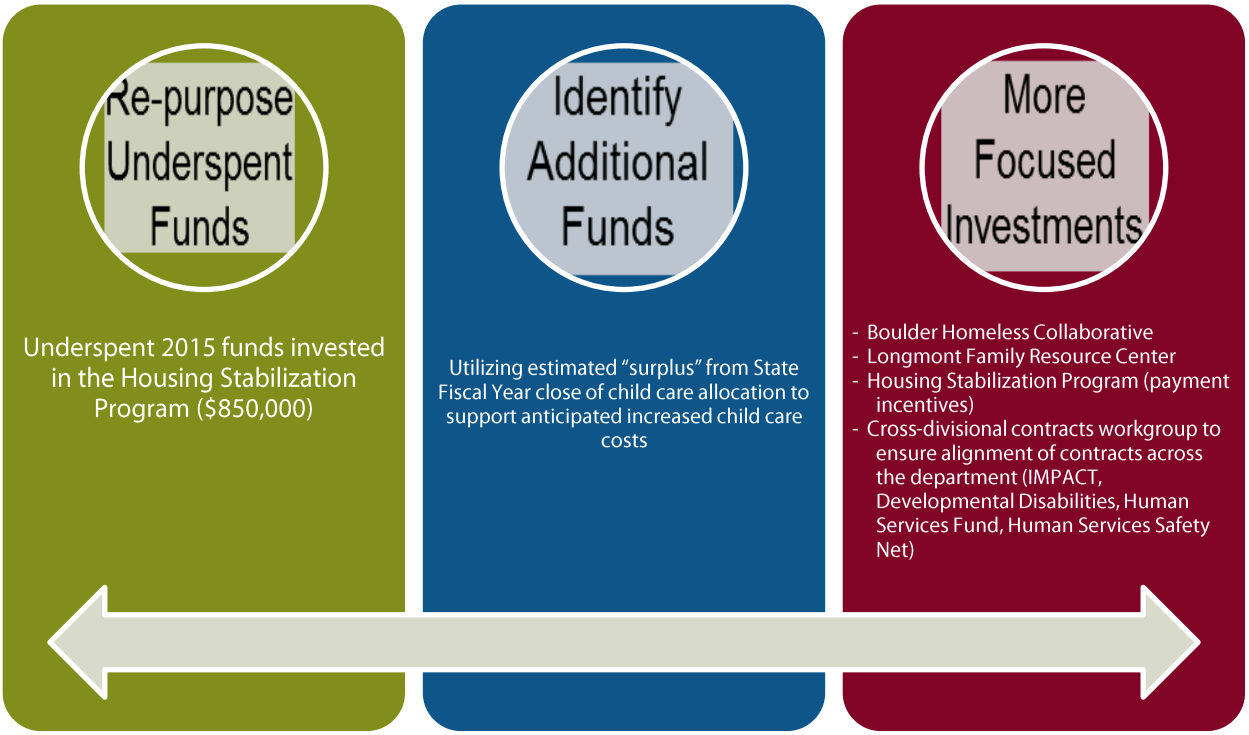
Leveraging of Community Resources (one budget strategy):



2016 Progress to Date:

2016 Progress to Date:

Frank—One example is that we were able to reinvest in the Genesis/Genesister program with Public health and then we started to look at strategies for more long term funding strategies. We've built the system within DHHS to repeat this pattern year after year. We then have additional resources to invest in high-impact areas.



Betsey: where does the Social Impact Bond strategy come into play to this strategy? Frank—we've spoken to a lot of investors that the bonds are a measure to get us to where DHHS already is: generating savings through wise investments to be reinvested in high-impact areas. Betsey: look at messaging value capture investment type language.

Jeff: Fund balance question--$8.7 million is undesignated? Will—that is correct.

CCAP discussion: has a community decision and impact—building in the right incentives and investing the right amount of dollars in the childcare assistance program. Over the next few months, we'd like this board to chime in on these decisions points. Where do we put the basic rate levels and how does this impact the number of CCAP slots. As the quality of the providers increase, this then equals

additional funding for the providers. Frank—need to look at the long view as well—5-10 year cycle. What does it mean for money that needs to be brought to the table—fact based conversations.

Bobbie—we have a large low income population in Lafayette. Need is very difficult to meet. Need to look at investments in the Lafayette schools and help to meet these needs.

5) **Facilitated Discussion and Feedback on Budget Priorities and Timelines for 2017—and balance of 2016—Frank (4:15 p.m. - 5:00 p.m.)**
   a) Housing and Homelessness
   b) Family Resource Partnerships
   c) Child Care Assistance Program
   d) Contract Partnership priorities

Frank—start to map out the next several months with the committee with the work we've started and the financial frame.

Jeff—the way you develop your strategic investments is very smart—not siloed and strategic way. Question about the pillars—do you see obvious areas where we need to focus on as a board/committee? Frank—few edges that we are intent on pushing. Believers in the value curve—we are in the collaborative space, not to the integrative space. Building these now and it is very difficult. Data driven system decisions. Our contracting processes connect funding and investments to an integrative systems approach. How do we integrate data, how do we provide seamless access to services with our homeless services partners for example? Jeff—the connection of the systems together is huge.

Betsey: First thought—big investment in data sharing and metrics is a strong need. Also, has DHHS looked at Housing First model—economic investment model. Disrupt poverty, wrap services around.

Second, as an advisory council, tough to follow some of the areas like CCAP for example. To some extent, we are siloed here as a committee. Some more education needed in the areas so we can start to become experts in areas. Frank—this is a continual community challenge. Does take a lot of time and investment. We need to discuss areas where we'd like to most focus to help the committee to be able to start to weigh in on key decision points and investment areas?

Dalia: lens, concerned about the community. Some of the talk that we'd have a diverse community, I hope that this thread continues. Where does this land in the strategic lens and planning?

Daphne: would it be useful to hear stories or cases where we've stabilized families? Child care assistance family for example.

Simon: the mapping of the overlap, complex patients, multiple chronic needs. We are looking to better integrate data. We met recently about the DHHS Client Portal and Clinica gave examples of how we work with complex patient (through data analytics and best practices). Could we have each member give a strategic plan presentation, small strategic presentations? We could then look at overlaps.
Betsey: we are in the collaborative space on the curve, this is how the group works.

Frank: we could narrow a bit more to a specific population or program. In a container like the Family Resource Model for example. Betsey: someone describes a really complex case and we can look for overlap.

Frank—one area that we see is to think about cross-sector solutions with a focus on young parents with young children. You can carry the thread through—single moms with young kids are disproportionally penetrating the systems. It is about bridging the sectors. Carrying out some of these population examples.

Daphne: we could circulate stories to this group to consider. Simon: home visit program, home visit team writes stories about the environment, the home, etc. Frank—we could tie out some of the data examples as well.

Jim—like the idea of looking at the data across the data from a family or individual. Frank—could dig into the predictive analytics and then look at a real-life example.

Betsey: my suggestion about a case study, spend an hour on the data side and then look at the case study.

6) BCDHHS All Staff meeting on June 15th (8:00 a.m. – 3:30 p.m., Plaza Conference Center, Longmont)

a) **Members are welcome to attend: additional information to follow

7) Adjourn

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BOULDER COUNTY HOUSING & HUMAN SERVICES

Hope for the future, help when you need it.

Boulder County Housing & Human Services Advisory Committee
July 2016 Meeting Packet

Department of Housing & Human Services

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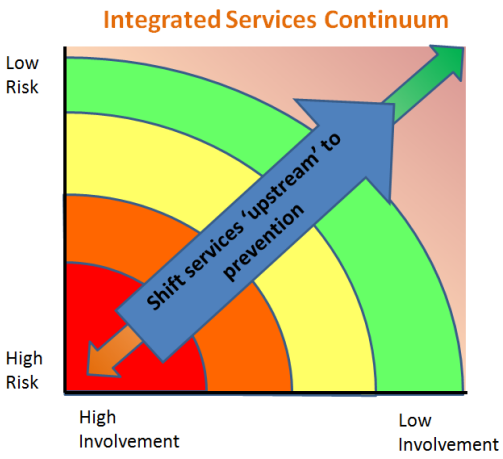
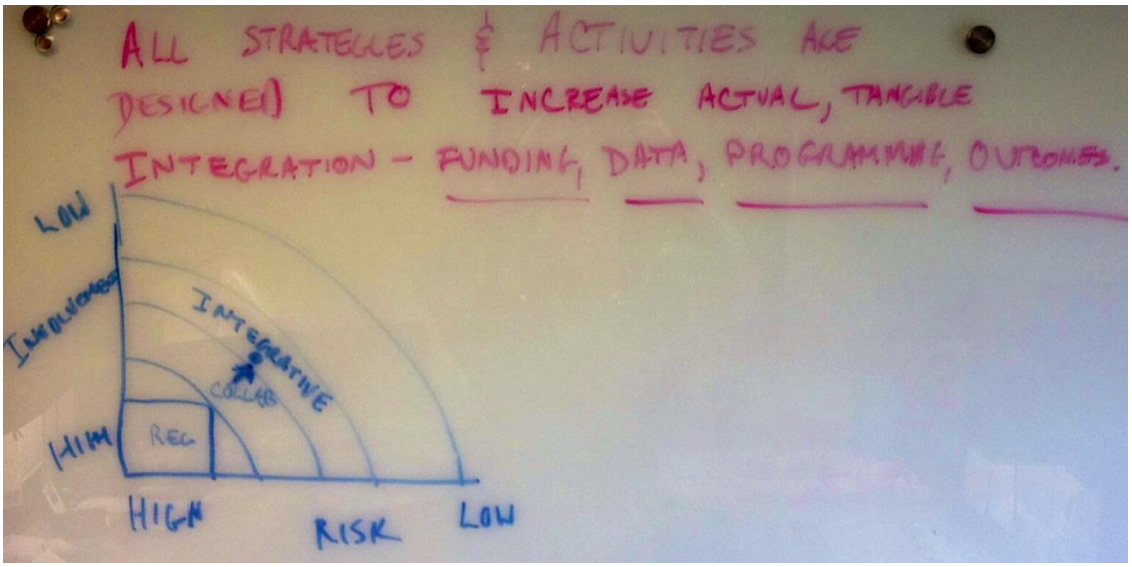
BCDHHS Advisory Committee
MONTHLY MEETING AGENDA
Tuesday, July 26, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder



1) **Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)**

2) **Review and approval of minutes from June 28, 2016 DHHS Advisory Committee Meeting (3:33 – 3:35 p.m.)**

3) **Governance discussion: moving from collaborative to integrative (3:35 – 4:05 p.m.)**
   a) Improving our governance – APHSA Maturity Model 2.0



4) **Revisit HHSAC project list (4:05 – 4:45 p.m.)**
   a) Highlight Early Childhood Integration Work Example – Bobbie Watson
   b) Narrowing our focus
      i. Early Childhood
      ii. Family Resource Framework / Dream Big
      iii. Affordable Housing
      iv. Other focus areas don't go away, but are integrated into these primary projects

5) **Discussion of focus and agenda for future joint HHSAC/HS/HA Board meeting (4:45 – 5:00 p.m.)**

Upcoming Meetings

Regular Advisory Committee Meeting—TBD. **August 2016, 2525 13th Street, Large Conference Room, Boulder. ** Need to discuss alternative date/time due to scheduling conflict**

Regular Advisory Committee Meeting—**September 27, 2016, 3:30 p.m., 2525 13th Street, Large Conference Room, Boulder**

Boulder County Housing Authority / Human Services Boards and Housing and Human Services Advisory Committee – JOINT MEETING (date TBD)

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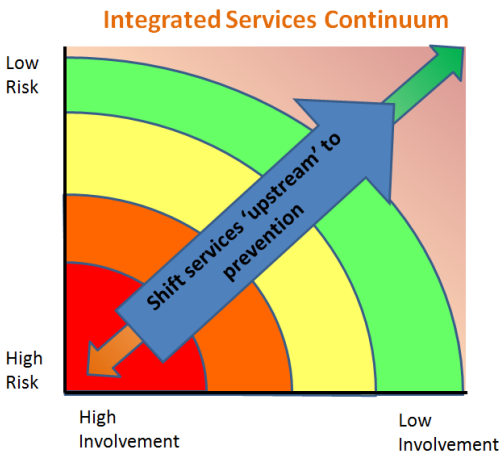


Meeting Minutes

Committee Members in Attendance: Dalia Dorta, Bobbie Watson, Jeff Zayach, Laura Kinder, Robin Bohannan, Suzanne Crawford, Pat Heinz-Pribyl, Elvira Ramos, Betsey Martens, Simon Smith

Staff in Attendance: Frank Alexander, Jason McRoy, Patrick Kelly, Susan Grutzmacher, Jim Williams, Maggie Crosswy, Chris Campbell

1) **Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)**

Approved as written

2) **Review and approval of minutes from April 26, 2016 DHHS Advisory Committee Meeting (3:33 p.m. – 3:35 p.m.)**

Approved as written

3) **All Staff Conference Summary – Takeaways and Experiences – Jim Williams, Maggie Crosswy, Frank Alexander (3:35 – 3:45 p.m.)**

The conference took place on June 15 from 8 a.m. – 3:30 p.m. Laura attended—the guest speaker was great. Spoke from the heart and he was great. Victor King: client who went several programs. Personal story—depth of the bottom in jail and to success was very inspiring. **Action Item: Jim will send out a link to his talk to the Advisory Committee members.**

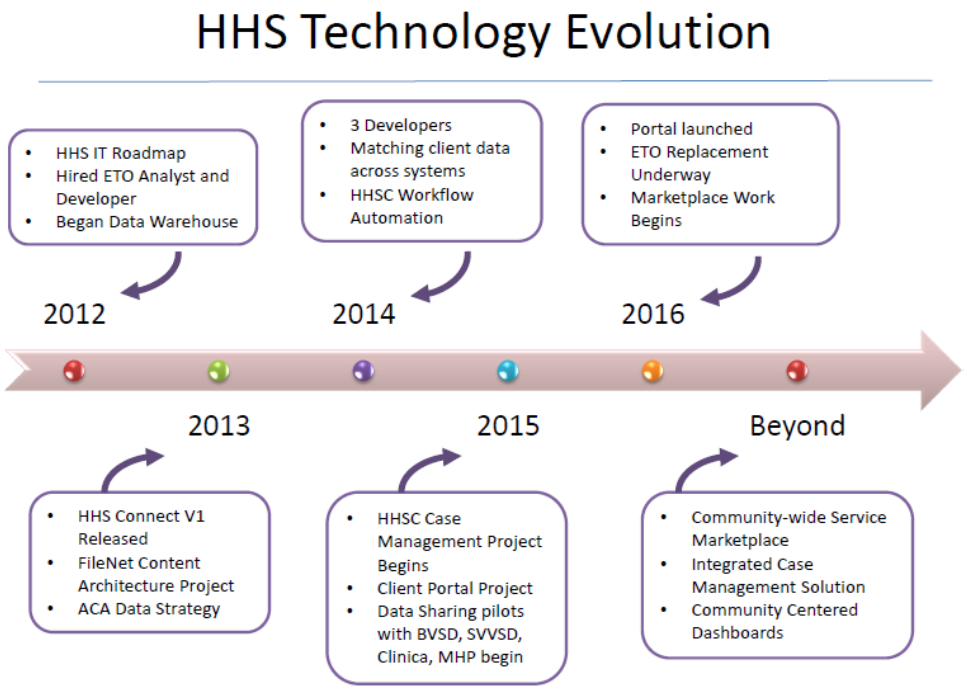
Laura—BCDHHS has awesome staff. Had the opportunity to sit with some Finance staff—they were able make connections to clients and how they are helping them.

Jeff—enjoyed the individual sessions and how the conference was formatted. Also did a strong job of grounding the day in the generative framework.

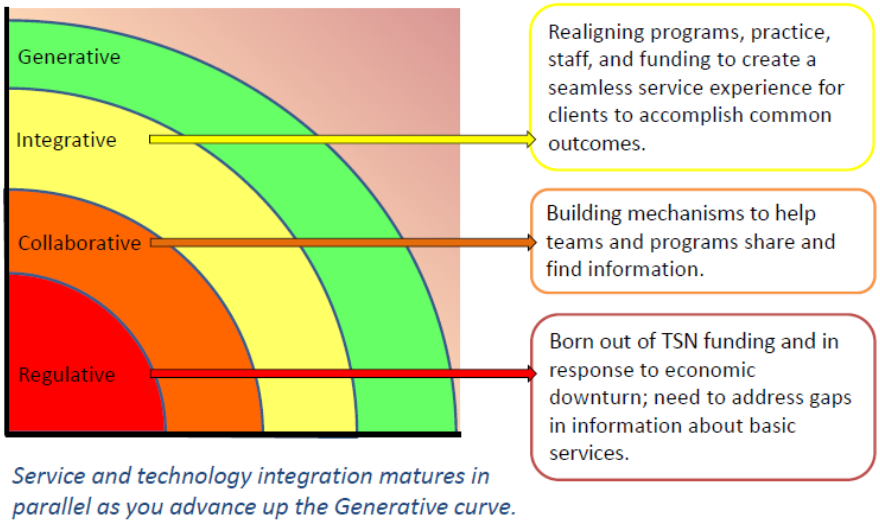
Frank—presenters were great about tying their services to BCDHHS services. It helped tie out how we better work together.

4) **Data presentation from Jason McRoy, Business Operations and Systems Support Division Director (3:45 – 4:15 p.m.)**
    a. Overview of Systems Architecture and progress on BCDHHS IT Roadmap
    b. Review of dashboards and indicators; how we are using data to evaluate programs and services
    c. What data/information is most useful for the committee?

Jason—presented to the committee about 1 year ago. This serves as an update from that presentation. **The presentation will be posted for the Committee members.**

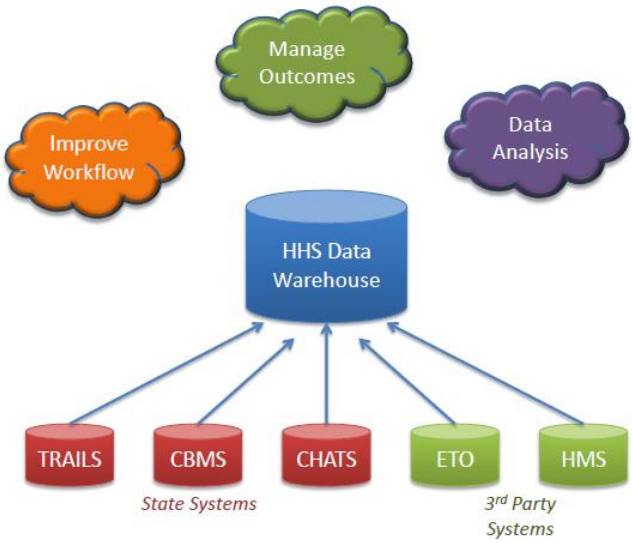


HHS Generative Technology Evolution



Service and technology integration matures in parallel as you advance up the Generative curve.

Core Components of HHS Data Strategy



Data integration, common systems and practice frameworks drive the engine that will ensure long term fiscal viability and success for families.

Jason—with the **data analytics** tools now starting to take shape, we are starting to be able to "peel back the onion" and see how we need to better serve certain client populations. What potential risk factors are we already collecting as part of our regular business? SNAP, we are asking certain questions and we can flag certain risk factors and areas of concern when they arise with a family/individual.

Robin—this type of data (like the housing data) revel that we should maybe move away from the point-in-time type of surveys (Jason's example of tracking 38,000 clients over a year shows that the self-identified homeless population is much higher than what the point-in-time survey shows).

Jason: www.bouldercountyconnect.org BCDHHS client portal. Marketplace concept: setting up the client to manage their own case, seek services, and upload documentation—part of our generative approach/strategy—client-driven services.

Elvira: what kind of services can be posted on the site? Jason, we are still building out the database of services. The only vet control that we have on the process, is that we create the agency admin account. If it does take off, we'll create a governance model. Robin: we'll share our governance model from BoulderCountyHelp.org.

Jason: Whitney Wilcox is scheduling some roadshows for the portal, or, folks can connect with Jason directly to learn more about getting their program.

Maggie—Newsfeed on the main page, we would like to share any community news on the main page of bouldercountyconnect. Feel free to send stories directly to Maggie.

Frank: as we've moved to more of a prevention based system of care, we've had to scale up and work more efficiently with a larger number of clients. This self-service tool will allow us to more efficiently provide services to folks.

Bobbie: Is court system or jail data tied into the data warehouse? Robin—this is part of our vision, just not connected to those systems yet. Jason—still working with other sources, SVVSD and BVSD for example. Very preliminary now, but working on it.

Laura—is their similar systems out there in the country like the client portal? Jason—not at the county-level, but some at the state level—very grassroots for Boulder County at this time. Frank—other communities are doing the integration on the data analytics/data integration side.

Frank—a lot of these sophisticated collaborations that are being built, need to look at the data at the individual level—this is the edge.

5) **Eligibility and Enrollment system update—Susan Grutzmacher, Community Support Division Director, Patrick Kelly, Project Director, Case Management and Community Outreach Division (4:15 – 4:45 p.m.)**
    (a) Community Support update
    (b) Open Enrollment 3, Plans for OE 4
    (c) New partnership alignments

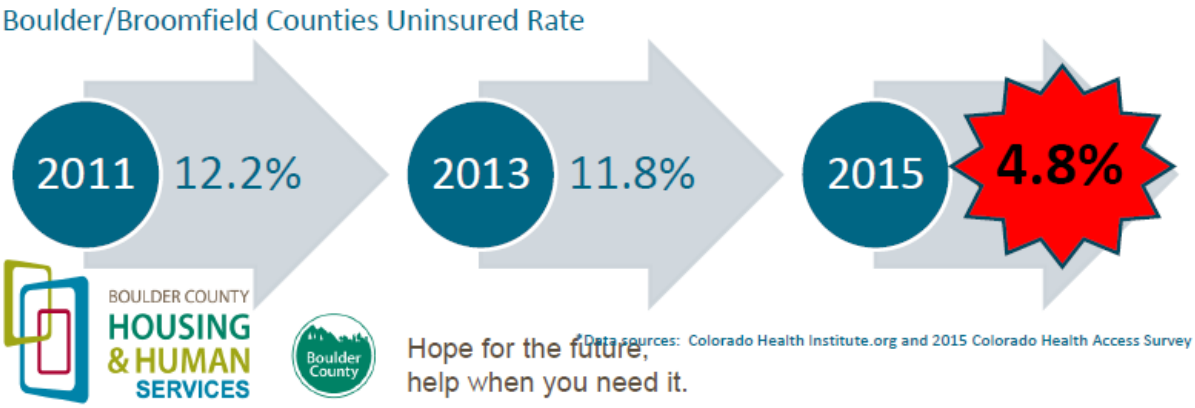
Presentation will be posted for access by Committee members.

Bobbie: underutilization of SNAP, national study on this. Is this the case in Boulder County? Patrick—depending on the study that you look at, CO is at 45th or 36th in the nation in terms of SNAP access. Western states tend to rate low historically. We are working with our partners and looking at data to dig into this currently and create a strong outreach plan. Group that includes EFAA, Sister Carmen, OUR Center, Community Food Share, Harvest of Hope, and Hunger Free Colorado. Boulder County's tend to be skewed a bit a student population (ineligible for SNAP) however; we are determined to reach more folks in the county.

Susan G: We will share out SNAP out reach plan with the committee.

Jim: we need this group's help in messaging and with certain populations like the Spanish-speaking/Latino/Hispanic populations in this outreach plan.

Patrick—current uninsured rate in the County:



Laura: Wanted to mention that 75% of the payer mix was Medicare/Medicaid at Longmont United Hospital. Simon: insured with the high deductibles have been problematic for Clinica—folks are starting to push off care/preventative care because of the costs (even though they are insured). Frank—we have 58,000 on Medicaid. Definitely better off on Medicaid versus the exchange products currently. 1 in 5 Coloradans are on Medicaid as their insurance and numbers are similar for Boulder County.

Dalia—been working with Dept. of Public Health and Environment on some issues and my advice would be to produce an outreach campaign that is created with the Latinos/Hispanic community input directly—not from a marketing firm's perspective, but from this population's perspective.

6) Highlight Early Childhood Integration Work Example – Bobbie Watson (4:45 – 5:00 p.m.)
**Tabled until next meeting

HEALTH AND HUMAN SERVICES INTEGRATION MATURITY MODEL 2.0

Based on APHSA's 21st Century Health and Human Services Business Model[1]

		MATURITY LEVELS Adapted from *The Human Services Value Curve*[2]			
		1—REGULATIVE	**2—COLLABORATIVE**	**3—INTEGRATIVE**	**4—GENERATIVE**[3]
Focus		Delivering services to program participants for which they are eligible while complying with categorical policy and program regulations	Ensuring the appropriate mix of existing services for program participants working across agency and programmatic boundaries	Addressing and solving the root causes of program participants' needs and challenges by seamlessly coordinating and integrating services	Creating healthy communities by working with others outside the H/HS enterprise to address complex health and social challenges
KEY FEATURES		***Characteristics of the Key Features at Various Maturity Levels of Integration***			
Vision	*For Program Participants*[4]	Program participants initiate engagement or are referred to a program within the agency.	Program participants initiate engagement or are referred to a program within the agency, accompanied by a hand-off to another program within the agency, with a sister agency, or beyond entities within government (heretofore referred to as partner organizations).[5]	Program participants are proactively engaged by the health and human services (H/HS) enterprise.[6]	Program participants are proactively engaged by the H/HS enterprise and external agencies by predicting current and future needs. A participant's behavior also serves as a catalyst toward achievement of shared outcomes defined collectively by H/HS community.
	For Organization/ Enterprise	H/HS agency complies with all relevant categorical and policy requirements—statutory, regulatory and executive.	H/HS agency works with partner organizations while complying with all categorical and policy requirements; retains organization's goals, some of which may overlap with partners.	H/HS enterprise addresses/solves root causes of program participants' needs via integrated service delivery and supports a customer-centric, integrated, outcome-oriented, modern marketplace experience.	H/HS enterprise identifies additional services beyond its immediate control to create healthy communities, improve program participants' outcomes, and population health and lowers costs-and through the use of analytics. Works seamlessly with other stakeholders, including other states, to generate long-lasting solutions and serve as a national model.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Governance	*Who*	Internal, senior executive-level decision-makers	Internal, senior executives with some external stakeholders from partner organizations	Internal, senior executives and other high-level stakeholders throughout the H/HS enterprise, along with external stakeholders from partner organizations	Internal, senior executives and a variety of other stakeholders from within and external to the H/HS enterprise and stakeholders in the community (such as advocates, providers, families, nonprofit organizations, industry)
	Decision-Making	Vertical/top-down—based on requirements of programs, risk is not intended to impact other programmatic areas.	Vertical/top-down, but influenced by partners' horizontal considerations. Risk is shared across collaborating entities to extent allowable.	Shared within the H/HS enterprise regardless of any single program's role. Risk is shared enterprise-wide so innovation is not limited.	Shared beyond the H/HS enterprise to reflect proactive, anticipatory, 360-degree orientation that considers drivers associated with the social determinants of health and well-being. Risk is balanced with generating new, creative solutions.
Adaptive Leadership and Capabilities	*Leadership View of Organization/Enterprise*	Leadership of single agencies/programs limited to fulfilling programmatic standards and mandates.	Leadership across the organization views collaborating organizations as partners who share common goals and bring valuable assets to the challenges faced by their shared program participants.	Leadership across the enterprise views the organization as seamlessly integrated with a holistic view of the program participants. Leadership places its highest value on outcomes-focused goals even at the expense of organizational norms. It also allows mid-course changes when prompted by new information and deemphasizes hierarchy and silos across the enterprise.[7]	Same view of enterprise as in Integrative Stage, but with the highest value placed on outcomes consistent with the creation of healthy communities. Leadership relies on new partnership models to generate a new community of nontraditional public/private sector partners focused on sustaining whole community well-being and generating new approaches and solutions.
	Drivers of Organizational Change	Outside statutory and regulatory process requirements associated with compliance with statute and regulations.	Collaborative efforts to address mutual challenges. Challenges stem from external requirements and inability to avail itself/oneself	Continual environmental scanning of current and anticipated statutory/ regulatory environment as well as marketplace of	The H/HS enterprise serves as a catalyst toward changing the statutory/ regulatory environment. Culture of receptivity that

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Adaptive Leadership and Capabilities (cont'd)	*Drivers of Organizational Change (cont'd)*	Challenges stem from limited to no ability to share information.	of opportunities identified through information sharing across organizational boundaries. Staff and systems strive to adapt their business processes and data flows to reinforce cooperation.	enterprise and stakeholders. A seamless cross-boundary exchange of information within the enterprise provides opportunities to address root causes and change traditional practices.	generates key solutions to leverage the enterprise's strengths, together with private and public partners sharing common goals. Information gathered from internal and external sources helps guide staff actions routinely and enables the enterprise to be highly adaptable to change.
Access Channels and Engagement	*Who is Responsible for Access?*	Access to services is transactional. It's sought out by program participants and the agency responds to the presenting need/request.	Access to services is also transactional, but additional communication may occur between program participants and partnering organizations to respond to the presenting need/request.	Access to services is the result of ongoing, preventive engagement and proactive communication from the enterprise to program participants.	Access to services is the result of ongoing, preventive engagement and proactive communication among the enterprise, program participants, and the community. Participants are activated to be a catalyst identifying beneficial programs that may help to prevent future, deeper service needs.
	• *Developing Access*	Participants' access is available on a program-by-program basis and is provided by multiple workers across multiple sites with minimal coordination between programs, except where required.	Participants' access is available on a program-by-program basis yet program workers coordinate with one another to assist participants in navigating multiple points of entry.	Participants' access is universally available and provided by workers utilizing a "no wrong door" approach.	The enterprise provides universal access and interaction with participants that anticipates future needs and serves to prevent or remedy potential downstream issues.
		Use of technology is focused on processing transactions and reducing administrative costs.	Use of technology is focused on facilitating data exchanges between partnering organizations. Web-based technologies, such as electronic participant portals, central data repositories, and document imaging and	Use of technology is focused on enabling program participants and staff to effortlessly navigate a variety of access channels across the enterprise. Enterprise service busses, universal	Use of technology is focused on enabling the enterprise to work collaboratively with the program participants as "choice architects." Online portals, smart phones, tablets, and kiosks work

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Access Channels and Engagement (cont'd)	• *Developing Access (cont'd)*		digitization of case records facilitate program participants' access and enrollment.	client registries, workflow and identity management tools, automated account creation technologies, and readily available case notes that can be shared with others (within privacy constraints), are used widely.	together seamlessly with traditional service centers and personal referrals. Community-based organizations serve as portals and extensions of government. The enterprise serves as a test site for innovative approaches to enhancing existing and generating new access channels.
	• *Gaining Access*	Program participants initiate direct, person-to-person contact at the local office, although some information may be available on-line.	Program participants initiate contact (in person or on-line) and guidance is provided regarding available complementary services that are provided to the participant by partnering organizations.	Enterprise initiates contact through automated alerts, notices of renewals, or other technologies advancing program participants' access to services with the enterprise assisting the participants in navigating the service system through the setting of decision points for choices that lead the participant toward health and wellness. In-person assistance remains available for high-touch participants.	Enterprise and community partners initiate contact with program participants through seamless technologies incorporating the latest advances in access channels including readily accessible 24/7 call centers. Enterprise, community partners, and the participant collectively work together to navigate the service system. Yet, at this level, program participants are empowered to act as own catalysts for making choices leading toward health and wellness. In-person assistance remains available for high-touch participants.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Common Process Functions	*Application/Intake and Enrollment*				
	• *Application/Intake Process*	Application/intake process is highly customized to specific programmatic mandates and standards; uses only program-specific applications.	Application/intake process can be separate or used across multiple programs while retaining programmatic mandates and standards.	Enterprise works together to create and use a simplified common application/intake process that is mutually acceptable across organizations.	Enterprise works with a simplified common application/intake process that is mutually acceptable with organizations across and external to the enterprise. Feedback loops are incorporated into application to handle new regulations and policy requirements across programs.
	• *Enrollment Activities*	Specific applications/intake processes are used to determine eligibility and enroll program participants in a given program.	Application/intake processes are completed collaboratively with partners through the use of cross-boundary data and most of which can be used by multiple programs. Programmatic enrollment responsibility is diversified across multiple partners.	Use of client registries, together with decision-support tools, enhances the staff's ability to overcome barriers inherent in traditional silos. Opportunities are created that allow program participants to be actively engaged in key decisions. Enrollment is centralized based on eligibility determination established from common system.	Through use of a universal client registry and other decision support tools, the enterprise and other partners can engage in activities beyond eligibility and enrollment such as integrated case management and innovative relationship management strategies to achieve the desired outcomes.
	• *Application/Data Characteristics*	Verification of eligibility is based primarily on paper records.	Verification is based on a mix of paper and electronic information.	Verification is based on electronic databases in various locations inside and outside of the enterprise.	Verification is based on the application of common business rules, electronic document management, and robust privacy and security controls coupled with robust data sharing.
	• *Technological Features of the Eligibility and Enrollment (E&E) System*	E&E systems that are tightly coupled[8] and have dated functionality that is difficult to modify/update, resulting in processing of applications, eligibility determinations and enrollment that is time-	E&E systems that are tightly coupled, but may use some cross-boundary communication enabled by add-ons to the existing legacy system rather than through functionality of integrated	E&E systems are loosely coupled[9] while completely integrated and connected seamlessly with organizations throughout the enterprise and based on well-defined data-use	E&E systems are loosely coupled while completely integrated within the enterprise and connected seamlessly with those outside the enterprise based on well-defined

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Common Process Functions (cont'd)	• *Technological Features of the Eligibility and Enrollment (E&E) System (cont'd)*	consuming for staff and delays access to the program participants. Participants' data are difficult to share across programs.	components across partnering organizations.	agreements.	data-use agreements. These resources, combined with multi-benefit screening, result in real-time eligibility determinations and seamless enrollment.
	Workflow Goals and Characteristics	Workflow processes are rules-driven, and designed to deliver a specific output,[10] including determination of eligibility, benefit level to be provided, etc.	Workflow processes are rules-driven yet are updated to build in efficiencies through collaboration with other programs, resulting in multiple "one-stop" opportunities.	Workflow processes are streamlined, seamless, and completely integrated. Processes are designed to achieve efficiencies and desired outcomes[11] identified in conjunction with program participants and the enterprise.	Workflow processes are similar to the Integrative Level, yet input from stakeholders internal and external to the enterprise, community partners, and program participants is instrumental in the design to enable the ability of participants to serve as catalysts toward the achievement of shared outcomes.
	Residence/Access of Consumer Data	Exclusively within the organizational boundaries of each programmatic business line or division, except where sharing is required.	Within individual programmatic business lines or divisions but is shared across organizational boundaries with data owners' and program participants' consent.	Able to be centralized or reside in multiple locations across the enterprise. Information is easily accessible by program participants, staff within the enterprise, agencies external to the enterprise (e.g., education, juvenile justice), and external community partners, to ensure efficient, end-to-end workflows and appropriate outcomes.	Data are centrally housed and available in real-time to all government staff internal and external to the enterprise, including front-line workers, and community partners, while maintaining the highest levels of privacy and security standards.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Coordinated Service Delivery	*Administration of Service Delivery System*	Administered efficiently within the span of control of the organization responsible for delivering the services, with coordination occurring where required.	Administered efficiently through coordination across partnering organizations when opportunities arise. "Best practices" to improve accessibility, accountability, and coordination in other organizations are viewed as possible sources of efficiency and innovation.	Administered efficiently across the enterprise to continuously improve accessibility, accountability and coordination and based on input from within the enterprise and from program participants. Increased flexibility allows ability to replicate, utilize, and customize evidence-based practices to achieve cross-programmatic outcomes.	Administered efficiently and effectively within and external to the enterprise. Flexibility is sustained through feedback loops that exist within and external to the enterprise, including from program participants and community partners, to allow improvement of accessibility, accountability, and customization of services into unique arrays that meet program participants' needs, while drawing upon a practice model that is shared across the enterprise.
	• *Role of Organization/ Enterprise*	Services are identified and delivered within the span of control of the organization responsible for delivering the services, with coordination occurring where required.	Services are identified and delivered in a coordinated manner when ability to avail itself/oneself of opportunities arises across partnering organizations.	Services are identified and readily accessed throughout the enterprise.	Services are identified and readily accessed within and external to the enterprise, as well as by program participants and community partners.
	• *Role of Staff*	Workers may help program participants find additional assistance but the participant needs to initiate access to services.	Workers are knowledgeable about services available through partnering organizations and help program participants access them in a timely way.	Workers collaborate seamlessly across multiple lines of business in such a way that program participants' needs are met and achieved through increased development and coordination of solutions.	Workers ensure that solutions are customized to meet program participants' needs, and that supplementary services are part of participants' service plan that also address the social determinants of health, where appropriate.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Coordinated Service Delivery (cont'd)	• *Role of Staff (cont'd)*	Workers may have informal knowledge of the variety of services offered across multiple lines of business yet there is no formal training provided or processes in place to facilitate coordinated access or service provision.	Workers have some formal orientation to the variety of programs and processes, if in place, to facilitate cross-programmatic access and service provision.	Where possible, workers are cross-trained and assist with service development and provision across multiple programs within the enterprise.	Workers utilize universal knowledge within and external to the enterprise, including the program participants and community partners, to anticipate and proactively address participants' needs.
	• *Role of Program Participant*	Program participants are viewed as recipients of services. The design and delivery of services to the participant remains the responsibility of the organization.	Program participants are viewed as both recipients of services and minimal contributors to their own service plan. The design and delivery of services to participants are a joint responsibility shared between the partnering organizations.	Program participants are viewed as partial partners to the development of a single, integrated service plan with assistance from the enterprise and community partners. Design and delivery of services is jointly conducted with the enterprise and participants.	Program participants are viewed as a full partner in the development of a highly customized service plan with assistance from the enterprise and community partners, drawing on, but not limited by, the services the enterprise has provided in the past and services proven in other contexts to generate positive outcomes.
Defining Success	*For Program Participants*				
	• *For Program Participants*	Defined by regulatory and statutory requirements associated with the efficient and effective processing of participant transactions.	Defined collaboratively with partner organizations sharing common values and goals although focus remains primarily on ensuring smooth, efficient transactions.	Defined by the program participant and the enterprise as a whole and used as benchmarks for evaluating progress toward achieving sustainable outcomes for participants.	Defined by the program participant, the enterprise as a whole, and other community partners. Outcomes are continually fine-tuned through feedback mechanisms to ensure that their continued appropriateness for participants and the broader general population.
	• *Process by Which Outputs/ Outcomes Are Defined*	Results for program participants are defined through transactional outputs (e.g., accuracy, timeliness) once received by the participant.	Results for program participants are defined through transactional outputs (e.g., accuracy, timeliness), including those involving partnering	Sustainable results or outcomes defined as those that favorably affect program participants over the short term.	Sustainable results or outcomes (e.g., sustainable employment, improved health and wellness), defined and identified by the enterprise, program

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Defining Success (cont'd)	• *Process by Which Outputs/ Outcomes Are Defined (cont'd)*		organizations.		participants, and community partners through feedback mechanisms continue to favorably affect participants over the long term.
	• *Accountability of Program Participants' Success*	Accountability for program participants' success rests with the system of service provision within the individual line unit's or division's span of control.	Accountability for program participants' success rests with the system of service provision collaborating across business lines to achieve mutually agreed-upon goals, as well as with the participant who has somewhat contributed to the service plan in place.	Accountability for program participants' success is seen as a joint responsibility between the participant and others, including groups that provide input to enterprise products, services, and strategy across program areas.	Accountability for program participants' success is shared equally between the systems of service provision, the community of which the participant is a member and the participant. Participants' are full partners with enterprise and community leaders in setting strategy for the enterprise.
	For the Organization/Enterprise				
	• *For the Organization/ Enterprise*	Defined by the statutory and regulatory outputs required of the organization or individual line of business. Success is determined by how well the organization or individual lines of business capture their inputs and maintain required levels of outputs.	Defined by the outputs jointly captured across the agency and partnering organizations, and that are supported by required inputs and outputs for each line of business. Success is determined by how well the programs and partnering organizations capture and maintain jointly shared outputs reflecting their shared goals.	Defined by the enterprise's shared outcomes and that are supported by required inputs or outputs. The enterprise works as a seamless whole to achieve the optimal outcomes for its users and accepts unanticipated outcomes generated from the enterprise. Success is determined by the degree to which the enterprise is able to achieve the shared outcomes and goals collectively agreed upon by stakeholders within it and at least partially by program participants.	Defined by the enterprise as a result of cumulative knowledge gained over time and reflects advancements attributable to continually evolving solution sets that are being generated by the enterprise, program participants, and community partners. Success is determined by the enterprise's continuous adaptability and ability to improve performance and is based on achievement of shared outcomes and goals collectively defined by participants, those within and external to the enterprise, and community partners.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Measures	*How They Are Defined*	Inputs and outputs of the organization delivering services capture specific activity and provide basic trend data over time, including program investment, number of families served, number or percentage of cases closed in a given period, etc.	Similar to the regulative, inputs and outputs of the partnering organizations are also capturing progress made on shared goals and collective actions.	Outcomes shared across the enterprise are quantified while using trend and root-cause analysis to inform progress, as well as to determine priorities and resource needs. Inputs and outputs of single and partnering organizations are still tracked but are used more to inform progress on shared outcomes of the enterprise.	Outcomes shared within and external to the enterprise are quantified while trend and root-cause analysis, as well as other types of advanced analytics,[12] are used to inform progress, priorities, and resource needs. Inputs and outputs of single and partnering organizations are still tracked but are used less as markers of success. Measures also continuously evolve over time.
Infrastructure[13]	*Workforce*	Primarily, staff working within an individual line of business with little knowledge of other programs across the organization. Formal orientation or training to increase awareness of other programs may be provided.	Primarily, staff working within an individual line of business but encouraged, both formally and informally, to learn and coordinate activities with partnering organizations. Formalized orientation or training and processes in place to increase awareness of other programs and coordinate work across lines of business.	Primarily, staff is formally cross-trained to develop awareness and universal knowledge of multiple programs across the enterprise, as well as establish formalized networks within the enterprise in order to provide customized, holistic, program participant–centered services. Less emphasis is placed on specialization in one program/line of business except in key areas within the enterprise.	Primarily, staff is formally cross-trained to continuously develop universal knowledge and maintain formalized networks within and external to the enterprise to strategically provide customized, holistic, program participant–centered services. Less emphasis is placed on specialization except in key areas within and external to the enterprise.
	Organization Structure and Capacity to Change	Structure is designed to be responsive to administrative process drivers within the individual service delivery units. Little to no data are shared across organizational boundaries.	Structure is designed to be responsive to administrative process drivers within the individual service delivery units, but with allowances made within the infrastructure to permit cross-boundary coordination	Structure is designed to be responsive to administrative process and other drivers within the enterprise; the infrastructure supports seamless data sharing and use with individual service	Structure is designed to be responsive to administrative process drivers and other drivers within and external to the enterprise; the infrastructure supports seamless data sharing and

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Infrastructure (cont'd)	*Organization Structure and Capacity to Change (cont'd)*		and data sharing among partnering organizations.	delivery units contributing resources and solutions across the enterprise without being hindered by differences in rules, vocabulary, or definitions.	use within and across the enterprise's boundaries in such a way as to generate administrative efficiencies as well as to generate innovations in policy and practice.
	Purpose of Technology	Systems are designed to be transaction-driven and focused on the individual division or line of business meeting its goals.	Systems are designed to be transaction-driven and focused on the individual division or line of business as well as data sharing across boundaries of partnering organizations. The partnering organizations may maintain their own systems and nomenclatures but electronic translators and other devices are used to facilitate clear comprehension of cross-boundary information, regardless of the source of the information or platform used.	Systems are designed to be outcome-driven and focused upon goals that have been defined for the enterprise as a whole. Data are universally defined across the enterprise such that no additional translation of terms, definitions, or codes is required and is used to identify consistency for individuals, and families beyond eligibility.	Systems are designed to be outcome-driven, focused upon goals defined for the enterprise as a whole that are continually being modified to take into consideration the larger milieu of drivers associated with the social determinants of health, even if those drivers arise from outside the enterprise's span of influence. Data are universally defined and used to identify consistency for individuals, families, and communities beyond eligibility.
	Communications	Communication may be conducted across multiple lines of business around achievement of process-focused goals.	Communication is more frequently conducted around achievement of shared goals with partner organizations.	Communication is conducted regularly and internally (both vertically and horizontally), and somewhat externally, to the enterprise to reinforce achievement of shared success.	Communication among all stakeholders is strategic, bi-directional, and efficient to reinforce achievement of shared success.
	Human Resources (HR)	HR functions (recruitment, selection, training, employee relations, performance management, and benefits) are primarily administered based on compliance with regulations.	Similar to the Regulative level, HR functions are primarily focused on staff acquisition and regulatory compliance, yet also focused on building a culture of engagement that fosters relationship building across	HR functions still maintain existing core tenets, yet the primary focus shifts to building a learning environment across the enterprise. Activities are directed at developing new competencies for the	HR functions still maintain existing core tenets, yet the primary focus shifts to building a learning environment within, and external, to the enterprise. Activities are directed at helping to identify, and

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
	Human Resources (cont'd)		employees in partnering organizations.	enterprise as a whole and for staff at every level to align with the priorities and outcomes of the enterprise.	then develop, new competencies for the enterprise as a whole and for staff at every level to align with the priorities and outcomes within and external to the enterprise.
Financing	*Provision of Funding*	Funding is provided by a variety of federal, state, local, and external sources and distributed to programs in conformance with strict cost-allocation rules and for the purposes of narrowly defined tasks/services. Most funding cannot be moved within a program for purposes outside of statutory or regulatory limits.	Funding is provided same as in Regulative level; cost-allocation rules followed, and in general, no tasks are allowed that are not related to specific programs. However, some tasks/services can be adjusted that support some coordination with partnering organizations within the general programmatic areas that are typically only allowed through state match or state-only dollars, local dollars, or other supplemental funding sources.	Funding is provided to support highly integrated services through proactive staff work across the enterprise to assist program participants' use of a broad range of multi-program services, benefits, organizations, and other resources. Continuous, intentional use of flexible, data-driven, and alternative financing approaches is explored within and across the existing funding authorities throughout the enterprise.	Flexible financing approaches (e.g., blended/braided funding, pay-for-success, multi-sector initiatives) are consistently used and modified based on feedback loops and through the use of enterprise-wide data metrics and analytic tools established across and external to the enterprise to assist program participants use broad range of related services, benefits, organizations, and other resources.
	• *How Priorities Are Set*	Decisions are highly mindful of operational and process compliance constraints attributable to funding sources and cost-allocation methodologies.	Same as in Regulative level but high value placed on collaboration with other partner organizations that may receive funding from other sources. Together, they work toward achieving shared goals.	Same as in Collaborative level, yet the enterprise seeks to maximize its effectiveness by flexibly leveraging various funding sources to achieve improved shared goals and outcomes across the enterprise.	Same as in the Integrative level but the enterprise and community partners not only place a high value on pooling resources to achieve shared outcomes, but place equally high value on proactive and routine seeking of new and innovative mechanisms to increase financial resources to support or even replace traditional funding streams.
	• *Risk*	Little to no risk as priorities reflect constraints attributable to funding	Risk is somewhat higher and dispersed among partnering organizations as priorities	Risk is shared across the enterprise upon testing of new financing solutions	Risk is shared across the enterprise and community partners upon testing and

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Financing (cont'd)	• *Risk (cont'd)*	sources largely measuring outputs and inputs.	reflect increased focus on identifying collaborative financing among those working toward shared goals, while still being risk averse.	and alternatives emphasizing solutions-oriented approaches toward shared goals and outcomes.	implementing new financing solutions and alternatives emphasizing solutions-oriented approaches toward achieving shared goals and outcomes. Continuous feedback loops, including use of data and analytics to identify (social) return on investment opportunities, allow re-prioritization of allowances for modification of funding distribution to achieve shared outcomes.

Endnotes

1. Cari DeSantis, M.A.L.S. *Business Model for Horizontal Integration of Health and Human Services*. American Public Human Services Association. 2012. p. 13–17.
2. Antonio M. Oftelie. *The Pursuit of Outcomes: Leadership Lessons and Insights on Transforming Human Services: A Report from the 2011 Human Services Summit on the Campus of Harvard University. Leadership for a Networked World*. 2011. p. 5–7.
3. The *Generative Level* incorporates the 10 key characteristics of the *21st Century Health and Human Services Business Model*.
4. For purposes of this model, which aims to view the individual/family across business lines and from an enterprise or agency-wide lens, we refer to the individual or family receiving services as the *program participants.*
5. *Partner organizations* may be defined as different programs or lines of business within a health and human service agency. As each state and locality are structured differently, this may also be defined as agencies operating as a separate entity but serving the same population (e.g., some states have a single-state agency for child welfare or behavioral health yet there may be shared outcomes/populations/systems spanning across sister agencies).
6. *Enterprise* is defined here as a group of departments and the health and human service programs that fall within them that constitute a given agency, as well as other single, sister health or human service agencies with similar missions serving the same population, that have collectively defined shared outcomes, strategic goals, operations/business processes and administrative functions to further the collective interest and benefit of those receiving services, those providing the services and the community at-large.
7. Antonio Oftelie, Julie Booth, and Tracy Wareing. *The Art of the Possible:* Leading Change in Human Services. *Policy & Practice (June 2012)* p.11–15.
8. *Tightly coupled* refers to a system in which components have, or makes use of, knowledge of the definitions of other separate components.
9. *Loosely coupled* refers to a system in which each of its components has, or makes use of, little or no knowledge of the definitions of other separate components.
10. *Outputs* are defined here as process measurements of time, quantity, or quality relative to a particular reporting requirement (e.g., how many individuals were served, how much time did it take to process an application). For purposes of this model, (shared) outputs are used to reflect how an organization measures success at the Regulative and Collaborative levels of maturity.
11. *Outcomes* are defined here as the changes that have taken place over time in knowledge, skills, behaviors, and conditions as a result of an organization's work, as well as the differences made by outputs of which are often expressed in terms of impact and sustainable changes of the health and well-being of individuals, families, and communities. For purposes of this model, shared outcomes are used to reflect how an enterprise determines success at the Integrative and Generative levels of maturity.
12. *Advanced analytics* are defined here as tools used to go beyond the collection and sorting of data to turn the information into data capable of providing future options and predictive capabilities. These capabilities can then forecast possible prospective results under different scenarios associated with each option through detailed pattern analysis. In addition to root cause and trend analysis, other tools include statistical analysis, forecasting, predictive analytics, and optimization. *Source:* American Public Human Services Association. *Analytics Capability Roadmap 1.0 for Human Service Agencies.* April 2014.
13. *Infrastructure* is defined here as the shared administrative and operational systems that support business needs across the entire health and human service enterprise intentionally designed to support the vision and offer innovation, while constantly learning and keeping pace with the evolving marketplace in which program participants live, work, learn, and play. For purposes of this model, the foundational infrastructure includes but is not limited to, components such as workforce, use of technology, communications, and human resources. *Source:* Cari DeSantis, M.A.L.S. *Business Model for Horizontal Integration of Health and Human Services*. American Public Human Services Association. 2012. p. 24.

Department of Housing & Human Services

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Memo

To: Department of Housing and Human Services Advisory Committee
From: Frank Alexander, Director, BCDHHS
Date: March 31, 2015
Re: Proposed Activities from HHSAC members to support DHHS Strategic Priorities in next 12 months

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Dear HHSAC members,
Based upon our discussions last month and follow-up conversations with HHSAC members and other community members, I am submitting the following proposal for your review and approval. As you know, HHS is in the the midst of some significant work in multiple areas that will strengthen and integrate our activity within the community. I am attaching the PowerPoint presentation I shared with the committee last month as reference regarding our strategic priorities and our overarching service context.

We are committed to long-term sustainable transformation in our sphere in order to co-create solutions for the well-being of our entire community. As our locally-developed community-based safety net becomes increasingly driven by individuals and families, focuses more effectively on upstream prevention oriented programming, and develops data-driven cross sector solutions, we would like to further leverage the collective strength of our partnerships by focusing on specific high-value propositions. Our pursuit of these high-value interventions will be examined through a combination of our collective success in the health, housing and human services sphere. In particular, I want to highlight the agency's overarching "Big Hairy Audacious Goal" (BHAG): ***"Within 10 years, DHHS will transform the health and the well-being of our community by shifting programming and funding upstream into prevention-oriented and consumer-driven cross-sector solutions that improve outcomes across the lifespan and significantly reduce high-cost institutional interventions within a social determinants of health framework."***

On slide 22 of the PowerPoint, I highlighted a few of the areas currently underway with significant relevance to HHS. They included: Medicaid Service Expansion Efforts, Boulder County Health Improvement Collaborative priorities, Public Health Improvement Plan, Dream Big Partnership, Supportive Housing Projects/Housing Stabilization Program, Flood Recovery Housing efforts,Ten-Year Board to Reduce Homelessness Priorities, Early Intervention and Child Welfare Prevention Supports, Early Childhood Council of Boulder County: Quality Improvement and Increased Access, Social Impact Bonds, IMPACT priorities, and Family Resource Centers/Resource Schools/Prevention Intervention Program. The members of the HHSAC have significant expertise in these and any number of critical areas.

I would like to recommend the following areas for focus for the HHSAC. These are just suggestions!

- **Medicaid Service Expansion Efforts:** Request for input and suggestions for specific ways that HHS can support capacity development within the Medicaid service provider population that will support the now expanded enrollees with better access to primary and specialty care services. In particular, are there funding priorities for service or capital dollars that can be provided? One specific request is guidance to review the Dental Aid summary for operating subsidy and give guidance to HHS on how to respond to this type of request, solicit other like requests, and suggest what the implications of these supports are. Recommended Primary HHSAC member: Simon Smith with Jeff Zayach Secondary. Staff Liaison: Frank Alexander.
- **Early Childhood Council of Boulder County: Quality Improvement and Increased Access**: Summary of the evaluative work of the ECCBC priorities at both the Advisory Council and Executive Board and a summary of HHS staffing and funding priorities that would align with the work of the ECCBC and that are accomplishable in next 12-24 months. Recommended Primary HHSAC member: Bobbie Watson with Secondary Suzanne Crawford. Staff Liaison: Terri Albion/Susan Grutzmacher.
- **Ten-Year Board to End Homelessness Priorities:** Review of the Ten Year Board current priorities and process and a recommendation on HHS staffing and funding priorities that would align with the work of the 10YB and that are accomplishable in next 12-24 months. Recommended Primary HHSAC member: Robin Bohannan with Secondary Penny Hannegan. Staff Liaison: Daphne McCabe.
- **Financial and Budget Transparency and Communication to Community on Return on Investment:** Review HHS "Transparency" website, Safety Net Mill Levy documents from TSN and HSSN, budget presentations and financial communications, and Board information from fiscal perspective and make recommendations to HHS on what you see as the level of transparency within the documents, how well we are meeting the needs of the taxpaying public. In particular, we are very focused on communicating around upstream investments in prevention, ROTI, and integrated/blended payments for services. Recommended Primary HHSAC member: Dan Thomas with Secondary Simon Smith. Staff Liaison: Jim Williams.
- **Enhanced service delivery for the Latino community and strengthening recruitment and retention of bilingual and bicultural staff:** Review current service and staff demographics in relation to population base and poverty rates, recommendations of the

Latino Task Force, community-wide needs assessments, the work of the Cultural Competency Committee, and conduct applicable focus groups with residents and partners to support the development of an HHS plan that will enhance both service delivery and staff retention and recruitment. Recommended Primary HHSAC member: Dahlia Dorta with Secondary Elvira Ramos. Staff Liaison: Myriam McDowell and Chris Campbell.

- **Evaluate PHIP priorities and HHS priorities for enhanced alignment:** Review the alignment of the Public Health Improvement Plan process and the HHS Social Determinants framework and make recommendations for enhanced alignment and focused community work within those contexts. Recommended Primary HHSAC member: Jeff Zayach. Staff Liaison: Summer Laws and Angela Lanci-Macris.
- **Community work with the Hospitals:** Evaluate the current hospital financial and service landscape and provide updated information to HHS on the opportunities for better system collaboration with the hospitals on enrolling the remaining uninsured populations and -most importantly- effectively serving the at-risk populations that are significant consumers of hospital resources with the Social Determinants of Health context. Provide updates on the data, fiscal and service trends occurring in a post-ACA world. Recommended Primary HHSAC member: Laura Kinder with Secondary Simon Smith. Staff Liaison: Stephanie Arenales.
- **Family Resource Centers**: Provide a summary of the current status of the Family Resource Center service and case management model. Define what progress has been made, where are the opportunities and risks within the next 1-2 years, and the potential to scale the model into the Longmont community. Provide a more detailed understanding of the financial benefits and challenges of the FRC model and the projections for growth and services in the coming years compared to the last five years. Recommended Primary HHSAC member: Suzanne Crawford with Secondary Bobbie Watson. Staff Liaison: Melissa Frank-Williams.
- **Dream Big Project**: Provide a summary of the current status of the Dream Big Project and how it connects with and will influence our efforts within early childhood investments, community-based case management, and supportive housing models. Define what progress has been made, where are the opportunities and risks within the next 1-2 years, and the potential to scale the model throughout different housing sites. Provide a more detailed understanding of the financial benefits and challenges of the Dream Big Project and the projections for growth and services in the coming years. What are the policy questions and implications of the expansion? Recommended Primary HHSAC member: Penny May with Secondary Robin Bohannan. Staff Liaison: Whitney Wilcox.

Once these sugggestions or others are adopted, I would recommend that the committee members come back to the April meeting with some basic sense of their targeted analysis, questions to help clarify the focus areas, and what will be required to provide some actionable recommendations that we can incorporate into our current work plan activities or begin to evaluate for our 2016 budget options. We can utilize the April meeting to have a wide-ranging discussion on the questions members have on their focus areas and we can collectively brainstorm next steps. We can also begin to set forth a calendar for May/June/July that will

continue to support the presentation of these recommendations and help us think about our budgeting, planning, and strategic resources for the next 18 to 24 months.

Westword

The Ugly Side Effects of Sky-High Rents

MONDAY, JULY 18, 2016 AT 5:27 A.M.

BY MICHAEL ROBERTS

A December 2015 photo of renovations at Kalmia, a 55-unit subsidized housing community in Boulder. Additional photos below.

When most people think about the high rent prices in the Denver-Boulder area, they tend to focus on how much folks are required to pay each month.

But this outlay is only the beginning. High rents impact a range of other issues, including employment, traffic, health care and the overall economic well-being of communities in which housing costs often seem out of control.

Jim Williams understands that very well. He's the communications specialist for Boulder County Housing and Human Services, so his comments are specific to the challenges in that area. But they can also be applied to Denver and plenty of other Colorado communities, as well as to hot housing markets around the country.

The rise in Boulder rents didn't happen overnight. As first reported by the Boulder *Daily Camera*, rents in the Boulder urban area have gone up 43 percent since 1980 — 9 percent faster than the national average over the same period. But far from shrugging off the issue as intractable, local officials are increasingly looking for ways to put a dent in the problem. "Obviously, this is something we're grappling with as the housing authority for Boulder County, but we're not alone," Williams says. "The City of Boulder has its own housing authority, and they're grappling with it within the city limits. Longmont also has a housing authority, and they're seeing some of the same issues in the far eastern part of Boulder County, because people are finding that they're having to move farther and farther out from the city.

"We're seeing people who work in Boulder moving to places like Broomfield and Westminster, out into western Weld County and up north to Larimer County just because Boulder County's rental rates are so high — and 38 percent of our population in Boulder County is renters. That's a significant number of people...."

The profile photo for Boulder County Housing and Human Services' Facebook page.

Individuals "moving out of Boulder County because they can't afford to live here anymore, even though they still work here" results in "a lot of commuters going back and forth on 119 and 36 and all the other highways in the county," Williams notes, "and you can certainly see the impacts. Anyone who has been on Highway 36 in the mornings or afternoons or pretty much any other time of the day has seen the effects of the high number of commuters coming in and out of Boulder County.

"Those traffic effects are tremendous, and we're concerned about the impacts they have on people's lives in general," he continues. "They involve more stress, less time with families, health impacts and other kinds of ripple effects that can grow more serious because of the increase of distance from home to work."

Also impacted are "the decisions people make on where they're going to spend money," Williams points out. "If you have less money to spend because you're spending more money on your housing, just because you need to be close to where you work, you have less money to spend on food, health care, child care and all the other things people need in their lives. And they're having to make difficult decisions about what to leave out."

When faced with these factors, some folks are concluding that they can no longer afford to work in Boulder.

"Anecdotally, we're hearing that and seeing that happening at restaurants, in grocery stores, in school districts," Williams confirms. "In Boulder County, we're seeing that teachers and custodial staff and others on the lower end of the salary spectrum in school districts are increasingly having a hard time maintaining their employment because they can't live close enough to where the schools are. If you're a school teacher in Lafayette who's being pushed out of the housing market and is challenged by the rising rent, there's additional stress on you to move to a place where you can afford to live. That's part of the shrinking middle class, not only in Boulder County, but in other parts of Colorado as well."

One way to keep such employees is to pay them more. But Williams says "there's some feeling that the disparity between salaries and housing costs is now large enough that it's going to be hard to make that up in any capacity — certainly in terms of increasing wages and how we get there, but also in how we can build enough affordable housing, and how we can convince enough landlords to accept housing-choice vouchers."

Aspinwall at Josephine Commons is an affordable-housing complex located in Lafayette.

The housing-choice voucher program in Boulder County was created to subsidize housing costs for "low-income individuals and households, military veterans, homeless families, and families and children involved in the child welfare system," its website states. But supply simply cannot keep up with demand, Williams concedes.

"We have a little over 700 housing-choice vouchers — but we have about 40,000 people living in households where they're paying more than half of their income on rent," he says. "So the wait list fills up very quickly, and any time we do have available vouchers, they're assigned immediately. And with the need continuing to increase and financial supports not necessarily increasing at the same rate, we can see this continuing for the foreseeable future."

In an effort to change the equation, what Williams describes as a "Regional Housing Network" has been launched in Boulder County; members of the steering committee include the Boulder County Housing Authority, Boulder Housing Partners, the Emergency Family Assistance Association, Mental Health Partners, Element Properties, Thistle Community Housing, Allison Development, the Safehouse Progressive Alliance for Nonviolence, Attention Homes, Bridge House, Boulder Shelter and the Boulder County AIDS Project. Additionally, the housing

authorities in Boulder and Longmont have been working with Boulder Housing Partners and officials representing both cities to put together a housing plan for Boulder County as a whole.

Williams is encouraged by these undertakings and is optimistic that collaboration will lead to concrete results. But he feels the analysis shouldn't stop there.

"As a community, we need to ask bigger questions," he says. "We need to decide what we value. And if we value the quality of life for the people who live here, and the quality of life for the people who teach our children and put out the fires and police our communities and serve us in restaurants and the wide range of other things people do — if we value their quality of life, then we need to be making some tough choices. And we need to do it now."

BOULDER COUNTY HOUSING & HUMAN SERVICES

Hope for the future, help when you need it.

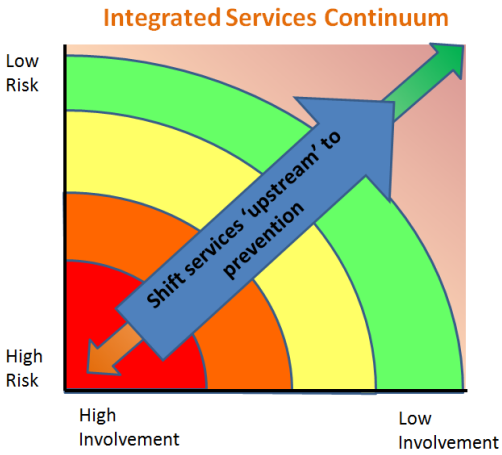
BCDHHS Advisory Committee
September 2016 Meeting Packet

Department of Housing & Human Services

Housing Office: 2525 13th Street, Suite 204 • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax: 720.564.2283
Human Services: Boulder Office • 3460 Broadway • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax 303.441.1523
Longmont Office • 515 Coffman Street, Suite 100• Longmont, Colorado 80501 • Tel: 303.441.1000

www.bouldercountyhhs.org

DHHS Advisory Committee
MONTHLY MEETING
Tuesday, September 27, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder



Agenda

1) **Review and approval of today's agenda** (3:30 – 3:33 p.m.)

2) **Review and approval of minutes from August 30 HHSAC meeting** (3:33 – 3:35 p.m.)

3) **Game of Life client simulation**—Daphne McCabe, Strategic Initiatives, IMPACT Care Management Division (3:35 – 4:00 p.m.)

4) **Continuation of governance discussion: moving from collaborative to integrative** — Susan Caskey, IMPACT Care Management Division Director; Angela Lanci-Macris, Case Management and Community Outreach Division Director; Jason McRoy, Business Operations and Systems Support Division Director (4:00 – 5:00 p.m.)

Upcoming Meetings:

a) October 25, 2016, 3:30 p.m., 2525 13th Street, Large Conference Room, Boulder
   i. Agenda Items: Continuation of visioning and governance discussion
b) **No November meeting
c) December 6, 2016, 3:30 p.m., 2525 13th Street, Large Conference Room, Boulder
   i. Agenda Items:

5) Adjourn

Access to current and past packets for the Boulder County Housing Authority Board, the Boulder County Human Services Board, and the Housing & Human Services Advisory Committee can be found by clicking on the links below:
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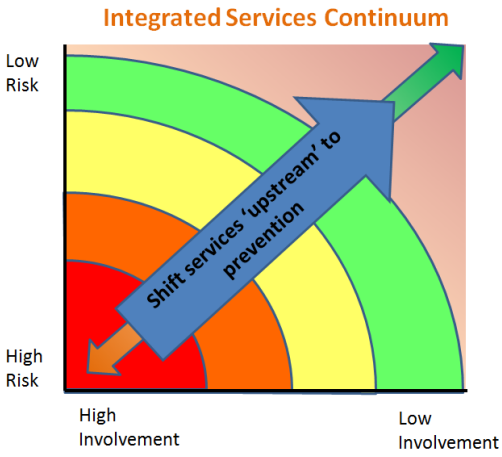
www.bouldercountyhhs.org

BCDHHS Advisory Committee
MONTHLY MEETING AGENDA
Tuesday, July 26, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder



Members Present: Bobbie Watson, Pat Heinz Pribyl, Laura Kinder, Robin Bohannan, Betsey Martens, Suzanne Crawford

Staff Present: Frank Alexander, Angela Lanci-Macris, Chris Campbell, Maggie Crosswy, Summer Laws

Committee Action Items:

Action Item—The next HHSAC meeting (August 30) will be dedicated to a visioning session where the group will decide on a clear vision and mission that will guide committee projects and committee governance moving forward.

Action item—DHHS staff will start to create a roadmap forward for the group for consideration for review well in advance in the next meeting. Staff will take a shot at a mission and vision statement for consideration in the visioning session next meeting

Meeting Minutes

1) **Review and approval of today's agenda (3:30 p.m. – 3:33 p.m.)**

Approved as written

2) **Review and approval of minutes from June 28, 2016 DHHS Advisory Committee Meeting (3:33 – 3:35 p.m.)**

Approved as written

3) **Governance discussion: moving from collaborative to integrative (3:35 – 4:05 p.m.)**
   a) Improving our governance – APHSA Maturity Model 2.0

Frank—We want to explore how to get better alignment and more strategic to move the ball down the field in less, more targeted areas. We've continue to have these conversations with other boards in the county—10 year board, public health improvement process, etc. We are looking for feedback and support about where the sweet spot is for this group. What this next year to feel supportive of your work, to build on itself, to move forward.

Some additional perspective: the partnerships have advanced at the county to a very significant degree—more data sharing, better and robust funding sources. Moving to a more integrated level of care is a big shift in the systems that we are working in. We are very collaborative with the community. As a department, we are looking at key strategic areas that are moving us to a more integrated system of care—this takes an enormous amount of capacity from the department. See the graph below.

See the APHSA Maturity Model 2.0 under the governance section. This illustrates some of our struggles as this board. DHHS has worked to bring the department closer to the public we serve. We use a multitude of influences to guide our decision making—client focus groups, community input, board input. As we move into the integrative level, more folks in the community are guiding our decision making and services. Things can get big very quickly.

This group has led us through a lot of difficult decisions through the merger and how to work with the community best on these decisions. We are turning the governance of the department over to the community. This is not an easy process.

We need to define the landing zone of the major efforts—too many groups (community groups, advisory committees, boards) can be problematic and challenging.

Moving forward, we'd like to look at narrowing projects and focus of this committee. For example, we could look at being the governance committee for the Family Resource Model work for example.

Laura—personally like finding the focus area where we can go out from that centering piece. It would frame our discussion a bit more. Not sure where we need to land—housing, early childhood work?

Betsey—Kudos to DHHS for great listening and vulnerable leadership—opening up. We are close to getting there as a committee but things are a bit muddy/sludgy…need further discussion about how we can be truly effective.

Bobbie—like the idea of starting with one project and see how we work together. Dream Big could be one area (hits a lot of topics, Early Childhood, Diversity, Housing, etc.). Touches all of us in the committee.

Robin—muddiness comes from lack of clarity of the role of this board. Be the bridge from the county agencies, and the community, more internal focus. Are we doing externally focused governance or internal governance? Second, what is the problem that we are trying to solve—community-wide issue or area that needs leveraging?

Summer: Internal/external question – you have your own truly internal governance structure built. Is this (HHSAC) an approach to look at HHS's integration with other projects and partners? That makes sense, as does prioritization… more effective that way.

Frank—Family Resource Framework and Dream Big, we put out some suggestions to have the FRM and Dream Big be a part of our work with the Committee. This is both internal and external combined. This committee could be more internal, but this begs the question of how the board functions—it is hard to give a lot of definition and depth in a lot of areas.

Betsey—Dream Big, we've long talked about a governing group to support the work of Dream Big—this is the group that we see at the table now, logical that this group would govern the work. Dream Big is missing the health component. Also a corollary in the regional housing side would be great if this would be housed with this group. Then we could look to fill a few gaps, like Bruce Meisinger with BVSD and some other areas.

Robin—10 year plan board could also take on the Regional Affordable Housing issues.

Angela—Family Resource Model—essentially is the safety net. The family resource framework is founded in having strong relationships with schools, other Family Resource Centers and county agencies. Want to clarify that the Dream Big project is one component of the FRC model.

Frank—vision for the FRC model is not fully agreed upon by the community—this is a tension point. We're going to playing out some of these tensions as we evolve as a community. Really hard from DHHS perspective, when has the conversation actually been had? When are we on the same page?

Suzanne—I get a little puzzled by the Dream Big, FRC framework. Need to be collaborative ultimately. We've been coevolving but not talking perhaps. We all need to support each other as agencies and move away from competition. We also need to coordinate funding as much as possible.

Frank—the actualizing of the work comes down to a defined practice framework and we agree to a level of community practice. We have to have some common processes and how we share the work. This work is underway and will continue. Need to build in CQI and common measures—outcome-based framework. And, there is the funding framework—needs to be coordinated and smart. Practice questions, data questions, need to be discussed with this committee. Strengths-based family work for example, keep moving forward on the same page in these core areas, we will all be able to learn and grow—the practice work will be more sophisticated.

Robin—are you looking for a model to govern the practice framework? Frank—it feels like we are at the precipice of doing amazing community-based work and we will be able to advance some amazing things—housing issue for example. We need to try to see if there is a collective area we can push together in some way?

Summer—talking about internal/external processes. Need to be clear about both process and end product.

Frank—we believe that poverty and disproportionality is a curable disease in our society—we can mitigate this through a big community effort and therefore, this is not just an internal/external approach.

Angela—from a staff perspective, we have an internal structure—Senior Leadership Team. From that perspective, it would great to have this committee drive our strategic priorities, our approach, our project management, and use this venue as a place to share agendas and help drive the DHHS work.

Bobbie—grassroots, ECCBC and the CCAP team are doing things together. We have a common goal, find the highest number of CCAP into high quality childcare. We have the CCAP team from DHHS and ECCBC. ECCBC work with the centers to increase quality. Must work together on this. We work together for mutually reinforcing strategies. Discuss areas of duplication and we have the same metrics that we report out on. ITQA project—work with centers to increase quality and get CCAP kiddos enrolled—in year 4 of the grant.

Bobbie—other area is the discussion of tiered reimbursement. Improve the quality level of the providers and then you get higher reimbursement. Now we are in the policy arena. DHHS had come up with initial framework. DHHS worked with ECCBC (board and staff) for feedback on the rollout of this plan—tension points, areas that would and would not work for the committee. This discussion drove some policy decisions.

Frank—DHHS needs to ensure that this group is bought into the strategic decisions and we could take these decisions back to the Board of County Commissioners. Need to build in these feedback loops. We've heard time and time again from clients—we would like community-based preventative services that meet my needs and that get the barriers out of the way.

Frank—we want this to be a powerful and effective place to come as a committee—define the role, narrow the focus, and we would be closer.

Summer—in the clinical world, you do small tests processes. May want to consider this.

Betsey—outcome goal is to disrupt the cycle of poverty. The job is not done until at the end of the day, the child is self-sufficient, ready for life. How does the model (2 generation focus) and the system issues get resolved? No person cannot fall out of—cannot do it alone, need all agencies and bodies.

Robin—tried this for the Human Services Strategic Plan and struggled a bit—what were the drop offs. We did not have the right governance in place, not at the right level of maturity. Not ready to be disrupted.

Betsey—we need to have the right folks at the table with authority over systems and can make actual changes to systems.

Laura—LUH is looking at the preventative models, health communities, health determinants, etc. Are aligned here with DHHS and this Committee.

Frank—have not seen a moment in time where we have the right folks ready to take the system to the next level since the first Human Services Strategic plan.

Robin—what it seems like is there is a will and a desire; however, the pathway is unclear.

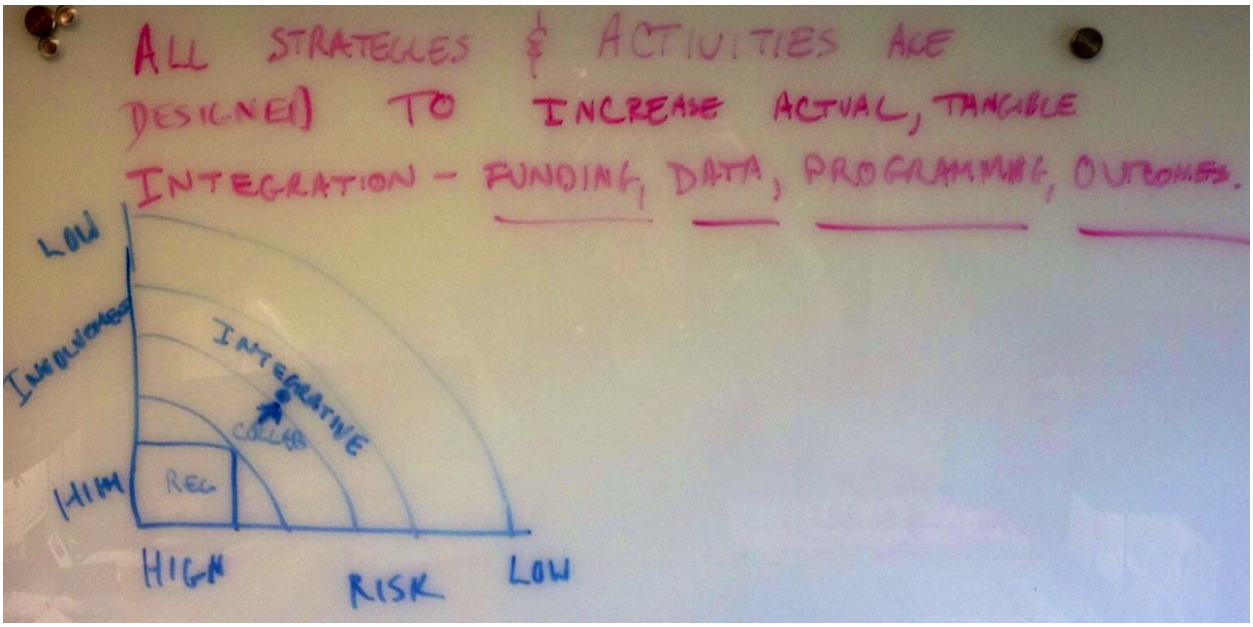
Frank—sweet spot that I've heard—How to advance a 2-gen (poverty model) family service delivery framework across multiple systems within a Social Determinants of Health structure. HHSAC would have members/partners - committed to planning, service delivery, outcomes – as a team.

Action item—DHHS will get a roadmap forward for the group for consideration for review well in advance in the next meeting. We will take a shot at a mission and vision statement for consideration.

Pat—we need to get a clearer picture of what this committee is charged with.

Betsey—demonstration at the micro level—the dream big program are planning an event for October. Maybe we should bring these items to the committee for consideration on the agenda. Some of these smaller issues should come forth in each meeting.

Suzanne—need to agree on a vision as a committee and go from there. Could be helpful for this committee.



Upcoming Meetings

Regular Advisory Committee Meeting—TBD. **August 2016, 2525 13th Street, Large Conference Room, Boulder. ** Need to discuss alternative date/time due to scheduling conflict**

Regular Advisory Committee Meeting—**September 27, 2016, 3:30 p.m., 2525 13th Street, Large Conference Room, Boulder**

Boulder County Housing Authority / Human Services Boards and Housing and Human Services Advisory Committee – JOINT MEETING (date TBD)

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HEALTH AND HUMAN SERVICES INTEGRATION MATURITY MODEL 2.0

Based on APHSA's 21st Century Health and Human Services Business Model[1]

		MATURITY LEVELS Adapted from *The Human Services Value Curve*[2]			
		1—REGULATIVE	**2—COLLABORATIVE**	**3—INTEGRATIVE**	**4—GENERATIVE**[3]
Focus		Delivering services to program participants for which they are eligible while complying with categorical policy and program regulations	Ensuring the appropriate mix of existing services for program participants working across agency and programmatic boundaries	Addressing and solving the root causes of program participants' needs and challenges by seamlessly coordinating and integrating services	Creating healthy communities by working with others outside the H/HS enterprise to address complex health and social challenges
KEY FEATURES		***Characteristics of the Key Features at Various Maturity Levels of Integration***			
Vision	*For Program Participants*[4]	Program participants initiate engagement or are referred to a program within the agency.	Program participants initiate engagement or are referred to a program within the agency, accompanied by a hand-off to another program within the agency, with a sister agency, or beyond entities within government (heretofore referred to as partner organizations).[5]	Program participants are proactively engaged by the health and human services (H/HS) enterprise.[6]	Program participants are proactively engaged by the H/HS enterprise and external agencies by predicting current and future needs. A participant's behavior also serves as a catalyst toward achievement of shared outcomes defined collectively by H/HS community.
	For Organization/ Enterprise	H/HS agency complies with all relevant categorical and policy requirements—statutory, regulatory and executive.	H/HS agency works with partner organizations while complying with all categorical and policy requirements; retains organization's goals, some of which may overlap with partners.	H/HS enterprise addresses/solves root causes of program participants' needs via integrated service delivery and supports a customer-centric, integrated, outcome-oriented, modern marketplace experience.	H/HS enterprise identifies additional services beyond its immediate control to create healthy communities, improve program participants' outcomes, and population health and lowers costs-and through the use of analytics. Works seamlessly with other stakeholders, including other states, to generate long-lasting solutions and serve as a national model.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Governance	*Who*	Internal, senior executive-level decision-makers	Internal, senior executives with some external stakeholders from partner organizations	Internal, senior executives and other high-level stakeholders throughout the H/HS enterprise, along with external stakeholders from partner organizations	Internal, senior executives and a variety of other stakeholders from within and external to the H/HS enterprise and stakeholders in the community (such as advocates, providers, families, nonprofit organizations, industry)
	Decision-Making	Vertical/top-down—based on requirements of programs, risk is not intended to impact other programmatic areas.	Vertical/top-down, but influenced by partners' horizontal considerations. Risk is shared across collaborating entities to extent allowable.	Shared within the H/HS enterprise regardless of any single program's role. Risk is shared enterprise-wide so innovation is not limited.	Shared beyond the H/HS enterprise to reflect proactive, anticipatory, 360-degree orientation that considers drivers associated with the social determinants of health and well-being. Risk is balanced with generating new, creative solutions.
Adaptive Leadership and Capabilities	*Leadership View of Organization/Enterprise*	Leadership of single agencies/programs limited to fulfilling programmatic standards and mandates.	Leadership across the organization views collaborating organizations as partners who share common goals and bring valuable assets to the challenges faced by their shared program participants.	Leadership across the enterprise views the organization as seamlessly integrated with a holistic view of the program participants. Leadership places its highest value on outcomes-focused goals even at the expense of organizational norms. It also allows mid-course changes when prompted by new information and deemphasizes hierarchy and silos across the enterprise.[7]	Same view of enterprise as in Integrative Stage, but with the highest value placed on outcomes consistent with the creation of healthy communities. Leadership relies on new partnership models to generate a new community of nontraditional public/private sector partners focused on sustaining whole community well-being and generating new approaches and solutions.
	Drivers of Organizational Change	Outside statutory and regulatory process requirements associated with compliance with statute and regulations.	Collaborative efforts to address mutual challenges. Challenges stem from external requirements and inability to avail itself/oneself	Continual environmental scanning of current and anticipated statutory/ regulatory environment as well as marketplace of	The H/HS enterprise serves as a catalyst toward changing the statutory/ regulatory environment. Culture of receptivity that

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Adaptive Leadership and Capabilities (cont'd)	*Drivers of Organizational Change (cont'd)*	Challenges stem from limited to no ability to share information.	of opportunities identified through information sharing across organizational boundaries. Staff and systems strive to adapt their business processes and data flows to reinforce cooperation.	enterprise and stakeholders. A seamless cross-boundary exchange of information within the enterprise provides opportunities to address root causes and change traditional practices.	generates key solutions to leverage the enterprise's strengths, together with private and public partners sharing common goals. Information gathered from internal and external sources helps guide staff actions routinely and enables the enterprise to be highly adaptable to change.
Access Channels and Engagement	*Who is Responsible for Access?*	Access to services is transactional. It's sought out by program participants and the agency responds to the presenting need/request.	Access to services is also transactional, but additional communication may occur between program participants and partnering organizations to respond to the presenting need/request.	Access to services is the result of ongoing, preventive engagement and proactive communication from the enterprise to program participants.	Access to services is the result of ongoing, preventive engagement and proactive communication among the enterprise, program participants, and the community. Participants are activated to be a catalyst identifying beneficial programs that may help to prevent future, deeper service needs.
	• *Developing Access*	Participants' access is available on a program-by-program basis and is provided by multiple workers across multiple sites with minimal coordination between programs, except where required.	Participants' access is available on a program-by-program basis yet program workers coordinate with one another to assist participants in navigating multiple points of entry.	Participants' access is universally available and provided by workers utilizing a "no wrong door" approach.	The enterprise provides universal access and interaction with participants that anticipates future needs and serves to prevent or remedy potential downstream issues.
		Use of technology is focused on processing transactions and reducing administrative costs.	Use of technology is focused on facilitating data exchanges between partnering organizations. Web-based technologies, such as electronic participant portals, central data repositories, and document imaging and	Use of technology is focused on enabling program participants and staff to effortlessly navigate a variety of access channels across the enterprise. Enterprise service busses, universal	Use of technology is focused on enabling the enterprise to work collaboratively with the program participants as "choice architects." Online portals, smart phones, tablets, and kiosks work

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Access Channels and Engagement (cont'd)	• *Developing Access (cont'd)*		digitization of case records facilitate program participants' access and enrollment.	client registries, workflow and identity management tools, automated account creation technologies, and readily available case notes that can be shared with others (within privacy constraints), are used widely.	together seamlessly with traditional service centers and personal referrals. Community-based organizations serve as portals and extensions of government. The enterprise serves as a test site for innovative approaches to enhancing existing and generating new access channels.
	• *Gaining Access*	Program participants initiate direct, person-to-person contact at the local office, although some information may be available on-line.	Program participants initiate contact (in person or on-line) and guidance is provided regarding available complementary services that are provided to the participant by partnering organizations.	Enterprise initiates contact through automated alerts, notices of renewals, or other technologies advancing program participants' access to services with the enterprise assisting the participants in navigating the service system through the setting of decision points for choices that lead the participant toward health and wellness. In-person assistance remains available for high-touch participants.	Enterprise and community partners initiate contact with program participants through seamless technologies incorporating the latest advances in access channels including readily accessible 24/7 call centers. Enterprise, community partners, and the participant collectively work together to navigate the service system. Yet, at this level, program participants are empowered to act as own catalysts for making choices leading toward health and wellness. In-person assistance remains available for high-touch participants.

	REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Common Process Functions	*Application/Intake and Enrollment*			
• *Application/Intake Process*	Application/intake process is highly customized to specific programmatic mandates and standards; uses only program-specific applications.	Application/intake process can be separate or used across multiple programs while retaining programmatic mandates and standards.	Enterprise works together to create and use a simplified common application/intake process that is mutually acceptable across organizations.	Enterprise works with a simplified common application/intake process that is mutually acceptable with organizations across and external to the enterprise. Feedback loops are incorporated into application to handle new regulations and policy requirements across programs.
• *Enrollment Activities*	Specific applications/intake processes are used to determine eligibility and enroll program participants in a given program.	Application/intake processes are completed collaboratively with partners through the use of cross-boundary data and most of which can be used by multiple programs. Programmatic enrollment responsibility is diversified across multiple partners.	Use of client registries, together with decision-support tools, enhances the staff's ability to overcome barriers inherent in traditional silos. Opportunities are created that allow program participants to be actively engaged in key decisions. Enrollment is centralized based on eligibility determination established from common system.	Through use of a universal client registry and other decision support tools, the enterprise and other partners can engage in activities beyond eligibility and enrollment such as integrated case management and innovative relationship management strategies to achieve the desired outcomes.
• *Application/Data Characteristics*	Verification of eligibility is based primarily on paper records.	Verification is based on a mix of paper and electronic information.	Verification is based on electronic databases in various locations inside and outside of the enterprise.	Verification is based on the application of common business rules, electronic document management, and robust privacy and security controls coupled with robust data sharing.
• *Technological Features of the Eligibility and Enrollment (E&E) System*	E&E systems that are tightly coupled[8] and have dated functionality that is difficult to modify/update, resulting in processing of applications, eligibility determinations and enrollment that is time-	E&E systems that are tightly coupled, but may use some cross-boundary communication enabled by add-ons to the existing legacy system rather than through functionality of integrated	E&E systems are loosely coupled[9] while completely integrated and connected seamlessly with organizations throughout the enterprise and based on well-defined data-use	E&E systems are loosely coupled while completely integrated within the enterprise and connected seamlessly with those outside the enterprise based on well-defined

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Common Process Functions (cont'd)	• *Technological Features of the Eligibility and Enrollment (E&E) System (cont'd)*	consuming for staff and delays access to the program participants. Participants' data are difficult to share across programs.	components across partnering organizations.	agreements.	data-use agreements. These resources, combined with multi-benefit screening, result in real-time eligibility determinations and seamless enrollment.
	Workflow Goals and Characteristics	Workflow processes are rules-driven, and designed to deliver a specific output,[10] including determination of eligibility, benefit level to be provided, etc.	Workflow processes are rules-driven yet are updated to build in efficiencies through collaboration with other programs, resulting in multiple "one-stop" opportunities.	Workflow processes are streamlined, seamless, and completely integrated. Processes are designed to achieve efficiencies and desired outcomes[11] identified in conjunction with program participants and the enterprise.	Workflow processes are similar to the Integrative Level, yet input from stakeholders internal and external to the enterprise, community partners, and program participants is instrumental in the design to enable the ability of participants to serve as catalysts toward the achievement of shared outcomes.
	Residence/Access of Consumer Data	Exclusively within the organizational boundaries of each programmatic business line or division, except where sharing is required.	Within individual programmatic business lines or divisions but is shared across organizational boundaries with data owners' and program participants' consent.	Able to be centralized or reside in multiple locations across the enterprise. Information is easily accessible by program participants, staff within the enterprise, agencies external to the enterprise (e.g., education, juvenile justice), and external community partners, to ensure efficient, end-to-end workflows and appropriate outcomes.	Data are centrally housed and available in real-time to all government staff internal and external to the enterprise, including front-line workers, and community partners, while maintaining the highest levels of privacy and security standards.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Coordinated Service Delivery	*Administration of Service Delivery System*	Administered efficiently within the span of control of the organization responsible for delivering the services, with coordination occurring where required.	Administered efficiently through coordination across partnering organizations when opportunities arise. "Best practices" to improve accessibility, accountability, and coordination in other organizations are viewed as possible sources of efficiency and innovation.	Administered efficiently across the enterprise to continuously improve accessibility, accountability and coordination and based on input from within the enterprise and from program participants. Increased flexibility allows ability to replicate, utilize, and customize evidence-based practices to achieve cross-programmatic outcomes.	Administered efficiently and effectively within and external to the enterprise. Flexibility is sustained through feedback loops that exist within and external to the enterprise, including from program participants and community partners, to allow improvement of accessibility, accountability, and customization of services into unique arrays that meet program participants' needs, while drawing upon a practice model that is shared across the enterprise.
	• *Role of Organization/ Enterprise*	Services are identified and delivered within the span of control of the organization responsible for delivering the services, with coordination occurring where required.	Services are identified and delivered in a coordinated manner when ability to avail itself/oneself of opportunities arises across partnering organizations.	Services are identified and readily accessed throughout the enterprise.	Services are identified and readily accessed within and external to the enterprise, as well as by program participants and community partners.
	• *Role of Staff*	Workers may help program participants find additional assistance but the participant needs to initiate access to services.	Workers are knowledgeable about services available through partnering organizations and help program participants access them in a timely way.	Workers collaborate seamlessly across multiple lines of business in such a way that program participants' needs are met and achieved through increased development and coordination of solutions.	Workers ensure that solutions are customized to meet program participants' needs, and that supplementary services are part of participants' service plan that also address the social determinants of health, where appropriate.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Coordinated Service Delivery (cont'd)	• *Role of Staff (cont'd)*	Workers may have informal knowledge of the variety of services offered across multiple lines of business yet there is no formal training provided or processes in place to facilitate coordinated access or service provision.	Workers have some formal orientation to the variety of programs and processes, if in place, to facilitate cross-programmatic access and service provision.	Where possible, workers are cross-trained and assist with service development and provision across multiple programs within the enterprise.	Workers utilize universal knowledge within and external to the enterprise, including the program participants and community partners, to anticipate and proactively address participants' needs.
	• *Role of Program Participant*	Program participants are viewed as recipients of services. The design and delivery of services to the participant remains the responsibility of the organization.	Program participants are viewed as both recipients of services and minimal contributors to their own service plan. The design and delivery of services to participants are a joint responsibility shared between the partnering organizations.	Program participants are viewed as partial partners to the development of a single, integrated service plan with assistance from the enterprise and community partners. Design and delivery of services is jointly conducted with the enterprise and participants.	Program participants are viewed as a full partner in the development of a highly customized service plan with assistance from the enterprise and community partners, drawing on, but not limited by, the services the enterprise has provided in the past and services proven in other contexts to generate positive outcomes.
Defining Success	*For Program Participants*				
	• *For Program Participants*	Defined by regulatory and statutory requirements associated with the efficient and effective processing of participant transactions.	Defined collaboratively with partner organizations sharing common values and goals although focus remains primarily on ensuring smooth, efficient transactions.	Defined by the program participant and the enterprise as a whole and used as benchmarks for evaluating progress toward achieving sustainable outcomes for participants.	Defined by the program participant, the enterprise as a whole, and other community partners. Outcomes are continually fine-tuned through feedback mechanisms to ensure that their continued appropriateness for participants and the broader general population.
	• *Process by Which Outputs/ Outcomes Are Defined*	Results for program participants are defined through transactional outputs (e.g., accuracy, timeliness) once received by the participant.	Results for program participants are defined through transactional outputs (e.g., accuracy, timeliness), including those involving partnering	Sustainable results or outcomes defined as those that favorably affect program participants over the short term.	Sustainable results or outcomes (e.g., sustainable employment, improved health and wellness), defined and identified by the enterprise, program

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Defining Success (cont'd)	• *Process by Which Outputs/ Outcomes Are Defined (cont'd)*		organizations.		participants, and community partners through feedback mechanisms continue to favorably affect participants over the long term.
	• *Accountability of Program Participants' Success*	Accountability for program participants' success rests with the system of service provision within the individual line unit's or division's span of control.	Accountability for program participants' success rests with the system of service provision collaborating across business lines to achieve mutually agreed-upon goals, as well as with the participant who has somewhat contributed to the service plan in place.	Accountability for program participants' success is seen as a joint responsibility between the participant and others, including groups that provide input to enterprise products, services, and strategy across program areas.	Accountability for program participants' success is shared equally between the systems of service provision, the community of which the participant is a member and the participant. Participants' are full partners with enterprise and community leaders in setting strategy for the enterprise.
	For the Organization/Enterprise				
	• *For the Organization/ Enterprise*	Defined by the statutory and regulatory outputs required of the organization or individual line of business. Success is determined by how well the organization or individual lines of business capture their inputs and maintain required levels of outputs.	Defined by the outputs jointly captured across the agency and partnering organizations, and that are supported by required inputs and outputs for each line of business. Success is determined by how well the programs and partnering organizations capture and maintain jointly shared outputs reflecting their shared goals.	Defined by the enterprise's shared outcomes and that are supported by required inputs or outputs. The enterprise works as a seamless whole to achieve the optimal outcomes for its users and accepts unanticipated outcomes generated from the enterprise. Success is determined by the degree to which the enterprise is able to achieve the shared outcomes and goals collectively agreed upon by stakeholders within it and at least partially by program participants.	Defined by the enterprise as a result of cumulative knowledge gained over time and reflects advancements attributable to continually evolving solution sets that are being generated by the enterprise, program participants, and community partners. Success is determined by the enterprise's continuous adaptability and ability to improve performance and is based on achievement of shared outcomes and goals collectively defined by participants, those within and external to the enterprise, and community partners.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Measures	*How They Are Defined*	Inputs and outputs of the organization delivering services capture specific activity and provide basic trend data over time, including program investment, number of families served, number or percentage of cases closed in a given period, etc.	Similar to the regulative, inputs and outputs of the partnering organizations are also capturing progress made on shared goals and collective actions.	Outcomes shared across the enterprise are quantified while using trend and root-cause analysis to inform progress, as well as to determine priorities and resource needs. Inputs and outputs of single and partnering organizations are still tracked but are used more to inform progress on shared outcomes of the enterprise.	Outcomes shared within and external to the enterprise are quantified while trend and root-cause analysis, as well as other types of advanced analytics,[12] are used to inform progress, priorities, and resource needs. Inputs and outputs of single and partnering organizations are still tracked but are used less as markers of success. Measures also continuously evolve over time.
Infrastructure[13]	*Workforce*	Primarily, staff working within an individual line of business with little knowledge of other programs across the organization. Formal orientation or training to increase awareness of other programs may be provided.	Primarily, staff working within an individual line of business but encouraged, both formally and informally, to learn and coordinate activities with partnering organizations. Formalized orientation or training and processes in place to increase awareness of other programs and coordinate work across lines of business.	Primarily, staff is formally cross-trained to develop awareness and universal knowledge of multiple programs across the enterprise, as well as establish formalized networks within the enterprise in order to provide customized, holistic, program participant–centered services. Less emphasis is placed on specialization in one program/line of business except in key areas within the enterprise.	Primarily, staff is formally cross-trained to continuously develop universal knowledge and maintain formalized networks within and external to the enterprise to strategically provide customized, holistic, program participant–centered services. Less emphasis is placed on specialization except in key areas within and external to the enterprise.
	Organization Structure and Capacity to Change	Structure is designed to be responsive to administrative process drivers within the individual service delivery units. Little to no data are shared across organizational boundaries.	Structure is designed to be responsive to administrative process drivers within the individual service delivery units, but with allowances made within the infrastructure to permit cross-boundary coordination	Structure is designed to be responsive to administrative process and other drivers within the enterprise; the infrastructure supports seamless data sharing and use with individual service	Structure is designed to be responsive to administrative process drivers and other drivers within and external to the enterprise; the infrastructure supports seamless data sharing and

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Infrastructure (cont'd)	*Organization Structure and Capacity to Change (cont'd)*		and data sharing among partnering organizations.	delivery units contributing resources and solutions across the enterprise without being hindered by differences in rules, vocabulary, or definitions.	use within and across the enterprise's boundaries in such a way as to generate administrative efficiencies as well as to generate innovations in policy and practice.
	Purpose of Technology	Systems are designed to be transaction-driven and focused on the individual division or line of business meeting its goals.	Systems are designed to be transaction-driven and focused on the individual division or line of business as well as data sharing across boundaries of partnering organizations. The partnering organizations may maintain their own systems and nomenclatures but electronic translators and other devices are used to facilitate clear comprehension of cross-boundary information, regardless of the source of the information or platform used.	Systems are designed to be outcome-driven and focused upon goals that have been defined for the enterprise as a whole. Data are universally defined across the enterprise such that no additional translation of terms, definitions, or codes is required and is used to identify consistency for individuals, and families beyond eligibility.	Systems are designed to be outcome-driven, focused upon goals defined for the enterprise as a whole that are continually being modified to take into consideration the larger milieu of drivers associated with the social determinants of health, even if those drivers arise from outside the enterprise's span of influence. Data are universally defined and used to identify consistency for individuals, families, and communities beyond eligibility.
	Communications	Communication may be conducted across multiple lines of business around achievement of process-focused goals.	Communication is more frequently conducted around achievement of shared goals with partner organizations.	Communication is conducted regularly and internally (both vertically and horizontally), and somewhat externally, to the enterprise to reinforce achievement of shared success.	Communication among all stakeholders is strategic, bi-directional, and efficient to reinforce achievement of shared success.
	Human Resources (HR)	HR functions (recruitment, selection, training, employee relations, performance management, and benefits) are primarily administered based on compliance with regulations.	Similar to the Regulative level, HR functions are primarily focused on staff acquisition and regulatory compliance, yet also focused on building a culture of engagement that fosters relationship building across	HR functions still maintain existing core tenets, yet the primary focus shifts to building a learning environment across the enterprise. Activities are directed at developing new competencies for the	HR functions still maintain existing core tenets, yet the primary focus shifts to building a learning environment within, and external, to the enterprise. Activities are directed at helping to identify, and

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
	Human Resources (cont'd)		employees in partnering organizations.	enterprise as a whole and for staff at every level to align with the priorities and outcomes of the enterprise.	then develop, new competencies for the enterprise as a whole and for staff at every level to align with the priorities and outcomes within and external to the enterprise.
Financing	*Provision of Funding*	Funding is provided by a variety of federal, state, local, and external sources and distributed to programs in conformance with strict cost-allocation rules and for the purposes of narrowly defined tasks/services. Most funding cannot be moved within a program for purposes outside of statutory or regulatory limits.	Funding is provided same as in Regulative level; cost-allocation rules followed, and in general, no tasks are allowed that are not related to specific programs. However, some tasks/services can be adjusted that support some coordination with partnering organizations within the general programmatic areas that are typically only allowed through state match or state-only dollars, local dollars, or other supplemental funding sources.	Funding is provided to support highly integrated services through proactive staff work across the enterprise to assist program participants' use of a broad range of multi-program services, benefits, organizations, and other resources. Continuous, intentional use of flexible, data-driven, and alternative financing approaches is explored within and across the existing funding authorities throughout the enterprise.	Flexible financing approaches (e.g., blended/braided funding, pay-for-success, multi-sector initiatives) are consistently used and modified based on feedback loops and through the use of enterprise-wide data metrics and analytic tools established across and external to the enterprise to assist program participants use broad range of related services, benefits, organizations, and other resources.
	• *How Priorities Are Set*	Decisions are highly mindful of operational and process compliance constraints attributable to funding sources and cost-allocation methodologies.	Same as in Regulative level but high value placed on collaboration with other partner organizations that may receive funding from other sources. Together, they work toward achieving shared goals.	Same as in Collaborative level, yet the enterprise seeks to maximize its effectiveness by flexibly leveraging various funding sources to achieve improved shared goals and outcomes across the enterprise.	Same as in the Integrative level but the enterprise and community partners not only place a high value on pooling resources to achieve shared outcomes, but place equally high value on proactive and routine seeking of new and innovative mechanisms to increase financial resources to support or even replace traditional funding streams.
	• *Risk*	Little to no risk as priorities reflect constraints attributable to funding	Risk is somewhat higher and dispersed among partnering organizations as priorities	Risk is shared across the enterprise upon testing of new financing solutions	Risk is shared across the enterprise and community partners upon testing and

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Financing (cont'd)	• *Risk (cont'd)*	sources largely measuring outputs and inputs.	reflect increased focus on identifying collaborative financing among those working toward shared goals, while still being risk averse.	and alternatives emphasizing solutions-oriented approaches toward shared goals and outcomes.	implementing new financing solutions and alternatives emphasizing solutions-oriented approaches toward achieving shared goals and outcomes. Continuous feedback loops, including use of data and analytics to identify (social) return on investment opportunities, allow re-prioritization of allowances for modification of funding distribution to achieve shared outcomes.

Endnotes

1. Cari DeSantis, M.A.L.S. *Business Model for Horizontal Integration of Health and Human Services*. American Public Human Services Association. 2012. p. 13–17.
2. Antonio M. Oftelie. *The Pursuit of Outcomes: Leadership Lessons and Insights on Transforming Human Services: A Report from the 2011 Human Services Summit on the Campus of Harvard University. Leadership for a Networked World*. 2011. p. 5–7.
3. The *Generative Level* incorporates the 10 key characteristics of the *21st Century Health and Human Services Business Model*.
4. For purposes of this model, which aims to view the individual/family across business lines and from an enterprise or agency-wide lens, we refer to the individual or family receiving services as the *program participants.*
5. *Partner organizations* may be defined as different programs or lines of business within a health and human service agency. As each state and locality are structured differently, this may also be defined as agencies operating as a separate entity but serving the same population (e.g., some states have a single-state agency for child welfare or behavioral health yet there may be shared outcomes/populations/systems spanning across sister agencies).
6. *Enterprise* is defined here as a group of departments and the health and human service programs that fall within them that constitute a given agency, as well as other single, sister health or human service agencies with similar missions serving the same population, that have collectively defined shared outcomes, strategic goals, operations/business processes and administrative functions to further the collective interest and benefit of those receiving services, those providing the services and the community at-large.
7. Antonio Oftelie, Julie Booth, and Tracy Wareing. *The Art of the Possible:* Leading Change in Human Services. *Policy & Practice (June 2012)* p.11–15.
8. *Tightly coupled* refers to a system in which components have, or makes use of, knowledge of the definitions of other separate components.
9. *Loosely coupled* refers to a system in which each of its components has, or makes use of, little or no knowledge of the definitions of other separate components.
10. *Outputs* are defined here as process measurements of time, quantity, or quality relative to a particular reporting requirement (e.g., how many individuals were served, how much time did it take to process an application). For purposes of this model, (shared) outputs are used to reflect how an organization measures success at the Regulative and Collaborative levels of maturity.
11. *Outcomes* are defined here as the changes that have taken place over time in knowledge, skills, behaviors, and conditions as a result of an organization's work, as well as the differences made by outputs of which are often expressed in terms of impact and sustainable changes of the health and well-being of individuals, families, and communities. For purposes of this model, shared outcomes are used to reflect how an enterprise determines success at the Integrative and Generative levels of maturity.
12. *Advanced analytics* are defined here as tools used to go beyond the collection and sorting of data to turn the information into data capable of providing future options and predictive capabilities. These capabilities can then forecast possible prospective results under different scenarios associated with each option through detailed pattern analysis. In addition to root cause and trend analysis, other tools include statistical analysis, forecasting, predictive analytics, and optimization. *Source:* American Public Human Services Association. *Analytics Capability Roadmap 1.0 for Human Service Agencies.* April 2014.
13. *Infrastructure* is defined here as the shared administrative and operational systems that support business needs across the entire health and human service enterprise intentionally designed to support the vision and offer innovation, while constantly learning and keeping pace with the evolving marketplace in which program participants live, work, learn, and play. For purposes of this model, the foundational infrastructure includes but is not limited to, components such as workforce, use of technology, communications, and human resources. *Source:* Cari DeSantis, M.A.L.S. *Business Model for Horizontal Integration of Health and Human Services*. American Public Human Services Association. 2012. p. 24.

Boulder County Housing & Human Services Advisory Committee (HHSAC) Member Expectations:

Boulder County Housing & Human Services Vision:

We believe in co-creating solutions for complex family and community challenges by fully, effectively, and efficiently integrating health, housing, and human services to strengthen the broad range of Social Determinants of Health, in turn generating a more self-sufficient, sustainable, and resilient community.

About the HHSAC:

Committee members provide advice and guidance to the Department of Housing & Human Services (DHHS) staff and leadership in their efforts to most effectively serve the community. Committee members strive to actualize the vision of the agency and to ensure that the vision is aligned with the identified needs of the Boulder County community. Committee members provide substantive recommendations on improving the organizational effectiveness based on community input and personal experience.

Additional Background:

With the department's continual push toward more community based, family driven, prevention oriented, and holistic service delivery, committee members will play a key role in this long-term, evidence-based strategy. Members with high-level, systems thinking approaches are needed to help conceptualize and implement this strategy for housing and human service delivery.

Time Commitment:

The HHSAC meets once a month on the last Tuesday of the month (meetings start at 3:30 p.m. and are held in Boulder at the DHHS Kaiser Offices). Meetings last approximately 1 ½ hours. In addition to monthly meetings, members may be required to attend and coordinate community dialogue meetings and other community events. Expectations also include authoring letters to the editor, providing analyses and recommendations for systems improvements and efficiencies, including evidence-based practice across the services continuum, and meeting with community partners. **Approximate Monthly Time Commitment: 3 hours to 10 hours per month.**

Revised 3/2015

BYLAWS
BOULDER COUNTY DEPARTMENT OF HOUSING AND HUMAN SERVICES
ADVISORY COMMITTEE

ARTICLE I – NAME

Section 1. Boulder County Housing and Human Services Advisory Committee.

ARTICLE II. – PURPOSE

Section 1. Serve as advisors to the Boulder County Department of Housing and Human Services.

Section 2. Strive to actualize the vision and mission of the agency and to ensure that the vision and mission are aligned with the needs of the Boulder County community.

Section 3. Enable community leaders, volunteers within the Department, residents and clients to make recommendations on improving the effectiveness of the Department.

ARTICLE III. – MEMBERSHIP

Section 1. Selection - Membership of the Advisory Committee shall be composed of up to 15 members. Membership shall be comprised of individuals with the capacity to support the development of a county-wide, coordinated service delivery model to improve community outcomes associated with the pillars of health and well-being. Membership on the Committee shall include balanced representation from community groups, human service agencies providing direct health, housing, and human services to Boulder County residents, and individuals from the community at large.

Section 2. Responsibilities – The responsibilities of the Committee members include but are not limited to:

A. Attend a minimum of 75% of scheduled meetings. If a member fails to attend three consecutive meetings, the DHHS staff will contact the member to determine if Committee membership is still a priority.

B. Provide advice and consultation to the Department. One of the most critical roles of the Advisory Committee is to provide advice and guidance to DHHS staff in order to better support the performance of their community responsibilities and to support alignment of their activities with community need. Advisory Committee members are in an important liaison role with the community and are positioned well to enhance and strengthen two-way communication between the department and various constituencies.

C. Actively participate in policy and program development of the Department. Participation may include: recommending modification of Department policies;

evaluating the effectiveness of programs; sharing DHHS current and emerging best practices; identifying emerging needs/gaps in population service delivery; as well as other activities which would provide for citizen participation in assisting the Director and/or Board of Human Services in determining program and budgetary priorities.

D. Become more knowledgeable about other resources in the County and share appropriate information with the committee and the staff of the Department.

E. Become familiar with County, State & Federal Human Services programs and policies.

F. Become familiar with existing legislation at the County, State, and Federal levels and to contact legislators regarding pending and needed legislation.

G. Assist in the Department's efforts to provide clear and effective access to the vital support services within the department.

Section 3. Appointment

A. Nominations to fill vacancies shall be presented to the Boulder County Board of Human Services in December of each year. Interested citizens are encouraged to make application. New members are to take office in January. An orientation will be provided to new members within 60 days of their appointment to the Committee.

B. Nominations to fill vacancies occurring during the year may be presented at any meeting of the Boulder County Board of Human Services for appointment. New members will take office the following month.

Section 4. Term of Office

A. The term of office for Committee members shall be three years beginning in January.

B. There shall be a limit of two consecutive terms or a maximum of six years. Exceptions to the six-year maximum term limit can be made under the following circumstances: recommendation of the Advisory Committee to approve the extension of office; and when no new members are under consideration for appointment to replace that member's position on the Advisory Committee.

C. Mid-year appointments shall complete their predecessor's term of office.

ARTICLE IV – OFFICERS

Section 1. The officers of the Committee shall be Chairperson and Vice-Chairperson. The Department's Director and a subcommittee appointed by the Advisory Committee will nominate persons to fill the positions of the Chairperson and Vice-Chairperson.

Nominations will be submitted for approval to both the Advisory Committee and the Board of Commissioners will be notified.

Section 2. The Director of Boulder County Housing and Human Services shall be an ex-officio member of the Advisory Committee and shall provide a backup administrator in his/her absence.

Section 3. The County Department shall provide a secretary to the Committee.

ARTICLE V – SUBCOMMITTEES

Section 1. The Committee shall act as a committee of the whole with the following exception:

A. The Chairperson may appoint Ad Hoc subcommittees as needed whose function and duration are subject to the approval of the Committee as a whole.

ARTICLE VI – MEETINGS

Section 1. Regular meetings: There shall be at least nine monthly meetings during the year. Members are expected to attend a minimum of 7 of these.

Section 2. Special meetings of the Committee may be called, with appropriate notification, at any time by the Chairperson or any two other members of the Committee.

Section 3. Quorum: A quorum shall consist of the members present at any meeting of the Committee. All decisions will be made by majority vote; defined as 51 percent of the membership of the Committee present.

ARTICLE VII – AMENDMENTS

Section 1. These Bylaws may be amended at any regular meeting of the Committee by a 2/3 vote of those present and voting. A copy of the proposed amendments must have been circulated to each Committee member prior to the meeting. Both the Committee and the Boulder County Board of Human Services must approve amendments.

ARTICLE VIII – PARLIMENTARY LAW

Section 1. The rules contained in the current edition of Robert's Rules of Order shall govern the Committee.

ARTICLE IX – RELATIONSHIP BETWEEN COMMITTEE AND DEPARTMENT

Section 1. Both the Department and Committee shall foster a constructive relationship which encourages open communication, trust, and mutual respect.

2016 BCDHHS Advisory Committee Roster

Board	Seat#	Requirement	First Name	Last Name	Start Date	End Date	Term	Email
Housing and Human Services Advisory Committee	1	Member-at-Large	Bobbie	Watson	03/15/2016	02/28/2019	3 Years	bwatson@eccbouldercounty.org
Housing and Human Services Advisory Committee	2	Member-at-Large	Betsey	Martens	09/01/2015	02/28/2018	3 Years	martensb@boulderhousing.org
Housing and Human Services Advisory Committee	3	Member-at-Large	Julie	Van Domelen	08/30/2016	08/31/2019	3 Years	julie@efaa.org
Housing and Human Services Advisory Committee	4	Member-at-Large	Elvira	Ramos	02/28/2015	02/28/2018	3 Years	elvira@commfound.org
Housing and Human Services Advisory Committee	5	Member-at-Large	Suzanne	Crawford	03/15/2016	02/28/2019	3 Years	suzanne@sistercarmen.org
Housing and Human Services Advisory Committee	6	Member-at-Large	Simon	Smith	02/28/2015	02/28/2018	3 Years	simon.smith@clinica.org
Housing and Human Services Advisory Committee	7	Member-at-Large	Robin	Bohannan	09/01/2015	02/28/2018	3 Years	rbohannan@bouldercounty.org
Housing and Human Services Advisory Committee	8	Member-at-Large	Laura	Kinder	02/28/2014	02/28/2017	3 Years	laura.f.kinder@gmail.com
Housing and Human Services Advisory Committee	9	Member-at-Large	Dalia	Dorta	03/15/2016	02/28/2019	3 Years	daliadorta@gmail.com
Housing and Human Services Advisory Committee	10	Member-at-Large	Jeff	Zayach	06/24/2014	02/28/2017	3 Years	jzayach@bouldercounty.org
Housing and Human Services Advisory Committee	11	City of Louisville Housing	Pat	Heinz-Pribyl	12/28/2015		Open Ended	patheinzpribyl@gmail.com

Department of Housing & Human Services
Housing Office: 2525 13th Street, Suite 204 • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax: 720.564.2283
Human Services: Boulder Office • 3400 Broadway • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax 303.441.1289
Longmont Office • 529 Coffman, Suite 100 • Longmont, Colorado 80501 • 303.678.6000
www.bouldercountyhhs.org

Boulder County Housing & Human Services Advisory Committee (HHSAC)

Boulder County Housing & Human Services Vision:

We believe in co-creating solutions for complex family and community challenges by fully, effectively, and efficiently integrating health, housing, and human services to strengthen the broad range of Social Determinants of Health, in turn generating a more self-sufficient, sustainable, and resilient community.

About the HHSAC:

Committee members provide advice and guidance to the Department of Housing & Human Services (DHHS) staff and leadership in their efforts to most effectively serve the community. Committee members strive to actualize the vision of the agency and to ensure that the vision is aligned with the identified needs of the Boulder County community. Committee members provide substantive recommendations on improving the organizational effectiveness based on community input and personal experience.

Remainder of 2016 & 2017 Meeting Schedule

Remainder of 2016

- September 27, 2016 – 3:30 p.m. – 5 p.m.
- October 25, 2016 – 3:30 p.m. – 5 p.m.
- December 6, 2016 – 3:30 p.m. – 5 p.m.

2017

- January 31, 2017 – 3:30 p.m. – 5 p.m.
- February 28, 2017 – 3:30 p.m. – 5 p.m.
- March 21, 2017 – 3:30 p.m. – 5 p.m.
- April 25, 2017 – 3:30 p.m. – 5 p.m.
- May 30, 2017 – 3:30 p.m. – 5 p.m.
- June 27, 2017 – 3:30 p.m. – 5 p.m.
- July 25, 2017 – 3:30 p.m. – 5 p.m.
- August 29, 2017 – 3:30 p.m. – 5 p.m.
- September 26, 2017 – 3:30 p.m. – 5 p.m.
- October 31, 2017 – 3:30 p.m. – 5 p.m.
- December 5, 2017 – 3:30 p.m. – 5 p.m.

***Meetings are typically held the last Tuesday of each month. Schedule subject to change.**

****All meetings are held at the DHHS Kaiser Building Location, 2525 13th Street, Second Floor Large Conference Room, Boulder, CO.**

BOULDER COUNTY HOUSING & HUMAN SERVICES

Hope for the future, help when you need it.

BCDHHS Advisory Committee
October 2016 Meeting Packet

Department of Housing & Human Services

Housing Office: 2525 13th Street, Suite 204 • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax: 720.564.2283
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Longmont Office • 515 Coffman Street, Suite 100• Longmont, Colorado 80501 • Tel: 303.441.1000

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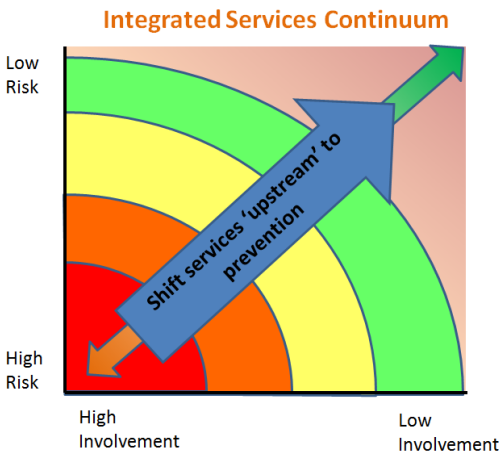
DHHS Advisory Committee
MONTHLY MEETING
Tuesday, September 27, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder



Agenda

1) **Review and approval of today's agenda** (3:30 – 3:33 p.m.)

2) **Review and approval of minutes from September 27 HHSAC meeting** (3:33 – 3:35 p.m.)

3) **Continuation of governance discussion: moving from collaborative to integrative** — Frank Alexander, Susan Caskey, IMPACT Care Management Division Director; Angela Lanci-Macris, Case Management and Community Outreach Division Director, Melissa Frank Williams, Integrated Services Manager (3:35 – 5:00 p.m.)
   a) Further discussion and clarification of the governance role for the Committee within the Family Resource framework and the role of Dream Big within the framework
   b) Discussion of Committee scope, vision, bylaws, and committee work plan
   c) Review of upcoming meeting focus and schedule

4) Adjourn

Upcoming Meetings:

a) **No November meeting
b) December 6, 2016, 3:30 p.m., 2525 13th Street, Large Conference Room, Boulder
   i. Agenda Items: Review of governance document, agreement on the role of the Committee, discussion of committee makeup
c) January 31, 2017, 2525 13th Street, Large Conference Room, Boulder

i. Agenda Items: Discussion of Local Area Collaborative model

Access to current and past packets for the Boulder County Housing Authority Board, the Boulder County Human Services Board, and the Housing & Human Services Advisory Committee can be found by clicking on the links below:
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Boulder County Human Services Board Packets

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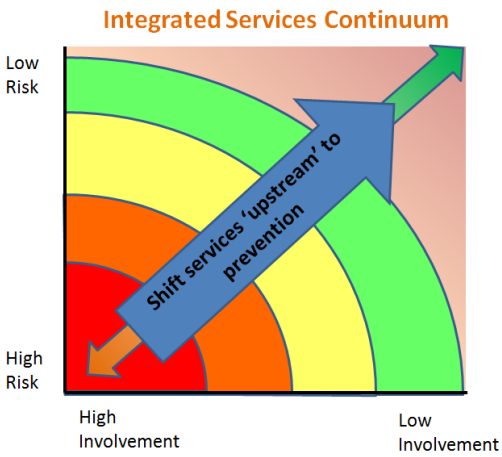
DHHS Advisory Committee
MONTHLY MEETING
Tuesday, September 27, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder



Committee Members in Attendance: Julie Van Domelen, Jeff Zayach, Robin Bohannan, Elvira Ramos, Bobbie Watson, Pat Heinz-Pribyl, Laura Kinder, Betsey Martens, Suzanne Crawford

Staff in Attendance: Frank Alexander, Susan Caskey, Angela Lanci-Macris, Maggie Crosswy, Daphne McCabe, Melissa Frank-Williams, Chris Campbell, Summer Laws

Member of Public in Attendance:
Kirsten Culp, Lydia Morgan Resident

Minutes

1) **Review and approval of today's agenda** (3:30 – 3:33 p.m.)
Approved as written

2) **Review and approval of minutes from August 30 HHSAC meeting** (3:33 – 3:35 p.m.)
Approved as written

3) **Game of Life client simulation**—Daphne McCabe, Strategic Initiatives, IMPACT Care Management Division (3:35 – 4:00 p.m.)
The committee went through an initial exercise to set the stage for the governance discussion. Resources available to clients were discussed and some of the issues/barriers clients face were

discussed by the committee members. Robin—Keep in mind that there is a more in depth poverty simulation upcoming that committee members may want to consider.

4) **Continuation of governance discussion: moving from collaborative to integrative** — Susan Caskey, IMPACT Care Management Division Director; Angela Lanci-Macris, Case Management and Community Outreach Division Director; Jason McRoy, Business Operations and Systems Support Division Director (4:00 – 5:00 p.m.)

Angela—Last meeting, we had a comprehensive discussion about governance and what is the focus of this committee. Some of the content reflected, what does DHHS want us to do? The history of the Committee has evolved from one of dealing with clients issues/complaints and feedback for the Director. When the departments were merged into housing and human services, Frank received feedback from Committee members on how to best approach the merger and integrated services.

In March 2015, the Committee contemplated the following goals and purpose:

March 2015
About the HHSAC - Committee members will:

- Provide advice and guidance to the DHHS staff and leadership in their efforts to most effectively serve the community.
- Strive to actualize the vision of the agency and to ensure that the vision is aligned with the identified needs of the Boulder County community.
- Provide substantive recommendations on improving the organizational effectiveness based on community input and personal experience.

Now we are looking to move from a more collaborative approach to our work to a more integrative approach. See the information from APHSA: HEALTH AND HUMAN SERVICES INTEGRATION MATURITY MODEL 2.0.

Susan C: our focus as an agency is on the following.

- Internal Practice
- Project Management
- Fiscal Planning
- Performance Management

Kestrel project for example: new housing for Louisville (200 units of affordable housing). Many systems impact from these high-level projects and we are working to look at these projects through the lens above (Internal practice, Project Management, Fiscal Planning, Performance Management).

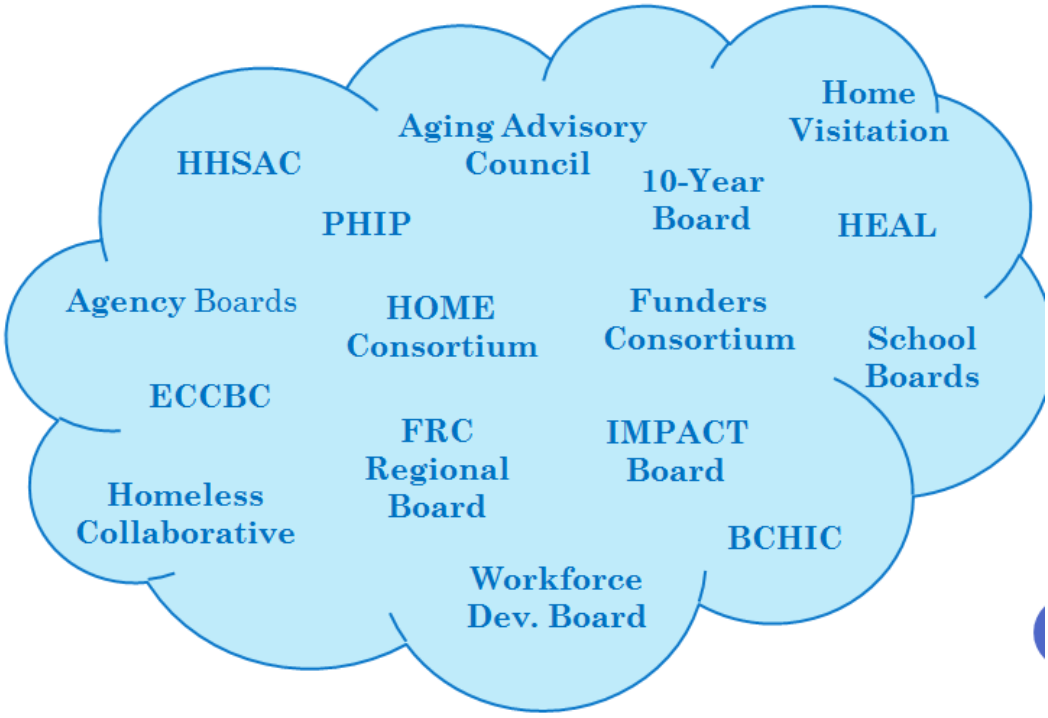
3-5 year strategic planning goals as of 2017 for DHHS:

- **Integrated Services Model.** Implementation of a department-wide agile, responsive, person-centered integrated human service delivery model of care that is designed to support families to achieve long-term self-sufficiency.

- **Institutional Services Utilization.** Reduce institutionalization rate across specific areas of the community (detention, placement, incarceration).
- **Wellness and Prevention.** Achieve improved mental health, physical health and substance use care coordination and outcomes that optimize wellness and prevention efforts for vulnerable populations.
- **Affordable Housing Capacity.** Increase the diversity of options and capacity of affordable housing to promote family well-being and stability.
- **Financial Empowerment Pathways.** Increase income development, financial empowerment and employment pathways for unemployed or under-employed populations.
- **Child Education and Development.** Improve child development and readiness for school.

Large focus for DHHS on the project review process. The goal is to ensure that projects are aligned with the strategic priorities, well-resourced, and focused moving the community toward a more generative safety net.

**Community Governance Dynamic: Another focus for our discussion today. There are many board/advisory committees out there and we are looking to better link these boards toward a common mission and goals.



As an example of some of the Board out there, see the comparison of IMPACT and CJMB. One thing to note is there is a lot of overlap on these boards in terms of membership, including many from this board.

IMPACT: 2 levels of the Board, executive Board and an operations board. Oversight of specific programs, joint decision making by the board is also part of the mandate of the boards.

Jeff/Robin: the Board has a very clear vision and is effective because it is very focused on targeted services/focus areas. Shared goal is keeping kids out of placement, right service at the right time, right dosage.

IMPACT's Long-Term Vision is key to the Board's success (see the attached PowerPoint)

Betsey: strikes me that the Committee is that IMPACT is trying to achieve a lot of the same goals. Good model for our Committee.

Julie: This group could go above, see the linkages, larger picture for the system in general. Not just focused on early childhood dimensions.

Task is to better define the identity and utility of this group. What role should this group have to pull together the larger system work (community safety net governance)?

Laura: are we more internal governance versus external governance.

Jeff: what works with IMPACT we have absolutely defined goals, we have data connected to the goals so we can measure outcomes, there a clear funding source. One of the things that is striking me is if the Pillars (Health, Housing, Employment, Safety, Education, Food) are the focus for this committee, do we have the best folks at the table and what is the best governance structure (Community of Hope structure).

Frank—the Committee has different roles at different times. More focus on more specific areas, not this broader governance role. With the current membership, the movement toward family functioning, family case management has been the focus. None of the existing boards does this. We're aiming in this but haven't landed on this.

Jeff—when I think about a specific project, I can see how it fits in; however, the entire system look is a bit overwhelming.

Susan C—we want to ensure that we are linked to the other work and boards out in the community.

Frank—the challenge from a business side are moving to the integrative space. This is where we are focused now, our funding streams are heading this way, our data systems are heading this way.

Susan—is this a group that wants to focus on one area of work or more general areas of focus to work with the community.

Bobbie: this group has been asked to be the higher level with Dream Big for example. I get fuzzy when we are talking at the 50,000 ft. level. The great goal may come with this. Betsey: would love to have the support and governance from this group.

Frank: FRC regional governance framework: in each area of the county, there are diverse ways families access support, the regional board would help to have common practice framework, common measures and Dream Big fits within this Framework.

Next steps, DHHS staff will take the recommendation and bring it to the next meeting. Focus on the Dream Big/Regional Governance Framework. The group took a straw poll in support of this approach.

Upcoming Meetings:

a) October 25, 2016, 3:30 p.m., 2525 13th Street, Large Conference Room, Boulder
   i. Agenda Items: Continuation of visioning and governance discussion
b) **No November meeting
c) December 6, 2016, 3:30 p.m., 2525 13th Street, Large Conference Room, Boulder
   i. Agenda Items:

5) Adjourn

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IMPACT and CJMB Governance Overview

HHSAC meeting
9/27/16

Outline

HHSAC: A History

- Where we are and where we've been

Governance Frameworks

- APHSA Governance Concept
- HHS Strategic Project Framework
- IMPACT and CJMB Governance
- Community Governance Dynamic

Role of HHS Advisory Committee

- Key questions for group

Next Steps

HHSAC: A brief History

March 2015

About the HHSAC - *Committee members will:*

- provide advice and guidance to the DHHS staff and leadership in their efforts to most effectively serve the community.

- strive to actualize the vision of the agency and to ensure that the vision is aligned with the identified needs of the Boulder County community.

- provide substantive recommendations on improving the organizational effectiveness based on community input and personal experience.

HHSAC: By-Laws

ARTICLE II. – PURPOSE

Section 1. Serve as advisors to the Boulder County Department of Housing and Human Services.

Section 2. Strive to actualize the vision and mission of the agency and to ensure that the vision and mission are aligned with the needs of the Boulder County community.

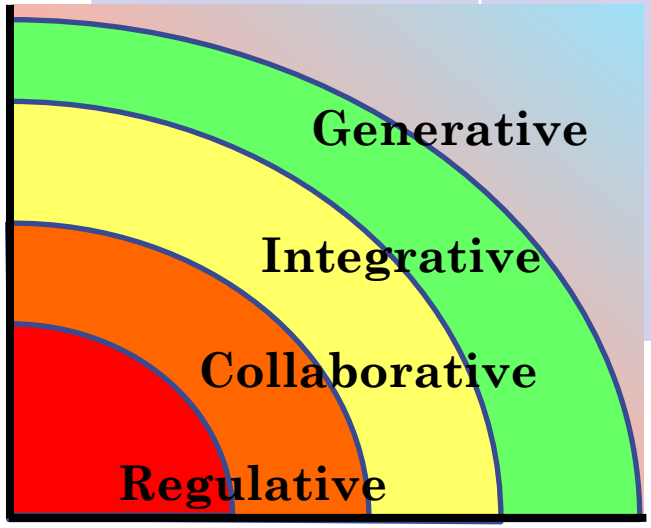
Section 3. Enable community leaders, volunteers within the Department, residents and clients to make recommendations on improving the effectiveness of the Department.

APHSA

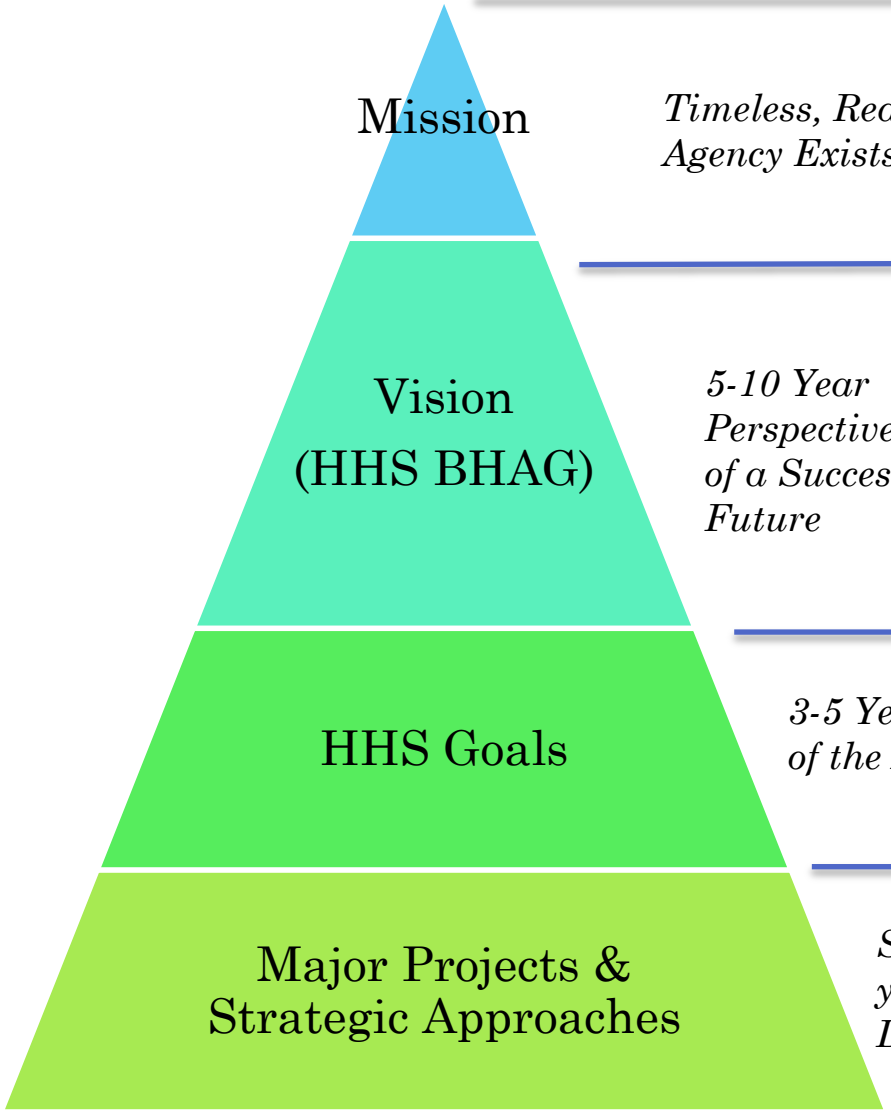
Generative Maturity Levels		Generative Definition
Focus		Creating healthy communities by working with others outside the H/HS enterprise to address complex health and social challenges
Vision	**For Program Participants**	Program participants are proactively engaged by the H/HS enterprise and external agencies by predicting current and future needs. A participant's behavior also serves as a catalyst toward achievement of shared outcomes defined collectively by H/HS community.
	For Organization/ Enterprise	H/HS enterprise identifies additional services beyond its immediate control to create healthy communities, improve program participants' outcomes, and population health and lowers costs-and through the use of analytics. Works seamlessly with other stakeholders, including other states, to generate long-lasting solutions and serve as a national model.
Governance	**Who**	Internal, senior executives and a variety of other stakeholders from within and external to the H/HS enterprise and stakeholders in the community (such as advocates, providers, families, nonprofit organizations, industry)
	Decision-Making	Shared beyond the H/HS enterprise to reflect proactive, anticipatory, 360-degree orientation that considers drivers associated with the social determinants of health and well-being. Risk is balanced with generating new, creative solutions.

BUILDING TO OUR BHAG

Internal Practice	Project Management	Fiscal Planning	Performance Management
• ISDMC • Common assessment practices • Common case plan model • No Programs • Prevention oriented	• Central project plan with defined number of projects • Project management resources • Planning 1 year in advance of implementation	• Blended program funding models • 'Programs' become a funding or allocation strategy • Coordinated Management of Services	• Program logic models tied to measures • Measures available to all sups and managers in consistent format • Measures tied to broader indicators • Regular review of performance



HHS Strategic Vision Pyramid



Mission	*Timeless, Reason the Agency Exists*	We are dedicated to a vision of healthy communities that are more self-sufficient, sustainable, and resilient.
Vision (HHS BHAG)	*5-10 Year Perspective, Picture of a Successful Future*	Within 10 years, DHHS will transform the health and the well-being of our community by shifting programming and funding upstream into prevention oriented and consumer driven cross-sector solutions that improve outcomes across the lifespan and significantly reduce high-cost institutional interventions within a social determinants of health framework.
HHS Goals	*3-5 Year Focus of the Agency.*	Development In Progress….
Major Projects & Strategic Approaches	*Shorter term 1-2 year projects, Division Level*	Development In Progress….

3-5 Year Strategic Priorities

Integrated Services Model. Implementation of a department-wide agile, responsive, person-centered integrated human service delivery model of care that is designed to support families to achieve long-term self-sufficiency.

Institutional Services Utilization. Reduce institutionalization rate across specific areas of the community (detention, placement, incarceration).

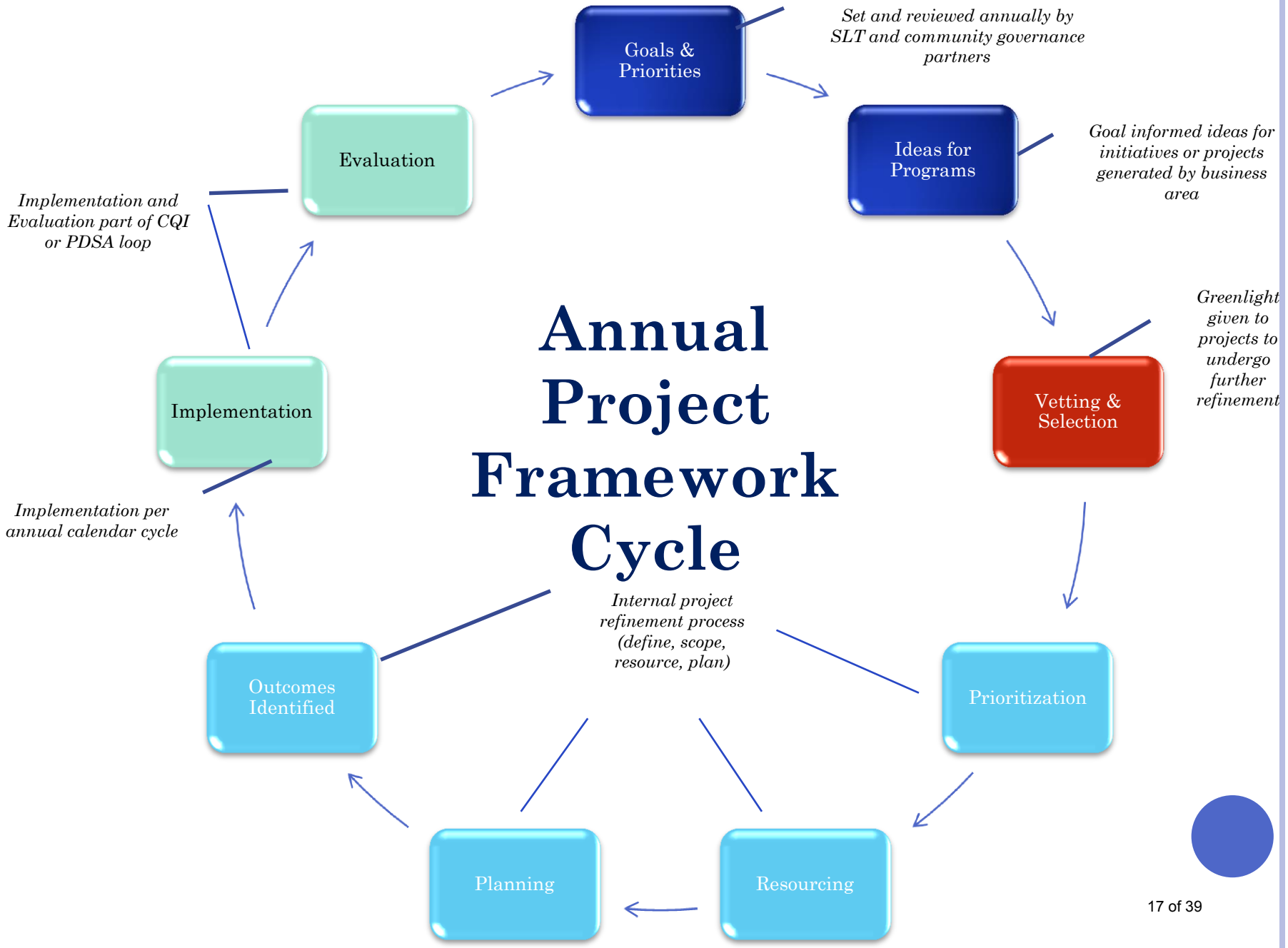
Wellness and Prevention. Achieve improved mental health, physical health and substance use care coordination and outcomes that optimize wellness and prevention efforts for vulnerable populations.

Affordable Housing Capacity. Increase the diversity of options and capacity of affordable housing to promote family well-being and stability.

Financial Empowerment Pathways. Increase income development, financial empowerment and employment pathways for unemployed or under-employed populations.

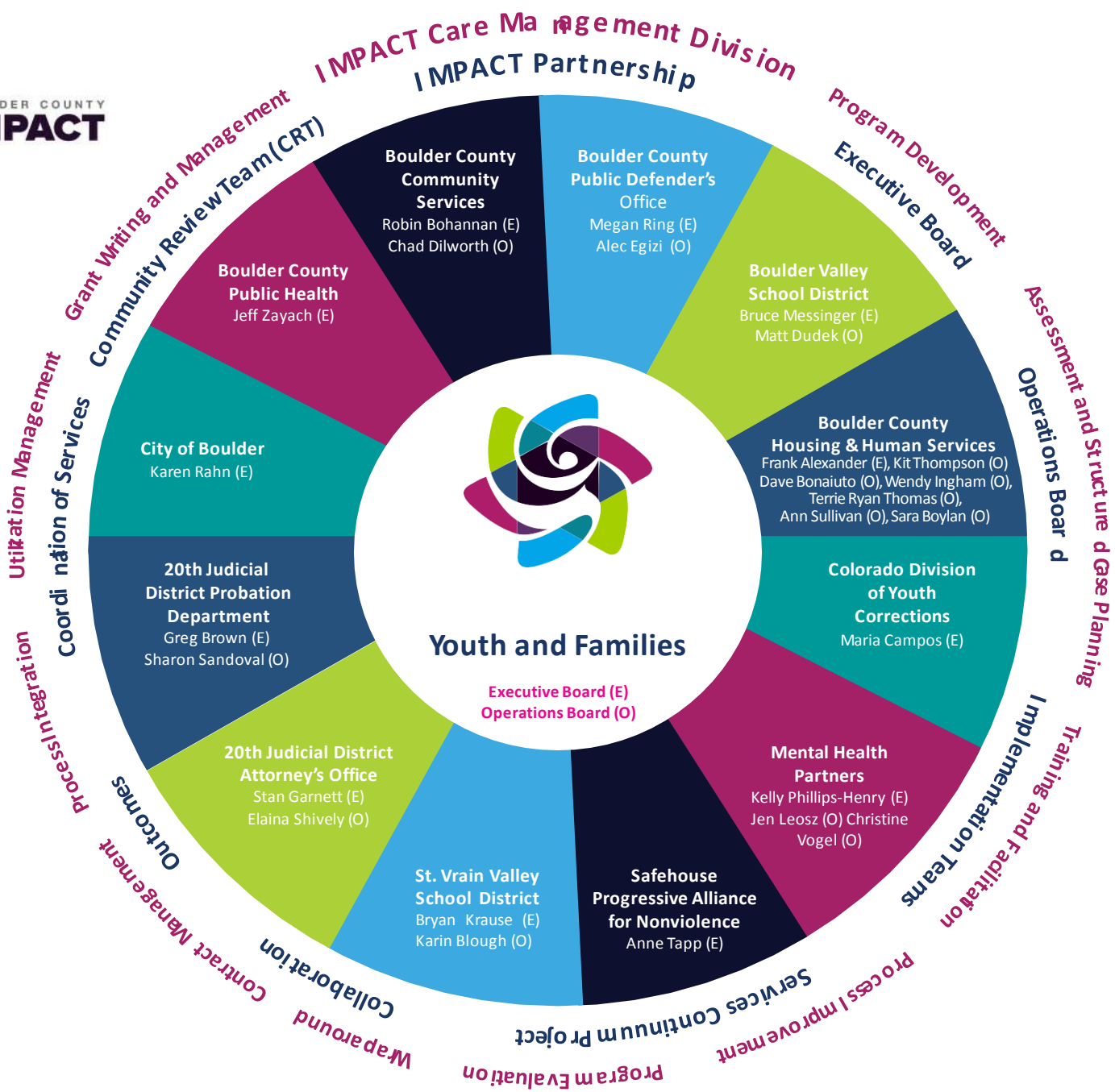
Child Education and Development. Improve child development and readiness for school.

Annual Project Framework Cycle



IMPACT & CJMB GOVERNANCE SNAPSHOT

	IMPACT	CJMB
Goals	Reduce Detention, Commitment, OOH placement for BC children and youth	Improving processes and collaboration in the adult criminal justice system
Funding Oversight	$5M in State contracts and grants	None
Program Oversight	See separate chart	No direct program oversight
Process Oversight	Collaborative processes, implementation	High level oversight board dedicated to collaborative issues and processes in the adult criminal justice systems
Membership	See separate chart	Chief Judge Berkenkotter, Kelly Phillips-Henry, Greg Brown, Frank Alexander, Jeff Zayach, Sheriff Joe Pelle, Megan Ring, Monica Rotner, Robin Bohannan, Stan Garnett, Josh Maximon, Jeff Goetz


IMPACT Care Management Division
IMPACT Partnership
Program Development
Executive Board
Assessment and Structured Case Planning
Operations Board
Training and Facilitation
Implementation Teams
Process Improvement
Service Continuum Project
Program Evaluation
Process Improvement
Wraparound
Collaboration
Contract Management
Outcomes
Coordination of Services
Utilization Management
Grant Writing and Management
Community Review Team (CRT)
Boulder County Community Services
Robin Bohannan (E)
Chad Dilworth (O)
Boulder County Public Defender's Office
Megan Ring (E)
Alec Egizi (O)
Boulder Valley School District
Bruce Messinger (E)
Matt Dudek (O)
Boulder County Housing & Human Services
Frank Alexander (E), Kit Thompson (O)
Dave Bonaiuto (O), Wendy Ingham (O),
Terrie Ryan Thomas (O),
Ann Sullivan (O), Sara Boylan (O)
Colorado Division of Youth Corrections
Maria Campos (E)
Mental Health Partners
Kelly Phillips-Henry (E)
Jen Leosz (O) Christine Vogel (O)
Safehouse Progressive Alliance for Nonviolence
Anne Tapp (E)
St. Vrain Valley School District
Bryan Krause (E)
Karin Blough (O)
20th Judicial District Attorney's Office
Stan Garnett (E)
Elaina Shively (O)
20th Judicial District Probation Department
Greg Brown (E)
Sharon Sandoval (O)
City of Boulder
Karen Rahn (E)
Boulder County Public Health
Jeff Zayach (E)
Youth and Families
Executive Board (E)
Operations Board (O)

IMPACT Partner Agency Services for IMPACT Youth

Department of Housing and Human Services

- Adolescent Intake and Ongoing Casework
- Project REACH
- **Wraparound**
- Lifeskills
- Family Group Decision Making Continuum
- Service and Out of Home Placement Utilization Management
- **Community Review Team**

Community Justice Services

- **Juvenile Assessment Center (JAC)**
- **Boulder Enhanced Supervision Team (BEST)**
- **Mentor Program**
- **Transport**
- **Detention Therapist**
- **Family Navigator**

Boulder Valley School District

- **Truancy Prevention Programs**
- Halcyon Day Treatment
- **Prevention Intervention Program**

Mental Health Partners

- **Functional Family Therapy, Family Interventionist, Family Advocate, Trauma Focused Cognitive Behavioral Therapy, Teen Programs**
- Halcyon Day Treatment
- **Intensive Outpatient Specialist**
- Child Crisis
- Community Infant Program
- Outpatient Services
- Adoption Counseling
- **Prevention Intervention Program**

St. Vrain Valley School District

- Truancy Prevention Programs

District Attorney's Office

- **Diversion**
- Restorative Justice
- Project REACH

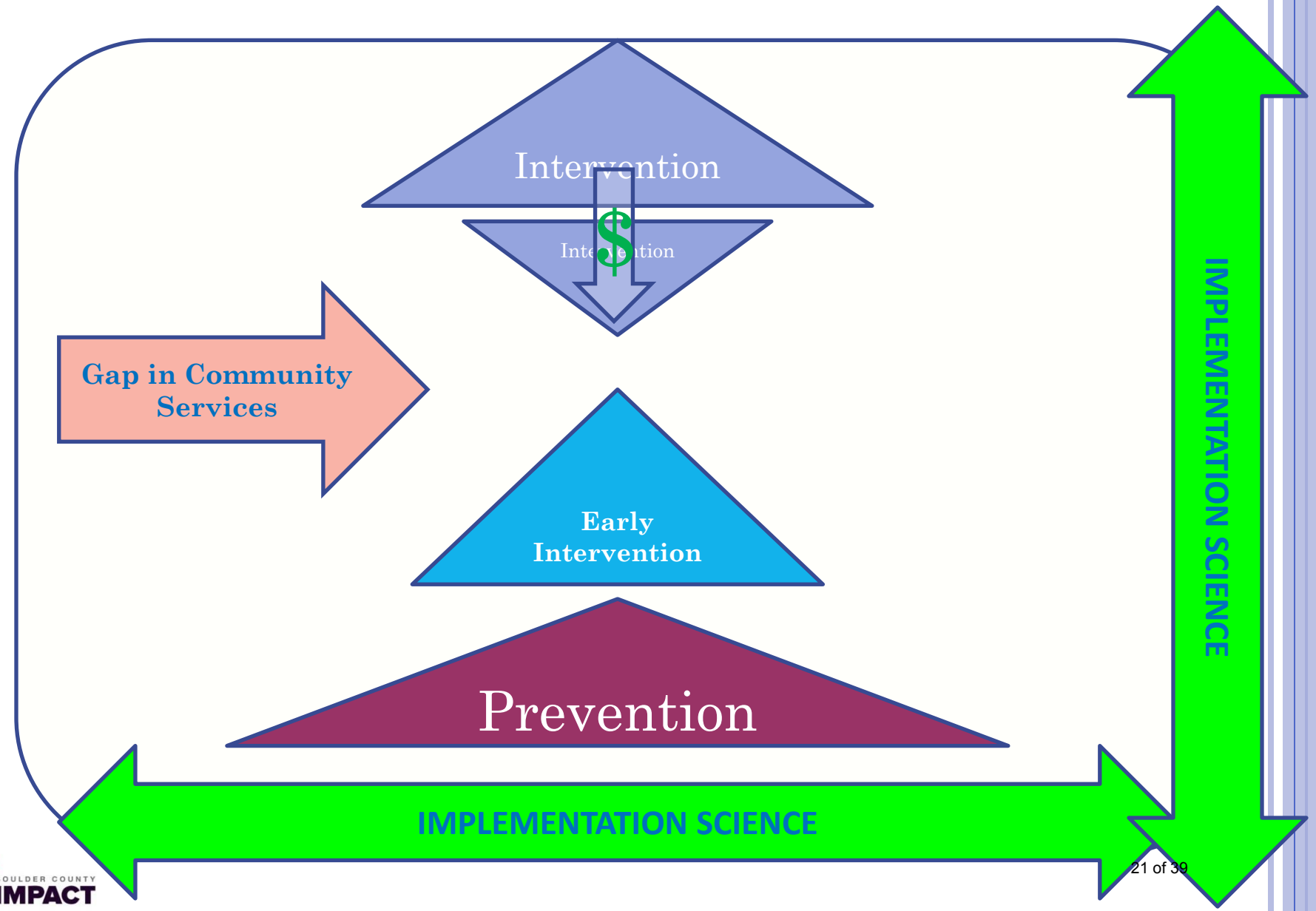
Probation

- Probation
- Juvenile Intensive Supervised Probation (JISP)
- **Project REACH**
- **Probation Supervision**
- **Division of Youth Corrections Placements and Case Management** (managed by IMPACT Infrastructure Team)

Contracted Services

- **Direct Instruction**
- **Cognitive Behavioral Therapy**
- **Project REACH**
- **Multi Systemic Therapy**
- Sexual Abuse Treatment
- Psychological Evaluations
- Virtual Residential Program
- Specialized Therapeutic Services

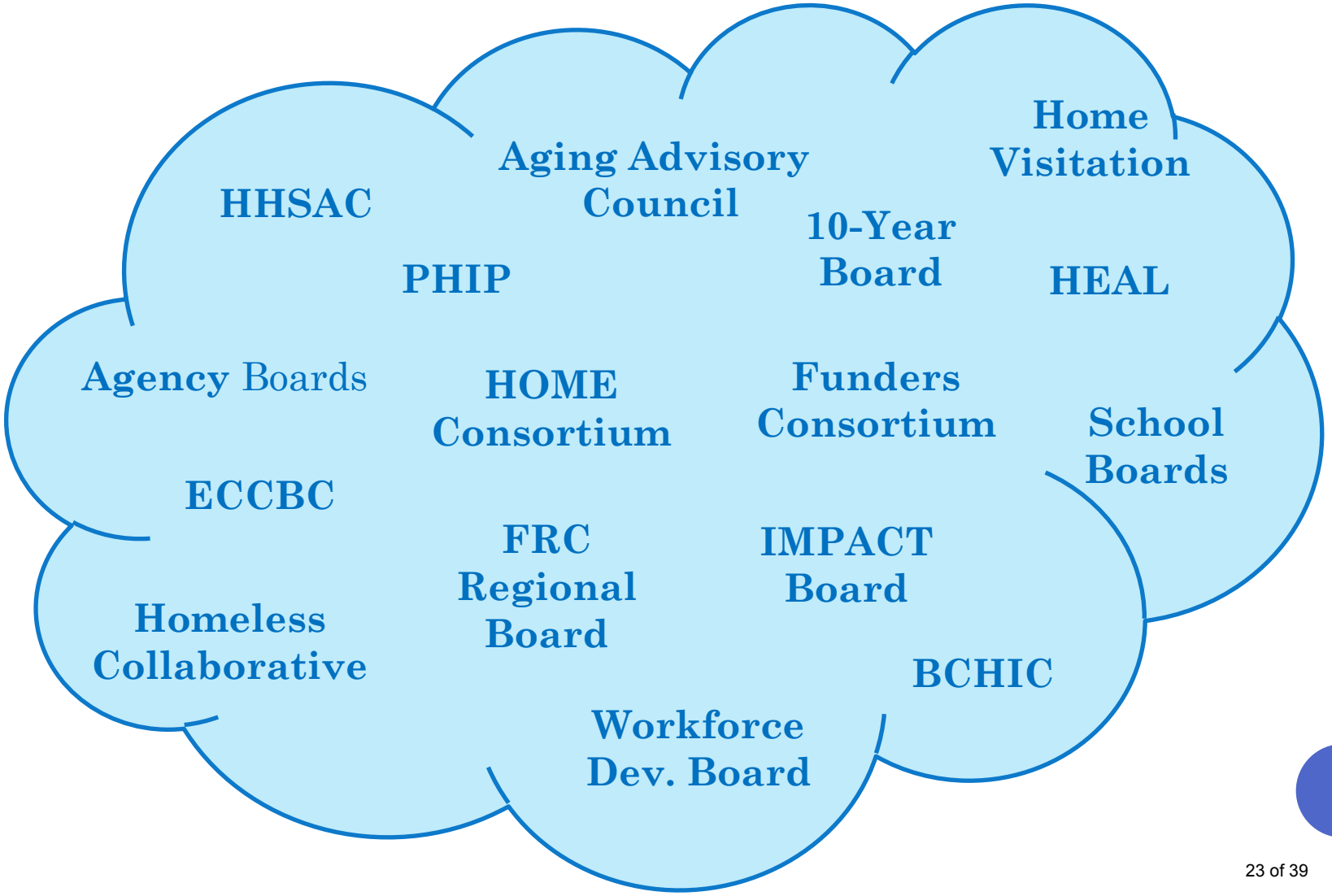
IMPACT's Long-Term Vision



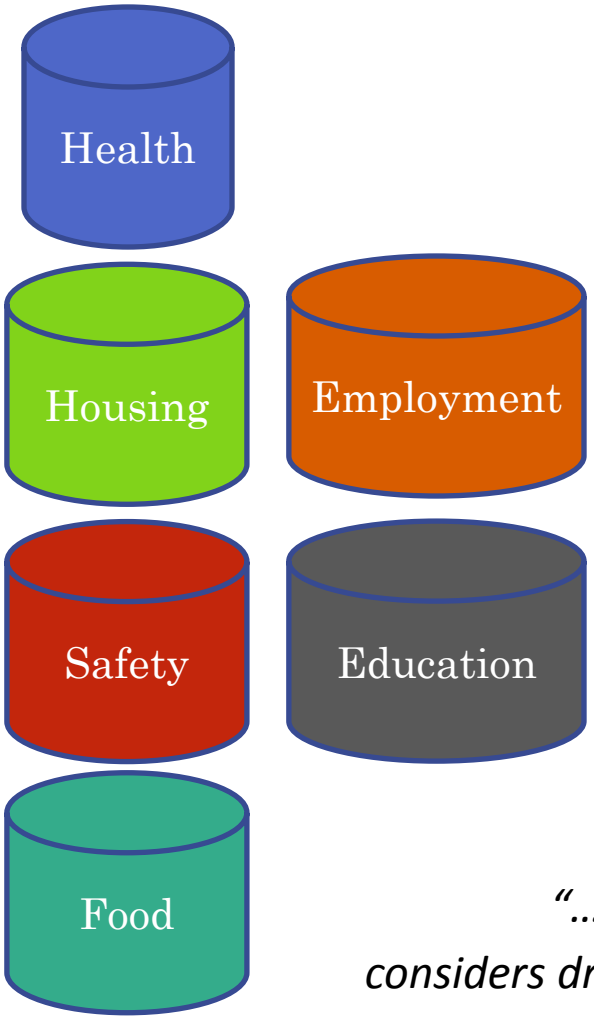
CJMB RECENT AREAS OF FOCUS

- Justice System Partners study of risk, substance abuse, and mental health in the adult systems
- Public health (opiate epidemic)
- Mental health (resources and education for law enforcement and jail)
  - Mental health holds and issues with hospitals seeing 'dangerous' adults and jails holding people with mental health issues
- Jail overcrowding and utilization
- Failure to appear program run by the courts
- Transporting defendants from the jail to the justice center.

Community Governance Dynamic



Community Governance Dynamic



"…reflect proactive, anticipatory, 360-degree orientation that considers drivers associated with the social determinants of health and well-being. Risk is balanced with generating new, creative solutions."

Question for Discussion

Our task is to better define the identity and utility of our HHSAC group.

Given our current dynamic of community safety-net governance, what role (if any) should the HHSAC committee play?

HEALTH AND HUMAN SERVICES INTEGRATION MATURITY MODEL 2.0

Based on APHSA's 21st Century Health and Human Services Business Model[1]

		MATURITY LEVELS Adapted from *The Human Services Value Curve*[2]			
		1—REGULATIVE	**2—COLLABORATIVE**	**3—INTEGRATIVE**	**4—GENERATIVE**[3]
Focus		Delivering services to program participants for which they are eligible while complying with categorical policy and program regulations	Ensuring the appropriate mix of existing services for program participants working across agency and programmatic boundaries	Addressing and solving the root causes of program participants' needs and challenges by seamlessly coordinating and integrating services	Creating healthy communities by working with others outside the H/HS enterprise to address complex health and social challenges
KEY FEATURES		***Characteristics of the Key Features at Various Maturity Levels of Integration***			
Vision	*For Program Participants*[4]	Program participants initiate engagement or are referred to a program within the agency.	Program participants initiate engagement or are referred to a program within the agency, accompanied by a hand-off to another program within the agency, with a sister agency, or beyond entities within government (heretofore referred to as partner organizations).[5]	Program participants are proactively engaged by the health and human services (H/HS) enterprise.[6]	Program participants are proactively engaged by the H/HS enterprise and external agencies by predicting current and future needs. A participant's behavior also serves as a catalyst toward achievement of shared outcomes defined collectively by H/HS community.
	For Organization/ Enterprise	H/HS agency complies with all relevant categorical and policy requirements—statutory, regulatory and executive.	H/HS agency works with partner organizations while complying with all categorical and policy requirements; retains organization's goals, some of which may overlap with partners.	H/HS enterprise addresses/solves root causes of program participants' needs via integrated service delivery and supports a customer-centric, integrated, outcome-oriented, modern marketplace experience.	H/HS enterprise identifies additional services beyond its immediate control to create healthy communities, improve program participants' outcomes, and population health and lowers costs-and through the use of analytics. Works seamlessly with other stakeholders, including other states, to generate long-lasting solutions and serve as a national model.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Governance	*Who*	Internal, senior executive-level decision-makers	Internal, senior executives with some external stakeholders from partner organizations	Internal, senior executives and other high-level stakeholders throughout the H/HS enterprise, along with external stakeholders from partner organizations	Internal, senior executives and a variety of other stakeholders from within and external to the H/HS enterprise and stakeholders in the community (such as advocates, providers, families, nonprofit organizations, industry)
	Decision-Making	Vertical/top-down—based on requirements of programs, risk is not intended to impact other programmatic areas.	Vertical/top-down, but influenced by partners' horizontal considerations. Risk is shared across collaborating entities to extent allowable.	Shared within the H/HS enterprise regardless of any single program's role. Risk is shared enterprise-wide so innovation is not limited.	Shared beyond the H/HS enterprise to reflect proactive, anticipatory, 360-degree orientation that considers drivers associated with the social determinants of health and well-being. Risk is balanced with generating new, creative solutions.
Adaptive Leadership and Capabilities	*Leadership View of Organization/Enterprise*	Leadership of single agencies/programs limited to fulfilling programmatic standards and mandates.	Leadership across the organization views collaborating organizations as partners who share common goals and bring valuable assets to the challenges faced by their shared program participants.	Leadership across the enterprise views the organization as seamlessly integrated with a holistic view of the program participants. Leadership places its highest value on outcomes-focused goals even at the expense of organizational norms. It also allows mid-course changes when prompted by new information and deemphasizes hierarchy and silos across the enterprise.[7]	Same view of enterprise as in Integrative Stage, but with the highest value placed on outcomes consistent with the creation of healthy communities. Leadership relies on new partnership models to generate a new community of nontraditional public/private sector partners focused on sustaining whole community well-being and generating new approaches and solutions.
	Drivers of Organizational Change	Outside statutory and regulatory process requirements associated with compliance with statute and regulations.	Collaborative efforts to address mutual challenges. Challenges stem from external requirements and inability to avail itself/oneself	Continual environmental scanning of current and anticipated statutory/ regulatory environment as well as marketplace of	The H/HS enterprise serves as a catalyst toward changing the statutory/ regulatory environment. Culture of receptivity that

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Adaptive Leadership and Capabilities (cont'd)	*Drivers of Organizational Change (cont'd)*	Challenges stem from limited to no ability to share information.	of opportunities identified through information sharing across organizational boundaries. Staff and systems strive to adapt their business processes and data flows to reinforce cooperation.	enterprise and stakeholders. A seamless cross-boundary exchange of information within the enterprise provides opportunities to address root causes and change traditional practices.	generates key solutions to leverage the enterprise's strengths, together with private and public partners sharing common goals. Information gathered from internal and external sources helps guide staff actions routinely and enables the enterprise to be highly adaptable to change.
Access Channels and Engagement	*Who is Responsible for Access?*	Access to services is transactional. It's sought out by program participants and the agency responds to the presenting need/request.	Access to services is also transactional, but additional communication may occur between program participants and partnering organizations to respond to the presenting need/request.	Access to services is the result of ongoing, preventive engagement and proactive communication from the enterprise to program participants.	Access to services is the result of ongoing, preventive engagement and proactive communication among the enterprise, program participants, and the community. Participants are activated to be a catalyst identifying beneficial programs that may help to prevent future, deeper service needs.
	• *Developing Access*	Participants' access is available on a program-by-program basis and is provided by multiple workers across multiple sites with minimal coordination between programs, except where required.	Participants' access is available on a program-by-program basis yet program workers coordinate with one another to assist participants in navigating multiple points of entry.	Participants' access is universally available and provided by workers utilizing a "no wrong door" approach.	The enterprise provides universal access and interaction with participants that anticipates future needs and serves to prevent or remedy potential downstream issues.
		Use of technology is focused on processing transactions and reducing administrative costs.	Use of technology is focused on facilitating data exchanges between partnering organizations. Web-based technologies, such as electronic participant portals, central data repositories, and document imaging and	Use of technology is focused on enabling program participants and staff to effortlessly navigate a variety of access channels across the enterprise. Enterprise service busses, universal	Use of technology is focused on enabling the enterprise to work collaboratively with the program participants as "choice architects." Online portals, smart phones, tablets, and kiosks work

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Access Channels and Engagement (cont'd)	• *Developing Access (cont'd)*		digitization of case records facilitate program participants' access and enrollment.	client registries, workflow and identity management tools, automated account creation technologies, and readily available case notes that can be shared with others (within privacy constraints), are used widely.	together seamlessly with traditional service centers and personal referrals. Community-based organizations serve as portals and extensions of government. The enterprise serves as a test site for innovative approaches to enhancing existing and generating new access channels.
	• *Gaining Access*	Program participants initiate direct, person-to-person contact at the local office, although some information may be available on-line.	Program participants initiate contact (in person or on-line) and guidance is provided regarding available complementary services that are provided to the participant by partnering organizations.	Enterprise initiates contact through automated alerts, notices of renewals, or other technologies advancing program participants' access to services with the enterprise assisting the participants in navigating the service system through the setting of decision points for choices that lead the participant toward health and wellness. In-person assistance remains available for high-touch participants.	Enterprise and community partners initiate contact with program participants through seamless technologies incorporating the latest advances in access channels including readily accessible 24/7 call centers. Enterprise, community partners, and the participant collectively work together to navigate the service system. Yet, at this level, program participants are empowered to act as own catalysts for making choices leading toward health and wellness. In-person assistance remains available for high-touch participants.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Common Process Functions	*Application/Intake and Enrollment*				
	• *Application/Intake Process*	Application/intake process is highly customized to specific programmatic mandates and standards; uses only program-specific applications.	Application/intake process can be separate or used across multiple programs while retaining programmatic mandates and standards.	Enterprise works together to create and use a simplified common application/intake process that is mutually acceptable across organizations.	Enterprise works with a simplified common application/intake process that is mutually acceptable with organizations across and external to the enterprise. Feedback loops are incorporated into application to handle new regulations and policy requirements across programs.
	• *Enrollment Activities*	Specific applications/intake processes are used to determine eligibility and enroll program participants in a given program.	Application/intake processes are completed collaboratively with partners through the use of cross-boundary data and most of which can be used by multiple programs. Programmatic enrollment responsibility is diversified across multiple partners.	Use of client registries, together with decision-support tools, enhances the staff's ability to overcome barriers inherent in traditional silos. Opportunities are created that allow program participants to be actively engaged in key decisions. Enrollment is centralized based on eligibility determination established from common system.	Through use of a universal client registry and other decision support tools, the enterprise and other partners can engage in activities beyond eligibility and enrollment such as integrated case management and innovative relationship management strategies to achieve the desired outcomes.
	• *Application/Data Characteristics*	Verification of eligibility is based primarily on paper records.	Verification is based on a mix of paper and electronic information.	Verification is based on electronic databases in various locations inside and outside of the enterprise.	Verification is based on the application of common business rules, electronic document management, and robust privacy and security controls coupled with robust data sharing.
	• *Technological Features of the Eligibility and Enrollment (E&E) System*	E&E systems that are tightly coupled[8] and have dated functionality that is difficult to modify/update, resulting in processing of applications, eligibility determinations and enrollment that is time-	E&E systems that are tightly coupled, but may use some cross-boundary communication enabled by add-ons to the existing legacy system rather than through functionality of integrated	E&E systems are loosely coupled[9] while completely integrated and connected seamlessly with organizations throughout the enterprise and based on well-defined data-use	E&E systems are loosely coupled while completely integrated within the enterprise and connected seamlessly with those outside the enterprise based on well-defined

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Common Process Functions (cont'd)	• *Technological Features of the Eligibility and Enrollment (E&E) System (cont'd)*	consuming for staff and delays access to the program participants. Participants' data are difficult to share across programs.	components across partnering organizations.	agreements.	data-use agreements. These resources, combined with multi-benefit screening, result in real-time eligibility determinations and seamless enrollment.
	Workflow Goals and Characteristics	Workflow processes are rules-driven, and designed to deliver a specific output,[10] including determination of eligibility, benefit level to be provided, etc.	Workflow processes are rules-driven yet are updated to build in efficiencies through collaboration with other programs, resulting in multiple "one-stop" opportunities.	Workflow processes are streamlined, seamless, and completely integrated. Processes are designed to achieve efficiencies and desired outcomes[11] identified in conjunction with program participants and the enterprise.	Workflow processes are similar to the Integrative Level, yet input from stakeholders internal and external to the enterprise, community partners, and program participants is instrumental in the design to enable the ability of participants to serve as catalysts toward the achievement of shared outcomes.
	Residence/Access of Consumer Data	Exclusively within the organizational boundaries of each programmatic business line or division, except where sharing is required.	Within individual programmatic business lines or divisions but is shared across organizational boundaries with data owners' and program participants' consent.	Able to be centralized or reside in multiple locations across the enterprise. Information is easily accessible by program participants, staff within the enterprise, agencies external to the enterprise (e.g., education, juvenile justice), and external community partners, to ensure efficient, end-to-end workflows and appropriate outcomes.	Data are centrally housed and available in real-time to all government staff internal and external to the enterprise, including front-line workers, and community partners, while maintaining the highest levels of privacy and security standards.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Coordinated Service Delivery	*Administration of Service Delivery System*	Administered efficiently within the span of control of the organization responsible for delivering the services, with coordination occurring where required.	Administered efficiently through coordination across partnering organizations when opportunities arise. "Best practices" to improve accessibility, accountability, and coordination in other organizations are viewed as possible sources of efficiency and innovation.	Administered efficiently across the enterprise to continuously improve accessibility, accountability and coordination and based on input from within the enterprise and from program participants. Increased flexibility allows ability to replicate, utilize, and customize evidence-based practices to achieve cross-programmatic outcomes.	Administered efficiently and effectively within and external to the enterprise. Flexibility is sustained through feedback loops that exist within and external to the enterprise, including from program participants and community partners, to allow improvement of accessibility, accountability, and customization of services into unique arrays that meet program participants' needs, while drawing upon a practice model that is shared across the enterprise.
	• *Role of Organization/ Enterprise*	Services are identified and delivered within the span of control of the organization responsible for delivering the services, with coordination occurring where required.	Services are identified and delivered in a coordinated manner when ability to avail itself/oneself of opportunities arises across partnering organizations.	Services are identified and readily accessed throughout the enterprise.	Services are identified and readily accessed within and external to the enterprise, as well as by program participants and community partners.
	• *Role of Staff*	Workers may help program participants find additional assistance but the participant needs to initiate access to services.	Workers are knowledgeable about services available through partnering organizations and help program participants access them in a timely way.	Workers collaborate seamlessly across multiple lines of business in such a way that program participants' needs are met and achieved through increased development and coordination of solutions.	Workers ensure that solutions are customized to meet program participants' needs, and that supplementary services are part of participants' service plan that also address the social determinants of health, where appropriate.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Coordinated Service Delivery (cont'd)	• *Role of Staff (cont'd)*	Workers may have informal knowledge of the variety of services offered across multiple lines of business yet there is no formal training provided or processes in place to facilitate coordinated access or service provision.	Workers have some formal orientation to the variety of programs and processes, if in place, to facilitate cross-programmatic access and service provision.	Where possible, workers are cross-trained and assist with service development and provision across multiple programs within the enterprise.	Workers utilize universal knowledge within and external to the enterprise, including the program participants and community partners, to anticipate and proactively address participants' needs.
	• *Role of Program Participant*	Program participants are viewed as recipients of services. The design and delivery of services to the participant remains the responsibility of the organization.	Program participants are viewed as both recipients of services and minimal contributors to their own service plan. The design and delivery of services to participants are a joint responsibility shared between the partnering organizations.	Program participants are viewed as partial partners to the development of a single, integrated service plan with assistance from the enterprise and community partners. Design and delivery of services is jointly conducted with the enterprise and participants.	Program participants are viewed as a full partner in the development of a highly customized service plan with assistance from the enterprise and community partners, drawing on, but not limited by, the services the enterprise has provided in the past and services proven in other contexts to generate positive outcomes.
Defining Success	*For Program Participants*				
	• *For Program Participants*	Defined by regulatory and statutory requirements associated with the efficient and effective processing of participant transactions.	Defined collaboratively with partner organizations sharing common values and goals although focus remains primarily on ensuring smooth, efficient transactions.	Defined by the program participant and the enterprise as a whole and used as benchmarks for evaluating progress toward achieving sustainable outcomes for participants.	Defined by the program participant, the enterprise as a whole, and other community partners. Outcomes are continually fine-tuned through feedback mechanisms to ensure that their continued appropriateness for participants and the broader general population.
	• *Process by Which Outputs/ Outcomes Are Defined*	Results for program participants are defined through transactional outputs (e.g., accuracy, timeliness) once received by the participant.	Results for program participants are defined through transactional outputs (e.g., accuracy, timeliness), including those involving partnering	Sustainable results or outcomes defined as those that favorably affect program participants over the short term.	Sustainable results or outcomes (e.g., sustainable employment, improved health and wellness), defined and identified by the enterprise, program

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Defining Success (cont'd)	• *Process by Which Outputs/ Outcomes Are Defined (cont'd)*		organizations.		participants, and community partners through feedback mechanisms continue to favorably affect participants over the long term.
	• *Accountability of Program Participants' Success*	Accountability for program participants' success rests with the system of service provision within the individual line unit's or division's span of control.	Accountability for program participants' success rests with the system of service provision collaborating across business lines to achieve mutually agreed-upon goals, as well as with the participant who has somewhat contributed to the service plan in place.	Accountability for program participants' success is seen as a joint responsibility between the participant and others, including groups that provide input to enterprise products, services, and strategy across program areas.	Accountability for program participants' success is shared equally between the systems of service provision, the community of which the participant is a member and the participant. Participants' are full partners with enterprise and community leaders in setting strategy for the enterprise.
	For the Organization/Enterprise				
	• *For the Organization/ Enterprise*	Defined by the statutory and regulatory outputs required of the organization or individual line of business. Success is determined by how well the organization or individual lines of business capture their inputs and maintain required levels of outputs.	Defined by the outputs jointly captured across the agency and partnering organizations, and that are supported by required inputs and outputs for each line of business. Success is determined by how well the programs and partnering organizations capture and maintain jointly shared outputs reflecting their shared goals.	Defined by the enterprise's shared outcomes and that are supported by required inputs or outputs. The enterprise works as a seamless whole to achieve the optimal outcomes for its users and accepts unanticipated outcomes generated from the enterprise. Success is determined by the degree to which the enterprise is able to achieve the shared outcomes and goals collectively agreed upon by stakeholders within it and at least partially by program participants.	Defined by the enterprise as a result of cumulative knowledge gained over time and reflects advancements attributable to continually evolving solution sets that are being generated by the enterprise, program participants, and community partners. Success is determined by the enterprise's continuous adaptability and ability to improve performance and is based on achievement of shared outcomes and goals collectively defined by participants, those within and external to the enterprise, and community partners.

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Measures	*How They Are Defined*	Inputs and outputs of the organization delivering services capture specific activity and provide basic trend data over time, including program investment, number of families served, number or percentage of cases closed in a given period, etc.	Similar to the regulative, inputs and outputs of the partnering organizations are also capturing progress made on shared goals and collective actions.	Outcomes shared across the enterprise are quantified while using trend and root-cause analysis to inform progress, as well as to determine priorities and resource needs. Inputs and outputs of single and partnering organizations are still tracked but are used more to inform progress on shared outcomes of the enterprise.	Outcomes shared within and external to the enterprise are quantified while trend and root-cause analysis, as well as other types of advanced analytics,[12] are used to inform progress, priorities, and resource needs. Inputs and outputs of single and partnering organizations are still tracked but are used less as markers of success. Measures also continuously evolve over time.
Infrastructure[13]	*Workforce*	Primarily, staff working within an individual line of business with little knowledge of other programs across the organization. Formal orientation or training to increase awareness of other programs may be provided.	Primarily, staff working within an individual line of business but encouraged, both formally and informally, to learn and coordinate activities with partnering organizations. Formalized orientation or training and processes in place to increase awareness of other programs and coordinate work across lines of business.	Primarily, staff is formally cross-trained to develop awareness and universal knowledge of multiple programs across the enterprise, as well as establish formalized networks within the enterprise in order to provide customized, holistic, program participant–centered services. Less emphasis is placed on specialization in one program/line of business except in key areas within the enterprise.	Primarily, staff is formally cross-trained to continuously develop universal knowledge and maintain formalized networks within and external to the enterprise to strategically provide customized, holistic, program participant–centered services. Less emphasis is placed on specialization except in key areas within and external to the enterprise.
	Organization Structure and Capacity to Change	Structure is designed to be responsive to administrative process drivers within the individual service delivery units. Little to no data are shared across organizational boundaries.	Structure is designed to be responsive to administrative process drivers within the individual service delivery units, but with allowances made within the infrastructure to permit cross-boundary coordination	Structure is designed to be responsive to administrative process and other drivers within the enterprise; the infrastructure supports seamless data sharing and use with individual service	Structure is designed to be responsive to administrative process drivers and other drivers within and external to the enterprise; the infrastructure supports seamless data sharing and

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Infrastructure (cont'd)	*Organization Structure and Capacity to Change (cont'd)*		and data sharing among partnering organizations.	delivery units contributing resources and solutions across the enterprise without being hindered by differences in rules, vocabulary, or definitions.	use within and across the enterprise's boundaries in such a way as to generate administrative efficiencies as well as to generate innovations in policy and practice.
	Purpose of Technology	Systems are designed to be transaction-driven and focused on the individual division or line of business meeting its goals.	Systems are designed to be transaction-driven and focused on the individual division or line of business as well as data sharing across boundaries of partnering organizations. The partnering organizations may maintain their own systems and nomenclatures but electronic translators and other devices are used to facilitate clear comprehension of cross-boundary information, regardless of the source of the information or platform used.	Systems are designed to be outcome-driven and focused upon goals that have been defined for the enterprise as a whole. Data are universally defined across the enterprise such that no additional translation of terms, definitions, or codes is required and is used to identify consistency for individuals, and families beyond eligibility.	Systems are designed to be outcome-driven, focused upon goals defined for the enterprise as a whole that are continually being modified to take into consideration the larger milieu of drivers associated with the social determinants of health, even if those drivers arise from outside the enterprise's span of influence. Data are universally defined and used to identify consistency for individuals, families, and communities beyond eligibility.
	Communications	Communication may be conducted across multiple lines of business around achievement of process-focused goals.	Communication is more frequently conducted around achievement of shared goals with partner organizations.	Communication is conducted regularly and internally (both vertically and horizontally), and somewhat externally, to the enterprise to reinforce achievement of shared success.	Communication among all stakeholders is strategic, bi-directional, and efficient to reinforce achievement of shared success.
	Human Resources (HR)	HR functions (recruitment, selection, training, employee relations, performance management, and benefits) are primarily administered based on compliance with regulations.	Similar to the Regulative level, HR functions are primarily focused on staff acquisition and regulatory compliance, yet also focused on building a culture of engagement that fosters relationship building across	HR functions still maintain existing core tenets, yet the primary focus shifts to building a learning environment across the enterprise. Activities are directed at developing new competencies for the	HR functions still maintain existing core tenets, yet the primary focus shifts to building a learning environment within, and external, to the enterprise. Activities are directed at helping to identify, and

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
	Human Resources (cont'd)		employees in partnering organizations.	enterprise as a whole and for staff at every level to align with the priorities and outcomes of the enterprise.	then develop, new competencies for the enterprise as a whole and for staff at every level to align with the priorities and outcomes within and external to the enterprise.
Financing	*Provision of Funding*	Funding is provided by a variety of federal, state, local, and external sources and distributed to programs in conformance with strict cost-allocation rules and for the purposes of narrowly defined tasks/services. Most funding cannot be moved within a program for purposes outside of statutory or regulatory limits.	Funding is provided same as in Regulative level; cost-allocation rules followed, and in general, no tasks are allowed that are not related to specific programs. However, some tasks/services can be adjusted that support some coordination with partnering organizations within the general programmatic areas that are typically only allowed through state match or state-only dollars, local dollars, or other supplemental funding sources.	Funding is provided to support highly integrated services through proactive staff work across the enterprise to assist program participants' use of a broad range of multi-program services, benefits, organizations, and other resources. Continuous, intentional use of flexible, data-driven, and alternative financing approaches is explored within and across the existing funding authorities throughout the enterprise.	Flexible financing approaches (e.g., blended/braided funding, pay-for-success, multi-sector initiatives) are consistently used and modified based on feedback loops and through the use of enterprise-wide data metrics and analytic tools established across and external to the enterprise to assist program participants use broad range of related services, benefits, organizations, and other resources.
	• *How Priorities Are Set*	Decisions are highly mindful of operational and process compliance constraints attributable to funding sources and cost-allocation methodologies.	Same as in Regulative level but high value placed on collaboration with other partner organizations that may receive funding from other sources. Together, they work toward achieving shared goals.	Same as in Collaborative level, yet the enterprise seeks to maximize its effectiveness by flexibly leveraging various funding sources to achieve improved shared goals and outcomes across the enterprise.	Same as in the Integrative level but the enterprise and community partners not only place a high value on pooling resources to achieve shared outcomes, but place equally high value on proactive and routine seeking of new and innovative mechanisms to increase financial resources to support or even replace traditional funding streams.
	• *Risk*	Little to no risk as priorities reflect constraints attributable to funding	Risk is somewhat higher and dispersed among partnering organizations as priorities	Risk is shared across the enterprise upon testing of new financing solutions	Risk is shared across the enterprise and community partners upon testing and

		REGULATIVE	COLLABORATIVE	INTEGRATIVE	GENERATIVE
Financing (cont'd)	• *Risk (cont'd)*	sources largely measuring outputs and inputs.	reflect increased focus on identifying collaborative financing among those working toward shared goals, while still being risk averse.	and alternatives emphasizing solutions-oriented approaches toward shared goals and outcomes.	implementing new financing solutions and alternatives emphasizing solutions-oriented approaches toward achieving shared goals and outcomes. Continuous feedback loops, including use of data and analytics to identify (social) return on investment opportunities, allow re-prioritization of allowances for modification of funding distribution to achieve shared outcomes.

Endnotes

1. Cari DeSantis, M.A.L.S. *Business Model for Horizontal Integration of Health and Human Services*. American Public Human Services Association. 2012. p. 13–17.
2. Antonio M. Oftelie. *The Pursuit of Outcomes: Leadership Lessons and Insights on Transforming Human Services: A Report from the 2011 Human Services Summit on the Campus of Harvard University. Leadership for a Networked World*. 2011. p. 5–7.
3. The *Generative Level* incorporates the 10 key characteristics of the *21st Century Health and Human Services Business Model*.
4. For purposes of this model, which aims to view the individual/family across business lines and from an enterprise or agency-wide lens, we refer to the individual or family receiving services as the *program participants.*
5. *Partner organizations* may be defined as different programs or lines of business within a health and human service agency. As each state and locality are structured differently, this may also be defined as agencies operating as a separate entity but serving the same population (e.g., some states have a single-state agency for child welfare or behavioral health yet there may be shared outcomes/populations/systems spanning across sister agencies).
6. *Enterprise* is defined here as a group of departments and the health and human service programs that fall within them that constitute a given agency, as well as other single, sister health or human service agencies with similar missions serving the same population, that have collectively defined shared outcomes, strategic goals, operations/business processes and administrative functions to further the collective interest and benefit of those receiving services, those providing the services and the community at-large.
7. Antonio Oftelie, Julie Booth, and Tracy Wareing. *The Art of the Possible:* Leading Change in Human Services. *Policy & Practice (June 2012)* p.11–15.
8. *Tightly coupled* refers to a system in which components have, or makes use of, knowledge of the definitions of other separate components.
9. *Loosely coupled* refers to a system in which each of its components has, or makes use of, little or no knowledge of the definitions of other separate components.
10. *Outputs* are defined here as process measurements of time, quantity, or quality relative to a particular reporting requirement (e.g., how many individuals were served, how much time did it take to process an application). For purposes of this model, (shared) outputs are used to reflect how an organization measures success at the Regulative and Collaborative levels of maturity.
11. *Outcomes* are defined here as the changes that have taken place over time in knowledge, skills, behaviors, and conditions as a result of an organization's work, as well as the differences made by outputs of which are often expressed in terms of impact and sustainable changes of the health and well-being of individuals, families, and communities. For purposes of this model, shared outcomes are used to reflect how an enterprise determines success at the Integrative and Generative levels of maturity.
12. *Advanced analytics* are defined here as tools used to go beyond the collection and sorting of data to turn the information into data capable of providing future options and predictive capabilities. These capabilities can then forecast possible prospective results under different scenarios associated with each option through detailed pattern analysis. In addition to root cause and trend analysis, other tools include statistical analysis, forecasting, predictive analytics, and optimization. *Source:* American Public Human Services Association. *Analytics Capability Roadmap 1.0 for Human Service Agencies.* April 2014.
13. *Infrastructure* is defined here as the shared administrative and operational systems that support business needs across the entire health and human service enterprise intentionally designed to support the vision and offer innovation, while constantly learning and keeping pace with the evolving marketplace in which program participants live, work, learn, and play. For purposes of this model, the foundational infrastructure includes but is not limited to, components such as workforce, use of technology, communications, and human resources. *Source:* Cari DeSantis, M.A.L.S. *Business Model for Horizontal Integration of Health and Human Services*. American Public Human Services Association. 2012. p. 24.

Boulder County

Department of Housing & Human Services

Housing Office: 2525 13th Street, Suite 204 • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax: 720.564.2283
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Boulder County Housing & Human Services Advisory Committee (HHSAC)

Boulder County Housing & Human Services Vision:

We believe in co-creating solutions for complex family and community challenges by fully, effectively, and efficiently integrating health, housing, and human services to strengthen the broad range of Social Determinants of Health, in turn generating a more self-sufficient, sustainable, and resilient community.

About the HHSAC:

Committee members provide advice and guidance to the Department of Housing & Human Services (DHHS) staff and leadership in their efforts to most effectively serve the community. Committee members strive to actualize the vision of the agency and to ensure that the vision is aligned with the identified needs of the Boulder County community. Committee members provide substantive recommendations on improving the organizational effectiveness based on community input and personal experience.

Remainder of 2016 & 2017 Meeting Schedule

Remainder of 2016

- September 27, 2016 – 3:30 p.m. – 5 p.m.
- October 25, 2016 – 3:30 p.m. – 5 p.m.
- December 6, 2016 – 3:30 p.m. – 5 p.m.

2017

- January 31, 2017 – 3:30 p.m. – 5 p.m.
- February 28, 2017 – 3:30 p.m. – 5 p.m.
- March 21, 2017 – 3:30 p.m. – 5 p.m.
- April 25, 2017 – 3:30 p.m. – 5 p.m.
- May 30, 2017 – 3:30 p.m. – 5 p.m.
- June 27, 2017 – 3:30 p.m. – 5 p.m.
- July 25, 2017 – 3:30 p.m. – 5 p.m.
- August 29, 2017 – 3:30 p.m. – 5 p.m.
- September 26, 2017 – 3:30 p.m. – 5 p.m.
- October 31, 2017 – 3:30 p.m. – 5 p.m.
- December 5, 2017 – 3:30 p.m. – 5 p.m.

***Meetings are typically held the last Tuesday of each month. Schedule subject to change.**

****All meetings are held at the DHHS Kaiser Building Location, 2525 13th Street, Second Floor Large Conference Room, Boulder, CO.**

Department of Housing & Human Services

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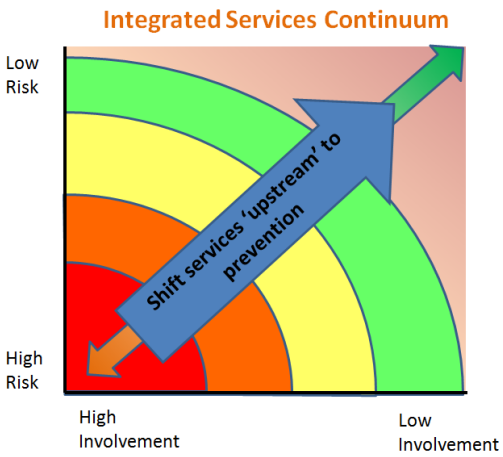
DHHS Advisory Committee
MONTHLY MEETING
Tuesday, December 06, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder



Agenda

1) **Review and approval of today's agenda** (3:30 – 3:33 p.m.)

2) **Review and approval of minutes from October 25, 2016 HHSAC meeting** (3:33 – 3:35 p.m.)

3) **Continuation of governance discussion: moving from collaborative to integrative** — Frank Alexander, Susan Caskey, IMPACT Care Management Division Director; Angela Lanci-Macris, Case Management and Community Outreach Division Director, Melissa Frank Williams, Integrated Services Manager (3:35 – 5:00 p.m.)

   a) Review scope of HHSAC – Melissa FW and Susan C. (15 min)
      i. Decision Item: FRF Regional Council

   b) High level review of the Family Resource Framework and proposed governance structure and role – Melissa FW (45 min)
      i. Discussion of general structure and role
      ii. Discussion of outstanding questions/issues to be addressed as they relate to the structure and role
      iii. Committee membership- Who do we need to invite?

   c) Overview of timeline – Melissa FW (15 min)
      i. Discussion of agendas for the next three meetings

ii. Feedback from group on content of meetings

d) Other Items? (5 min)

4) Adjourn

Upcoming Meetings:

a) January 31, 2017, 2525 13th Street, Large Conference Room, Boulder
   i. Agenda Items: TBD

b) February 28, 2017, 2525 13th Street, Large Conference Room, Boulder
   i. Agenda Items: TBD

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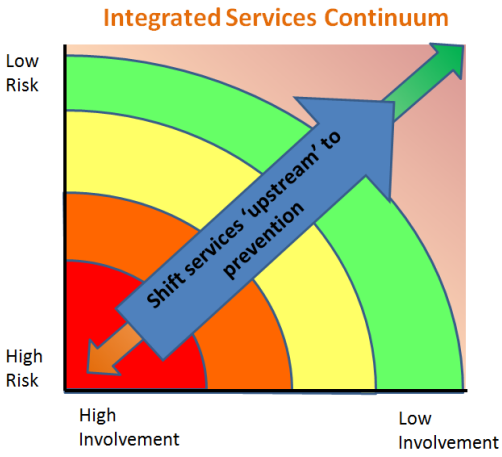
Department of Housing & Human Services

Housing Office: 2525 13th Street, Suite 204 • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax: 720.564.2283
Human Services: Boulder Office • 3460 Broadway • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax 303.441.1523
Longmont Office • 515 Coffman Street, Suite 100• Longmont, Colorado 80501 • Tel: 303.441.1000

www.bouldercountyhhs.org

DHHS Advisory Committee
MONTHLY MEETING
Tuesday, September 27, 2016, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder



Committee Members in attendance: Simon Smith, Laura Kinder, Bobbie Watson, Robin Bohannan, Julie Van Domelen, Penny Hannegan (on behalf of Betsey Martens), Jeff Zayach, Suzanne Crawford, Dalia Dorta

DHHS Staff in attendance: Frank Alexander, Jim Williams, Susan Caskey, Melissa Frank-Williams, Daphne McCabe, Whitney Wilcox, Chris Campbell

Members of Public in attendance: Judy Feland and Kirsten Culp, Lydia Morgan Senior Housing residents

Committee Action Items

1. **Action Item:** for the December 6, 2016 meeting, DHHS staff will bring back a summary governance document that will crystalize the governance proposal/structure for the Committee. This document will contain a suggested vision, scope of work, suggested focus areas for systems work, and suggestions on other Committee seats that may need to be filled in the new structure.

Detailed Minutes

1) **Review and approval of today's agenda** (3:30 – 3:33 p.m.)

Approved as written

2) **Review and approval of minutes from September 27 HHSAC meeting** (3:33 – 3:35 p.m.)

Approved as written

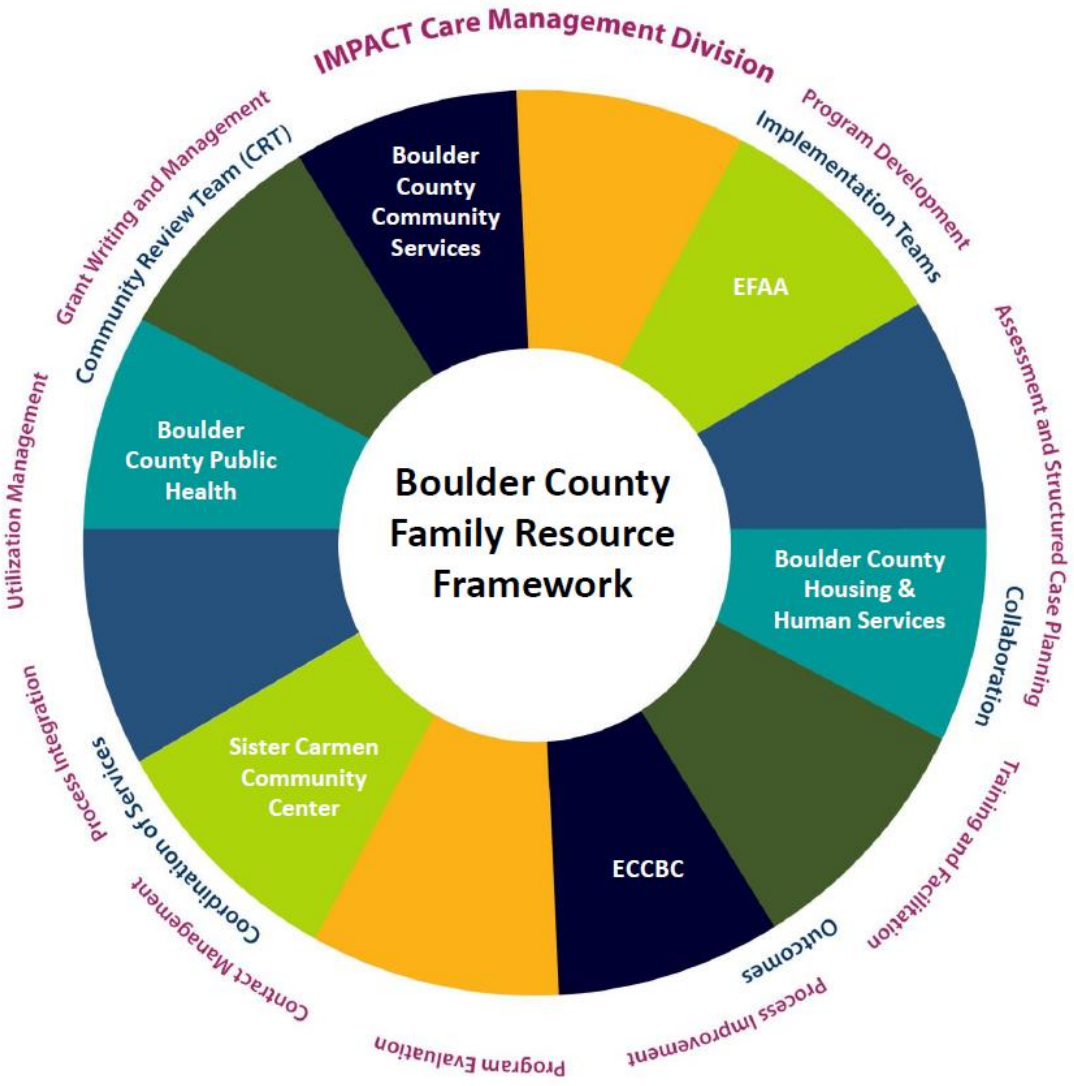
3) **Continuation of governance discussion: moving from collaborative to integrative** — Frank Alexander, Susan Caskey, IMPACT Care Management Division Director; Angela Lanci-Macris, Case Management and Community Outreach Division Director, Melissa Frank Williams, Integrated Services Manager (3:35 – 5:00 p.m.)
   a) Further discussion and clarification of the governance role for the Committee within the Family Resource framework and the role of Dream Big within the framework
   b) Review of upcoming meeting focus and schedule

Frank—wanted to acknowledge the loss of Betsey—she is a community titan. We owe her a deep level of gratitude for all of her work in the affordable housing world. She will be retiring in June 2017.

Frank—Today's conversation is a further discussion from last month around a proposed governance framework, we as a team thought this through and coming back with a continued dialogue for this Committee to consider.

Susan C—we will do a quick review of the last meeting, outline what we want to accomplish for the next 3 meetings, define the scope of the committee's work and discuss the governance structure today.

What are the areas of our work that needs this committee's support and oversight. As we discussed at the last meeting, the IMPACT model addresses the early intervention area as well. What we are wanting to discuss today is creating a similar governance structure in the early intervention area. This is the beginning of what could develop-see the visual.



Frank—this Committee should be defining the partners who should be part of the work and we will need to bring to the table to support our vision moving forward.

We'd like to discuss how the Dream Big initiative and the Family Resource Model are similar and how Dream Big fits well into the larger framework—see highlights from the PowerPoint.

Suzanne: clarification of the costs comparison between the Dream Big initiative and the Family Resource Model? Melissa—these do include staff costs as well.

Julie—it seems to me that it is based on the I Have a Dream cohort too—this is 200 kids as well. The IHAD is complementary to the Family Resource Framework.

Robin—if we went forward, where would our work focus? Would it just be Dream Big?

Frank—what we are proposing, this body would focus on the Family Resource Model with Dream Big as a component. If we are governing a common practice and assessment framework, our work would fall under the larger picture, Family Resource Framework.

Penny—Dream Big would need to fit with the Universal Assessment Framework. These systems need to be able to talk to each other.

Dalia—when will this model move out to Longmont? The Dream Big initiative is looking at Lafayette. In terms of the FRM, OUR Center (in Longmont) is working toward a Family Resource Center model currently.

Frank—what we've been hoping for is light touch, less people in our deep end systems, and more folks accessing lighter touch, front end supports. We also will have folks that are in the mid-tier level supports as well. Our goal is to figure out how we align, how do we share data, how do we align funding to meet these needs?

Julie—it is interesting that we could focus on the low involvement high risk category. Could we get characterizations on these folks?

Simon—Other work is going on in Lafayette where we could leverage dollars, looking at similar models. We should also add dental to the health care needs.

Bobbie—if you look at Sanchez, look at the feeders into the school. We used to have School Readiness, and this is where we have the lever. We need to keep this in mind at the model.

Frank—what we wanted to do is characterize how Dream Big fits into the larger support model for the county. This is the conversation we want to continue moving into the coming months.

Robin—when I think about the community-level, systems level, we need to keep in mind that there are other systems initiatives happening out there. We could use a mapping of these initiatives. Suzanne—agreed…we are often pulled into many initiatives and this can be time consuming. Would be good to map this out and look for alignment.

Potential areas of governance for this Committee:

Regional Council—this would be the Committee

- Communicate a shared vision
- Support progress on community wide outcomes
- Advocate and inform on relevant state and federal policy
- Support and advise on program improvement
- Support coordinated and consistent processes
- Facilitate and approve formal agreements for operation of the Framework
- Support resource procurement and allocation
- Inform and Support the Boulder County Integrated Services Delivery Model of Care

Robin—when you are moving a system across a community, it will impact business process, and funding approaches.

Frank—all agencies are running their teams and making decisions, but as we are looking at a population-based model, the more aligned we are across a Social Determinants of Health model, the stronger the work will be for the community. The group can work to work together on evidence-based models, policy decisions, funding frameworks, partnership models. More information sharing and alignment is key to our community success.

Bobbie—I get the communicate a shared vision (see above), don't understand the jump to programs? Would like to see vision, outcomes, strategy, common indicators.

Julie—empirical-based, evidenced-based best practices—we could share this information/data and learn as a group. This could inform and be a strong component of this committee.

Frank—we have been recommending a narrowing of the Committee's work. We are trying not to duplicate other work by other boards/committees. From a service and practice framework, we'd feel like we need to focus on family and children in the school systems.

Penny—how will this group work through this through the rest of 2017. Melissa—we would create a governing document, get feedback from this group, and this would form the basis for us to move forward. We would get this document out prior to the next meeting.

Suzanne, really appreciate the visuals comparing Dream Big to the Family Resource Framework and how they complement each other.

Robin: what is Dream Big's governance model? Penny—currently a collaborative but no formal Board as of yet.

Next steps would be to meet with the Dream Big steering committee and see the areas for alignment and discuss next steps. Frank—Common assessment and shared data framework is key to next steps. Defining the scope of work, governance structure, and who else needs to be at the table (additional partners). Staff will bring back these recommendations to the next meeting for the Committee members to consider.

Julie—seems like the FRM is a lot larger than Dream Big. Dream Big is an initiative. As it evolves into the family support side, are we at a stage where this group takes on the Dream Big governance structure? Frank—need to ensure that the initiatives are scalable, Dream Big would be a partner in the scaling. We would not want to get down into the operational level on these initiatives but work toward alignment on indicators and not duplicating services and funding.

Susan C—This council would be advisory to the other operational bodies and boards. That would be a goal. Jeff, how do we operationalize this? Would DHHS work with Dream Big

directly to operationalize, work on programming for example. Frank—this would be the approach.

Dalia—after many months of hearing the conversations, assuming the diversity piece is interwoven? Example: BVSD just decided to cancel their diversity conferences—how do we keep this lens?

Suzanne—folks that are a part of the Family Resource Center Association, are required to use a document called the quality standards assessment, there is a big focus on cultural competency. Built into the framework. Share this document with the Committee.

Frank—in an ideal world, once we commit to the level of scope, this will begin to determine what levels we would have in certain areas—this would determine what we'd want to tackle. Susan C—we could bring some prioritized areas that this group could focus on over the next 6 months to a year. This could help us determine a long term plan (2-3 years).

Frank—bring back a summary document, crystalize the governance proposal, and make suggestions on priority areas of focus, we'll bring this back next month.

4) Adjourn

Upcoming Meetings:

a) **No November meeting
b) December 6, 2016, 3:30 p.m., 2525 13th Street, Large Conference Room, Boulder
   i. Agenda Items: Review of governance document, agreement on the role of the Committee, discussion of committee makeup
c) January 31, 2017, 2525 13th Street, Large Conference Room, Boulder
   i. Agenda Items: Discussion of Local Area Collaborative model

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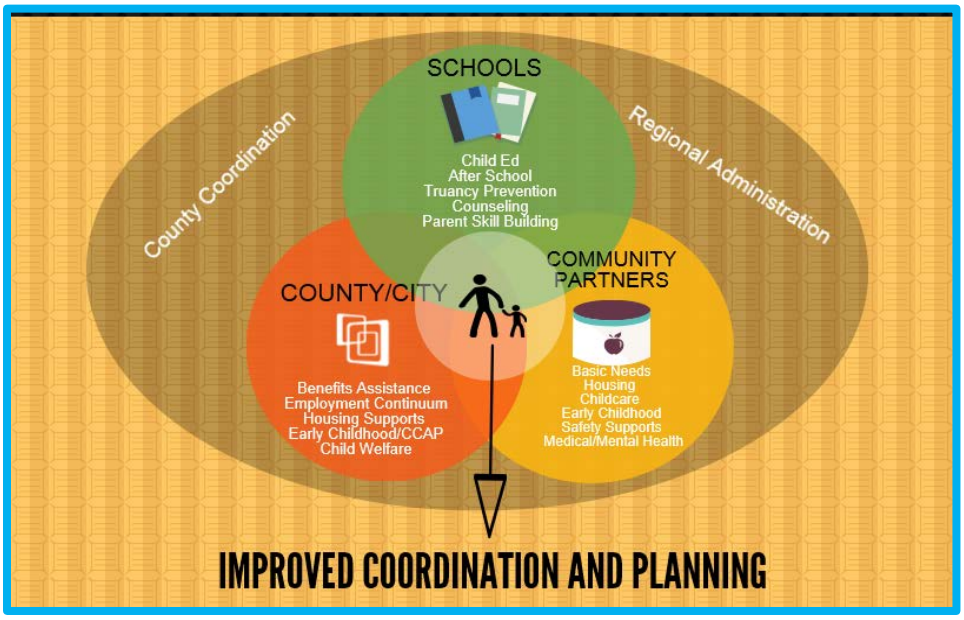
Family Resource Framework Governance Charter

December 1, 2016

1. PURPOSE

Family Resource Framework

Organized and administered through a Regional Council, the Boulder County Family Resource Framework is a tightly coordinated network of participant-driven neighborhood hubs consisting of our local school districts, county and city programs, and community-based partners aimed at improving self-sufficiency outcomes for families and academic and behavioral outcomes of children.

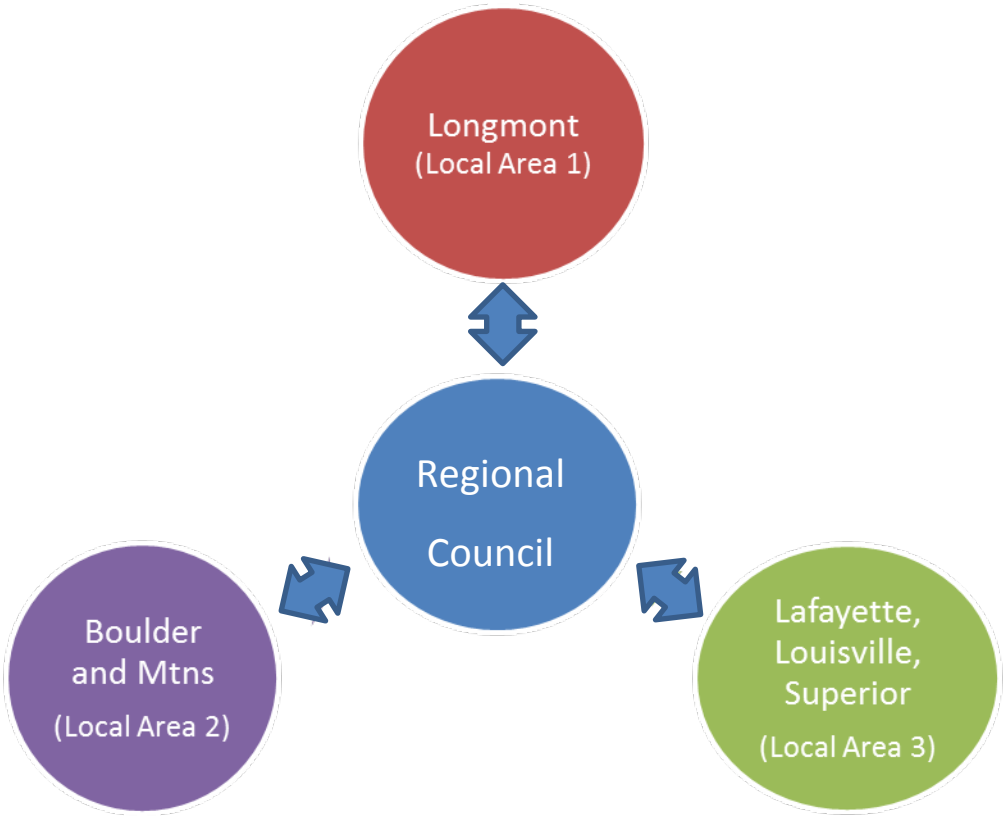


The FRF Regional Council (RC)

The Boulder County Human Services Advisory Committee (HHSAC) will serve as the Family Resource Framework Regional Council and provide overarching governance to the Family Resource Framework and achievement of collective service outcomes to improve overall well-being of Boulder County families. The Council consists of leaders representing the major areas of Boulder County (see graphic on next page) across three key sectors (schools, county/city, community-based organizations) and is primarily responsible for communicating the shared vision; supporting coordinated and consistent processes within their agencies and between agencies; advising on resource procurement and allocation; facilitating and approving formal agreements for operation of the Framework; ensuring positive movement toward collective service outcomes; reviewing data and outcome reports from the local areas; reviewing and approving recommendations from Local Area Collaborative (LACs).

Local Area Collaboratives

Given that a core principle of the Family Resource Framework is that each community hub address the specific needs of the local area, Local Area Collaboratives (LACs) will be created consisting of representatives in each of the three regions. Using data informed practices, LACs are responsible for forming and overseeing the local "hubs" (networks of support) to include: reviewing access and referral processes; reviewing and analyzing local data and reports on family resource programming; implementing referral, access and data quality improvement plans; tracking progress on implementation; establishing and ensuring adherence to Family Resource Framework and Service Standards; and developing agreed upon measurable outcomes, outputs, and measures.



Boulder County Staff Roles

Two designated Boulder County staff will provide guidance, technical assistance and support to the Regional Council and the Local Area Collaboratives (LACs) to achieve desired process and service outcomes.

Regional Council Liaison- IMPACT Strategic Initiatives Manager (Melissa Frank-Williams)
Duties include:

- Leads monthly Regional Council Meetings.

- Organizes meeting agendas, produces pertinent materials, identifies primary decision needed to advance the FRF, and responds to requests/needs of members.
- Provides recommendation to the Council necessary for making key decisions.
- Facilitates linkages between Council members and other key stakeholders to the FRF including other HHS staff and related initiatives, local/state/federal human services divisions and policy makers, funding entities, etc.
- Provides summary of activities, needs, recommendations and requests from LACs.
- Ensures high-level data and reporting and analysis on process and system-wide service outcomes.
- Facilitates development and distribution of communications on FRF for RC and stakeholders.
- Provides stewardship of pertinent agreements between entities including Memorandums of Understanding, Intergovernmental Agreements, contracts, etc.
- Facilitates data-driven decision making
- Updates committee on HHS Integrated Services Delivery Model of Care (ISDMC) work as a fundamental basis for service delivery by FRF partners.
- Provides any pertinent fiscal reports (i.e. funding reports).
- Facilitates feedback on strategic investments.

Local Area Collaborative Liaison - The IMPACT Strategic Initiatives Coordinator (Whitney Wilcox)
Duties include:

- Provides assistance with analysis of Local Area Collaborative data and outcomes and report to Regional Council.
- Facilitates support for programs on FRC guidelines and principles including coordination of technical assistance to member sites.
- Stays apprised of local need and, in partnership with Strategic Initiatives Manager, develops recommendations for program and model improvements at local and regional levels.
- Supports development of Family Resource Centers in each local area.
- Provides technical assistance as needed to LACs and/or specific member agencies.
- Serves as Regional Council Liaison in the absence of the Strategic Initiatives Manager.

Administrative Supports – IMPACT Strategic Initiatives Assistant (Monica Serrato)
Duties Include:

- Compiles all materials for RC and LAC meetings and sends in advance.
- Schedules all meetings and addresses all logistical needs.
- Takes minutes, tracks action items, and follows up with identified members to ensure completion.
- Compiles and sends all relevant correspondence.
- Gathers data reports for LACs and RC.

- Provides summaries on pertinent related initiatives and investments (i.e. Truancy project, childcare contracts, etc.) for LACs and RC.

2. MEMBERSHIP

Regional Council
At minimum, the Regional Council will be comprised of the following primary representatives (or their designee serving in a senior leadership role)-

SCHOOL
St. Vrain School District Assistant Superintendent
Boulder Valley School District Assistant Superintendent

COUNTY/CITY GOVERNMENT
Boulder County Housing and Human Services Director
Boulder County Community Services Director
Boulder County Department of Public Health Director
City of Longmont- Human Services Director
City of Boulder – Human Services Director

COMMUNITY-BASED AGENCY
OUR Center Director (LAC 1)
Sister Carmen Community Center Director (LAC 2)
EFAA Director (LAC 3)

Other considerations:
Mental Health Partners Administrator
Dream Big Director

A chair will be identified.
At their own discretion, the Council may expand membership beyond the above representatives based on a majority vote.
A quorum must be in place for final decisions to be valid.

Local Area Collaboratives
At minimum, membership consists of directors and/or program staff (or their designee) from each local area to include the local Family Resource Center; city program staff; local school administrators; Family Resource Schools (FRS) program staff; parent/participant advisory members; mental health providers, and a the County Liaison. At least one Local Area Collaborative member will sit on the Regional Council.

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SCHOOL

- St. Vrain School District – TBD (attends for LAC 1)
- Boulder Valley School District – TBD (attends for LAC 2 and 3)

COUNTY/CITY GOVERNMENT

- Boulder County Housing and Human Services - FRF Liaison (attends all 3 LACs)
- BCDHHS Early Intervention Team Program Manager (attends all 3 LACs)
- Boulder County Community Services – Workforce Boulder County staff member (attends all 3 LACs)
- Boulder County Department of Public Health representative (attends all 3 LACs)
- City of Longmont- Children and Youth Center (LAC 1)
- City of Boulder – Family Resource Schools Administrator (LAC 2 and 3)

COMMUNITY-BASED AGENCY

- OUR Center FRC Program staff and FRC parent advisory member (LAC 1)
- Sister Carmen Community Center FRC Program staff and parent advisory member (LAC 2)
- EFAA – FRC program staff and parent advisory member (LAC 3)

Other Considerations
Mental Health Partners Program Manager
Dream Big program staff
ECCBC program staff
Clinical program staff

3. SCOPE and ROLES

Regional Council

The Family Resource Framework Regional Council serves as an advisory role and guides overarching governance to the Family Resource Framework with support of the staff liaison.

- **Communicate a shared vision** - RC members will be responsible for formalizing and communicating the FRF vision and key objectives within their agencies and in the community.

- **Support progress on community wide outcomes**- The RC will be responsible for formalizing both process and collective program outcomes for the FRF (see attachments A and B), finalize an agreed upon logic model with tangible measures, and monitor progress in achieving these outcomes.

- **Advocate and inform on relevant state and federal policy** - RC members will inform the Council, LAC and staff of pertinent policy changes that will impact local Family Resource Centers and/or affiliated services. Members will also advocate for local needs to these entities.

- **Support and advise on program improvement** - Review LAC process and program related recommendation grounded in data and outcome reports from the local areas. With support from the County Liaison, the LAC will provide the RC with quarterly reports to include successes and challenges with recommendations to support any program or system improvements. The RC will advise and, when appropriate, vote on specific recommendations. This will inform any investment and strategic direction of the Family Resource Framework.

- **Support coordinated and consistent processes** - Based on coordination protocols recommended by the LAC, the RC will be responsible for approving and promoting the protocols within and between their agencies.

- **Facilitate and approve formal agreements for operation of the Framework –** This includes memorandums of understanding regarding service coordination, data sharing, etc**.**

- **Resource procurement and allocation** – The RC will be responsible for advising on investments and for identifying and supporting procurement of private and public resources (i.e. federal grants) to support the operations. The County Liaison will coordinate administrative supports when necessary.

- **Inform and support the Boulder County Integrated Services Delivery Model of Care** including use of common assessment and practice.

Local Area Collaborative

LAC activities will focus on defining, measuring and achieving the Collective Service Outcomes. Using the Family Resource Center Association logic model as a basis and guidance from the FRF Regional Council, activities will include: review access and referral processes; review and analysis of local data and reports on family resource programming; implement referral, access and data quality improvement plans; track progress on implementation; establish and ensure adherence to Family Resource Framework and Service Standards; and develop agreed upon measurable outcomes, outputs and measurements.

- **Review access and referral processes**- The LAC will identify primary service providers in the local area, map out access and referral processes currently in place, identify gaps and or areas of service duplication, and formalize a set of primary service providers and

referral process to support the family resources services in their area. Referrals will be linked to assessment and supported through a common data system (HHSC/Marketplace).

- **Implement referral, access and data quality improvement plan –** Information obtained from data reports, client feedback, participant advisory boards, focus groups, local surveys, etc., will be used to make appropriate adjustments in services, inform recommendations for funding and other resources, and guide relevant policies.

- **Track progress on implementation of collective service outcomes** (see section 4 below)

- **Establish and ensure participant programs adhere to standards outlined by the FRF, Quality Service Standards outlined by the Family Resource Center Association.**

4. OUTCOMES

Development and Implementation of the Family Resource Framework

The FRF Regional Council, with assistance from Boulder County staff, will participate in a series of stages of development and implementation grounded in Implementation Science. These will largely be process oriented and meant to establish the structure to optimize collective program outcomes for families. FRF implementation outcomes are related but separate to the collective program outcomes which are meant to measure impact of services provided by FRF members at an "enterprise" or systems level. These are outlined in attachment B.

Collective Family Resource Services Outcomes

The development and implementation of the Family Resource Framework is directly linked to the outcomes for Family Resource Centers and related partners.

Modeled after the Colorado Family Resource Center Association (FRCA) logic model, the collective service outcomes outlines the changes anticipated as a result of the combined efforts of FRF partners in implementing the framework (see attachment A for the complete logic model; note that the outcomes in orange are additions from Boulder County).

The majority of these outcomes will be represented at the program level for FRCs and other primary partners. The collective change achieved by regionally (by LAC) and Boulder County as a whole will provide the Regional Council with viable data regarding areas of successes and challenges in order to make measure adjustments to service coordination.

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Date ratified _____

Revision _____

Revision _____

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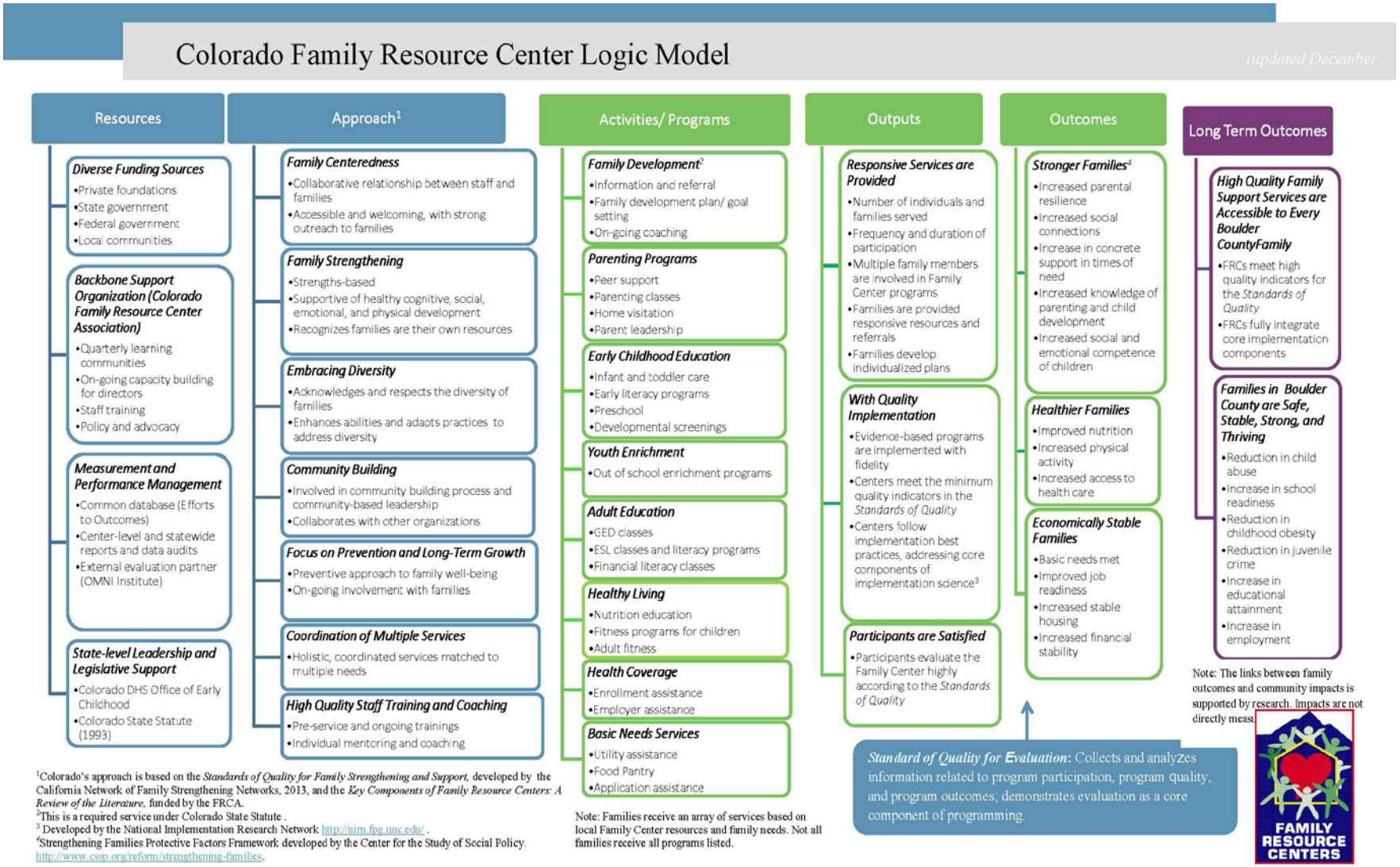
Attachment A



- **Success in School for Children and Youth**

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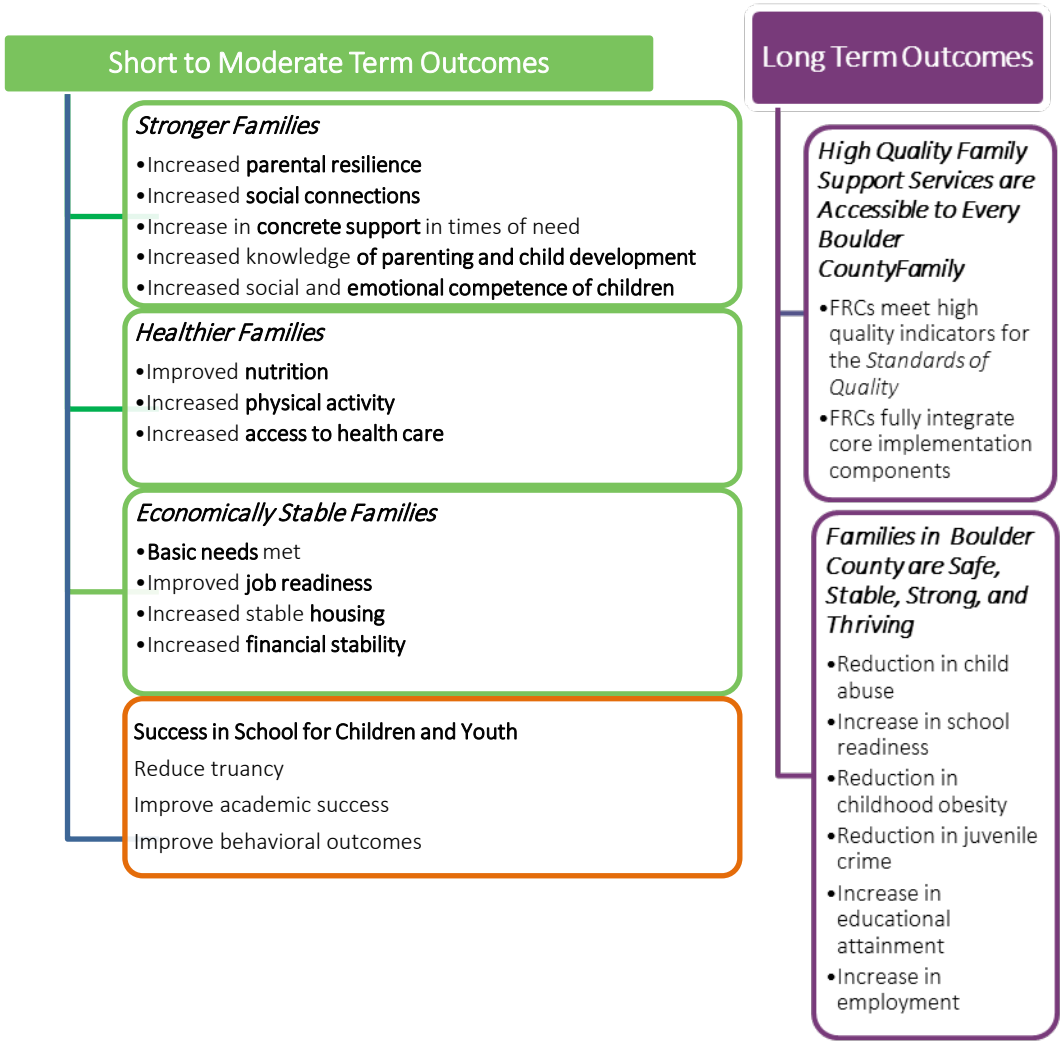
Boulder County Revision (orange box)



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Attachment B

Stages of Development and Implementation for FRF Structure

Development Team

A Development Team comprised of members of the Regional Council (or designee from their agencies) will formalize the "what" of the FRF, ensuring roles and scope are detailed and clearly defined at all levels of the structure and related practices (Regional Council, Local Area Collaborative, individual programs, and county staff liaisons).

Implementation Team

An Implementation Team comprised of members of the Regional Council (likely the same members as the Development Team) will convene to review the Family Resource Framework, refine core components, and make final updates to the fidelity matrix. This will help finalize what is being implemented in the initial implementation phase, and will define the fidelity standards that the Implementation Team will use to identify implementation supports.

The Implementation Team will then meet to consider all of the factors that will affect the group's capacity to implement the Framework as intended. The Implementation Team will be responsible for identifying barriers and developing strategies for overcoming those barriers, and will engage with all relevant stakeholders to increase implementation capacity for the framework.

Installation

The Implementation Team will coordinate the resources needed to install the framework, establish tracking procedures, oversee quality improvement cycles, and develop practice profiles for the new way of collaborating to support families.

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Initial Implementation

The Implementation Team will assess if the implementers have the skills, coaching, support, and resources needed to adopt the new framework and ensure that it is being delivered as intended. The Implementation Team will also coordinate and improve communication channels to more effectively identify necessary policy changes that can support and enhance the new framework and to engage those who are in a position to make the needed policy changes.

Full Implementation

The Implementation Team will evaluate progress and will determine when the new structure and related practices have effectively been integrated to such an extent that it is considered the new "normal".

Sustainability

The Implementation Team will define and establish permanent structures and procedures for sustaining implementation capacity and monitoring outcomes over time.

Time commitment

FRF Implementation Team
Up to 8 hours a month for one year

- Two (2 hour) meetings per month to include monthly HHSAC
- Plus an estimated 2-4 hours of additional work time per month