



Family Resource Network Regional Council Meeting

November 9, 2017

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**DHHS Advisory Committee Meeting
Thursday, November 9, 2017**

3:00-4:30 p.m.

Sister Carmen Community Center
655 Aspen Ridge Drive, Lafayette, CO 80026

Objectives for Today:

- 1) Membership vote- Marc Schaffer**
- 2) Approval of minutes from August**
- 3) Review progress to date on 2017 FRN timeline, ISDMC practice, and LAC implementation**
- 4) Discuss alignment opportunities (Family Homelessness work, WfBC, and Dream Big/EFAA partnership)**

- 1. Review of agenda and consent items- Frank (3:00- 3:10)**
Consent items to be approved- Decision point: Vote Needed
 - a) Approval of minutes from August
 - b) Approval of member to be added to the Regional Council upon expansion
 - Marc Schaffer, BVSD, Assistant Superintendent of School Leadership
- 2. Updates on BOCC approved members and updates to bylaws to allow up to 20 members on the Board- Frank (3:10-3:15)**
 - a) Members Pending
 - Diane Lauer, SVVSD
 - Karen Rahn, City of Boulder
 - Christina Pacheco Sims, City of Longmont
 - Betsey Martens, Bringing Schools Home
 - b) FRN Regional Council Vice Chair, Suzanne Crawford confirmed
 - c) BHP Rep- Karen Stayton
- 3. Timeline update, practice model and data system roll out to FRN partners - Melissa (3:15-3:30)**
 - a) Update on ISDMC Mid-level Practice and status update for FRN partners
 - b) Data system roll out to SCCC, OUR Center, and EFAA- what it means
- 4. Update on Regional Council Sub Committee and LAC implementation - Whitney (3:30-3:40)**
 - a) Review of steps and progress to date
 - b) Lafayette LAC – Kick off meeting
- 5. Funding update – Frank (3:40-3:55)**

6. **Updates and alignment opportunities with FRN (3:55-4:25)**
 - a) Family Homelessness Forum update and next steps – Julie
 - Next steps
 - b) FRC and Workforce Boulder County partnership and next steps - Robin
 - c) Dream Big – Betsey/Lori

 7. **2018 meeting schedule reminder and proposed agenda for next meeting on January 11 at OUR Center - Frank (4:25-4:30)**
 - a) Finalize Boulder locations for 2018 meetings
 - b) January Meeting Items
 - First set of outcomes and indicators reviewed (subcommittee to identify in advance)
 - Status update on LAC launch in each area
 - Updates on practice model roll out for phase 1 and 2

 8. **Adjourn (4:30)**
-

2018 Regional Council Meeting Dates

January 11, 2018 - Longmont @ OUR Center, 220 Collyer Street

March 8, 2018 - Boulder

May 10, 2018 - Lafayette @ Sister Carmen Community Center, 655 Aspen Ridge Drive

July 12, 2018 - Longmont @ OUR Center, 220 Collyer Street

September 13, 2018 - Boulder

November 8, 2018 - Lafayette, Sister Carmen Community Center, 655 Aspen Ridge Drive

FRN Subcommittee Meeting Dates (prep and launch of Local Area Collaborative groups)

November 29, 3-4:30 at 1333 Iris, Room 5, Boulder (call 720-326-5563 to be let in)

February, 2018 TBD

April, 2018 TBD

June, 2018 TBD



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BCDHHS Advisory Committee

Meeting Minutes

August 29, 2017

Members Present: Bobbie Watson, Robin Bohannan, Betsey Martens, Julie Van Domelen, Suzanne Crawford, Lori Canova, Pat Heinz-Pribyl, Jeff Zayach, Simon Smith, Christina Pacheco Sims, Edwina Salazar, Karin Stayton, Diane Lauer (phone)

Staff Present: Frank Alexander, Angela Lanci-Macris, Susan Caskey, Melissa Frank-Williams, Whitney Wilcox, Monica Serrato, Jim Williams

Guests: Dr. Marc Schaffer, BVSD

1. Call to Order

Bobbie Watson called the meeting to order.

2. Introductions of Guests

Dr. Marc Shaffer is the Assistant Superintendent of School Leadership for the Boulder Valley School District (BVSD). Dr. Shaffer is responsible for the supervision and leadership of BVSD's k-8, middle, and high schools and the principals. Dr. Schaffer has been invited to join HHSAC to represent BVSD as part of the Family Resource Network and Regional Council.

3. Consent Agenda Items

- Approval of minutes from April
- Approval to membership to expand up to 20 members
- Approval of Suzanne Crawford to be Vice-Chair
- Approval of members to be added to the Regional Council upon expansion

Bobbie reviewed the consent agenda items and asked if there were any questions. Bobbie then asked for a motion to approve the consent agenda items. All consent agenda items were approved.

4. Review of Family Resource Network (FRN) timeline and status updates

Melissa Frank-Williams reviewed the FRN mission, road map, and timeline that was presented as part of the FRN orientation provided to HHSAC members in June 2017. This information will be reviewed at each HHSAC meeting to keep everyone grounded in the work and updated to any changes in timeline.

5. Updates on Regional Council Subcommittee (RCSC) and Local Area Collaborative (LAC) Implementation

Melissa reported that the Regional Council Subcommittee (RCSC) met for the first time on August 2 to discuss the launch of each of the LACs. The initial proposal was for each of

the LACs to launch in phases, beginning with the first LAC launch in January 2018. After review and discussion, Julie Van Domelen (EFAA), Suzanne Crawford (Sister Carmen), and Edwina Salazar (OUR Center) recommended that the Boulder, East County, and Longmont LACs launch simultaneously.

- Suzanne reported that Sister Carmen, who will coordinate the East County LAC, has invited organizations to attend an informational meeting about the Family Resource Network in October.
- Whitney Wilcox provided a brief update on a tool that will guide the planning for the work of each of the LACs.
- Suzanne shared that Health Resources and Services Administration (HRSA) and the City of Lafayette hosted a meeting as part of their multi-year community engagement work, which included a presentation on the FRN. This group shares some alignment with the FRN and may be linked to the East County LAC. The City of Lafayette, and the Mayor Pro Tem Gustavo Reyna, in particular, has been very supportive of these efforts.
- Betsey Martens acknowledged the immense amount of work that has happened over the past year.

6. Practice Model and Data System Roll Out to FRN partners

Melissa provided an overview and update of the Integrated Services Delivery Model of Care (ISDMC) Training in October. The training will be provided to resource specialists, support specialists, and advocates working to provide support to participants and families. Training attendees will include staff from BCDHHS Case Management and Community Outreach and the Early Intervention Program, Workforce Boulder County, EFAA, Sister Carmen, and OUR Center. The three-day training will include training around the Colorado Family Support Assessment (CFSA) 2.0, case management practice, and the Boulder County Connect (BCC) data system. The training will be offered twice in October, including October 3-5 and 17-19. The use of the CFSA and case management practice model will officially launch in January 2018.

Angela Lanci-Macris noted the shift in developing and training to standardized practice across multiple teams and providers and acknowledged the effort that went in to developing the training.

Melissa also provided an update on the BCC data system, noting that both Sister Carmen and Community Food Share had transitioned on to the system.

- Frank Alexander expressed gratitude to Suzanne and Sister Carmen for being the first organization to transition to the new system and for their partnership with the BCC Development team.
- Suzanne expressed gratitude for how responsive the BCC Development team have been (especially John Green and Eline O'Donnell) and offered kudos to HHS as a whole.

- Whitney and Melissa were acknowledged by Suzanne for all their work with the FRN.

Melissa reviewed information about reports that will be available as a result of the new shared data system. BCDHHS, EFAA, Sister Carmen, and OUR Center mid-level case management staff will all use the CFSA with participants and families. This information will be recorded in the data system, allowing for individual and aggregated reporting across key self-sufficiency domains, including income, food access, employment, and housing. Reports will be available in the systems and will include data at the client, program, and community level. This level of reporting will help to significantly facilitate understanding about the impact of services and programs across the community over time. These reports will be reviewed at HHSAC and LAC meetings.

7. Updates and Alignment Opportunities with FRN

Community Partner Meeting: Frank announced that he, in partnership with Jeff Zayach and Robin Bohannon, will be hosting a meeting on August 31 for community partners. The meeting will include funding updates from Frank, Jeff, and Robin and opportunities to hear and address concerns and questions from community partners. Frank said that for those who will not be able to attend that a report and video will be produced.

Workforce Boulder County Partnership Opportunity: Robin shared an upcoming funding opportunity that she asked HHSAC members to support. Workforce has been partnering with EFAA to provide subsidized employment/internships plus case management that leads to career enhancement and employment. Robin will bring more information to HHSAC about next steps.

Family Homelessness Forum: Julie shared that EFAA will be holding a series of meetings with service providers working with families who are experiencing homelessness to better understand current services and coordination in place to address family homelessness. The meeting will include providers from across Boulder County.

ACES in Colorado: Bobbie shared that ECCBC will be hosting Dr. Sarah Watamura, who will speak to the links between parental history of adversity and child well-being. Dr. Watamura's presentation will be in Longmont on October 3.

8. 2018 Meeting Schedule

Bobbie reviewed the proposed meeting schedule and locations for HHSAC meetings. She shared that the time with the most support was to meet the second Thursday of every other month from 3-4:30pm. Membership approved of the new time and agreed to rotate meetings between Boulder, Lafayette, and Longmont, effective the next HHSAC meeting. The next HHSAC meeting will be November 9 at Sister Carmen, followed by the meeting January 11 at OUR Center.

9. Proposed agenda for November

Bobbie outlined the proposed agenda for the next HHSAC meeting on November 9, including:

- Review November Agenda and August Minutes
- Funding Updates
- Updates on the WFBC partnership
- Update on EFAA and OUR Center's transition to BCC
- Update on EFAA's Family Homelessness Forum
- Update on ISDMC Mid-Level Trainings

10. Meeting Adjourned

Bobbie adjourned the meeting at 5pm.

Boulder County

Family Resource Network



November, 2017

FRN Work Plan Update



The FRN Road Map

Our destination

All FRN partners using the same screening, assessment and planning processes with families

Services to which navigators and advocates/case managers are referring are proven to work

We have common outcomes

We are all using the same data and reports to measure progress and make improvements

Roles

Executive

Regional Council

Set policy related to data, practice and service coordination

Define and monitor outcomes

Inform resource allocation

Information sharing

Communicate shared vision

Operations

LACs

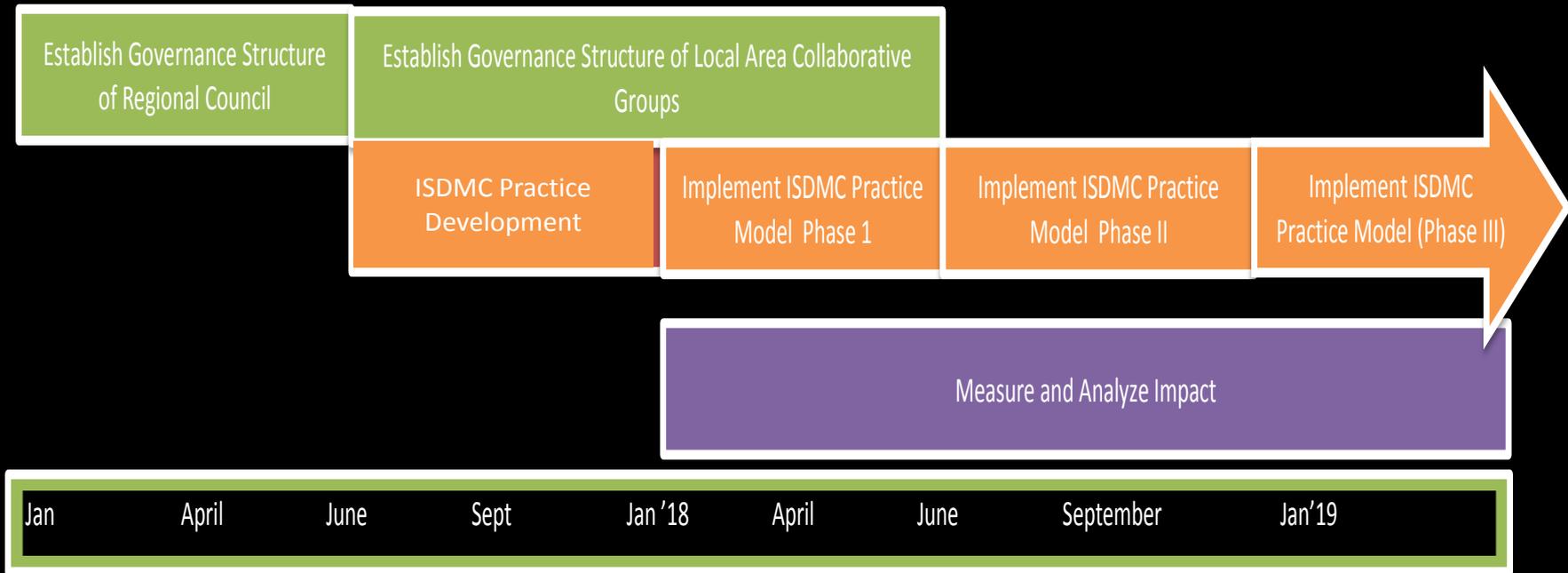
Implement practice model

Ensure service coordination

Compile data-informed program recommendations

Peer coaching

Needs assessment and service mapping



Work Plan Updates

July 30-September 28

LAC plan development with agency directors

October 1-October 31

LAC work plan implementation begins

Agencies trained on data system and ISDMC practice model

November 9

FRN Regional Council – Review LAC implementation progress, practice model implementation, FRN metrics, and funding plan

ISDMC PRACTICE MODEL ROLL OUT

Phase I -October 2017-June 2018

FRCs

- Sister Carmen
- OUR Center
- EFAA

Phase II- August 2018- May 2019 (estimated)

Potential Participants- Schools, Community Services, Public Health, IHAD, BHP, Clinica

Phase III – August 2019-May 2020 (estimated)

TBD



Our Practice Model (ISDMC)- phase 1

- 60+ Staff from HHS, SCCC, OUR Center, and EFAA, Workforce BC have been trained to the model and the new data system (HHSC/BCC)
- Standard reports created
- Approx. 20 supervisors to be trained in use of reports in January, 2018
- Metrics collected on impact of practice in 2nd quarter 2018

Metrics and Data Reports

- Primary metrics being measured
 - Outputs (#'s served)
 - Outcomes based in SSM/CFSA domains on client, worker, program and systems level
 - Process measures- to be determined
- Metrics to be defined and evaluated in 2018
 - Cross systems impact data (i.e. reductions in child welfare re-referral, early childhood metrics, “overlap data”, improved academic performance, cost savings/reinvestments, etc.)

Client-Level Report- test client

Report Results



Program Report- HSP (HHS only)

Agency
All

Program
HHS - Housing Case Mana..

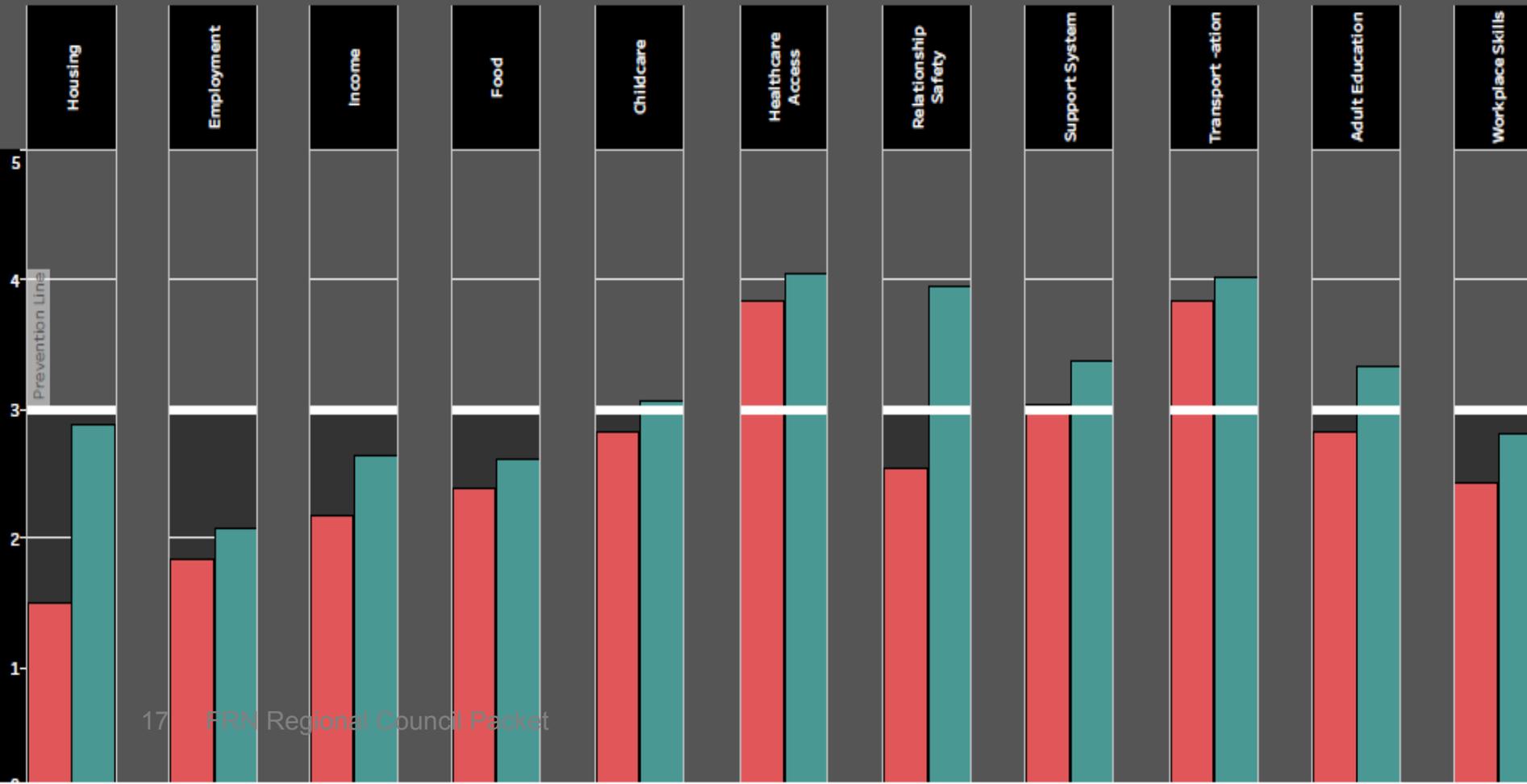
Funding Source
Multiple values

Caseworker
All

SSM Timeframe
■ Baseline
■ Exit/Latest Score

Count of Clients

80



Community-Wide Report – All HSP Programs

LAC
All

Agency
All

Program
Multiple values

Funding Source
All

Caseworker
All

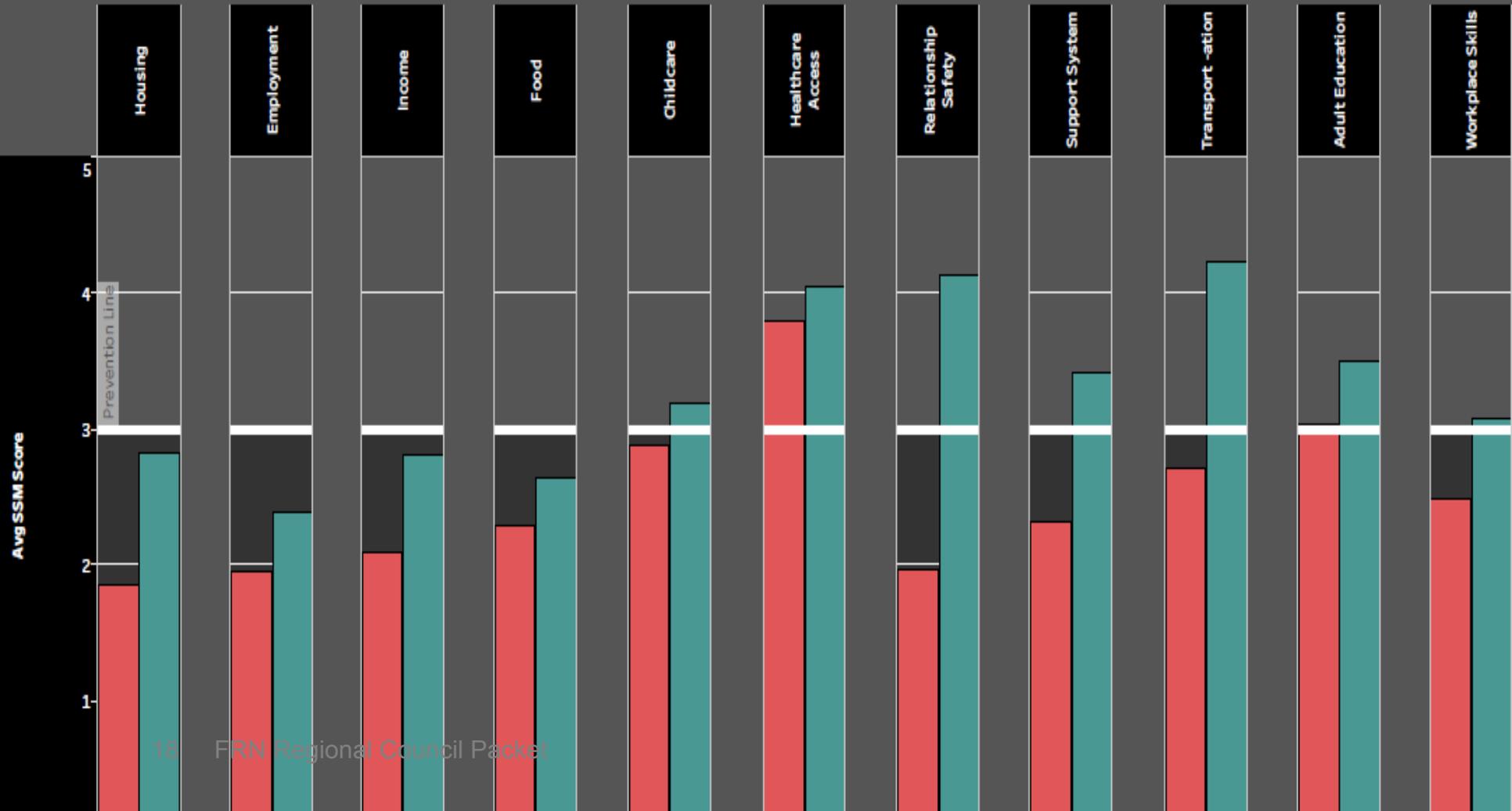
SSM Timeframe

Baseline

Exit/Latest Score

Count of Clients

326



LAC Implementation

Orient local community to FRN

Convene 8-10 stakeholders

Area Specific Work Plan

Needs and Gaps Analysis

Outcomes and Roles

Family Name _____ Baseline or Follow-up _____

Date Completed _____ Family Advocate _____

Part A: Colorado Family Support Assessment Domains

1. Income: Assesses family income adequacy using Federal Poverty Level (FPL)* guidelines

- How many people are in your family (including yourself)? _____
- What is your total annual family income before tax? _____
- Income does not include noncash such as CCAP, Medicaid, and SNAP, but it does include TANF, SSI, or other cast benefits.

<input type="checkbox"/>	5	Family income is greater than 300% of poverty adjusted for family size.
<input type="checkbox"/>	4	Family income is between 251%-300% of poverty adjusted for family size.
<input type="checkbox"/>	3	Family income is between 201%-250% of poverty adjusted for family size.
Prevention Line		
<input type="checkbox"/>	2	Family income is between 101-200% adjusted for family size.
<input type="checkbox"/>	1	Family income is between 0-100% of poverty adjusted for family size.
<input type="checkbox"/>	N/I	Not enough information at this time

*use table below (2014 FPL) or go to <http://www.safetyweb.org/fpl.php> for an online calculator.

Household Size	100%	133%	150%	200%	250%	300%	400%
1	\$11,670	\$15,521	\$17,505	\$23,340	\$29,175	\$35,010	\$46,680
2	15,730	20,921	23,595	31,460	39,325	47,190	62,920
3	19,790	26,321	29,685	39,580	49,475	59,370	79,160
4	23,850	31,721	35,775	47,700	59,625	71,550	95,400
5	27,910	37,120	41,865	55,820	69,775	83,730	111,640
6	31,970	42,520	47,955	63,940	79,925	95,910	127,880
7	36,030	47,920	54,045	72,060	90,075	108,090	144,120
8	40,090	53,320	60,135	80,180	100,225	120,270	160,360

2. Employment: Assesses the status and stability of employment

- Adult = Individuals responsible for children in the family.
- Employable = 1) Does not have a disability (not receiving SSI/SSD), 2) is over the age of 16, and/or 3) desires or needs employment.
- Stable Employment = in a permanent (regular/dependable) position for 3 months or longer.
- Benefits = earned vacation/sick/holiday pay; retirement plans; and/or health insurance.

<input type="checkbox"/>	5	At least one adult has full-time stable employment AND Access to employer-based benefits
<input type="checkbox"/>	4	At least one adult has full-time stable employment
<input type="checkbox"/>	3	At least one adult in the family is employed full-time AND no adult has stable employment
Prevention Line		
<input type="checkbox"/>	2	At least one adult in the family has temporary or part-time employment AND no adult has full-time employment
<input type="checkbox"/>	1	All employable adults in the family are not employed.
<input type="checkbox"/>	N/I	Not enough information at this time
<input type="checkbox"/>	N/A	All adults are not employable

3. Housing: Assesses the ability of the family to obtain appropriate housing of choice based on their circumstances

- Housing-cost burden calculation = monthly rent/mortgage ÷ monthly before tax income (e.g. \$1000 rent ÷ \$2000 monthly gross pay = 50% of income).
- Substandard = Any home that is not safe and adequate (i.e., dry, clean, pest-free, contaminant-free, well ventilated, and well maintained)

<input type="checkbox"/>	5	Without subsidies, owning or renting without cost burden (monthly mortgage/rent below 30% monthly pretax income). AND Living in a neighborhood of choice.
<input type="checkbox"/>	4	Without subsidies, owning or renting without cost burden (monthly mortgage/rent below 30% monthly pretax income).
<input type="checkbox"/>	3	Any of the following: <ul style="list-style-type: none"> • Living in steady subsidized or transitional housing that is safe and adequate • Monthly rent/ mortgage is 30-49.9% of monthly pretax income (moderate cost burden).
Prevention Line		
<input type="checkbox"/>	2	Any of the following: <ul style="list-style-type: none"> • Living in substandard housing • Receiving short-term rental assistance • Facing threatened eviction or foreclosure • Monthly rent/ mortgage is 50% or more of monthly pretax income (severe cost burden).
<input type="checkbox"/>	1	Any of the following: <ul style="list-style-type: none"> • Homeless • “Couch surfing” • Doubling up with others (do not include voluntary roommate situations) • Eviction notice • Forced displacement (fire; flood; discharge from institution with no housing).
<input type="checkbox"/>	N/I	<i>Not enough information at this time</i>

4. Transportation: Assesses the degree to which family transportation needs are met

<input type="checkbox"/>	5	All family members always have transportation needs met through public transportation, a car, or a regular ride (91%-100% of the time)
<input type="checkbox"/>	4	All family members have transportation needs met at least most of the time through public transportation, a car, or a regular ride (76%-90% of the time)
<input type="checkbox"/>	3	All family members can find a way to meet basic transportation needs some of the time through public transportation, a car, or a regular ride (between 51% to 75% of the time)
Prevention Line		
<input type="checkbox"/>	2	At least one family member's transportation needs are inconsistently met through public transportation, a car, or a regular ride (~25-50% of the time)
<input type="checkbox"/>	1	Any family member rarely has transportation needs met through public transportation, a car, or a regular ride (< than 25% of the time)
<input type="checkbox"/>	N/I	<i>Not enough information at this time</i>

5. Food Security: Assesses a family's level of access to food based on USDA definitions

<input type="checkbox"/>	5	High food security: Family members have no problems, or anxiety about, accessing enough quality food with variety
<input type="checkbox"/>	4	Marginal food security: <u>without</u> food assistance program SNAP or WIC or Free/Reduced school lunch Family members have problems at times, or anxiety about, accessing food, but the quality, variety, and quantity of their food intake are not substantially reduced.
<input type="checkbox"/>	3	Marginal food security: <u>with</u> food assistance program SNAP, WIC and/or Free/Reduced school lunch Family members have problems at times, or anxiety about, accessing food, but the quality, variety, and quantity of their food intake are not substantially reduced.
Prevention Line		
<input type="checkbox"/>	2	Low food security: <u>With or without assistance, family members reduce the quality, variety, and desirability of their diets,</u> but the quantity of food intake and normal eating patterns are not substantially disrupted. Any of the following: <ul style="list-style-type: none"> • The family worries whether their food will run out before they get money to buy more. • They can't afford to eat balanced meals.
<input type="checkbox"/>	1	Very low food security: <u>With or without assistance, at times, eating patterns of one or more family members are disrupted and food intake reduced</u> because the household lacks money and other resources for food.
<input type="checkbox"/>	N/I	<i>Not enough information at this time</i>

6. Child Care: Assesses the family's ability to obtain reliable, affordable, and quality childcare

- Unreliable = provider can't be counted on for pre-arranged care or inconvenient hours
- Low quality = parent has concern about quality (e.g., high provider/child ratios; concerned that provider is unable to meet child's needs).
- Unaffordable = other basic needs are sacrificed to pay for child care

<input type="checkbox"/>	5	All of the following: <ul style="list-style-type: none"> • Child care is reliable • Child care is affordable without subsidies (CCAP) • Child care is quality • Reliable back-up child care options are available when needed
<input type="checkbox"/>	4	All of the following: <ul style="list-style-type: none"> • Child care is reliable • Child care is affordable without subsidies (CCAP) • Child care is quality
<input type="checkbox"/>	3	All of the following: <ul style="list-style-type: none"> • Child care is reliable • Child care is affordable with subsidies (CCAP) • Child care is quality
Prevention Line		
<input type="checkbox"/>	2	Any of the following (with or without CCAP): <ul style="list-style-type: none"> • Child care is unreliable • Child care is low quality • Child care is unaffordable
<input type="checkbox"/>	1	Any of the following: <ul style="list-style-type: none"> • Needs child care, but none is available/ accessible. • Child is unsupervised and may be unsafe..
<input type="checkbox"/>	N/I	<i>Not enough information at this time</i>
<input type="checkbox"/>	N/A	<i>(No children < 11 or family is able to adequately care for children and does not need child care)</i>

7. Child Education: Assesses school-aged children’s access to and engagement in educational institutions

- Home-schooled children are enrolled in school if Colorado homeschool requirements are met:
http://www.cde.state.co.us/choice/homeschool_law

<input type="checkbox"/>	5	No child in the family has truancy / disciplinary actions at school AND all children are meeting academic achievement expectations AND any child is exceeding academic achievement expectations.
<input type="checkbox"/>	4	No child in the family has truancy / disciplinary actions at school AND all children are meeting academic achievement expectations.
<input type="checkbox"/>	3	No child in the family has truancy / disciplinary actions at school AND Any child in the family is not meeting academic achievement expectations and <u>is receiving academic support</u> services during the school day.
Prevention Line		
<input type="checkbox"/>	2	Any child in the family is experiencing any of the following: <ul style="list-style-type: none"> • Truancy or disciplinary actions at school • Not meeting academic achievement expectations and <u>is not receiving academic support</u> services during the school day
<input type="checkbox"/>	1	Any child in the family is not enrolled in school
<input type="checkbox"/>	N/I	<i>Not enough information at this time</i>
<input type="checkbox"/>	N/A	<i>All children are not school-aged or have earned GED</i>

8. Adult Education: Assesses adult(s) academic, institution-based achievements

- Adult = Individual(s) responsible for children in the family

<input type="checkbox"/>	5	<u>All adults in the family</u> have a high school diploma or GED and <u>have obtained</u> any of the following: <ul style="list-style-type: none"> • A professional certification or training • An Associate’s degree • A Bachelor’s degree or higher
<input type="checkbox"/>	4	At least one adult in the family has a high school diploma or GED and <u>has obtained</u> any of the following: <ul style="list-style-type: none"> • A professional certification or training • An Associate’s degree • A Bachelor’s degree or higher
<input type="checkbox"/>	3	At least one adult in the family has a high school diploma or GED and <u>is enrolled</u> in post-secondary education or specialized training (professional certificate program, Associate’s, Bachelor’s).
Prevention Line		
<input type="checkbox"/>	2	At least one adult in the family has a high school diploma or GED and is not pursuing further education.
<input type="checkbox"/>	1	No adult in the family has a GED or high school diploma.
<input type="checkbox"/>	N/I	<i>Not enough information at this time</i>

9. Cash Savings: Assesses the degree to which a family is building liquid assets via cash savings

- Cash savings refer to assets that are or can be quickly converted to cash without penalty. Examples include cash, checking, savings, money market, government-issued bonds.

<input type="checkbox"/>	5	Three months or more of monthly income saved
<input type="checkbox"/>	4	One to three months of monthly income saved
<input type="checkbox"/>	3	Some but less than one month of monthly income of cash savings
Prevention Line		
<input type="checkbox"/>	2	No cash savings and has plan or has just begun to implement cash savings
<input type="checkbox"/>	1	No cash savings and no desire/ability to set savings goals
<input type="checkbox"/>	N/I	<i>Not enough information at this time</i>

10. Debt Management: Assesses the degree to which a family is managing debt

<input type="checkbox"/>	5	Family is debt-free
<input type="checkbox"/>	4	Income pays towards debt and debt reducing (pays more than minimum monthly payments and is not adding to debt)
<input type="checkbox"/>	3	Income pays towards debt and debt stabilized (pays minimum monthly payments and is not adding to debt)
Prevention Line		
<input type="checkbox"/>	2	Income pays towards debt but debt increasing (pays minimum monthly payments and is adding to debt).
<input type="checkbox"/>	1	Inability or limited ability to pay down debt (may be making payments but cannot meet minimum required payments)
<input type="checkbox"/>	N/I	Not enough information at this time

11. Health Coverage: Assesses the degree to which family members have adequate medical health insurance

- Underinsured = unable to pay out-of-pocket medical expenses (family does not seek care because of out-of-pocket payments; family unable to pay current medical expenses)

<input type="checkbox"/>	5	All family members have basic primary health insurance (other than Medicaid, CHP+, or CCIP) AND All family members have dental insurance.
<input type="checkbox"/>	4	All family members have basic primary health insurance (other than Medicaid, CHP+, or CCIP)
<input type="checkbox"/>	3	All family members have basic primary health insurance AND At least one family member receives coverage through: <ul style="list-style-type: none"> • Medicaid • CHP+ • CCIP
Prevention Line		
<input type="checkbox"/>	2	Any of the following: <ul style="list-style-type: none"> • Some family members are uninsured • Family is underinsured.
<input type="checkbox"/>	1	All family members are uninsured.
<input type="checkbox"/>	N/I	Not enough information at this time

12. Physical Health: Assesses degree to which **any** family member's physical health concerns interfere with life activities

NOTE: please consider the family member with the highest need.

- Important life activities include work, school, caring for children, managing a household (shopping, preparing meals, cleaning, etc.)
- Consider the impact of a family members' physical health concerns on other family members as well as themselves

<input type="checkbox"/>	5	Any of the following: <ul style="list-style-type: none"> • Family member(s) have no ongoing physical health problems • Physical health problems are well managed and do not interfere with other spheres of life
<input type="checkbox"/>	4	Family member(s) physical health concerns typically do not interfere with important life activities <ul style="list-style-type: none"> • Health concerns usually taken care of without work/school absences
<input type="checkbox"/>	3	Family member(s) physical health concerns only occasionally interfere with important life activities Any of the following <ul style="list-style-type: none"> • Regularly misses work/school about 1 time per month due to illness/treatments • May occasionally be late to work/school/scheduled appts, but not more than 1 time per month due to illness/treatments
Prevention Line		
<input type="checkbox"/>	2	Family member(s) physical health concerns considerably interfere with important life activities Any of the following <ul style="list-style-type: none"> • Regularly misses work/school 2 or more times per month due to illness/treatments • Late to work/school/scheduled appts 2 or more times per month due to illness/treatments • Work opportunities limited due to health concerns • Physical health concerns create considerable stress and/or disrupt family functioning
<input type="checkbox"/>	1	Family member(s) physical health concerns prohibit important life activities
<input type="checkbox"/>	N/I	Not enough information at this time

13. Mental Health: Assesses degree to which **any** family member’s mental health issues interfere with life activities

NOTE: please consider the family member with the highest need.

- Important life activities include work, school, caring for children, managing a household (shopping, preparing meals, cleaning, etc.)
- Consider the impact of family members’ mental health issues on other family members as well themselves
- Mental health issues can include symptoms of illnesses (e.g., anxiety, depression) without diagnosis

<input type="checkbox"/> 5	Any of the following: <ul style="list-style-type: none"> • Family member(s) have no ongoing mental health problems • Mental health problems are well managed and do not interfere with other spheres of life
<input type="checkbox"/> 4	Family member(s) mental health concerns typically do not interfere with important life activities <ul style="list-style-type: none"> • Mental health concerns usually taken care of without work/school absences
<input type="checkbox"/> 3	Family member(s) mental health concerns only occasionally interfere with important life activities Any of the following <ul style="list-style-type: none"> • Regularly misses work/school about 1 time per month due to illness/treatments • May occasionally be late to work/school/scheduled appts, but not more than 1 time per month due to illness/treatments
Prevention Line	
<input type="checkbox"/> 2	Family member(s) mental health concerns considerably interfere with important life activities Any of the following <ul style="list-style-type: none"> • Regularly misses work/school 2 or more times per month due to illness/treatments • Late to work/school/scheduled appts 2 or more times per month due to illness/treatments • Work opportunities limited due to health concerns • Mental health concerns create considerable stress and/or disrupt family functioning
<input type="checkbox"/> 1	Family member(s) mental health concerns prohibit important life activities
<input type="checkbox"/> N/I	<i>Not enough information at this time</i>

14. Substance Abuse: Assesses degree to which any family member’s substance abuse interfere with important life activities

NOTE: please consider the family member with the highest need.

- Important life activities include work, school, caring for children, managing a household (shopping, preparing meals, cleaning, etc.)
- Consider the impact of family members’ substance use on other family members as well as themselves

<input type="checkbox"/> 5	Any of the following: <ul style="list-style-type: none"> • Abstains from substances • May use prescription drugs as prescribed or alcohol within healthy limits and without negative consequences • Continued sobriety for one year or longer
<input type="checkbox"/> 4	Continued sobriety for more than 6 months but less than one year
<input type="checkbox"/> 3	Any of the following: <ul style="list-style-type: none"> • Family member(s) occasionally experience negative consequences from substances, but does not interfere with life activities • Continued sobriety for more than 3 months but less than 6 months
Prevention Line	
<input type="checkbox"/> 2	Any of the following: <ul style="list-style-type: none"> • Misses or is late to work/school due to substance use • Substance abuse create considerable stress and/or disrupt family functioning • Continued sobriety for less than 1 month
<input type="checkbox"/> 1	Any of the following: <ul style="list-style-type: none"> • Abuse of substances by a family member prohibits important life activities • Abuse of substances by a family member creates an unsafe environment
<input type="checkbox"/> N/I	<i>Not enough information at this time</i>

Part B: Protective Factors Survey

This survey contains questions about your general experiences as a parent and your outlook on life in general. This is not a test and there are no right or wrong answers. Please choose the best answer for you and your family. Circle the number that best describes your situation. If you do not find a perfect fit, circle the answer that comes closest. There is one section that asks you to focus on the child that you hope will benefit most from your participation in our services. For these questions, it is important that you answer with only that child in mind. Please remember to fill in the space with the child's age so that we can better understand your responses.

Part 1. Please *circle* the number that describes how often the statements are true for you or your family. The numbers represent a scale from 1 to 7 where each of the numbers represents a different amount of time. The number 4 means that the statements is true about half the time.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
1. In my family, we talk about problems.	1	2	3	4	5	6	7
2. When we argue, my family listens to "both sides of the story."	1	2	3	4	5	6	7
3. In my family, we take time to listen to each other.	1	2	3	4	5	6	7
4. My family pulls together when things are stressful.	1	2	3	4	5	6	7
5. My family is able to solve our problems	1	2	3	4	5	6	7

Part 2. Please *circle* the number that best describes how much you agree or disagree with the statement.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
6. I have others who will listen when I need to talk about my problems.	1	2	3	4	5	6	7
7. When I am lonely there are several people I can talk to.	1	2	3	4	5	6	7
8. I would have no idea where to turn if my family needed food or housing.	1	2	3	4	5	6	7
9. I wouldn't know where to go for help if I had trouble making ends meet.	1	2	3	4	5	6	7
10. If there is a crisis, I have others I can talk to.	1	2	3	4	5	6	7
11. If I needed help finding a job, I wouldn't know where to go for help.	1	2	3	4	5	6	7

Part 3. This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit most from your participation in our services. Please write the child’s age or date and then answer questions with this child in mind.

Child’s Age _____ **or** **DOB** ___/___/___

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
12. There are many times when I don’t know what to do as a parent.	1	2	3	4	5	6	7
13. I know how to help my child learn.	1	2	3	4	5	6	7
14. My child misbehaves just to upset me.	1	2	3	4	5	6	7

Part 4. Please tell us how often each of the following happens in your family.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
15. I praise my child when he/she behaves well.	1	2	3	4	5	6	7
16. When I discipline my child, I lose control.	1	2	3	4	5	6	7
17. I am happy being with my child.	1	2	3	4	5	6	7
18. My child and I are very close to each other.	1	2	3	4	5	6	7
19. I am able to soothe my child when he/she is upset.	1	2	3	4	5	6	7
20. I spend time with my child doing what he/she likes to do.	1	2	3	4	5	6	7

Part 5. Please answer the following question about your current relationships.

21. I feel safe in my relationships? Yes No

Part C: Readiness to change

Please check where you would MOST like to make a change. Please check and rate all that apply.

Area	Rating	Area	Rating
<input type="checkbox"/> Employment	_____	<input type="checkbox"/> Adult Education	_____
<input type="checkbox"/> Housing	_____	<input type="checkbox"/> Income	_____
<input type="checkbox"/> Transportation	_____	<input type="checkbox"/> Cash Savings	_____
<input type="checkbox"/> Food Security	_____	<input type="checkbox"/> Debt Management	_____
<input type="checkbox"/> Child Care	_____	<input type="checkbox"/> Health Coverage	_____
<input type="checkbox"/> Child Education	_____	<input type="checkbox"/> Physical Health	_____
<input type="checkbox"/> Child Development	_____	<input type="checkbox"/> Mental Health	_____
<input type="checkbox"/> Parenting Skills	_____	<input type="checkbox"/> Substance Use	_____
<input type="checkbox"/> Social Support	_____	<input type="checkbox"/> Other	_____

On a scale from 1 to 10, how ready are you to make a change in those areas? Please mark your rating next to the items that you checked above.

1	2	3	4	5	6	7	8	9	10
Not at all Ready									Extremely Ready

Goal Setting



Community Partners Forum | August 31, 2017 | St. Vrain Community Hub, Longmont

On Thursday, August 31, 2017, the Boulder County Departments of Housing and Human Services and Community Services and Boulder County Public Health hosted a Community Partners Forum at the St. Vrain Community Hub in Longmont. The purpose of the forum was to share information from the three departments about known impacts on funding and policy during a time of uncertainty around many of the programs we administer to support our community, and to have a dialogue with partners about impacts they are experiencing or expecting. Over fifty directors and other staff representing deep expertise across many disciplines from several dozen organizations were joined by county staff for the forum, which featured 45-minute table discussions followed by report-outs and additional questions and answers with the full group.



Boulder County Housing and Human Services Director Frank Alexander, Community Services Director Robin Bohannon, and Public Health Director Jeff Zayach kicked off the forum with summaries as follows:



Frank Alexander: We have been in a time of uncertainty, and while we have expected potential major cuts to programs or funding, we have not yet seen this. This is overall a positive thing. All of us in this room have been working together for years, decades in some cases. We've been through recessions, disasters, major policy changes together, and each time we work stronger together as a community, communicate better and share information, and increase our trust in these partnerships.

At Boulder County Housing and Human Services, we have been working on significant preparation as a result of what we do and don't know. Despite the fact that we haven't yet seen major cuts, we anticipate difficulty ahead. Our systems are strong, but we don't see significant funding improvements from where we are, and we know that proactive and strategic preparation is what has helped us as a community be in the strong place we are in today.

Much of our work over the past six months on the federal level has been focused on the Affordable Care Act, and in particular the Medicaid expansion. When we look from a macro community perspective Medicaid funding is the single largest federal funding stream our system receives. This past year, Medicaid represented nearly \$300 million coming into Boulder County, and currently about 63,000 of our residents are utilizing the Medicaid program. So we've been working with people in this room and across the state to ensure that the importance of Medicaid to the entire health, housing, and human services safety net is as understood as much as possible by our federal and state delegations. We feel positive about the fact that there is more substantive conversation on health reform occurring at this time.

From a federal budgetary level, we don't know what's going to happen. There's not much time to pass a new budget now. It's likely there will either be a federal government shutdown or a continuing resolution passed by to the end of September. We will know this fairly soon (**note: this has in fact now occurred for three months until the end of December 2018**). The president's proposed budget has shown major cuts to the federal funding streams that all of us rely on in the community and that support the clients and families we serve. These proposed cuts have not yet passed, so these are not actualized reductions that we can address at this time.

At the state level, the current funding streams that we rely on, many of which are federal pass-throughs with a state match, are more constrained than they have been in prior years.

Within our Child Welfare system, we already know we have to implement a \$1.2 million cut to those services this year. The primary reason for the reduction is that there has been a significant increase in the Child Welfare system workload statewide from the implementation of the new statewide hotline. Additional funding to keep up with this increased workload hasn't occurred, so the distribution of the funding doesn't go as far. Also, there are many unknowns related to the federal IV-E Waiver, which is about \$1 million in flexible funding we use through Child Welfare to help stabilize families and keep them together. Congress hasn't acted on Child Welfare funding or reform yet.

In our child care assistance program, we are also seeing operating in an increasingly constrained environment. The Human Services Safety Net property tax initiative, when it was passed in 2010, had as a central focus area the funding of child care in Boulder County. This allowed us to expand access to child care here in part with these local matching funds. We have recently moved to a system of increased child care provider reimbursement that is based on tiers of quality. This, in combination with the fact that we have access to about \$2 million per year less than we have had in the past in statewide funding, is constraining the 2018 child care budget.

At the local level, we're in a positive environment in Boulder County with a healthy economy, a low unemployment rate, and an increase in property tax revenues. Economically we are in a good situation as a community to deal with uncertainty. I know one question we have been asked repeatedly is *do we anticipate that there would be cuts to the community-based organization funding streams (?)*, and the answer to that is "no." Our agency is working to handle the

federal and state budget uncertainties and to ensure that community funding and direct funding for clients for 2018 is preserved at its current level. While it's impossible to make promises about what we don't know, we do not anticipate changes to this community and direct client funding.



Robin Bohannan: Like every federally-funded agency, we are worried about what first came out in the federal budget and the huge cuts we were anticipating. We're still a bit worried about significant cuts to our Workforce Center, and to the Community Services Block Grant (CSBG), which funds Circles. We know that the Assets for Independence fund already got cut, and that funds the PIE program. Luckily, we have funding in that program for the next few years so we are not stopping it.

But I want to speak to the vulnerability and anxiety that we're all feeling about the unknown. Like Frank said, we're looking internally, making adjustments, and holding hiring for a while, until we get through this next month to see what's happened. But what I want to stress is our community values. Whatever happens, it's not going to change our values and our mission and how we provide services. We're also worried about policy issues that impact the residents we serve. The County Commissioners and the County Attorney's office have made it clear that regardless of what happens at the federal level around immigration policy, we are not going to become agents of immigration policy. So locally we're doing a lot to ensure that the community feels safe and knows that we are not going to hand over data or report people, that people have access to services that make a healthy community.



Jeff Zayach: I want to start by saying that the reason we are more stable in this county than our counterparts across the state is because of the support of many of you in this room who I know have worked on the supportive taxes that have allowed us to be in this place. So thank you to those of you in this room who are committed to this work. These values come through in this community and it's why we are as resilient as we are.

With a government shutdown, the biggest threat to Public Health is really our Women, Infants and Children Program, WIC. It's not having funding in place to continue our services. We were in this spot in 2013 and we are doing the same thing today that we did then. We will cover the funding. We can't do that forever, but we can do that for a while to be sure that we don't have to lay off our staff. We are working with Community Food Share to assure that if there is a shutdown, there's still food available to our clients in the community. Again, it's a demonstration of the resiliency in this community and how we work together to make sure that we don't fall down.

Also, we are tracking administrative actions that are happening at the federal government that are impacting people. The administration has made a decision around Title X Family Planning services and pregnancy prevention, so instead of funding it to 2020, they've cut it back to mid-2018. We are doing everything we can to advocate on issues like this.

I also want you to hear that Robin, Frank, and I have all been working closely together along with our County Commissioners and national, state, and local officials, and we have done a lot of outreach to our Congressional delegation. They have heard from us and multiple bipartisan groups around the state, including business representatives and university and healthcare leaders. We are very invested in this, we're going to continue to support that kind of approach, and we'll do everything we can to make sure we support our community and the work we've built for so many years.

Following these introductions, table discussions took place, and three questions were put forward:

1. What are your agency's specific concerns, how do you see them playing out, and in what time frame?
2. What are your specific concerns for the broader community, how do you see them playing out, and in what time frame?
3. What suggestions do you have for actions we could take as a safety net to prepare for a response to cuts during the next 1 to 2 years?

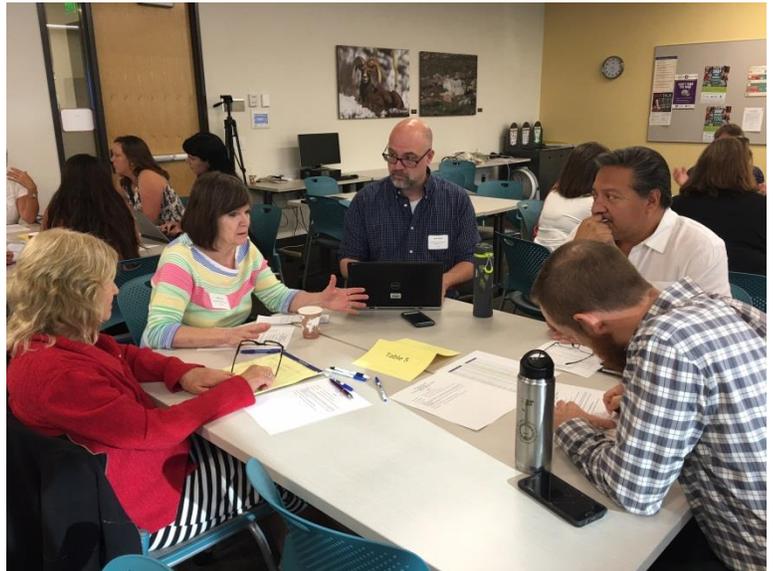
This report captures the most common concerns and suggestions that emerged from those table discussions.

Concerns

There were many concerns expressed around potential loss of **Medicaid funding** in the community, particularly the Medicaid expansion under the Patient Protection and Affordable Care Act (ACA). Among other impacts, loss of this funding would have a ripple effect throughout Boulder County as access to preventive care would decline and medical bills would accumulate for many who are most in need of health care, but would then lack coverage. This would lead to reduced spending on other critical needs such as food, housing, and transportation, deepening the need for assistance in these and other areas.

Housing affordability was also a major issue for many partners. Support organizations are increasingly hearing from clients that lack of access to safe affordable housing is creating a ripple effect for families and individuals, leading more people toward instability and crisis. Enhanced by the after-effects of the 2013 Flood, the competitive housing market and relatively strong economy continue to drive housing prices upward, and the region is unable to keep up with the need for significantly more permanently-affordable housing.

Homelessness came up in many discussions, as well, closely tied to the need to sustainably address housing affordability and boost employment and mental health supports across the community.



Alongside this, many discussed the desire to help ensure we as a community don't lose our focus on **early intervention and prevention**, and that we continue to target funding toward upstream supports. Some indicated concern around how we can accomplish this with reduced funding. "We can only do so much," one report-out stated. "How can we do more with less?"

Immigration issues are also a central concern across our community. Undocumented people and their families face increasing pressure from uncertainty around the federal government's immigration policies in light of the conversation at the national level. Some forum participants said that this uncertainty is increasing clients' barriers to a range of supports by reducing their access due to fear of deportation, and that this is leading to a reduction in undocumented people and others seeking assistance. Additional concerns included predation –taking advantage of the undocumented population financially and otherwise. The Deferred Action for Childhood Arrivals (DACA) initiative was also listed as a concern, as approximately 17,000 people in Colorado and 1,500 in Boulder County could be impacted by its rescission.

Federal grant funding was also a central concern for many at the forum, as related to serving homeless and pregnant/parenting youth and workforce access supports in particular, as well as senior populations supported through the Older Americans Act.

Some attendees discussed the impacts that funding cuts (AmeriCorps, for example) may have on the ability of organizations to provide **volunteers**, which are an essential component of service provision for many.

While there is still much that is unknown about the future of budgets related to the collective work of our partnership, deep concern was expressed around the potential that **flat funding** could be a best case scenario. During a time when

the need for supports continues to rise across our community and wages are generally not keeping up with the cost of living, flat funding is not seen as sufficient. For many partners, the cost of the work they do (utilities, housing, food) also continues to rise and this is not being matched by flat (or in some cases reduced) funding.

It was also mentioned that **foundation funding processes** can often be competitive in nature and may not incentivize collaboration.



Regulatory restrictions are also seen as significant obstacles for many of the supports we provide to members of our community, and feedback indicated a need to work together to help soften some of these. Some attendees suggested we pursue more **local control and flexibility** with the resources we have available so that decisions around key supports are made in closer proximity to where those supports are needed. Other suggestions included ensuring that initiatives around local tax revenues are constructed in ways that make them flexible and better able to adapt to local needs as they change or as they are determined.

Food insecurity was an issue for many at the forum, and discussions ranged from the need for better

collaboration across the community on getting nutrition supports to people to ensuring that people have access to the transportation they need to visit food banks and other supportive organizations.

The need for additional **child care assistance** supports and the recent re-establishment of a Child Care Assistance Program waitlist in Boulder County were also concerns that were expressed, as reductions in these supports make it difficult for more parents to maintain adequate employment.

The **increase in substance use** across our community is also seen as a worsening issue, as this creates problems in many other areas – child welfare concerns, homelessness, decreased school performance, and much more. This is closely tied to the need to focus resources on increased access to **mental health supports**, and for organizations to work together more to ensure our collective clients are getting the help they need in behavioral health. Some concern was expressed around the increased availability and potency of marijuana in the community and its impact on younger populations.

It was expressed that there has been a general **increase in anxiety** in our community, leading to an overall feeling of vulnerability.

While there is a **swing toward focusing on outcomes** across our community, including for prioritization of funding, some are concerned that some outputs are now not being given the weight they should have – how much food we are providing, for example.

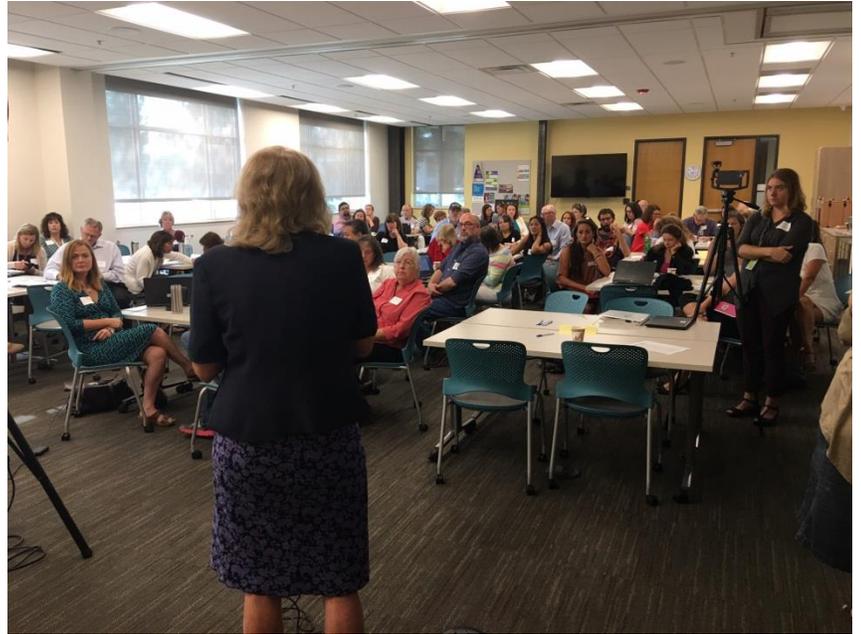
There were also some concerns expressed that, as a community, we are not necessarily good at **working across our complex systems** currently.

A perspective was also shared that we should work to collectively address **geographic concerns** (for example, in mountain communities) around available services and funding priorities.

Suggestions and Potential Solutions

Better Coordination and Communication

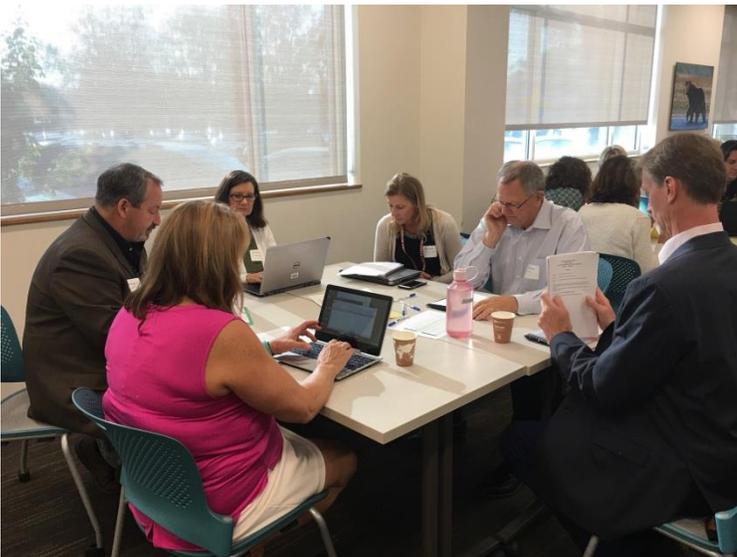
Work collaboratively across the community on a coordinated communication plan and public awareness campaigns, including the creation of messaging that de-stigmatizes the supports we collectively provide and helps boost awareness around the significant equity gaps that exist. There were suggestions that this issue should be tackled head-on, utilizing data-driven evidence that supports the work we are doing to help address it, and that we should refine our messaging around what it costs to live in Boulder County and how many people are unable to do so. Some of this messaging could be disseminated through the board members of many of our organizations.



Facilitate more coordinated services with each other, and the notion that leveraging coordination and integration will boost our collective ability to serve our community during leaner times.

Develop better ways to communicate with the county and municipalities around immediate needs.

Continued and Enhanced Collaboration



Continue these conversations in a proactive manner, potentially on a quarterly basis, to collectively understand how prioritizing certain areas over others will lead to reductions in some supports and potentially produce other impacts on how resources are distributed. Continue to do more advanced planning. Come up with contingency plans as a group to address cuts when and if they appear. Also, potentially seek to engage the broader community, foundations, and businesses in these conversations.

This was also presented as a need for the county and municipalities to continue to engage with community providers when there is a *specific issue* that needs to be addressed. This could include engaging the group around workforce support reductions or another major issue to determine a collective response.

The voices of a full range of community members should be elevated in policy discussions, and we should consider other supports we can provide these community members to help them participate.

Pursue greater collaboration and consolidation among agencies, utilizing lean process improvements to evaluate programs and services to ensure they're meeting the needs of our community and that our agencies are as efficient and effective as possible.

Explore and connect the dots between the interplay of the concerns that came up in the forum, and how they work together to exacerbate each other.

Develop shared metrics to collectively measure the outcomes we are generating in our work together, particularly as funding changes are being considered at the federal and state levels.

Boost data integration and sharing across and between our organizations.

Get together in celebration (i.e. not just in crisis).

Advocacy

Pursue more local control and flexibility with the resources we have available so that decisions around key supports are made in closer proximity to where those supports are needed. Another suggestion included ensuring that initiatives around local tax revenues are constructed in ways that make them flexible and better able to adapt to local needs as they are determined.

The community as a whole should come together to develop policies and initiatives with a unified voice and with language that is relatable, i.e. use of messaging that is more empowering for our residents and more reflective of compassion.

Collectively advocate against cuts to the Affordable Care Act and against reductions in subsidies for those who are currently in the Colorado Health Insurance Exchange (Connect for Health Colorado).

Collectively advocate for additional federal resources to help treat the opioid epidemic impacting our community and foster dialogue in our community on the issue.

Support the **Worthy Cause tax extension** question on the November 2017 ballot.

Support the **Boulder County Regional Affordable Housing Plan** which creates a goal for affordable housing creation by the year 2035.

Create a plan to support employers in keeping DACA young people employed in the community.

Help funders understand that current budget levels only allow us to do so much and stretching beyond this during leaner times can be very difficult.

Pursuit of New Opportunities

Think outside the box in pursuit of funding supports and more creative partnerships from



be

the

business community.

Consider ideas like universal home visitation to help reach people earlier and prevent deeper problems or crisis down the road and better stabilize families.

From the Directors: Next Steps

As we indicated during the forum, we are committed to continuing these conversations, and the perspectives we heard in the table discussions and reports that followed will help inform how we do that in the coming months. Please look for additional communications from us on this in the months ahead.

We welcome additional feedback from you, as well. Please feel free to share your thoughts with us, including questions or comments about this report or elaborations on anything that is stated within it. You can reach us at the email addresses listed below.

We are deeply grateful to be working in collaboration with you. Boulder County is truly fortunate to have a strong network of community and governmental partners who have a common vision of a family-driven, prevention-oriented, and holistic safety net. It is always heartening to be reminded that we are all in this together, through both good times and uncertainty. Thank you for all you do. See you soon.

Frank Alexander, Boulder County Housing and Human Services, falexander@bouldercounty.org

Robin Bohannon, Boulder County Community Services, rbohannon@bouldercounty.org

Jeff Zayach, Boulder County Public Health jzayach@bouldercounty.org

Report produced 09.14.2017



**Family Homelessness in Boulder County
Forum of Service Providers
October 19 - 1:00pm - 5:00pm
Boulder JCC, 6007 Oreg Ave 80303**

1:00 Welcome and introductions
Review of the agenda

Presentations - Session 1: Needs and Resources

1:10 What do we know about family homelessness in Boulder County? (Julie Van Domelen, EFAA)

1:25 The Continuum of Care - Inventory of Services and Facilities for Homeless Families in Boulder County (DeAnne Butterfield)

Group Work - Session 1

1:40 Break into small groups by geographical areas. Review services on the continuum available in each community to families at risk or experiencing homelessness.

- Boulder
- Longmont
- Tri-cities
- Mountains

2:40 Reports from Small Groups

3:00 Break

Presentations – Session 2: Systems and Partnerships

3:10 Coordinated entry - the experience of the Boulder County Housing Resource Panel (Sara Buss, Boulder County Community Supportive Housing Program Manager)

- 3:25 Integrating data and service delivery - the Family Resource Network (Melissa Frank-Williams, Boulder County HHS Integrated Services Manager)
- 3:40 Role of the schools to help homeless children and families - McKinney Vento (Ema Lyman, BVSD McKinney-Vento Specialist)

Group Work - Session 2

- 3:55 Break into Small Groups:
Coordinated Entry and Navigation for Families
Common Practice/Core Services for Families
Overall System Coordination/Integration for Families
- 4:30 Reports from Small Groups

Wrap Up

- 4:50 Wrap up and commitment to Next Steps
- 5:00 END

Packet

Agenda
EFAA Family Homelessness white paper
Family Resource Network Description
Housing Panel Description
McKinney-Vento Summary
Boulder County DHHS Housing Programs
Statistics of Housing Cost and Homeless Families
Acronyms



1. Objective

The purpose of this paper is to identify the key issues facing families experiencing episodes of homelessness in Boulder County. The intended uses include:

- to educate the community on the level and nature of family homelessness.

2. Understanding the family homelessness context

Definitions for key terms used in discussions about family homelessness include:

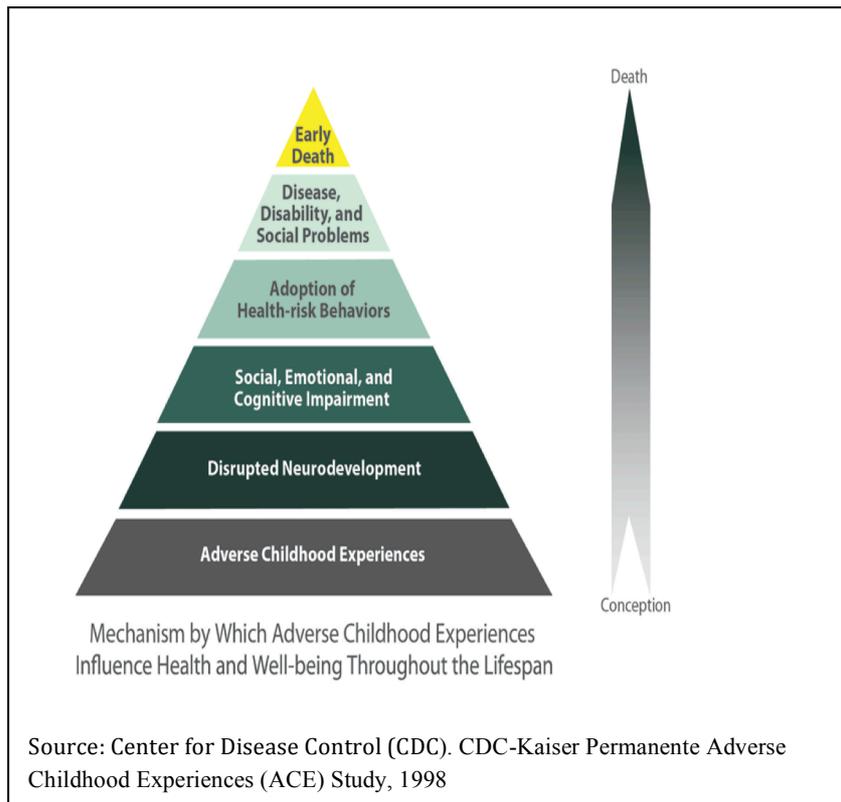
- **Family homelessness:** When people think of homelessness, they often think of people sleeping in parks or under bridges. This stereotype does not fit the profile of homeless families. Homelessness is defined by the Federal Government as individuals who lack a fixed, regular, and adequate nighttime residence. Homeless families are characterized as households with children 0-18 year of age who are:
 - a) living in emergency or transitional shelters (for example, including EFAA housing);
 - b) sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;
 - c) temporarily living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations;
 - d) living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar public or private places not designed for or ordinarily used as a regular sleeping accommodation for human beings;
 - e) families with children who have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barriers to employment.
 - f) People who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening situations related to violence; have no other residence; and lack the resources or support networks to obtain other permanent housing.
- **McKinney-Vento Homeless Assistance Act:** The McKinney–Vento Homeless Assistance Act of 1987 (Pub. L. 100-77, July 22, 1987, 101 Stat. 482, 42 U.S.C. § 11301 et seq.) is a United States federal law that provides federal resources for various homeless shelter programs. The McKinney-Vento Act supports programs providing a range of services to homeless people, including emergency shelter, transitional housing, job training, primary health care, education, and some permanent housing. In education, school districts must have procedures to identify and remove

barriers that prevent homeless students from achieving academic goals. Under the McKinney-Vento Act, each school district is required to have a Homeless Liaison and homeless children are registered to receive services. Major benefits offered by McKinney-Vento include assistance enrolling children who don't have access to their records, assistance to keep a child in their home school for the duration of the school year, and fee waivers for extracurricular activities.

- **Housing insecurity:** is a less exact term, often referred to alternatively as housing instability, used to describe the capacity of a household to maintain safe, stable, and adequate housing. Housing insecurity is typified when households spend more than 50 percent of their income on housing. Households that spend more than 50 percent of their income on rent are at high risk for experiencing episodes of homelessness.¹

- **Adverse childhood experiences (ACE):**

Research into health outcomes of adults has looked into childhood experiences as explanatory factors. A series of adverse childhood experiences are linked to poor health outcomes. These experiences include abuse (emotional, physical, or sexual); neglect (emotional or physical), and household dysfunction (violence, mental illness, substance abuse, separation/divorce, or incarceration). Most



families experiencing homelessness also have a combination of risk factors that potentially adversely affect their children. In addition, the experience of homelessness itself is usually a stressful and traumatic experience on the whole family. The effects on families, particularly the long-term implications for children, are devastating. Homeless children face frequent instability and dislocation, with lost school days and greater health and behavioral problems due to the physical environment and emotional strain. Hunger, poor nutrition and developmental delays are more prevalent. Periods of homelessness have lasting effects on children, affecting school readiness, school performance, and their long-term ability to break the intergenerational poverty cycle. Homeless families also experience a higher risk of out-of-home placement of their children, increasing the trauma and adverse effects to which they are subjected.

¹ For a deeper discussion of housing affordability and instability, please refer to EFAA's position paper on Housing Security.

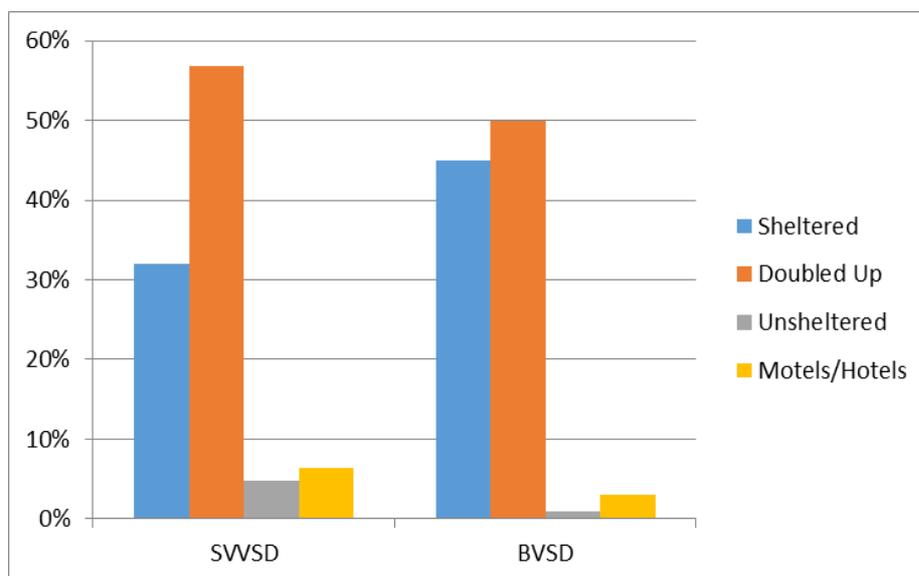
3. The current reality and evolving dynamics of our environment relative to family homelessness

Extent of family homelessness

Every year 600,000 families with 1.35 million children experience homelessness in the United States, making up about 50 percent of the homeless population over the course of the year. Nationally, this rate is growing faster than for individual homelessness. At a state level, the National Center on Family Homelessness study ranked Colorado 35th out of 50 states in terms of the prevalence of family homelessness (1 best to 50 worst). In Colorado about 25,000 school-aged children were homeless in the 2014-2015 school year (most recent year with data), a number which has tripled over the last ten years

Family homelessness is a critical but less visible issue in Boulder County. Half of the homeless individuals in Boulder County belong to families with children. Last year, over 1,200 school-aged children were registered as homeless in Boulder County through the McKinney Vento program, with 500 in Boulder Valley School District (of which almost 300 in the City of Boulder schools) and 736 students in the St Vrain Valley School District. In fact, despite its relatively affluent image, 2.1 percent of school children in the city of Boulder are homeless during the most recent year, only slightly better than the national average of 2.7 percent. As a reminder, this does not include children not yet of school age. Accounting for some degree of under-registration and estimating the share of children 0-5, a realistic estimate of the total number of children in Boulder county experiencing homelessness during a year is closer to 1,800 or about 2.5 percent of the population of those ages 18 or less.

Where are homeless families living? Based on McKinney-Vento data for school-aged children, the most frequent arrangement is doubled up, sharing housing with others in often highly unstable situations, representing about 54 percent of registered homeless children. Thirty-eight percent are in shelters. Five percent are in temporary motel situations. Three percent are technically unsheltered, most typically living in cars. This is slightly more prevalent in SVVSD than in BVSD where there appears to be better relative coverage of shelter services for families. The absolute number of families that are unsheltered, typically living in their cars, is quite small, as is the relative share of families living in motels and hotels, typically as short-term solutions.



Source: McKinney-Vento data, BVSD, SVVSD, 2015.

Causes of family homelessness

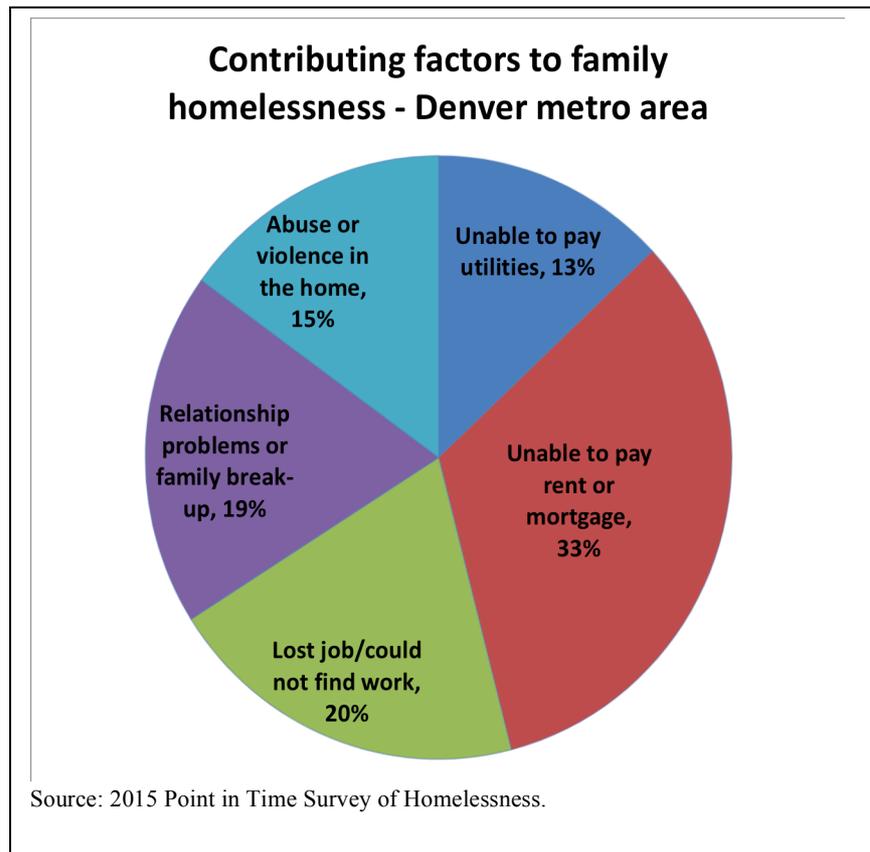
There are many reasons why families find themselves at risk for homelessness. Inability to pay rent/mortgage is the leading cause of family homelessness in Boulder County. This may be driven by loss of a job, illness, divorce, domestic violence or other shock to the household. But increasingly, rising rents and the lack of affordable housing are leaving families without options. Overall, in our community the primary reasons for family homelessness are divided between two-thirds due to economic factors and one-third relationship/family structure issues (see chart).

Underlying the economic shocks to households is the local housing affordability crisis. This is most acute in the City of Boulder where, as of June 2016, the average apartment rent was \$1,759. This would require an annual income of \$70,360 to meet the standard of 'affordable housing' as spending only one-third of income on rent. In fact almost one-third of renters in Boulder County spend more than 50 percent of their income on rent. The number of affordable units available in Boulder County has contracted significantly over the last 10 years. In 2000, there were 26,817 rental units affordable to incomes at or below 50 percent of AMI. In 2012, this declined to 18,624, a drop of over 30 percent.

As housing costs have risen dramatically, incomes for lower-income families have stagnated. The number of families living below the Federal poverty line is substantial and growing in Boulder County (Fed poverty threshold is about \$20,000 per year for a family of three). In 2000, 7 percent of the County's families with children were living below the poverty line. This increased to 13 percent in 2015. The total number of children living in poverty rose from about 7,700 in 2010 to 8,300 in 2015.

Effects of family homelessness

The long-term effects of children growing up in highly stressful situations are alarming. The immediate effects are apparent locally. While the homeless students represent about 2 percent of all students in City of Boulder BVSD schools, they represent 25 percent of enrolled students in the City's main alternative schools (Arapahoe High, Boulder Prep and Halcyon).



Homeless students are far more likely to have behavioral issues, learning challenges, truancy and attendance issues.

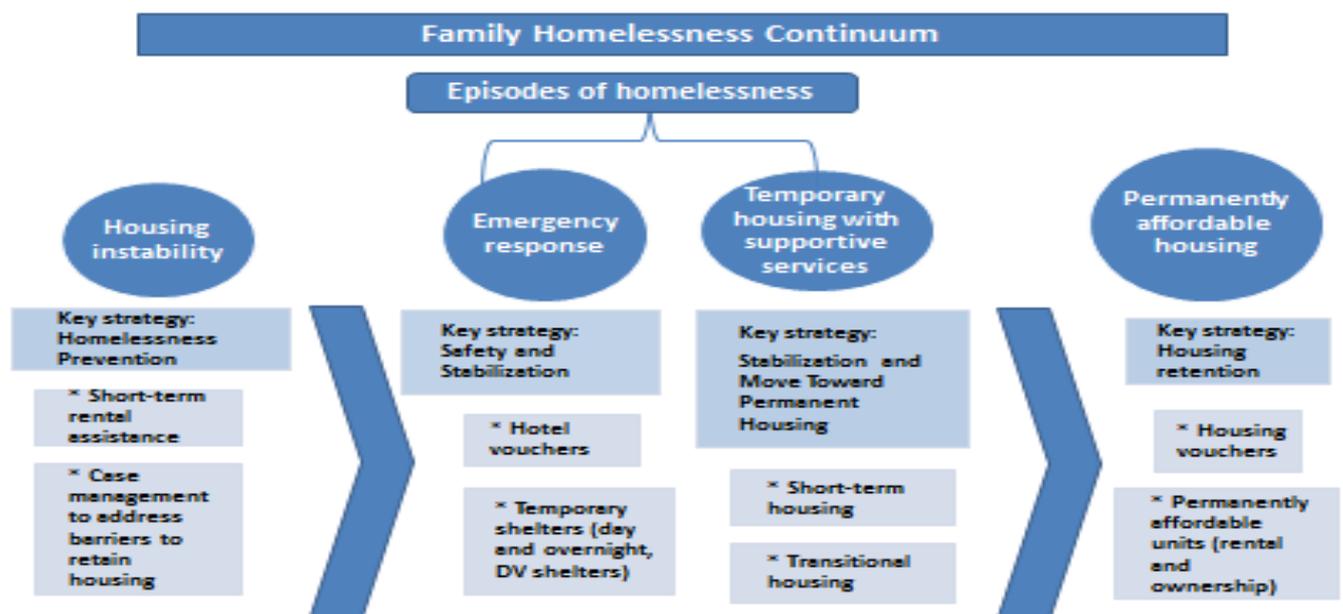
While mental health and substance abuse problems are not a major cause of homelessness among families with children, there is significant evidence that the conditions of poverty and homelessness have adverse effects on mental health. In fact, many homeless parents have themselves experienced physical and sexual abuse, constant crisis, family and community violence, isolation, and the cumulative stress of persistent poverty

Another significant impact is the more difficult time leasing up after episodes of homelessness, especially with an eviction notice on their record. Families entering homelessness have typically depleted savings and assets and strained core relationships of economic solidarity (family and friends), making it more difficult to get back on their feet.

4. Responses to family homelessness – EFAA’s role

The responses to family homelessness exist along a continuum, from a preventive stance through levels of emergency and temporary service through to the securing of permanently affordable housing:

+



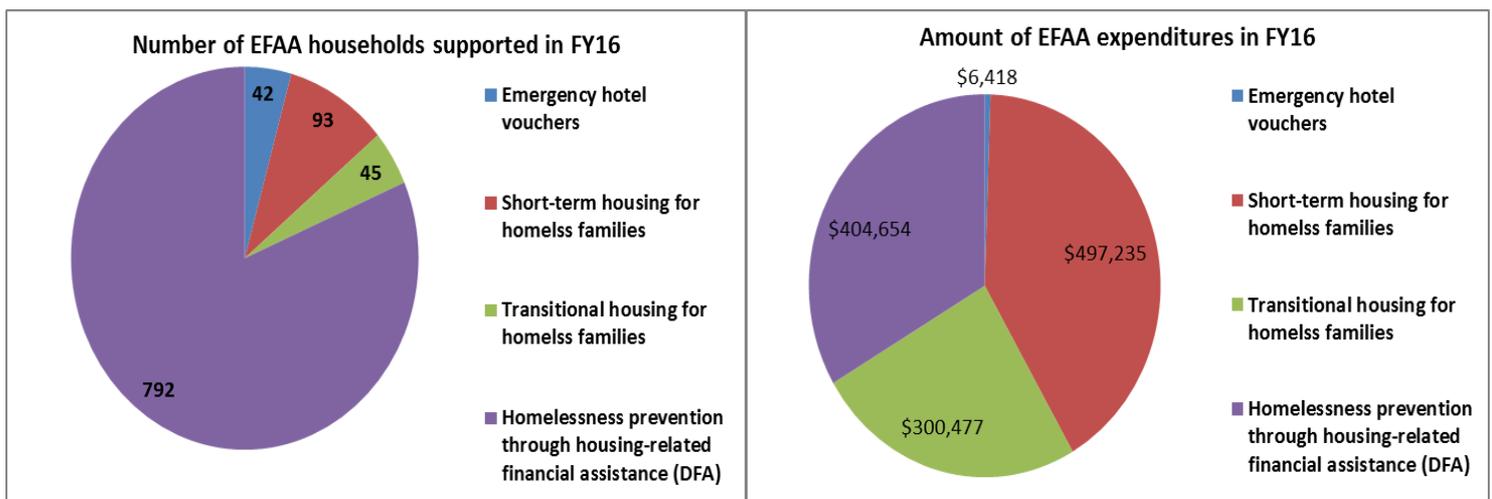
EFAA plays a central role in the issue of family homelessness. EFAA provides a significant portion of the direct services available for homeless families in Boulder County. EFAA directly supports its families in several ways along this homelessness/housing continuum. This includes both preventing as well as addressing family homelessness. Assistance includes:

- **Financial assistance to prevent homelessness** – including financial assistance and, in certain instances, case management. Provides financial and case management to help families stay in their homes, encompassing:
 - One time financial assistance to keep people in their homes
 - Multi-month rental assistance for most vulnerable families up to 12 months with the Boulder County-funded Housing Stabilization Program
 - Keep Families Housed, a program with City of Boulder to provide 200 families with kids with financial assistance up to three times per year based on making essential investments in child wellbeing.
- **Vouchers** for very short-term, emergency stays in motels.
- **Short-term housing** – rent-free stays of up to 12 weeks for families with children in EFAA’s 20 short-term apartments.
- **Transitional housing** – modest rent for stays of up to 2 years for families with children in EFAA’s 30 transitional apartments.

The provision of short-term and transitional housing is meant to stabilize families in crisis, helping them to get back on their feet, save money and, through intensive case management, move towards self-sufficiency. Last year, 75 percent of families in short-term housing and 87 percent of families in transitional housing successfully exited to sustainable housing situations upon completion of the program.

Because of the high risks facing children in families experiencing homelessness, EFAA expanded its programming towards those children last year. EFAA’s children’s program encompasses after school programming and intensive case management linking families to resources, ensuring access to services, and setting and monitoring goals for children’s outcomes.

In terms of number of households supported, the bulk of EFAA’s coverage is in homelessness prevention. Since prevention is less expensive than providing support once homeless, the bulk of EFAA’s financial resources are concentrated in the short-term and transitional housing program.



EFAA has recently expanded its programming in preventing family homelessness through rental support in the City of Boulder. In addition, EFAA has been a member of several of the key collaborative groups addressing homelessness, including the Boulder County 10 Year Plan to End Homelessness Board, the Human Service Advisory Committee, and the City of Boulder Homelessness Planning group, to name a few. Within these groupings, the issue of homelessness is typically viewed in terms of the adult single population. EFAA provides a voice for families within the broader homelessness discussions and strategies and has played an important role in raising the profile of family homelessness within these broader coalitions.

1. Community challenges in family homelessness

Limited community awareness. Family homelessness is less visible than individual adult homelessness and therefore tends to be less covered as a community issue.

Identification of gaps in family homelessness services. There are no day shelter services for families with children in Boulder County. The current system provides a strong system of prevention and diversion directly into more stable housing options. The focus is on immediate stability through, for example, temporary hotel vouchers and rapid rehousing, getting families into more stable, family-centered surroundings. The focus is also on providing housing solutions to families already residing in Boulder County rather than becoming a pole of attraction for families looking to come to Boulder County but unable to secure housing.

Key to this is the Boulder County Community Housing Resource Panel. The Housing Panel convenes all of the major providers of homelessness prevention and temporary housing resources, including EFAA, to review cases of housing instability and family homelessness and identify the best match with existing resources. This has been successful in keeping families out of extremely inadequate situations, providing a rapid rehousing approach to building greater family stability.

Coordinating service delivery. EFAA and Boulder County are currently piloting a standardized assessment and prioritization of need (a family VI-SPDAT) that would allow for more objective prioritization of access to services. However, addressing family homelessness is not just about housing. To address the negative effects of family homelessness requires comprehensive services to all family members, particularly the children, in order to break to cycle of poverty for the next generation. Mental health, educational support, access to health services, financial literacy and counseling, employment assistance, and other supports help prevent future episodes of homelessness and mitigate the effects on children's longer term outcomes.

Increasing pressures from the housing affordability crisis. Without a stronger response to expanding affordable housing options for families, the number of families experiencing homelessness can be expected to rise. Rapidly rising housing costs are the prime factor in families finding themselves homeless. Housing costs are also making it more difficult to exit from periods of homelessness.

2017



BOULDER COUNTY FAMILY RESOURCE NETWORK

Governance Charter

April, 2017

A governing document of the Boulder County Housing and Human Services Advisory Committee (HHSAC)

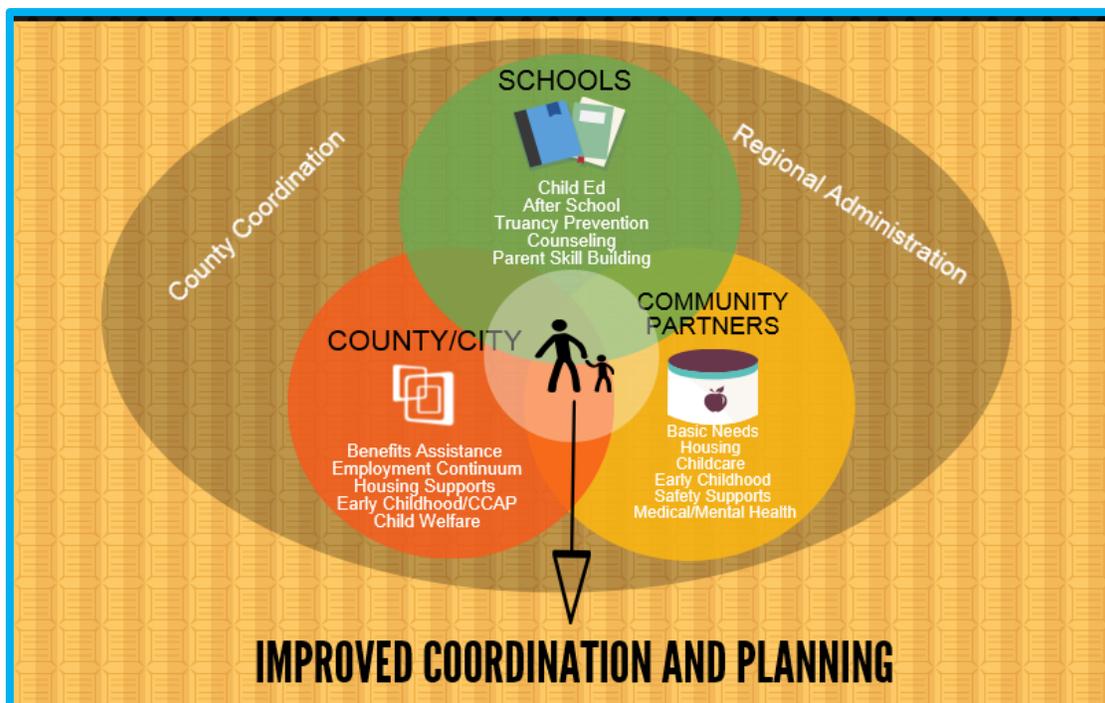
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1. Overview

A. Boulder County Family Resource Network (FRN)

Vision: Based on a two generational approach, create a fully integrated system* of service delivery, organized through a county-wide governance structure comprised of citizens, schools, community-based entities, and city/county government aimed at improving self-sufficiency of families and academic outcome for children and youth.



*A fully integrated system is a **holistic approach** to serving each consumer, using an **interoperable data exchange** to link the people, services, and information across systems and programs for robust **care coordination, integrated case planning, timely service delivery, and cross-system relationship management**.

B. The FRN Regional Council (RC)

The Regional Council is responsible for achieving a visionary, yet complex, large system-change process, aligning strategic direction and implementation consistent with the integration vision outlined above designed to produce the positive, long-term, sustainable outcomes for children, families, and individuals served throughout the community.

The Boulder County Housing and Human Services Advisory Committee (HHSAC) will serve as the Family Resource Network Regional Council (RC). This Governance Charter serves as a component to the HHSAC by-laws.

The Regional Council provides the overarching governance to the Family Resource Network and oversees achievement of collective service outcomes to improve overall well-being of Boulder County families. In this model, the Regional Council consists of high-level leaders with a stake in the outcome of the effort, people in a position to make significant policy decisions, break down barriers, and provide vision and strategic direction. It 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 the following:

- communicating a clear shared vision;
- defining strategy and expected community-wide outcomes;
- ensuring that the input by those being served by the FRN is guiding its direction;
- monitoring performance on key metrics;
- advocating and informing on relevant local, state and federal policy;
- supporting and advising on program improvement;
- supporting coordinated and consistent processes, policies, and management of the FRN;
- facilitating and approving formal agreements for operation of the Network ;
- facilitating resource procurement and allocation;
- informing and supporting the Boulder County Integrated Services Delivery Model of Care (ISDMC);
- reviewing and approving recommendations from Local Area Collaborative groups (LACs);
- increasing efficiency and collaboration among partners;
- reducing duplication of services/efforts and identify gaps; and
- making decisions required to assure success of the FRN.

The FRN Regional Council will be responsible for ensuring focus on the vision and strategic direction and must monitor progress toward implementation in order to create the seamless that benefits both consumers and the community.

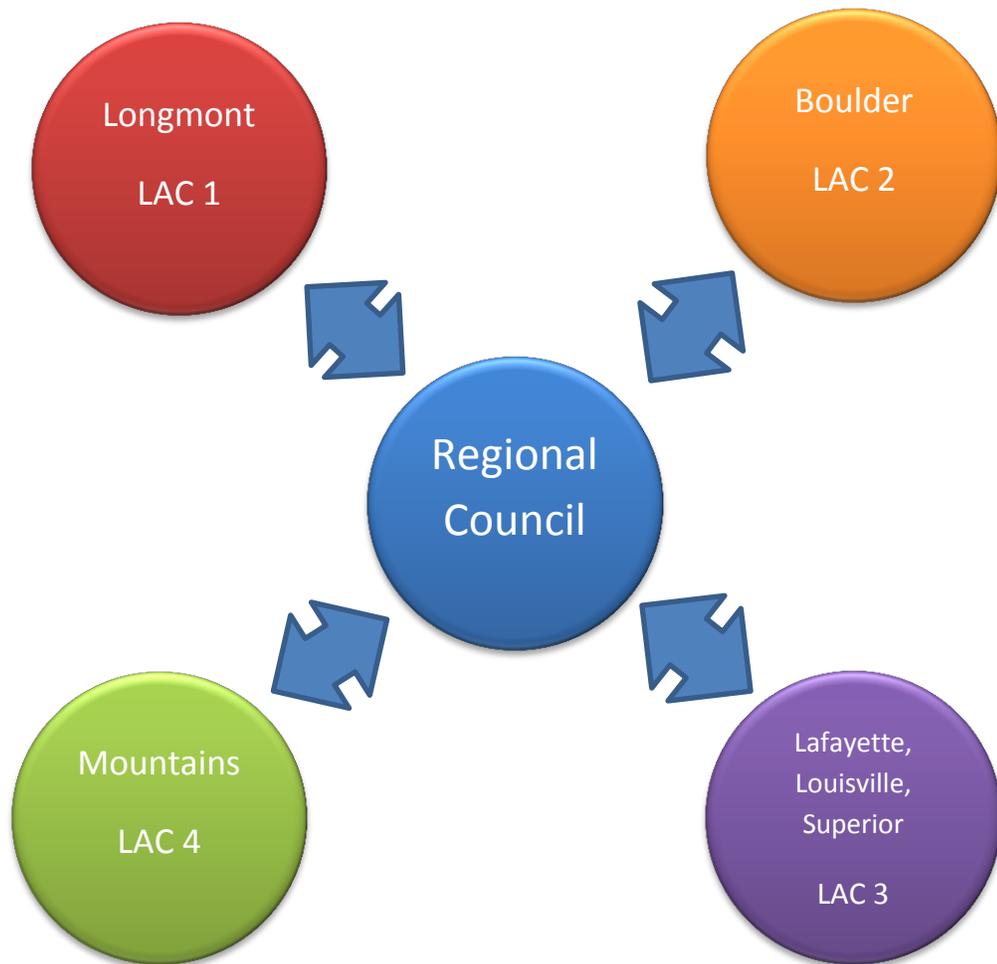
Note: The FRN does not take the place of any individual agency's Board of Directors.

C. Local Area Collaborative Groups

Given that a core principle of the Family Resource Network is that each community hub address the specific needs of the local area, Local Area Collaborative (LAC) groups will be created consisting of representatives in four regions (see page 4). Using data-informed practices, LACs are responsible for forming and overseeing the local "hubs" (networks of support) to include:

- reviewing access and referral processes;
- identifying challenges and opportunities, helping the Regional Council leadership understand the barriers, working through them, and delivering on the vision;
- ensuring that the input by those being served by the FRN is guiding its direction;
- reviewing and analyzing local data and reports on family resource programming;

- implementing referral, access and data quality improvement plan;
- tracking progress on implementation of collective service outcomes;
- establishing and ensuring participant programs adhere to standards outlined by the FRF and Quality Service Standards by the Family Resource Center Association;
- coordinating training and “communities of practice” within areas and collaboration between areas; and
- informing and supporting the Boulder County Integrated Service Delivery Model of Care.



D. Boulder County Staff Roles

Three designated Boulder County staff will provide guidance, technical assistance and support to the Regional Council and the Local Area Collaborative groups to achieve desired process and service outcomes.

Regional Council Liaison- IMPACT Strategic Initiatives Manager

Duties include:

- Leads monthly Regional Council (RC) meetings;
- Organizes meeting agendas, produces pertinent materials, identifies primary decision needed to advance the FRN, and responds to requests/needs of members;
- Provides recommendation to the RC necessary for making key decisions;
- Facilitates linkages between RC members and other key stakeholders to the FRN 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 FRN 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 work as a fundamental basis for service delivery by FRN partners;
- Provides any pertinent fiscal reports (i.e. funding reports); and
- Facilitates feedback on strategic investments.

Local Area Collaborative Liaison - The IMPACT Strategic Initiatives Coordinator

Duties include:

- Provides assistance with analysis of Local Area Collaborative data and outcomes and reports to the 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 programs 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; and
- Serves as Regional Council Liaison in the absence of the Strategic Initiatives Manager; and
- Oversees Boulder County Department of Human Services contract scopes and agreements with Family Resource Centers.

Administrative Support – IMPACT Strategic Initiatives Specialist

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

2. Membership

A. 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 or designee
 Boulder Valley School District Assistant Superintendent or designee

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 Community Services Director
 City of Louisville - Housing Representative
 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)
 The Early Childhood Council of Boulder County Director (ECCBC)
 Clinica Director
 Boulder Housing Partners Director
 Peak to Peak Representative
 I Have a Dream Foundation Director

Current or Previous Participant in FRC Services

MEMBERS AT-LARGE

Per the HHSAC by-laws-

- 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.

B. Local Area Collaborative Groups

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.

SCHOOL

- St. Vrain School District – TBD (attends for LAC 1)
- Boulder Valley School District – TBD (attends for LAC 2, 3 and 4)

COUNTY/CITY GOVERNMENT

- Boulder County Housing and Human Services - FRF Liaison (attends all 4 LACs)
- City of Longmont- Children and Youth Center staff member(LAC 1)
- City of Boulder – Family Resource Schools Administrator (LAC 2 and 3)

The following representatives will attend meetings as needed. An agenda for each monthly meeting will be sent in advance to the representative in order for the designated representative and the county liaison to determine if attendance is needed.

- BCDHHS Early Intervention Team Program Manager (attends all 4 LACs)
- Boulder County Community Services – Workforce Boulder County staff member (attends all 4 LACs)
- Boulder County Department of Public Health representative (attends all 4 LACs)

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)

The following representatives will attend meetings as needed. An agenda for each monthly meeting will be sent in advance in order for the representative and the county liaison to determine if attendance is needed.

- ECCBC Associate Director (all 4 LACs)
- I Have a Dream Foundation staff (all 4 LACs)
- Clinica program staff (all 4 LACs)
- Boulder Housing Partners program staff (LAC 3)
- Peak to Peak Representative (LAC 4)

Current or Previous Participant in FRC Services

3. Scope and Roles

A. Regional Council

The Family Resource Network Regional Council guides overarching governance of the Family Resource Network with support of the staff liaison. The RC will use key principles in the Standards of Quality and

ISDMC practices to guide implementation.

- **Communicate a clear shared vision** - RC members will be responsible for formalizing and communicating the FRN vision and key objectives within their agencies and in the community.
- **Define strategy and expected community-wide outcomes**- The RC will be responsible for formalizing both process and collective program outcomes for the FRN (see page 9), finalizing an agreed upon logic model with tangible measures, and monitoring progress in achieving these outcomes.
- **Ensure that the input by those being served by the FRN is guiding its direction**- Either through representation on the RC or LACs or through feedback provided by FRC Participant Advisory groups or related forums, ensure that guiding principles, policy, and service delivery are reflective of participant needs, input and guidance.
- **Monitor performance on key metrics** – Using Transformational Collaborative Outcomes Management (TCOM) regularly monitor and report progress on outcomes across the FRN.
- **Advocate and inform on relevant local, 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** – RC members will review the LAC process and program-related recommendations 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 Network .
- **Support coordinated and consistent processes, policies and management of the FRN** - 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 FRN** – This includes memorandums of understanding regarding service coordination, data sharing, etc.
- **Facilitate 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** – The RC will inform and stay apprised of ISDMC work and ensure adherence to the practice model.

- **Review and approve recommendations from Local Area Collaborative entities**
- **Increase efficiency and collaboration among partners** – Identify and implement opportunities to streamline interagency effectiveness to include sharing of resources, optimizing data systems and best practices.
- **Reduce duplication of services/efforts and identify gaps.**
- **Make decisions required to assure success of the FRN**

B. Local Area Collaborative Groups

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 FRN Regional Council, activities included are listed below. The RC will use key principles in the Standards of Quality and ISDMC practices to guide implementation.

- **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 a referral process to support the family resource services in their area. Referrals will be linked to assessment and supported through a common data system (HHSC/BC Connect).
- **Review and analyze local data and reports** on family resource programming.
- **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**, to include Quality Service Standards by the Family Resource Center Association.
- **Coordinate training and “communities of practice”** within areas and collaborate between areas.
- **Inform and support the Boulder County Integrated Service Delivery Model of Care** (see attachment B).

4. OUTCOMES

The FRN Regional Council and Local Area Collaborative Groups will be responsible for defining and tracking process measures and collective service outcomes.

A. Process Measures (Outputs) – The How

The process measures are the specific steps taken by the FRN to reach the desired collective service outcomes. Process measures will be defined by the FRN Regional Council and implemented and tracked by the LACs.

FRN process measures are related to the collective program outcomes which measure impact of services provided by FRN members at an “enterprise” or systems level. For example, a LAC will be responsible for defining the service network and role of each partner in that network. Once defined and a protocol is in place, a process measure would be to determine if programs within the LAC were following the steps outlined by the LAC. The improvement in service coordination is linked to improved outcomes in core areas of self-sufficiency.

B. Collective Service Outcomes

Collective Services Outcomes will be defined and agreed upon by the Regional Council. Implementation will be managed by the LACs.

Modeled after the Colorado Family Resource Center Association (FRCA) logic model, the collective service outcomes outline the changes anticipated as a result of the combined efforts of FRN partners in implementing the Network (see attachment A for the complete logic model; note that the outcomes on page 11 are additions suggested for Boulder County). This document will assist in development of the Boulder County FRN logic model to be completed per the FRN implementation work plan.

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

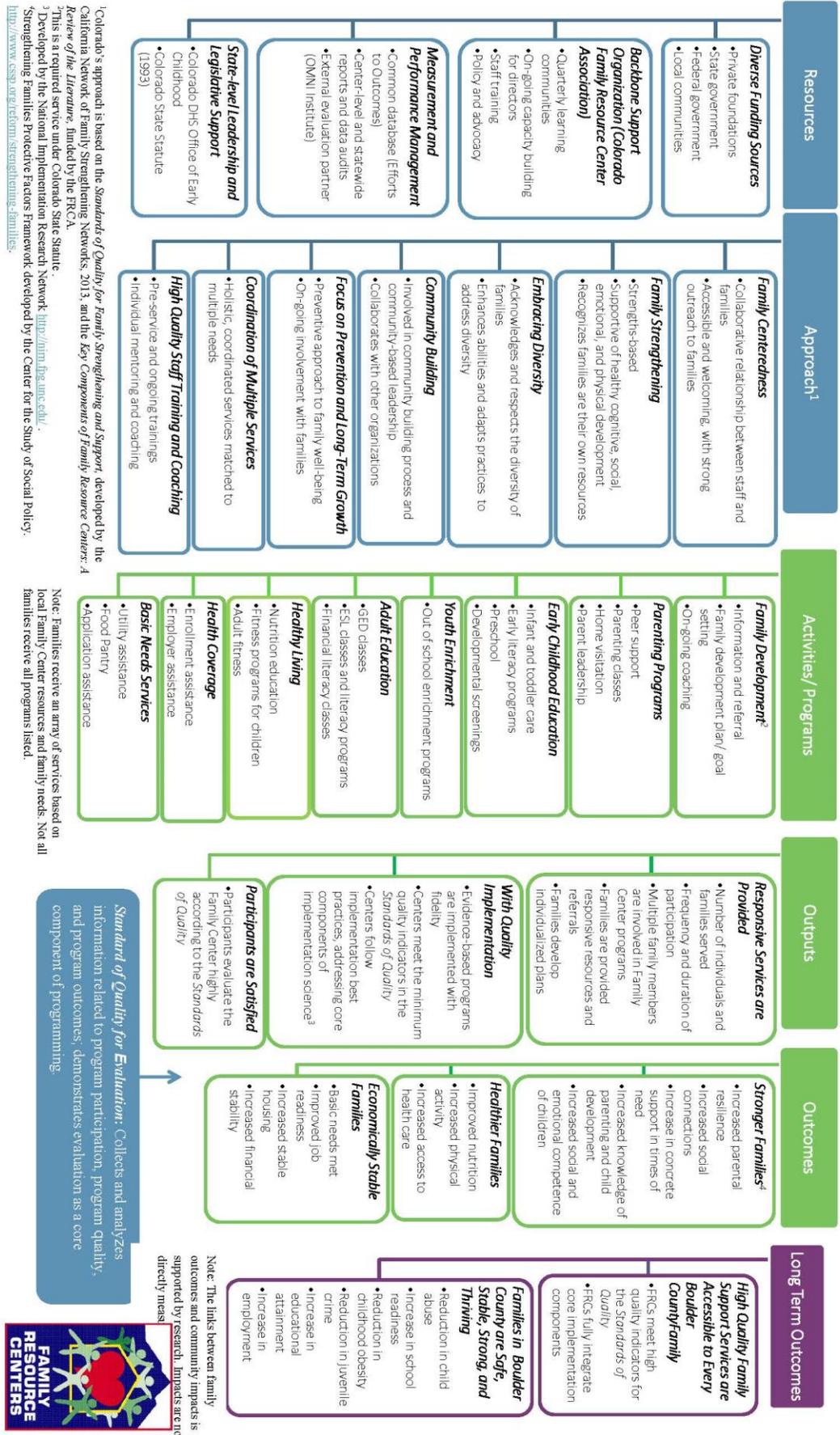
Date ratified _____

Revision _____

Attachment A

Colorado Family Resource Center Logic Model

(updated December)



¹Colorado's approach is based on the *Standards of Quality for Family Strengthening and Support*, developed by the California Network of Family Strengthening Networks, 2013, and the *Key Components of Family Resource Centers: A Review of the Literature*, funded by the FRCA.

²This is a required service under Colorado State Statute.

³Developed by the National Implementation Research Network (<http://nimr.psu.edu/>).

⁴Strengthening Families Protective Factors Framework, developed by the Center for the Study of Social Policy. (<http://www.cssp.org/learn/strengthening-families>).

Note: Families receive an array of services based on local Family Center resources and family needs. Not all families receive all programs listed.



Boulder County Revision

(orange box)

Short to Moderate Term Outcomes

Stronger Families

- Increased parental resilience
- Increased social connections
- Increase in concrete support in times of need
- Increased knowledge of parenting and child development
- Increased social and emotional competence of children

Healthier Families

- Improved nutrition
- Increased physical activity
- Increased access to health care

Economically Stable Families

- Basic needs met
- Improved job readiness
- Increased stable housing
- Increased financial stability

Success in Early Childhood through Early Adulthood

- Improve academic success of children and youth
- Improve behavioral outcomes for children and youth
- Improve quality, accessibility and affordability of early childhood programs and services.

Long Term Outcomes

High Quality Family Support Services are Accessible to Every Boulder County Family

- FRGs meet high quality indicators for the *Standards of Quality*
- FRGs fully integrate core implementation components

Families in Boulder County are Safe, Stable, Strong, and Thriving

- Reduction in child abuse
- Increase in school readiness
- Reduction in childhood obesity
- Reduction in juvenile crime
- Increase in educational attainment
- Increase in employment

Attachment B

Integrated Services Delivery Model of Care Practice Model



Boulder County Department of Housing and Human Services Housing Panel

In October 2014, BCDHHS established the Housing Panel in response to an ever-increasing need for a coordinated and collaborative approach in awarding housing assistance resources to vulnerable homeless or imminently homeless households in Boulder County. The Housing Panel is comprised of representatives from the community safety net partner organizations who administer supportive housing case management for participants selected at the Housing Panel. Through a shared release of information and a common intake form, the following agencies may refer directly to the Housing Panel:

- BCDHHS: Family and Children Services, Family Self-Sufficiency, Housing Stabilization Case Management, Section 8 Occupancy, Financial Counselors, and Workforce Boulder County
- Emergency Family Assistance Association (EFAA) – basic needs and housing non-profit serving primarily City of Boulder and mountain residents
- Sister Carmen Community Center – basic needs and Family Resource Center non-profit serving primarily eastern Boulder County (Lafayette, Louisville, Superior)
- OUR Center – basic needs non-profit serving primarily Longmont and Saint Vrain Valley School District area
- Safehouse Progressive Alliance for Nonviolence (SPAN) – domestic violence shelter and resource center serving primarily Boulder and surrounding area
- Safe Shelter of St. Vrain Valley – domestic violence shelter and resource center serving primarily Longmont and surrounding area
- Bridge House – providing housing and employment services for Boulder’s chronically homeless
- Attention Homes – transition-aged youth shelter and resource center serving all of Boulder County

The Housing Panel meets every two weeks to make eligibility determinations based on a common release of information document and a common intake form for the majority of our supportive programs described in detail below. With our community partners assisting in vetting and approving households, it is a shared learning environment, where creative housing solutions and case management approaches are suggested and implemented and where decisions are made collectively. To date, all funding decisions have been made by reaching 100% consensus on every case. This has resulted in a collaborative culture of connection.

For information contact Sara Buss. sbuss@bouldercounty.org

The McKinney-Vento Law

Immediate enrollment in school for all children

Supports for families and students

The intention of the federal McKinney-Vento law is to **remove all barriers** to **enrollment, attendance, and academic success** that children and youth who do not have permanent housing might face.

The McKinney-Vento law provides for rights and services to families and students who **lack “a fixed, regular, and adequate nighttime residence.”**

- A **fixed** residence is one that is stationary, permanent, and not subject to change.
- A **regular** residence is one which is used on a regular (i.e., nightly) basis.
- An **adequate** residence is one that is sufficient for meeting both the physical and psychological needs typically met in home environments.

International law defines adequate as follows:

“Adequate shelter means ... adequate privacy, adequate space, adequate security, adequate lighting and ventilation, adequate basic infrastructure and adequate location with regard to work and basic facilities - all at a reasonable cost.”

Some of the living situations that qualify under this definition are:

- Sheltered (EFAA, Safehouse, youth shelter, emergency/temporary foster care, etc.)
- Doubled Up due to Economic Hardship with Family or Friends
- Unsheltered (Cars, Parks, Campgrounds, etc)
- Hotels/Motels
- In addition, many other situations that may be fixed and regular but not adequate, as utilities are off, space is too small, no food.

Services and Rights under McKinney-Vento:

- **Immediate Enrollment – even if lacking address and documents**
- Free Lunch and Breakfast – without filling out an application
- School Stability – when possible
- Transportation – when appropriate
- Referrals for any needed services, within and outside of BVSD
- Waiver of **all** School Fees (i.e. field trips, materials, supplies, etc.)
- Programs and services to insure academic success
- Confidentiality

Please contact the Boulder Valley School District McKinney-Vento Specialist:
Ema Lyman 720-561-5925 ema.lyman@bvsd.org



McKinney-Vento
*Apoyo para los estudiantes que carecen
de un hogar fijo, regular y adecuado*

6500 Arapahoe, P.O. Box 9011
Boulder, Colorado 80301

Especialista: Ema Lyman
*Telefono: (720)561-5925
Fax (720) 561-5173*

La Ley McKinney-Vento

Inscripción inmediata de todos los niños en la escuela

Apoyos para familias y estudiantes

El cometido de la ley federal McKinney-Vento es eliminar todas las barreras a la inscripción, asistencia, y éxito académico con que se pueden encontrar los niños y los jóvenes que no tienen un hogar.

La ley McKinney-Vento define “no tener hogar” como la *“falta de una residencia fija, regular y adecuada durante la noche”*

- Una residencia **fija** es un hogar estacionario, permanente y que no está sujeto a cambios.
- Una residencia **regular** es la que se usa de forma habitual (es decir, todas las noches).
- Una residencia **adecuada** es aquella que cumple suficientemente las necesidades físicas y psicológicas que ofrecen normalmente los entornos de hogar.

La Ley Internacional define “inadecuado” de la siguiente manera:

“Un albergue adecuado significa ... privacidad adecuada, espacio adecuado, seguridad adecuada, luz y ventilación adecuada, infraestructura básica adecuada y ubicación adecuado según empleo y facilidades básicas – todo a un costo razonable.”

Algunas situaciones de vida que entran dentro de esta definición son:

- Protegida (EFAA, Safehouse, centro de acogida juvenil, hogar de acogida de emergencia/temporal, etc.)
- Vivienda conjunta con familia o amigos debido a dificultades económicas
- Desprotegida (autos, parques, tiendas de campaña, etc.)
- Hoteles/moteles
- Y muchas otras situaciones que pueden ser fijas y regulares, pero no adecuadas, como por ejemplo que no dispongan de servicios públicos (electricidad/gas/agua), que el espacio sea demasiado pequeño, que haya falta de comida.

Servicios y Derechos comprendidos en McKinney-Vento:

- **Inscripción Inmediata – aunque no tengan una dirección ni documentos**
- Comida y desayuno gratis – sin tener que completar una solicitud
- Estabilidad escolar - cuando sea posible
- Transporte – cuando sea apropiado
- Remisiones a cualquier servicio necesario dentro y fuera del distrito escolar
- Exención de pago de **todas** las tarifas escolares (incluyendo SAC, K-Care)
- Programas y servicios para garantizar el éxito académico
- Confidencialidad

**Por favor pónganse en contacto con la especialista McKinney-Vento
del Distrito Escolar del Valle de Boulder:**

Ema Lyman 720-561-5925 ema.lyman@bvsd.org

LONGS PEAK ENERGY CONSERVATION (LPEC)	HOUSING & FINANCIAL COUNSELING	CDBG-DR FUNDING FOR FLOOD RECOVERY
<p>WHAT: Free or low-cost weatherization and energy efficiency upgrades; upgrades of electrical systems, plumbing, and roofing with low-interest loans available</p> <p>WHO: Homeowners/renters who receive certain assistance (e.g., TANF, SNAP, OAP) or qualify based on income</p> <p>HOW: Application available online or by mail</p> <p>LENGTH: Varies (project-based)</p> <p>LEARN MORE: chatch@bouldercounty.org</p>	<p>WHAT: Free classes, workshops, and individual counseling sessions on a variety of topics including: pre-purchase, homebuyer education, financial counseling, foreclosure prevention, reverse mortgage, renter education</p> <p>WHO: Open to all; classes offered in English & Spanish</p> <p>HOW: Find/register for classes on our website; individual appointments can be made online or by phone</p> <p>LENGTH: Varies</p> <p>LEARN MORE: hcinfo@bouldercounty.org 720-564-2279</p>	<p>WHAT: Community Development Block Grant – Disaster Recovery funds; provide financial assistance for eligible projects including home repairs, septic & well systems, home access, & temporary rental assistance</p> <p>WHO: Qualifying residents whose primary residence was directly affected by 2013 Flood</p> <p>HOW: Apply in-person, online or by phone/e-mail; prioritized according to need</p> <p>LENGTH: Varies</p> <p>LEARN MORE: floodgrants@bouldercounty.org</p>

Additional Housing & Shelter Resources in Boulder County

Longer-Term/Permanent Housing

Boulder Housing Partners (BHP)

4800 North Broadway
Boulder, CO 80304
Phone: 720-564-4610
boulderhousing.org

Housing authority for the city of Boulder; provides affordable rentals, market rate rentals, and public housing within city limits

Longmont Housing Authority

1228 Main Street
Longmont, CO 80501
Phone: 303-651-8581
longmontha.com

Housing authority for the city of Longmont; offers housing & related services to low/moderate income, elderly and disabled households

Thistle Community Housing

1845 Folsom Street
Boulder, CO 80302
Phone: 303-443-0007
thistlecommunities.org

Provides below-market rental and homeownership opportunities to low- and moderate-income households

Habitat for Humanity

1455 Dixon Avenue Lafayette, CO 80026
Phone: 303-447-3787
flatironshabitat.org

1833 Sunset Place Longmont, CO, 80501
Phone: 303-682-2485
stvrainhabitat.org

Provides homeownership opportunities for families through the concept of "sweat equity"

Emergency and/or Transitional Housing

Attention Homes

3080 Broadway
Boulder, CO 80304
Phone: 303-447-1207
attentionhomes.org

Serves at-risk youth; offers shelter, community-based living and teaching of life skills necessary for an independent future

Boulder Shelter for the Homeless

4869 North Broadway
Boulder, CO 80304
Phone: 303-442-4646
bouldershelter.org

Provides overnight shelter in winter; other services including Transition Program and Morning Services available year-round

Emergency Family Assistance Association

1575 Yarmouth Avenue
Boulder, CO 80304
Phone: 303-442-3042
efaa.org

Provides food, housing, financial assistance, and additional supports for families in crisis

The Inn Between of Longmont

250 Kimbark Street
Longmont, CO 80501
Phone: 303-684-0810
theinnbetween.org

Affordable, time-limited transitional housing and case management services

Mother House

2041 Pearl Street
Boulder, CO 80302
Phone: 303-447-9602
mother-house.org

Provides shelter for homeless pregnant women 16 years of age and older; small rental payment required

OUR Center

303 Atwood Street (Intake Office)
Longmont, CO 80501
Phone: 303-772-5529
ourcenter.org

Provides shelter referrals, housing/rental assistance, food, clothing, and a variety of other supports for St. Vrain Valley families

Sister Carmen Community Center

655 Aspen Ridge Drive
Lafayette, CO 80026
Phone: 303-665-4342
sistercarmen.org

Family Resource Center offering comprehensive services to individuals & families in Lafayette, Louisville, Superior and BVSD part of Erie; provides direct financial assistance for rent and utilities along with resources and referrals to community housing and shelter programs

Safehouse Progressive Alliance for Nonviolence

24-hour crisis line: 303-444-2424
safehousealliance.org

Offers a safe shelter at a confidential location for individuals and families who are seeking refuge from interpersonal violence and/or elder abuse

Safe Shelter of St. Vrain Valley (Longmont)

24-hour crisis line: 303-772-4422
safeshelterofstvrain.org

Offers a safe shelter at a confidential location for individuals and families who are affected by domestic abuse

Some Statistics on Family Homelessness and Housing Cost

Boulder County Point in Time 2017 identified homeless families = 52 families with 157 people. 26% of homeless were in households with children.

McKinney-Vento students (PreK-12) School year 2016-17

St. Vrain Valley School District 631 children in (est.) 350 families

Boulder Valley School District 417 children in 265 families

1,048 children 515 families

Homeless Families with children under 5 only (estimated @ 25%) = 130

Average rent for 2-bedroom one bath apartment Boulder County September 2017 is \$1,566. Income required for this apartment to not be burdened @ 33% is \$56,376. 49.5% of all Boulder County Households spend > 35% of income on rent. Nearly three-quarters (72%) of renter households with one or more severe housing problems earn less than 30 percent of AMI.

2016 Census: Families in Boulder County with incomes

<**Poverty** = 3,520 = 10.1% of families

<\$35,000 = 10,138 families = 14% of families

(\$35,000 = approx. 150% poverty for family of four)

Countywide, 69.6% of rental units have two or more bedrooms.

There are 3,711 mobile homes in Boulder County (2016)

There are **waiting lists** or lotteries for public housing, subsidized rentals, most Housing Choice Vouchers. From BCHA: *In an effort to not give any false hope or expectations to residents in need, I want to make it clear that 1) our property waitlists are long and are vacancies are few and far between (and there's no opportunity to apply for our subsidized units at this time), and 2) that we have no vouchers or Short-Term Housing units available at this time. And we're not currently issuing Section 8 vouchers, and if/when we do, we'll be using applicants from a lottery we held just over 2 years ago. Sorry for the discouraging news – again, we want to make sure our capacity (or lack thereof) is communicated to residents in need.*

Sources: MDHI, school districts, Metro Denver Apartment Association, 2016 Census ACS

Family Homelessness Acronyms

BCHA	Boulder County Housing Authority
BHP	Boulder Housing Partners
BVSD	Boulder Valley School District
CFS	Community Food Share
CO WORKS	Colorado Works/TANF
CoC	HHS (HSP) Continuum of Care
EFAA	Emergency Family Assistance Association HHS Family and Children's Services (Child Protection, Foster Care)
FCS	
FRS	City of Boulder Family Resource Schools
FRT	HHS internal Financial Resources Team
FSS	HHS Family Self-sufficiency Program Project-based Sec 8
FUP	HHS FCS Family Unification Program
HSP	HHS Housing Stabilization Program
HSSN	HHS (HSP) Human Services Safety Net
LHA	Longmont Housing Authority
LIHEAP	HHS Low Income Heating Assistance
MHP	Mental Health Partners
OUR	OUR Center
SCCC	Sister Carmen Community Center
SNAP	HHS Supplemental Nutrition Assistance
SPAN	Safehouse Progressive Alliance for Nonviolence
SVVSD	St. Vrain Valley School District
TBRA	Tenant-based Rental Assistance
WIC	Public Health: Women, Infant, Children Nutrition Assistance

**BCDHHS Advisory Committee
January 2017 Meeting Packet**

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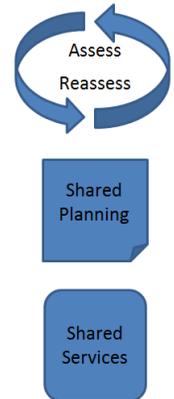
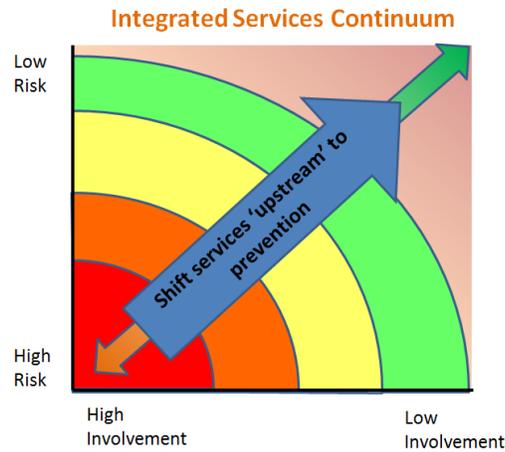
Department of Housing & Human Services

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

www.bouldercountyhhs.org

**Boulder County Department of Housing & Human Services
Advisory Committee
Monthly Meeting Agenda
Tuesday, January 31, 2017, 3:30 – 5:00 p.m.
DHHS Kaiser Building
Large Conference Room, 2525 13th St., Boulder, Colorado**

Vision: We are building a healthy, connected community that empowers people and strengthens families by confronting the root causes of crisis and instability.



Objectives for Today:

1. Vote on members to be added to the Committee
2. Identify additional members to be recruited for the Committee
3. Decide via vote on revisions on Amendment to By-Laws to include Family Resource Framework
4. Finalize the Membership and the Roles and Scope sections of the FRF Governance Charter

Agenda

1. Review and approval of today's agenda and above objectives (3:30 – 3:33 p.m.)
2. Review and approval of minutes from December 6th HHSAC meeting (3:33 – 3:35 p.m.)
 - a. **Decision point: Approval of minutes**

3. Recognition of Laura Kinder for her work with the committee (3:35 – 3:40)
4. Update on National Collaborative work—Frank (3:40 – 3:55)
 - a. Future integration efforts
 - b. Strategic planning work
 - c. Work with the new administration
5. Outcome of IHAD meeting with Lori Canova (3:55-4:05)
 - a. **Decision point: Identify and agree on next steps with IHAD/Dream Big**
6. Discussion of Amendment to Bylaws to include FRF governance language (4:05-4:15).
 - a. **Decision point: Do we want to change the name to Family Resource Network? Vote on addition of FRF(N) governance language**
7. Discussion and voting on members (4:15 – 4:25)
 - a. **Decision/Discussion points:**
 - i. **Vote on adding Edwina Salazar, OUR Center as a HHSAC Board Member.**
 - ii. **Identify additional members to add to the group.**

**See the Membership section of the Governance Charter document for recommendations.

8. Discussion and edits to the FRF Governance Charter (4:25-4:50)
 - a. Review feedback submitted by the group.
 - b. Discuss questions or concerns.
 - c. **Decision points:**
 - i. **Decide on addition of Local Area 4 for Mountain Communities and determine representation.**
 - ii. **Finalize the Membership and the Roles and Scope sections of the document.**
9. Review of agenda for next meeting(s) (4:50-5:00)
 - a. **Decision/Discussion Point: Start time of meetings for 2017**
10. Adjourn

Upcoming Meetings

Boulder County Housing & Human Services Advisory Committee Meetings —Tuesday, February 28, 2017, 3:30 p.m. (tentative). DHHS Kaiser Large Conference Room, 2525 13th Street, Boulder, Colorado

Boulder County Housing & Human Services Advisory Committee Meetings —Tuesday, March 21, 2017, 3:30 p.m. (tentative). DHHS Kaiser Large Conference Room, 2525 13th Street, Boulder, Colorado

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:
[Boulder County Housing Authority Board Packets](#)

[Boulder County Human Services Board Packets](#)
[Housing & Human Services Advisory Committee Packets](#)

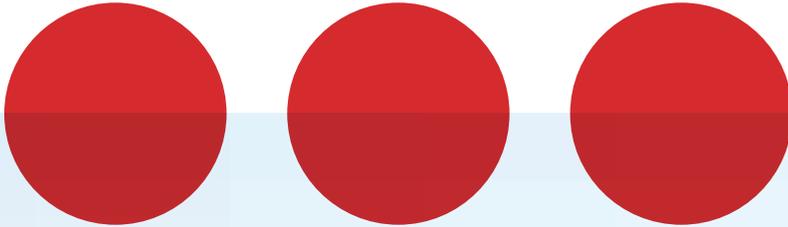
**Any member of the Public may speak on any subject related to Boulder County housing and human services. It is the policy of the Board to facilitate an orderly and respectful hearing where all points of view may be heard. Please keep comments to a maximum of 3 minutes. For more on addressing the Board, see the County's guide to public hearings:
<http://www.bouldercounty.org/doc/bocc/guidetopublichearings.pdf>

It is the policy of BCDHHS to make programs, meetings, activities and services accessible to individuals with disabilities. In order to provide special services such as interpreters or provide special materials in special formats such as large print, Braille, or computer disks the county needs to be informed of the individual's special needs. If you need special assistance contact Julia Yager, ADA Coordinator, or the Human Resources Division at 303-441-3508 at least 48 hours before the scheduled event.

La política de BCDHHS es hacer que los programas, juntas, actividades y servicios sean accesibles para gente discapacitada. Para poder ofrecer servicios especiales como interpretes o material en algún formato especial, como impresiones mas grandes, Braille, o disco de computadora, el condado requiere que le informen de las necesidades especiales de cada individuo. Si Ud. requiere atención especial, por favor comuníquese con Julia Yager, coordinadora del ADA o a la oficina de Recursos Humanos al 303-441-3508 cuando menos 48 horas antes del evento.



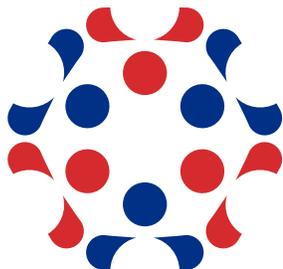
American Public Human Services Association



**National
Collaborative for
Integration of Health
and Human Services:
Promoting
Greater Health
and Well-Being**

Guiding Principles, Policy
Priorities, and Helpful Tools

**NATIONAL
COLLABORATIVE**
FOR INTEGRATION OF
HEALTH & HUMAN SERVICES



NOVEMBER 2016



American Public Human Services Association

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National Collaborative for Integration of Health and Human Services: Promoting Greater Health and Well-Being

Guiding Principles, Policy Priorities, and Helpful Tools

INTRODUCTION

For all of us, health and well-being are key factors to living well and having a prosperous life. Where we are born, the quality of our schools, the health and safety of our communities, the availability of jobs, livable incomes, and the levels of stress on ourselves, our families, and our colleagues are among the many factors that impact our health from a young age through adulthood and beyond. **Understanding how these determinants affect our health and well-being, and connecting them holistically to helpful supports along the way, are key to ensuring that each of us can achieve our full potential.**

A growing body of evidence shows that improved care and service coordination across multiple sectors, including beyond traditional health care services, has the potential to enable the achievement of improved health and well-being outcomes for families and communities. By connecting health systems, both physical and behavioral, with human service programs like energy assistance and nutrition supports, and public health programs like prevention efforts to reduce infant mortality rates – in concert with other systems touching the lives of all Americans like justice and education – we can leverage existing public care systems and make better use of taxpayer investments to ensure “upstream” or preventive supports are available to Americans across their lifecycle. **Human service programs and providers already in place are uniquely positioned to provide essential contributions to improving overall health outcomes if they are effectively linked to, and coordinated with, the traditional and evolving health system.**

The notion that good health is largely indicative of the **social and environmental determinants** that surround daily life experiences is becoming increasingly more apparent and recognized by multiple sectors. Research has shown that health care alone contributes only 10 to 25 percent to improving health status over time. What we do to *support* good health, such as promoting healthy eating and exercise, and our social and economic environments such as good jobs, quality child care, and a safe place to live, impact our health outcomes even more than medical care.¹ While the health system contributes significantly to well-being, more intentional efforts to coordinate human services with health will contribute greatly to better and more sustainable outcomes in individual, family, and community quality of life outcomes.

ASSESSING WHAT WE HAVE AND PLANNING FOR WHAT WORKS

For the Administration:

- Partner with APHSA to comprehensively define the scope and reach of the present health and human services ecosystem and map its needs and gaps.
- Support flexibility of federal agencies overseeing human service programs to conduct such assessments.

¹ The Institute for Alternative Futures indicates that health behaviors (30-40 percent), social and economic factors (15-40 percent), and physical environmental factors (5-10 percent) all have important roles to play in improving health outcomes. Institute for Alternative Futures. *Community Health Centers Leveraging the Social Determinants of Health*, 2012. Available at www.altfutures.org/leveragingSDH (Accessed June 25, 2014).

ARTICULATING A COMMON VISION OF INTEGRATED SERVICE DELIVERY

APHSA's National Collaborative for Integration of Health and Human Services² (the National Collaborative) has set out a vision for the health and human services public and private sectors to operate a system designed to provide a modern marketplace experience and to improve population well-being, while bending the health and human services cost curve over the next decade. This system would be anchored in seamless, streamlined information exchange, shared services, and coordinated care delivery and payment models that are person- and family-centered. Since its inception in 2011, the National Collaborative has supported state and local health and human service agencies and their partners in the community through guidance and tools to improve the customer experience and equitable opportunities to support individuals and families throughout their lives, to reconfigure access, and increase administrative efficiencies within the context of the evolving healthcare delivery system. With and through our members, the National Collaborative is advancing a number of initiatives that will improve policy, practice, and the collective impact that is possible through integration and alignment.

We know there is a correlation between improved health outcomes and enhanced investment in social services. We see it in other countries that spend less of their Gross Domestic Product on health (vs. social services) and have better health outcomes. We also hear it from sources like the World Health Organization³ and researchers in the field.⁴ Additionally, those on the front lines⁵ understand the need to address the social factors impacting health outcomes outside of traditional physical health care to impact community well-being.

What do we know about the existing systems and programs that were designed to impact social and environmental factors?

To truly understand what we know about existing systems, we need to ask the following questions to get a better sense of both the opportunities and potential roadblocks to integrating those systems more seamlessly:

- Do they still meet the needs of 21st-century individuals, families, and communities?
- What must change about policies, financial incentives, service delivery, and infrastructure to accelerate how they contribute to the shared outcomes we are setting out to achieve?
 - For example, attainment of sustainable employment, available quality child care, increased educational attainment, affordable housing, safe communities, reduction of chronic illnesses, access to quality and affordable physical and behavioral healthcare, access to nutritional foods, connecting to strong social support networks, alleviating toxic stress, and access to/attainment of affordable and quality preventive health care (including behavioral and physical health).
- Are we doing so in a collective approach inclusive of all stakeholders?
- How are these new roles, responsibilities, and payment mechanisms developed and supported?

We must start with a commitment by stakeholders across health care, human services, public health, and other sectors like justice and education, to acknowledge one another's value in this space and learn to speak each other's language.

2 For more information on APHSA's National Collaborative for Integration of Health and Human Services, a public/private partnership aimed to improve the nation's health and human services care networks, visit www.aphsa.org.

3 World Health Organization's Social Determinants of Health Unit. www.who.int/social_determinants/en/.

4 Elizabeth H. Bradley, Maureen Canavan, Erika Rogan, Kristina Talbert-Slagle, Chima Ndumele, Lauren Taylor, and Leslie A. Curry. "Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000-09." *Health Affairs* 35, No. 5 (2016):760-768; doi:10.1377/hlthaff.2015.0814.

5 Alliance for Stronger Children and Families. "Scanning the Horizons: Issue Brief 2, Social Determinants of Health". March, 2012. www.alliance1.org/sites/default/files/PDF/12-068_issue_brief_2.pdf.

We need to collectively envision and assess the full environment of human-serving programs to create upstream solutions making well-being attainable to everyone in our communities.

There is limited awareness of what is meant by “health” and by “human services” and the value and power of these systems—that when aligned—can impact population health and well-being. The

ALIGN EXISTING RESOURCES WITH THIS VISION

How can this be accomplished? As our collective understanding of the different systems begins to solidify and the connection points are more readily identifiable, we can develop standardized approaches, rethink workflows, and assure effective use of the technology required to support care coordination and integrated service delivery. To do so will require equitable investments in infrastructure, deliberate analysis of risk-sharing, redefining roles and responsibilities of workers, agreement on shared outcome and success measures, and rethinking how procurement and distribution of savings are conducted across programs and providers.

There are already many promising efforts, especially at the local and provider levels, aimed at reducing health costs and improving care. These examples, including utilization of less expensive medical treatments and coordinated care models that promote team-based care and efforts to connect people with services outside of traditional medical care to prevent high-cost interventions, like emergency room utilization or incarceration, are shaping how we improve our communities and connect our human serving delivery systems. Upstream prevention initiatives include housing-first models, where individuals are placed in housing units coupled with wraparound health and human services designed to reduce chronic homelessness and to help them back onto a path to self-sufficiency and well-being. Another example is crisis-intervention models where police are trained to identify and de-escalate mental health and substance use crises and

programs and services within these systems are complex and comprised of conflicting requirements and various touchpoints with multiple other services. This lack of understanding too often fosters distrust between and across stakeholders, which impedes the development of shared goals, risk, and care coordination. We must address this gap if we are to eliminate “turfism,” and create a seamless delivery system across sectors.

reconnect individuals with their existing health and human services care networks—enabling recovery rather than (continued) incarceration and, potentially, further decompensation.

Human service programs continue to incorporate evidence-informed interventions to strengthen their impact on individuals and families through approaches like multi-generational service delivery models, data-sharing across programs, and systems to establish a 360-degree view of people. Yet, these goals and intervention models are not adequately aligned with one another at the policy, program, or provider levels. Many times, in a rush to implement new payment, delivery, practice, or other reforms, reworking the business model across programs gets overlooked.

H/HS agencies at all levels of government and across sectors are working to shift from business-centric or program-centric models toward ones that put people, families, and communities at the core. Health care continues on a path toward modernization and rethinking its business processes to begin transforming to this client-centered approach, albeit somewhat in part due to statutory and other market forces. Human services, even though it lacks most of the same types of resources, is also taking advantage of this cultural convergence to rethink how it operates efficiently and effectively. This approach can allow multiple programs and sectors to build new connections through ensuring programs, data, providers, and funding channels are in place to address the social determinants of health and the

health determinants on one’s social environment—the determinants of well-being. State and local agencies are making important advancements to improve their operational efficiencies, program effectiveness, and coordinated care models by combining national frameworks, policies, and tools like the Triple Aim⁶, health care reform, and the National Collaborative’s Business and H/HS Maturity models.⁷ In conjunction with APHSA’s Pathways⁸ initiative and Harvard University’s Human Services Value Curve,⁹ states employ these blueprints to benchmark and implement paradigm and operational shifts in care delivery.

As we work toward seamless care coordination across health and human services, there are several opportunities for improvement across all human-serving programs and systems, including:



Data and Information Technology

States, localities, and service providers recognize that development of connected information technology systems and the ability to share data across programs are tools that enable them to further their efforts to administer and provide effective person-centered services. Many states are leveraging current opportunities, like modernizing their Medicaid Eligibility and Enrollment systems to also update the technology platforms of and connections to human service programs, or by creatively thinking about how to share data across programs and making the business case for resources to build out that capacity. Additionally, some programs have developed service-oriented architecture frameworks to assist in constructing their business and IT platforms.

Recent allowances and waivers have been of great assistance to state human service programs to modernize some of the IT functionality of their systems spanning across H/HS and other programs like education. The majority of states have been able to use the federal cost allocation waiver to upgrade and use IT and business components of health and human service programs such as Medicaid, SNAP, TANF, Child Care, and LIHEAP. Yet, there is still much work to do and other human service programs that could benefit from these upgrades and the potential connectivity to other programs servicing the same population. The more flexible rules associated with the cost allocation waiver have helped to bring eligibility and enrollment systems to a point where they are comparable to 21st-century technology, which helps to meet the needs and expectations of the workforce and of the people we serve. Nevertheless, additional flexibilities and equitable investments in IT modernization across all health and human service programs would help these programs better connect to one another, coordinate care, reduce operational costs, and improve program integrity.

6 Institute for Healthcare Improvement. The “Triple Aim” is a framework used to improve health care performance through improving the patient experience, improving population health, and reducing the cost of health care. www.ihl.org/engage/initiatives/tripleaim/pages/default.aspx.

7 www.aphsa.org/content/APHSA/en/pathways/NWI/BUSINESS_MODELS/h-hs-integration-maturity-model.html.

8 www.aphsa.org/content/APHSA/en/pathways.html

9 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. www.lnwprogram.org/sites/default/files/The_Pursuit_of_Outcomes.pdf

There are still issues around consent, privacy/confidentiality, data governance, and capacity of the workforce to be able to implement effective analytic strategies. States, localities, and providers still struggle with different interpretations and guidance provided by federal agencies around what is and is not allowed to be shared. There is real inconsistency between the messaging promoted at the federal level around how improved data sharing and interoperability can enable integration and the lack of alignment in practice with existing federal legislation and regulations across programs. These, as well as inconsistent interpretations across federal agencies (including at the regional office level) and in some cases contiguous state laws, create barriers for streamlining administrative processes (e.g., procurement, contract management, audits), program integrity, and shared outcome achievement that could begin to shift culture and design of coordinated service delivery models to be developed through a more intentionally aligned approach.

States and localities have to consistently revisit federal laws around these issues to dispel data sharing myths in an effort to move their jurisdictions and agencies beyond a risk-based paradigm and siloed approach to ones that emphasize the role data plays in the achievement of shared outcomes.

Additionally, the landscape of IT continues to evolve. Cybersecurity, the movement to a cloud-based infrastructure, and increasing utilization of agile solutions for state systems are becoming more prevalent across public-sector health and human services. Different programs have different IT-related requirements, so it is critical to understand these different requirements and know how consumers and the workforce are impacted by them.

While these considerations and approaches are being implemented in programs like Medicaid and child welfare, many related human service programs are not part of the conversation, which provides challenges for states when trying to modernize, connect, and re-use solutions.

DATA AND INFORMATION TECHNOLOGY

For the Administration:

- Support permanent or at least extended waivers to existing regulations allowing states the flexibility in how to cost allocate the development, build, and maintenance/operations of cross-programmatic IT systems being tailored to the realities of their agencies
- The federal Department of Health and Human Services should be the "single source of truth" for data sharing allowances across programs to obtain one official legal interpretation of what is permissible. Based on these single interpretations, there should be disallowances of state or local rules as to why data sharing cannot happen
- HHS should continue to build out the Confidentiality Toolkit to include a focus on physical, behavioral, and public health
- Dedicate resources to build out the National Human Services Interoperability Architecture
- Align IT procurement and development approaches across HHS and USDA

For Congress:

- Pass legislation and appropriate equitable investments enabling human services to modernize their IT comparable to recent investments in health
- Align data sharing and access requirements and capabilities across privacy and confidentiality statutes across health and human service programs
- Prioritize alignment and automation of operations

Funding and Programmatic Alignment

Many of the current health and human service silos are a direct result of decision-making based on federal funding streams, which are complex and constrained by limited flexibility to target dollars resulting from current cost allocation methodologies and narrow programmatic requirements. They are not aligned at the federal – and many times at the state – levels, which creates reporting and service delivery environments that do not allow for seamless coordination across sectors and shared outcomes to improve community well-being. People could benefit from receipt of services in a more consistent and coordinated manner if state and local jurisdictions are allowed to invest and distribute dollars in more flexible ways – that focus on upstream, preventive services to mitigate adverse effects downstream and to ultimately improve economic, social, and health opportunities.

Many philanthropic organizations are looking to invest in communities focused on developing and embedding integrated service delivery. However, many such community resources cannot be used toward the local or state match, which is

a disincentive to both community funders and the agencies. The standard approach to testing innovating approaches is typically through waivers and grants that require sustainability paths, yet few resources are provided to assist in building the necessary capacity to sustain the initial effort. As a result, this often prevents efforts from being scaled and generates frustration among both administrators and the workforce.

Rules for allocating staff time to funding streams must be redesigned to support blended and braided funding approaches and other targeted, flexible ways of using federal support where it is most effective. Redirection of resources and staff time – and thus continuation of scaling successful innovations – should also be promptly allowed as soon as demonstration projects or waivers show positive results.

As care delivery and payment models begin to focus more on what may work best for people at a given point in their lifespan – as opposed to only what they are eligible for at a given moment – we must develop proactive financing mechanisms that support this preventive, upstream approach to impacting human

FUNDING AND PROGRAMMATIC ALIGNMENT

For the Administration:

- Demonstrations, like the Disconnected Youth Pay for Performance Initiatives, should be sustained and developed to have a broader reach for different populations.
- Federal agencies overseeing health and human service programs must intentionally work together to align elements of the programs and funding streams where possible.
- Regulatory bodies should begin using a cross-programmatic lens to screen regulation promulgation across policies, especially when they are impacting

populations served by multiple programs, departments, and agencies.

- Federal agencies should establish incentives and further enforce cross-collaboration in the regional offices and states to foster integrated and aligned approaches to service delivery.

For Congress:

- Increased need for human service programs to shift towards automation of processes – e.g., in SNAP through the next Farm Bill.
- Committees of Jurisdiction overseeing health and human service programs must intentionally work together to align elements of the programs and funding streams where possible.

potential. At the program administration level where multiple agencies are working with the same person or family, **we must consider the same types of financial and accounting allowances for service delivery that are available for IT development across programs.**

Measures and Accountability

One significant challenge in measuring holistic outcomes is how to quantify facets of someone's life that continue to shift and are often impacted by unexpected life events that may or may not be related to any one specific health or human service program. Take, for example, someone who loses a job and their home. Even if the system quickly identifies new housing for them, if they remain unemployed, this could have a profound impact on their psychological well-being – and of which could impact their physical health. Even though one “social determinant” has been met (housing), the stress placed on someone who has temporarily lost another “social determinant” (employment) is still difficult to quantify in terms of how medical care currently measures, pays, gets reimbursed, and shares savings for achieving improved health outcomes.

There is a lack of holistic outcome measures across programs – typically characterized by different eligibility and verification standards, definitions, and time frame models – and consequently, a strong need to develop definitions for standardization and alignment of measures across programs. Different languages and labels for measures across agencies should be consolidated. Each program does have its own unique needs but there are commonalities. For example, some common measures across programs that touch the lives of Americans may include improved behavioral health care access; reduced interaction with the child welfare or justice

system; lower incidences of domestic violence; attainment of affordable housing and reductions in homelessness; increased educational attainment; access to nutritional food; and the reduction of teen pregnancy. Each of these measures reflects connected environments that enable successful outcomes across programs and supports aimed at ensuring all Americans can live to their full potential.

These would be success measures of improved care coordination in general but true partnership and non-duplicated efforts are most often absent – most notably in the policies and research that shape the design and delivery of services. In existing and transforming human-serving care systems that share the same goals – the health and well-being of individuals, families, and communities – there is a lack of communication and alignment of service delivery and payment design, which exemplifies the deep disconnection between core elements and functions of our care delivery network.

MEASURES AND ACCOUNTABILITY

For the Administration:

- Allow health and human services align goals and measurement across all programs to focus on safety, economic security, and sustainable well-being
- To move from measuring process to outcomes, federal agencies need to develop a comprehensive monitoring approach

For Congress:

- Align outcomes, eligibility requirements, definitions, and accountability mandates for human service programs with health services (e.g., SNAP in the next Farm Bill)



Research and Adequate Investments in Human Services

These have lagged behind those in the health sector over the past decade. This has made it difficult to study, measure, and therefore scale evidence-based or -informed social interventions. In the evolving context of value-based payment on the health care side, this lack of information adds another level of complexity. The value of human services is real but difficult to measure and, many times, is measured differently than in quantifiable data. How do we know where savings on reductions in health care costs and improved outcomes are attributable to specific social interventions?

This question must be pursued within the historical presence of human services in communities, the deeply embedded trust citizens have for the social serving non-profit organizations serving them, services provided beyond eligibility and referrals, and the reality of the under-resourced and highly regulated environment in which human service programs operate.



RESEARCH AND ADEQUATE INVESTMENTS IN HUMAN SERVICES

For the Administration:

- Allow for flexibility to test and demonstrate numerous new models of care, financing, and outcome measurement across health and human service programs and providers

For Congress:

- Invest in comparable research for what works best in human services programs as a means to sustainably improve economic, health, and social opportunities

IN CONCLUSION

Human services, **and its companion sectors and partners at all levels of government**, are uniquely positioned to design and support new approaches to service delivery that can significantly support better health and stronger individuals, families, and communities. Human service resources – along with health care, public health entities, and others already strategically located throughout communities across the country – can play a major role in preventing and mitigating serious downstream health and well-being issues like inadequate employment, mental health and substance (mis)use, heart disease, diabetes, and other adverse social circumstances.

Our opportunity to rethink how we are collectively impacting the lives and potential of all Americans is now. We must continue to create healthy communities by strengthening relationships within the H/HS enterprise and working with others outside the H/HS enterprise to address complex social and health challenges. We must continue engaging individuals and families throughout the H/HS enterprise by accurately assessing current and future needs. Both customer and system behaviors and interactions serve as catalysts for achieving shared outcomes defined collectively by the local and larger H/HS.

The American Public Human Services Associations and its members, the nation's public human service agencies, are creatively generating solutions that lift individuals toward independence, add value to communities, strengthen families, and achieve more at less cost. We do this through dynamic leadership, path-breaking partnerships, innovation, alternative funding models, and breakthrough technologies that are transforming human services into a system that creates community-wide change and supports meaningful and sustainable outcomes. As we prepare for a new Federal Administration and new Congress, APHSA offers this series of Pathways policy briefs outlining our plans for continuing improvement and sustainable progress in this critical area of national life.

Additional details on APHSA's National Collaborative are available at: www.aphsa.org/content/APHSA/en/pathways/NWI.html.



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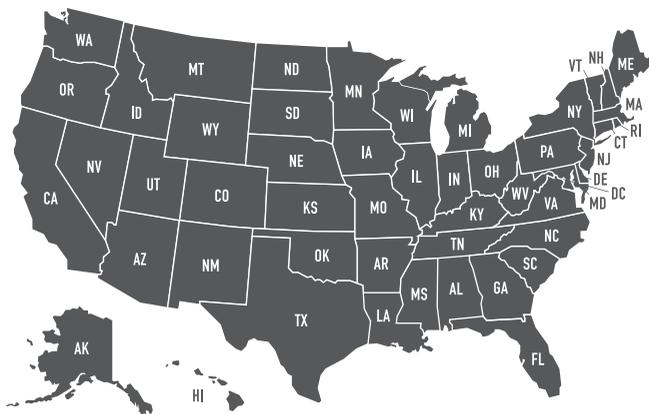


American Public Human Services Association



Creating a Modern and Responsive Health and Human Services System

A Report to Federal
Policymakers on the
Evolution and
Transformation of the
Nation's HHS System:
Guiding Principles, Policy
Priorities, and Helpful Tools



NOVEMBER 2016



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Creating a Modern and Responsive Health and Human Services System

EXECUTIVE SUMMARY

Health and human serving system leaders are discarding the old ways of doing business in favor of new approaches that are innovative, efficient, effective, and responsive to the needs and demands of a dynamic and rapidly changing society. We are rejecting one-size fits all programming in favor of outcome-focused services informed by population-based data, whole family approaches, and advances in brain and behavioral sciences. We are shifting from a reactive and crisis-oriented services delivery model to one that focuses “upstream” and better enables all of us to live to our full potential and to more effectively identify and address root causes when we do encounter roadblocks along the way.

As health and human services (H/HS) leaders,¹ we share a core belief that all of us should have the opportunity to live healthy lives and be well regardless of where we live, what our histories are, or what our life experiences have been. The nation’s H/HS system is a cornerstone to building a strong, dynamic, and healthy nation. In coordination with other “human serving” systems – including education, employment, and justice – we can provide all Americans with the opportunities and tools to live well and build a sustainable future for ourselves and for our families.

As leaders, we also recognize that to achieve this desired state, we must evolve our H/HS system from a traditional “regulative model” rooted in regulatory compliance and programmatic outputs, to a “generative approach” that works seamlessly across sectors and engages whole communities in addressing the multi-dimensional socioeconomic issues that its families face. In this paper, we will introduce you to the multi-year efforts of H/HS

leaders around the country to drive system change. We will share our guiding principles, captured in our members’ *Pathways* initiative, and introduce you to the Human Services Value Curve, a framework and tool by which H/HS agencies are charting progress, catalyzing community resources and partnerships, and focusing efforts on outcomes.

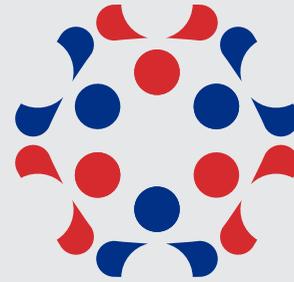
Our belief is that the time is ripe for significant leaps forward in creating a modern, nimble H/HS system that leads to stronger, healthier families and communities. We believe the new Federal Administration and Congress must be partners in this effort and can pull key policy and fiscal levers to accelerate the change. As national policymakers, you are uniquely positioned to play a pivotal role in promoting innovation at all levels of government; further improving the interoperability of systems and the use of technology; fostering economic advancement through employment; promoting the well-being of children and parents together; and providing critical bridge supports across the life span.

As explained in more detail in this paper, and in a number of our prior publications, health and human services agencies are already leveraging a number of current opportunities, including alternative funding models, breakthrough technologies, and path-breaking partnerships to find new solutions to old problems. Passage of the Workforce Innovation and Opportunity Act in 2014 and clarifying regulations in June of 2016 present an extraordinary opportunity by bringing six different employment programs within numerous agencies into harmony, and encouraging further alignment of work-related services with Temporary Assistance for Needy Families (TANF) and low-income supports. Similarly, systems that deliver

¹ This paper is presented on behalf of the members of the American Public Human Services Association. We are a bipartisan, nonprofit membership organization representing state and local human service agencies through their top-level leadership. APHSA has been working to improve public health and human services for over 80 years by collaborating with state and local agencies, partners and national policymakers to promote effective policies and innovative strategies. Through this paper, it is APHSA’s goal to help you, federal policymakers, shape future policy around and for the nation’s H/HS system.

program benefits are becoming more integrated due to the availability of federal matching funds that help to align many elements of IT systems for Medicaid, TANF, and the Supplemental Nutrition Assistance Program (SNAP). New data sharing arrangements with the Social Security Administration are on the horizon. H/HS leaders are also focusing on person- and family-centered services and public-private partnerships that are bridging the gaps between government and other sectors so that common resources and strengths can be leveraged on behalf of all Americans.

H/HS leaders know, however, that system transformation is not simply about aligning service delivery, integrating data systems, leveraging technologies, or applying family-centered approaches; it is ultimately about shaping a new ecosystem across sectors and systems that create efficiencies and lead to better outcomes. To drive these larger systemic changes, we believe we must focus on three major outcome-areas: (1) child and family well-being, (2) employment and economic well-being, and (3) improved population health. This paper explains why each of those outcome areas is key to generating a modern and responsive H/HS system that is not only efficient and cost effective but leads to improved well-being for all Americans. In addition to this paper, in a series of jointly- (and to be-) published policy briefs, we provide more detailed recommendations in support of these modernization efforts. As an immediate takeaway, our hope is that national policymakers will better understand the opportunities before us, invite H/HS leaders in our membership network to share their on-the-ground experiences, and join with us on this *Pathways* journey by enabling the policy and fiscal levers that can accelerate our path forward.



**NATIONAL
COLLABORATIVE**
FOR INTEGRATION OF
HEALTH & HUMAN SERVICES

APHSA COLLABORATIVE
American Public Human Services Association CENTER



CCFWB

Center for Child and Family Well-Being

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American Public Human Services Association CENTER



CEEWB

Center for Employment & Economic Well-Being

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Creating a Modern and Responsive Health and Human Services System

OVERVIEW – THE *PATHWAYS* INITIATIVE

For the past several years, the nation's public H/HS system has engaged in an effort to steadily move toward a modern, outcome-based, client-centered system that is designed to strengthen families, create opportunities for sustained economic independence, and increase the overall health and well-being of all Americans. Developed by H/HS leaders across the country in 2011, *Pathways: The Opportunities Ahead for Human Services*,² has become the roadmap for a reimagined health and human services system. Through a clearly articulated desired future state and a set of guiding principles, *Pathways* now encompasses a series of policy positions, practical guidance, and examples of innovative solutions to chart a meaningful course and drive system transformation. Utilizing a range of innovative strategies drawn from the on-the-ground experience of families, science, business, academia, and philanthropy, H/HS leaders are transforming the nation's public H/HS system from one that relies on outdated practices and archaic business models to one that is based on evidence-informed practice and is more responsive to the individual needs of families and communities. New methods for engaging and empowering families, advances in information technology, improved collaboration across services and sectors, and program alignment have fostered unprecedented efficiencies and have enabled public and private H/HS organizations to knit multiple resources together to create services that are more outcome-oriented and client-centric.

Embedded in this transformation process is the drive to move up what has become known as the Human Services Value Curve (Value Curve).³ The Value Curve is a lens through which we collectively envision the transformation of health and human services and

PATHWAYS GUIDEPOSTS

We envision a modern, nimble H/HS system that is focused on:

- Person- and family-centered services designed to engage in meaningful ways with families up front and deliver the right services, at the right time, and for the right duration
- Modern, efficient business solutions and customer connections that draw from the best innovations in government and the private sector
- Data-reliant and evidence-informed programs that can achieve better, faster results, provide more targeted interventions, and reduce costs
- Application of decades of research in brain science and understanding of executive functioning to improve the ways we engage and empower families
- Accountability for sustainable outcomes, return on taxpayer investment, and impacts that matter rather than for compliance with processes and outputs
- Generative partnerships that bridge traditional divisions both within government agencies and across the public-private sectors, and that leverage common resources and strengths
- Widespread testing to spark innovations and prompt implementation of what works.

² APHSA, The Pathways Initiative, <http://www.aphsa.org/content/APHSA/en/pathways.html>

³ The Human Services Value Curve was developed by Antonio Oftelie, PhD, Fellow, Technology and Entrepreneurship Center at Harvard and Executive Director, Leadership for a Networked World, Harvard School of Engineering and Applied Sciences, Cambridge, Mass.

provides a shared path by which H/HS professionals can lead system change to achieve improved outcomes for families and communities. It, along with a growing set of tools, provides a well-marked roadmap for improving outcomes and the value and legitimacy of human services through the lens of four different business models: regulative, collaborative, integrative, and generative.⁴

Now widely adopted by jurisdictions across the nation (and internationally), the Value Curve is a guiding framework in the field for understanding the enablers and barriers to designing a generative system where solutions are developed with and through families and communities. The four stages of the Value Curve are like well-marked signs along the way to help agencies regularly assess progress

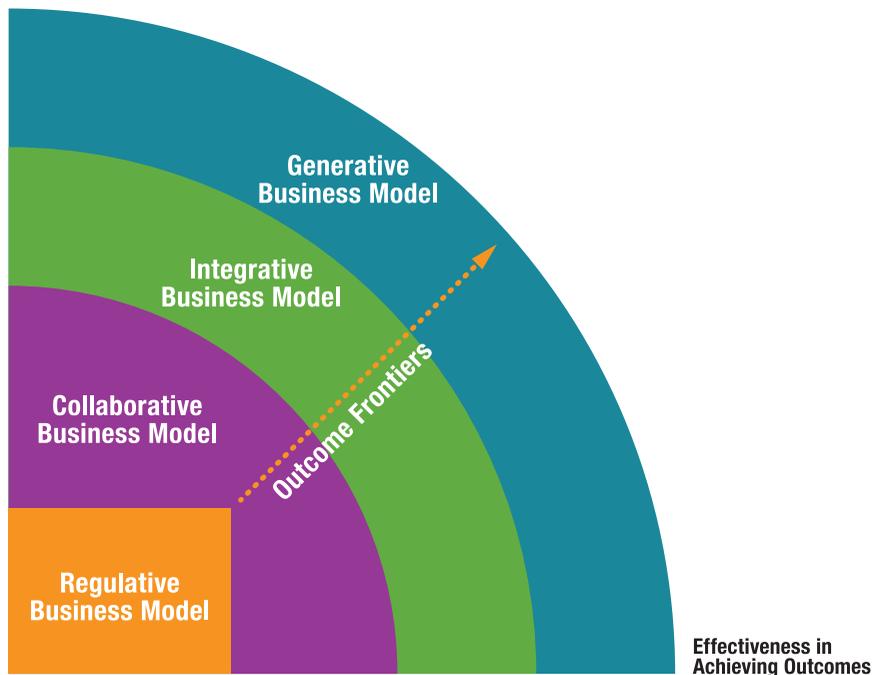
and make mid-course adjustments. Ultimately, Value Curve progression is about realizing the full potential of people and systems so that all of us can live well.

This transformation takes time and is an iterative, multi-faceted process. It has required public H/HS leaders to ensure a strong foundation (through the regulative and collaborative stages) by focusing on the alignment of programs, the modernization of service delivery, the development of the workforce, and the effective use of knowledge management techniques.

Transformation has also required that federal, state, and local governments work more seamlessly together and that the federal government provide flexible fiscal and policy levers that enable states and localities to innovate and tailor services based on

HUMAN SERVICES VALUE CURVE

Efficiency in
Achieving Outcomes



GENERATIVE

Using a population-based health and well-being approach to find solutions that get at root causes and are implemented collectively with families and communities.

INTEGRATIVE

Working across sectors to address problems at their root through data analytics and a customized service array.

COLLABORATIVE

Working towards a single-door approach to link services across programs and agencies, easing access and reducing duplication.

REGULATIVE

Accurate and timely administration of programs to assure compliance and integrity; focus on efficiency and accountability for proper use of funds

Effectiveness in
Achieving Outcomes

© Leadership for a Networked World. 2011. 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.

⁴ The Toolkit for the Human Services Value Curve may be found at: http://www.aphsa.org/content/dam/aphsa/pdfs/Resources/Publications/TOOLKIT_Moving%20through%20the%20Value%20Curve%20Stages_.pdf

the specific needs within their communities. H/HS leaders at all levels must be in tune to the converging opportunities that can accelerate this change; we refer to these as the “six agents of change”:⁵ leveraging integrated policy, maximizing modern platforms, creating space for innovation, investing in outcomes, applying science, and partnering for impact (more on this below).

CONTEXT SETTING – THE NATION’S HEALTH AND HUMAN SERVICES SYSTEM TODAY

The Current Ecosystem

Human services is a complex system of “human serving” programs and services.⁵ It appears in different combinations and configurations as you move from one state to the next, and often from community to community, which adds to the challenge in concisely defining it. We increasingly refer to the system through the broader lens of the **health and** human services system as the nation strives to strengthen the connection of what have historically been two distinct systems of care. Despite this complexity, it is helpful to recognize a common thread that runs through the system: the nation’s H/HS system incorporates a wide range of services aimed at enabling all Americans, regardless of their zip code, to have the opportunity to live to their full potential.

Generally, these services help mitigate situations that all of us may weather at some time during our lifetime, especially those that may interfere with our ability to remain self-sufficient, such as losing a job, getting sick, or losing our home. During times of financial difficulty, human services provide bridge supports so that parents can continue to ensure their children have food, shelter, and quality child care. Human services provide connections to employment and to housing – keys to overall economic well-being.

Before moving forward with a discussion of the specific ways this transformation has taken place and can be accelerated, we provide some context on what the H/HS system entails. Following this brief description, this paper will focus on the levers that H/HS leaders are pulling to achieve change and our shared policy priorities.

Human services help assure the safety of our children through protective services and provide key supports for people with disabilities to help assure their full integration into the community.

It is the very services provided by this country’s human serving network that hold so much potential for improving overall population health and well-being, especially if we can more intentionally apply whole family approaches and link them to education, housing, health care, and labor. At its core, H/HS is grounded in the social determinants of health – nutrition, affordable and safe housing, quality child care, supportive work environments, violence prevention, etc. If we can assess family strengths and risk factors up front in the community settings in which we all live, we can shift the impact of human services “upstream” and reduce reliance on government supports. As more fully explained below, the time for doing so is now.

We also know that the current system has not made the strides we believe it should. While this paper is not designed to provide a detailed analysis of the current outcomes for children and families in this nation, we all know that the statistics are not nearly what they should be for the United States. For example:

⁵ Specific examples of the types of services human service agencies may provide include temporary financial assistance; employment supports; vocational rehabilitation supports; nutrition assistance; home energy assistance; early childhood education; child care; child welfare services including protective services, foster care, and adoption; youth supports (both preventative and juvenile justice); supports for people with disabilities; aging supports including abuse against the elderly; housing and homelessness supports; domestic violence prevention and intervention; and support to military families, among many others; on the health care side, in addition to traditional health care, services may include behavioral health, including mental health and substance abuse treatments; Medicaid enrollment; public health; vaccines and immunizations; and home health care.

The U.S. ranks 30th among industrialized nations for the number of children living in poverty; only Greece, Mexico, Israel, and Turkey have higher child poverty rates than the U.S.⁶ According to the United States Census Bureau, 43.1 million people (13.5 percent) currently live in poverty, including 14.5 million children (20 percent) under the age of 18,⁷ and almost 40 percent of American children spend at least one year living in poverty before they turn 18.⁸

42.2 million Americans live in food-insecure households, of which 13 million are children.⁹ “Persistently poor children are 13 percent less likely to complete high school and 43 percent less likely to complete college than those who are poor but not persistently poor as children.”¹⁰

As noted in the 2016 Kids Count Data Book,¹¹ which captures key data in this nation as to child well-being, inequities among children of color continue to persist. On nearly all of the measures that the Data Book tracks, African-American, American Indian and Latino children continue to experience negative outcomes at rates higher than the national average. For example, African-American children are twice as likely to live in high poverty neighborhoods and to live in single-parent families. American-Indian children are twice as likely to lack health insurance coverage, and Latino children were the least likely to live with a household head who has at least a high school diploma.

Adults living below the poverty line are significantly more likely to be in fair or poor health. Nearly one-quarter (23 percent) of all adults living below poverty report fair or poor health, compared with seven percent of adults whose income is four times above the federal poverty level or more reporting fair or poor health.¹²

Nearly 1 in 10 million Americans live with a serious mental illness and 1 in 5 will experience a mental illness in a given year.¹³ 21.7 million people aged 12 or older needed substance abuse treatment over the past year.¹⁴

Adults and children living in poverty experience significant levels of homelessness. Nearly 65,000 families with over 120,000 children live in shelters or are unsheltered¹⁵ and in the course of a year at least 253,000 school children are unsheltered or live in homeless facilities. Another 1,107,000 have no permanent place to live.¹⁶

These are just a few national data points that speak to the need for modernizing and aligning H/HS systems.

The External Landscape.

Consider just a handful of the external factors impacting the terrain that H/HS leaders must maneuver every day:

- widespread frustration and distrust in government at all levels;
- shifting demographics, including an aging population that is living (and working) longer than ever before;
- the impact on communities across the nation of pervasive mental health conditions affecting millions of Americans;
- increasing misuse of opioids resulting in more people now dying from overdosing than automobile accidents;
- the ubiquitous use of mobile and app technology;

6 Organization for Economic Co-operation and Development (2016), Poverty rate (indicator). doi: 10.1787/0fe1315d-en (Accessed on 02 November 2016)

7 United States Census Bureau, Income and Poverty in the United States: 2015, September 13, 2016. Report Number: P60-256, Bernadette D. Proctor, Jessica L. Semega, Melissa A. Kollar

8 Caroline Ratcliffe, “Child Poverty and Adult Success”, Urban Institute, Washington, DC, September 2015

9 United States Census Bureau, Income and Poverty in the United States: 2015, September 13, 2016. Report Number: P60-256, Bernadette D. Proctor, Jessica L. Semega, Melissa A. Kollar

10 Caroline Ratcliffe, “Child Poverty and Adult Success”, Urban Institute, Washington, DC, September 2015

11 2016 Kids Count Data Book, the Annie E. Casey Foundation, <http://www.aecf.org/resources/the-2016-kids-count-data-book>

12 J.S. Schiller, J. W. Lucas, and J. A. Peregoy. 2012. “Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2011.” Vital and Health Statistics 10 (256): Table 21. http://www.cdc.gov/nchs/data/series/sr_10/sr10_256.pdf

13 National Alliance for Mental Illness, Mental Health By the Numbers, <http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>

14 2015 National Survey of Drug Use and Health, <https://nsduhweb.rti.org>

15 U.S. Department of Housing and Urban Development. 2015 Annual Homeless Assessment Report to Congress: Part 1 - PIT Estimates of Homelessness in the U.S. November 2015. <https://www.hudexchange.info/resource/4832/2015-ahar-part-1-pit-estimates-of-homelessness/>

16 <http://eddataexpress.ed.gov/data-elements.cfm/gid/62>

- the emergence of the sharing economy (e.g., Uber and Airbnb);
- the ability to capture big data and rapidly synthesize it into bite size pieces of meaningful information.

Given this rapid pace of change, the need for a modern, nimble H/HS system is paramount. H/HS leaders believe we are at a “point of inflection” – a point at which changes in the external environment are so significant that current modes of operating achieve diminishing returns; the choice is to either change as an industry or become irrelevant.

Leadership Matters

While policies, resources, and tools are essential, how leaders govern and prepare our agencies remains a bedrock requirement for successful transformation. The ever-changing landscape of H/HS requires leaders to be highly adaptive and to foster a culture of innovation and continuous improvement within their agencies. Today, there are numerous examples of this adaptive leadership at all levels of government and in the extended social serving network (both non-profit and private industry) that embodies the larger human serving system. Through our innovations map, we have captured many stories of innovation, practical solutions, and evidence-informed practices generated within agencies with such forward-leaning leaders.¹⁷

Your Role as Federal Partners

As Federal policymakers, you play a key role in driving system transformation. The choices you make in adjusting policy and fiscal levers can be major accelerants and barrier busters for the change we all seek. Modernization of the H/HS system requires that together we identify the enablers and barriers to drive better outcomes and generate an adaptable, nimble ecosystem that can catalyze our collective efforts.

Together we can accelerate change with your leadership by:

- Removing structural obstacles to innovative funding approaches, especially those that braid and blend funding from evidence-informed programs and across related sectors;
- Promoting efforts to embed and integrate two generation approaches and the social determinants of health into prevention and early intervention strategies that help us get at root causes;
- Aligning federal funding to what we know works for children and families, with a particular focus on creating a more seamless system of services;
- Promoting use of demonstrations and waivers to spark innovation and learning;
- Recognizing the central role of work to our overall well-being and therefore supporting sustainable and career-based employment outcomes for those not connected to the world of work;
- Allowing states, and by extension, local jurisdictions and the social serving networks that deliver services on the ground to use performance rather than process-oriented measures (such as those required by the current TANF work participation rate);
- Fostering partnerships with the private, university, and philanthropic sectors that generate solutions for better population-based health and well-being and ways to break the cycle of generational poverty.

Within this framework of federal incentives and innovations is an understanding that states and localities must develop new and innovative service models that are evidence-informed and accountable to families, to our own communities, and to the nation.

¹⁷ APHSA Innovation Center – Stories from the Field – Interactive Map

Converging Opportunities

Over the course of the past few years, we have worked with H/HS leaders to leverage what we see as six converging opportunities for system transformation. As explained more fully below, the conditions are ripe for major advancements based on how these factors and trends are converging and what H/HS leaders are actively doing to leverage them. Taken together, these are the key catalysts for significant advancements:

Leveraging Integrated Policy – For too long, federal and state policies governing H/HS have remained siloed, complex, and out of sync with each other and with the realities of modern families. In recent years, there has been significant movement to reduce needless policy differences and conflicts among programs and agencies; share needed information across agencies and sectors while protecting privacy; use funding to align with real needs and priorities rather than with narrowly defined and outdated categories; and secure policy and funding options that deliver real results. These efforts must be continued and accelerated; federal agencies play a central role in ensuring that integrated policy is the new norm and not the exception.

Maximizing Modern Platforms – H/HS must have a sound infrastructure - particularly the technology and business processes that support our work. Outdated legacy systems and governance structures are being replaced with the latest business process reforms and tools such as apps that support modern customer access; aligned business processes that enable modern service delivery; and new workforce capabilities and incentives that respond to modern demands, ensure a diverse workforce, and develop a robust talent pipeline by attracting a new generation to the public sector.

Creating Space for Innovation – Modernizing and transforming H/HS will succeed only through learning what innovations can best improve service delivery, practice models, and business processes and then rapidly implementing and scaling those that work. “Innovation labs” must become widespread

throughout the H/HS system along with research and development; including the consumer’s voice in driving change and using human centered design to quickly reimagine service delivery; establishing formal innovation funding offices at all levels of government; and learning from reform efforts in other countries.

Investing in Outcomes – Identifying, scaling, and funding what innovations work best will ensure sustained and meaningful outcomes. Tools that can facilitate this include data-driven reporting tools; transparency in reporting; predictive data analysis; “rapid cycle evaluation” that quickly adjusts and continuously improves program design; and outside “social impact financing” that underwrites positive and cost-effective changes. Data sharing, data use, and data analytics are creating a more agile, responsive, and accountable human serving system. Promptly testing new approaches to service delivery, analyzing results of those changes based on real-time data, mastering the skills of converting data into intelligence, shifting governance structures to meet this outcome-focus, and making well-informed adjustments to practice and service delivery design are all key to achieving the impacts we must have.

Applying Science – H/HS is increasingly applying advances in science that can shape innovative and effective approaches to the work of H/HS leaders. New developments in brain science, executive functioning, trauma-informed care, and behavioral economics are particularly important for those under the severe stress that results from low income and multiple environmental challenges. New understandings of communication tools and strategies through “framing science” are also helping to provide effective messages and to demonstrate how H/HS impacts both families and the broader society.

Partnering for Impact – H/HS leaders know that agencies must establish new and often non-traditional alliances to successfully transform systems. This “co-creation” of new and more effective joint initiatives is characterized by shared ownership in measuring and articulating desired impacts and by increasing dynamic and outcome-driven public-private partnerships.



**Leveraging
Integrated
Policy Levers**

- Use of population-based health data / Social determinants of health
- Adoption of two generation / Whole-family approaches
- A widely shared belief that employment is an engine to economic mobility
- Focused national attention on reducing youth and family violence



**Maximizing
Modern
Platforms**

- Application of advanced analytics to inform decision-making
- Reuse opportunities in shared platforms and open data sources
- Continued focus on interoperability and IT support for integrated H/HS systems / Data-sharing



**Creating Space
for Innovation**

- Increased grant opportunities that are designed to incentivize innovation and generate solutions
- All levels of government repurposing resources to spur innovation and create a cultural environment that encourages creativity and a safe space for testing new ideas



**Investing in
Outcomes**

- Increased willingness to explore alternative financing mechanisms
- Bipartisan support for pay-for-success approaches
- Incentives aimed at increasing evidence-informed and evidence-based practices
- Application of rapid cycle experimentation and other modern approaches to research that accelerates adoption of what works



**Applying
Science**

- Deliberate application of brain science and executive functioning research to redesign service delivery models
- Use of motivational interviewing and trauma-informed care approaches to inform family engagement strategies
- Use of behavioral insights to design and test behavioral interventions
- Applying implementation and systems science to understand what it takes to align and integrate systems toward measurable outcomes



**Partnering
for Impact**

- Greater synchronization across public and private sector efforts
- Increased effort to leverage the expertise, reach and nimbleness of the non-profit, social-serving sector as well as for-profit industry/ employers
- Application of collective impact strategies

HEALTH AND HUMAN SERVICES POLICY PRIORITIES

Policy Priority 1: Building Well-Being for All Children and Families

The goal is to help children and their families realize their full capacity and potential, and interact successfully within their community. We know that we are best able to do so when we are physically, socially, and emotionally safe. We also know that these conditions do not occur in a vacuum but rather depend on one's family, school, and community and the larger society in which one lives. If H/HS programs are to successfully enable children and families to realize their full capacity, we must take into consideration the environmental factors that impact (and possibly threaten) their trajectory. To do so, H/HS systems are increasingly applying two generation approaches to serving the whole family and incorporating public health approaches as part of prevention strategies.

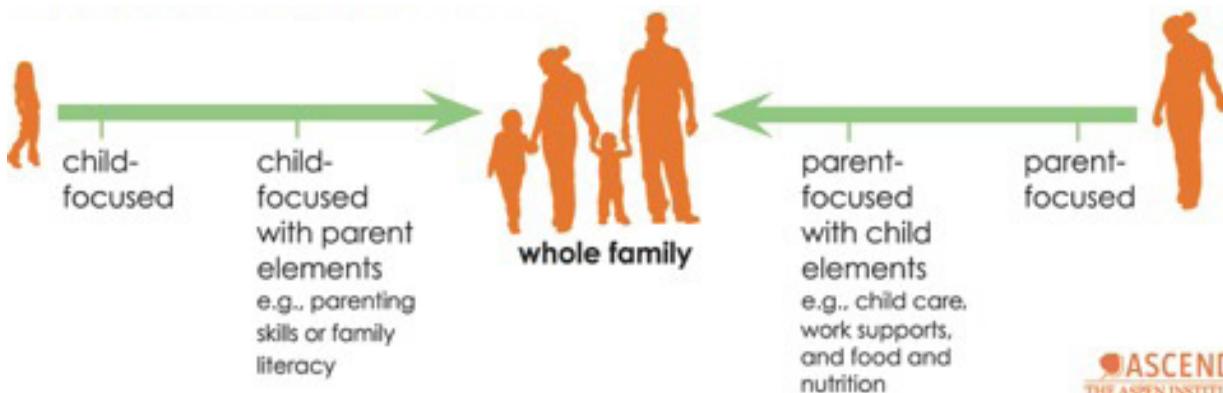
Two generation approaches meet the needs of children and parents together. This requires "knitting" traditional child focused services--quality child care, ensuring child safety, and supporting healthy adolescent development--more closely with workforce, education, health, and economic programs that serve parents. Through this whole family approach, H/HS can play a critical role in the lives of parents by supporting their placement in the

workforce and helping them secure better paying jobs and the necessary bridge supports to economic well-being while simultaneously assuring that their children are healthy and well.

STATE AND LOCAL H/HS AGENCIES ARE WORKING TO:

- Apply two generational or multi-generational approaches (see graphic below) that address the needs of children and their parents together;
- Apply advances in brain science to redesign programs and services to better promote the social and emotional well-being of children and families and enhance family functioning;
- Apply predictive analytics to identify potential challenges earlier, and to work with families to increase protective factors and reduce risk factors;
- Infuse public health approaches as prevention strategies, especially for child abuse and neglect; and
- Create healthier environments through social engagement and community supports that build health and wellness.

THE TWO-GENERATION CONTINUUM



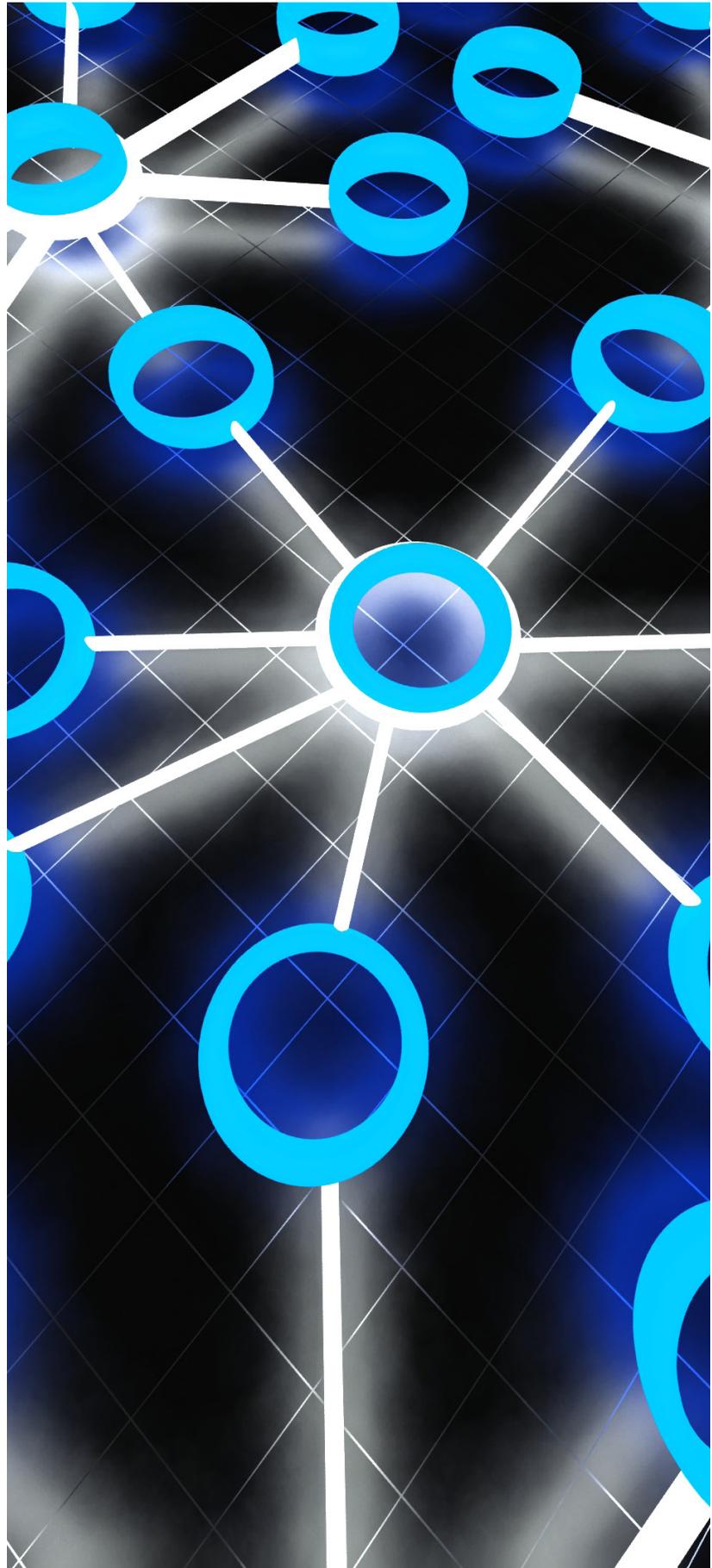
*Reprinted with permission from Ascend; <http://www.ascend.aspeninstitute.org>

An effective H/HS system increases resiliency and builds protective factors to enable parents to better manage setbacks and to mitigate the effects of trauma on them and their children. In the broader context of well-being, an effective H/HS system promotes vibrant and thriving communities where businesses, school districts, neighborhood organizations, and medical facilities are well-connected and work in service of each other.

The Public Policy Solutions We Need

In order to accelerate this systemic change, H/HS leaders urge policymakers to:

- Align federal policy consistent with whole family approaches and incentivize states to adopt two generation approaches;
- Allow for significant expansion of demonstration efforts and local experimentation aimed at reducing disparities and inequities among various populations;
- Embed prevention strategies that include public health approaches;
- Invest in infrastructure capacities to scale up promising approaches and evidence-informed/evidence-based practices;
- Align federal funding with desired practices (e.g., child welfare) and allow the blending and braiding of funds to better leverage resources and meet the specific needs of children and their families.



Policy Priority 2: Achieving Gainful Employment and Economic Well-Being

If there is anything that all of us have come to agree on it is that gainful employment is central to the American experience. Meaningful and sustainable employment is the surest way to economic well-being for ourselves and our families. Having a job, enjoying the many benefits that come from work, providing for one's family, setting examples for our children, and looking forward to a secure retirement are among the top achievements we all aspire to. Moreover, gainful employment is one of our most essential building blocks for strong, healthy, and productive individuals and families. Public H/HS leaders have been at the forefront of initiatives to help make the experiences and benefits of gainful employment available to all. They are partnering with one another to:

- Advance best practices, resources, and innovative solutions that will help move low-income individuals into initial jobs that have sustainable career pathways;
- Leverage the knowledge and resources of the public, nonprofit, and private sectors toward these goals;
- Identify and support public policies that provide the opportunities, resources, and flexibility needed to strengthen individuals, families, and communities through successful engagement in the workforce.

Among the many programs that support work are the Earned Income Tax Credits (EITC), the child tax credit, nutritional assistance, child care, and child support collections. A significant opportunity in the employment arena is the integration of work-related services under TANF, SNAP, Department of Labor American Job Centers, and other programs under the Workforce Innovation and Opportunity Act (WIOA). Others include redesigned skills training offered by community colleges or through sector-based initiatives, direct job development, and placement services. Transitional and subsidized employment can provide important pathways toward success in the workplace, as can employment and training

opportunities for people with disabilities that enable their full inclusion in the workplace.

Current approaches to connecting individuals to the workforce are spread across many programs and agencies and are typically judged not by meaningful employment outcomes but instead by compliance with process mandates. H/HS agencies across the nation are implementing comprehensive approaches to strengthen individuals and families and to support their sustained progress toward greater independence through meaningful employment. And this is not being done because it is a matter of law – TANF must meet certain work requirements – but because there is clear evidence that when an individual and family are able to support themselves through gainful employment, the family and ultimately the community benefits.

Public health and human services leaders are advancing strategies and identifying partnerships that can help clients not only achieve gainful employment but move forward down a successful career path, which is vital to on-going success in the world of work.

The Public Policy Solutions We Need

Unfortunately, current programs and federal supports aimed at successfully moving H/HS customers into the workforce are often held back by requirements that focus too much on process compliance and too little on progress toward true self-sufficiency. Overlapping education, training, and employment preparation programs too often operate independently, do not allow for leveraging resources across sectors, and are frequently duplicative and inefficient. H/HS leaders are looking for opportunities to integrate policies, practices, and systems to better serve individuals.

Aligning the existing collection of federal programs that address workforce engagement; building on what we know works to develop workforce skills; growing individual capacity; meeting the needs of the modern workplace; reducing barriers to sustainable employment; promoting asset building; linking the

efforts of the public sector with those of the nonprofit and private sectors; and advancing other initiatives that will help build and support an environment of strength, capacity, and well-being for families and communities.

As immediate, practical steps to advance this agenda, H/HS leaders urge Congress to reauthorize the TANF program to:

- Contribute to achieving sustainable employment outcomes based on tailored services delivered at the right time and for the right duration.
- Encourage strong partnerships that leverage other sectors and resources to provide social return on investments and maximize sustainable outcomes for the community.
- Allow states to align with related sectors, programs, and policy opportunities such as those provided by the WIOA, including such innovations as common funding streams and customer databases.
- Allow significant expansion of demonstration initiatives, similar for example to those enacted in the 2014 Farm Bill for SNAP, which will test

innovations for incentivizing and supporting gainful work opportunities across multiple approaches, programs, and sectors.

- Allow states, at their option, to use performance measurements based on skill development, employment entry, and retention, rather than the current process-focused activities of the Work Participation Rate.

We urge the Federal Administration to:

- Use existing regulatory authority and administrative discretion to expand innovation demonstrations as described above (see sidebar on Locals initiative).
- Use existing authority to blend and braid funding streams to the extent possible so that multiple programs can more flexibly serve populations and situations most in need.¹⁸
- Support creation of a common client information base that encompasses multiple sectors and programs.¹⁹

CHARTING A NEW PATHWAY TO PROSPERITY AND WELL-BEING

Local human service agency leaders across the country are concurrently implementing new initiatives to improve service delivery. Collectively, these leaders propose “creating a pathway for prosperity and well-being”²⁰ by designing, testing, evaluating, and spreading key elements of a fully integrated and effectively coordinated health and human service system that can be tailored to local organizations’ maturity, resources, and priorities. These leaders stand ready to work with partners at all levels of government and across sectors to accomplish our vision that within 10 years, we can transform the health and well-being of communities across the country 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.

¹⁸ The Department of Housing and Urban Development has provided local programs with the authority to braid housing funds with human services funds so that local programs are able to provide housing and the supportive services necessary to ensure continued client success. See: <http://aphsa.maps.arcgis.com/apps/MapJournal/index.html?appid=a438d6ed41ce4d0ab25d65c82e357a5f>

¹⁹ States are taking advantage of current, yet time-limited, funding opportunities to modify and improve their eligibility and enrollment systems spanning health and human service programs. Many states are building and leveraging shared IT services, like master client indexes, to have common identifiers for people and to facilitate increased care coordination across human serving programs.

²⁰ APHSA “Locals” Charting a New Pathway to Prosperity and Well-Being http://www.aphsa.org/content/dam/aphsa/pdfs/Locals/P%26P_August16_APHSA%20Locals%20Charting%20a%20New%20Pathway%20to%20Prosperity%20and%20Well-Being.pdf

Policy Priority 3: Health and Well-Being

For all of us, our health and well-being are key to living well and maintaining our quality of life. Where we are born, the quality of our schools, the safety of our communities, the availability of jobs, and the level of stress on our families, our colleagues, and ourselves are just some of the external factors that impact our health from a young age through adulthood. Understanding how these social determinants affect our health and well-being, and connecting them to helpful supports along the way, are key to ensuring that each of us can achieve our full potential. Simply put, one's zip code should not determine one's destiny.

Healthy Individuals, Families, and Communities Matter

A growing body of evidence shows that improved care and service coordination across multiple sectors beyond traditional clinical health care services – doctors, hospitals, laboratories – along with timely access to critical population-based health information, including behavioral health, and leveraging existing public investments more effectively, can produce healthier and dramatically better and more sustainable outcomes for all families and communities. Human service programs already in place are uniquely positioned to provide valuable contributions to improving overall health outcomes if they are effectively linked to and integrated with the traditional health system.

Research has shown that health care alone contributes only 10 to 25 percent to improving health status over time. What we do to support good health, such as healthy eating and exercise, and the social and economic environment that is around us such as good jobs, quality child care, and a safe place to live, impact our health outcomes even more than medical care. Recent research also indicates an association between higher level of investment in social services and improved health outcomes.²¹

With this knowledge, H/HS programs across the country are leading the way on such multi-disciplinary and population-based care approaches.

Modern Health and Human Services Systems of Care

H/HS agencies at all levels of government are building new connections to better ensure programs, data, providers and funding channels are in place to address the social determinants of health. State and local agencies are making important advancements nationally to improve their operational efficiencies and program effectiveness by using a variety of strategies to create a blueprint and benchmarks to implement these paradigm and operational shifts.

The Benefits of Health and Human Services Collaboration

H/HS and its companion sectors are uniquely positioned to design new initiatives that can significantly support better health and stronger individuals, families, and communities. Human service resources already strategically located throughout communities across the country can play a major role in prevention to mitigate serious downstream health issues like pneumonia or diabetes. Examples include providing energy assistance to families to keep their heat on throughout the winter or providing nutrition assistance that encourages healthy food habits – relatively “light-touch” supports that reduce the need for costly acute and longer-term medical interventions that would otherwise be needed.

Mushrooming health care costs, the need to more effectively leverage existing but not currently well-coordinated public investments, and a rapidly growing appreciation for the value that locally based human service assets can bring to a collaborative effort to support population health by addressing the social determinants of health, are key drivers in addressing this topic. The tangible results of these efforts will

²¹ Elizabeth H. Bradley, et.al, Variation In Health Outcomes: The Role Of Spending On Social Services, Public Health, And Health Care, 2000–09, Yale University School of Public Health, March 2011, http://ghli.yale.edu/sites/default/files/imce/bmjqs.2010.048363.full_.pdf and Jennifer Rubin, et.al., “Are better health outcomes related to social expenditure? A cross-national empirical analysis of social expenditure and population health measures,” Rand Corporation, 2016 http://www.rand.org/content/dam/rand/pubs/research_reports/RR1200/RR1252/RAND_RR1252.pdf

be improved outcomes, lower costs, and a healthier society as a whole.

The Public Policy Solutions We Need

In order to accelerate this system-wide change, we need the Administration and Congress to better enable us to:

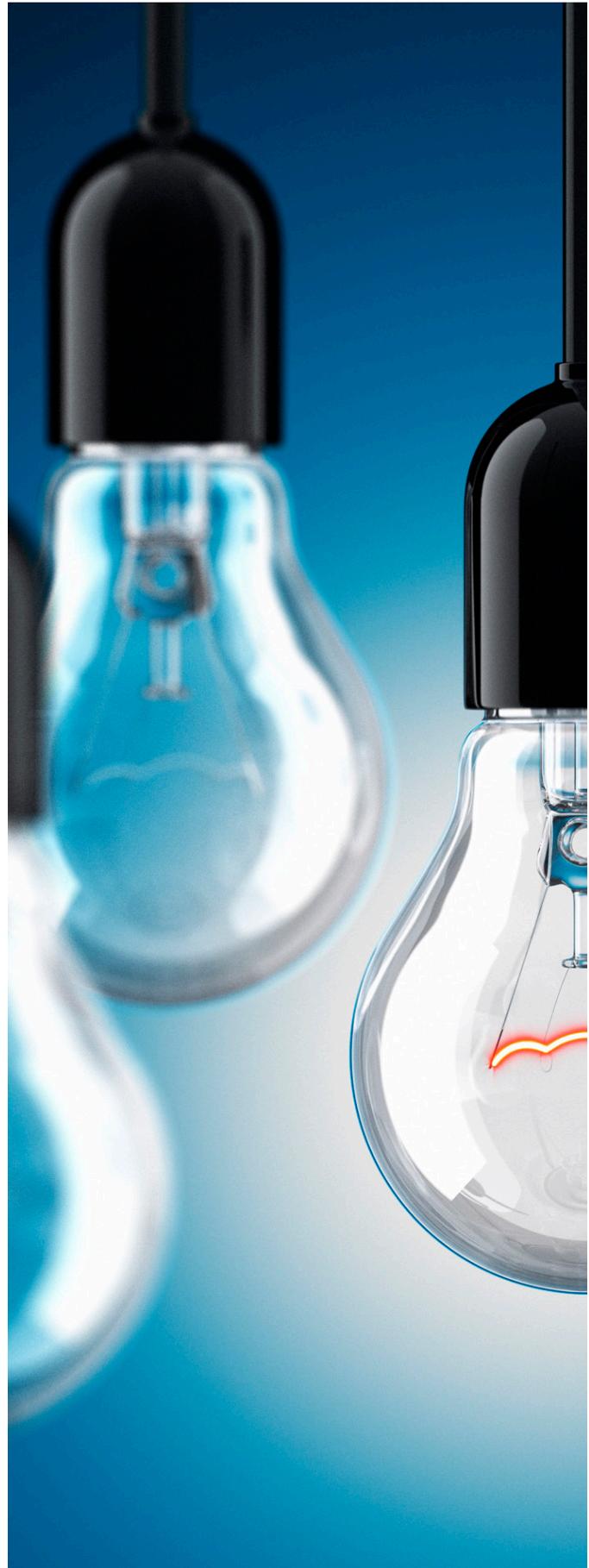
- Link with the health care system and support the evolving delivery of H/HS from a public health approach enterprise;²²
- Further interoperability and integrated service delivery across H/HS;²³
- Build partnerships across service delivery providers supporting health and well-being outcomes;
- Share best practices so that H/HS leaders can strategically position their organizations for system improvement;²⁴
- Influence federal policy to enable connected service design and delivery across public and private health and human systems, particularly removal of unnecessary barriers to greater funding flexibility and fragmented structures and outcome requirements among related programs;²⁵ and
- Be part of an effective and coherent voice on how human service agencies can continue to contribute their experiences, leadership, staff, and assets in the field to address and overcome the challenges associated with the social determinants of health.²⁶

22 APHSA Innovation Center – Stories from the Field – Interactive Map
 23 CA Department of Social Services, Department of Health Care Services and Counties Global Memorandum of Understanding (MOU) for Child Welfare Services: This Global Memorandum of Understanding (MOU) between the California Department of Social Services (CDSS), the California Department of Health Care Services (DHCS), California Counties and Title IV-E Tribes sets forth the terms and conditions for the exchange of confidential data, collected and retained by CDSS and DHCS, for the purpose of matching the confidential data, referred to as ‘matched data,’ to administer and implement the applicable federal and/or state health and public social service programs. The Global MOU is available in full at <http://www.cdss.ca.gov/pdf/GlobalDataSharingAgreement.pdf>.

24 APHSA Innovation Center – Stories from the Field – Interactive Map

25 APHSA Innovation Center – Stories from the Field – Interactive Map

26 APHSA Innovation Center – Stories from the Field – Interactive Map



Policy Priority 4: The Tools We Need

The Ability to Innovate through Federally Supported Demonstrations

The H/HS system needs new and innovative policy, funding, and accountability structures that align with modern day realities, realize the potential of technological and scientific advances, especially in neuroscience and behavioral economics, apply modern research methodologies that show results faster, and optimize limited resources.

Recent Demonstrations That Test How to Achieve Better Outcomes. Among the program innovations that public H/HS leaders are embracing are:

- Child welfare waivers that have provided states and localities with the flexibility they need to use foster care funds for preventative and early intervention services that are designed to keep foster care-eligible children with their parents or other kin.²⁷
- Performance Partnership Pilots (P3) that have allowed state and local H/HS programs to pool a portion of their existing Departments of Labor, Health and Human Services, Education, Housing and Urban Development and Justice, and the Corporation for National and Community Service discretionary funds for innovative programs with measurable outcomes that promote better education, employment, and other outcomes for disconnected youth.²⁸
- A \$200 million Department of Agriculture program that has allowed for the development, implementation, and evaluation of up to ten pilot projects designed to reduce dependency and increase work participation rates under SNAP.²⁹
- Two Office of Management and Budget (OMB) established programs that have modernized

the system for moving children across state lines for adoption and foster care in six states (the National Electronic Interstate Compact Enterprise (NEICE)) and have enabled states to come together to build a common SNAP recipients data base (National Accuracy Clearinghouse (NAC)) are examples of the way that government can ensure quicker service and program integrity for households that move between states.³⁰

These types of demonstrations need to be continued and the funding and flexible authority needed to make them possible must be continued and expanded. For more information, see the article, APHSA “Locals” *Charting a New Pathway to Prosperity and Well-Being* at www.aphsa.org/content/dam/aphsa/pdfs/Locals/P%26P_August16_APHSA%20Locals%20Charting%20a%20New%20Pathway%20to%20Prosperity%20and%20Well-Being.pdf

Leveraging Innovations in Funding, Data, Metrics and Accountability

H/HS leaders are seeking alternatives to current funding, the use of data, and ways of measuring outcomes and establishing accountability.

In the case of funding, alternative methods of financing public H/HS programs are becoming increasingly important. H/HS leaders are seeking alternatives to current siloed funding streams, including through use of blended and braided funding streams that make it possible to leverage resources smartly and provide services that are focused on the specific needs of families, and enhanced public-private partnerships that make possible up-front private sector funding like social innovation funds and pay for success initiatives.

27 The 114th Congress attempted to pass legislation that would modernize child welfare funding and allow states and localities to use funds for early interventions so that children may remain in their families rather than be placed in foster care. H.R. 5456 or the Family First Act was introduced in the House and Senate with insufficient time for staff and members to address some of the reasonable concerns that were raised. There are numerous examples of states and localities using funds for early intervention. They can be found at: APHSA Innovation Center – Stories from the Field – Interactive Map

28 APHSA Innovation Center – Stories from the Field – Interactive Map

29 APHSA Innovation Center – Stories from the Field – Interactive Map

30 For examples of the NEICE see APHSA Innovation Center – Stories from the Field – Interactive Map; For examples of the SNAP common data projects see APHSA Innovation Center – Stories from the Field – Interactive Map

Federal rules and regulations often make it difficult to use funds in innovative and original ways. While traditional funding generally provides a relatively stable flow of funds for specific categories of service, traditional funding does not meet the needs of individuals, households or communities where innovation and flexibility are necessary to achieve desired outcomes. We must enable state and local H/HS agencies with the ability use tailored, cost-efficient and measurably effective financing alternatives.

America's H/HS leaders are calling on Congress and the Administration to test approaches that will use available funds in far more productive ways (see more detailed recommendation in next section). Most of these approaches rest on modern business practices and flexibility that facilitate multi-agency and cross-sector collaboration and program integration. Advances in research and interoperable technology have paved the way for critical oversight and feedback loops that allow us to continuously determine which programs are achieving desired outcomes. The application of a rapid cycle evaluation methodology provides evidence to support program modifications when obvious benefits emerge, while long-term evaluations can continue to ensure the results achieved are sustainable and meaningful over time. *All federal mandates should be accompanied by the funds necessary to implement these mandates.* Regulatory and policy changes that either directly or unintentionally shift costs to states undercut a state's ability to accomplish the desired results.

Information Technology (IT) costs that are shared by multiple programs has traditionally been allocated among the benefiting programs in direct proportion to their use, as outlined in the federal OMB's Circular A-87 guidance. Beginning in 2012, an exception to this approach was approved by the OMB to help states pay for the much-needed modernization of their Medicaid eligibility determination and enrollment systems (E&E) due to the requirements of the Affordable Care Act (ACA). Known as the "A-87 Cost Allocation Exception," the new, time-limited policy that expires in 2018 allows human service

programs to share a wide range of IT components already needed by Medicaid, and can also be used by human services programs at little or no additional cost except for interfaces or other services uniquely required by those programs.

Although the impetus behind this exception was the ACA, its application was not limited to those states that have expanded their Medicaid population or developed state-based health insurance marketplaces. As a result, all states had the opportunity to modernize their health and human service eligibility and enrollment systems. *This type of funding innovation should be continued after 2018 (ideally, made permanent) so that states and localities continue to have the support they need to ensure that their health and human services information systems are modern and effective.*

In the case of data and metrics, vast quantities of data and other types of information are collected by localities, states and the federal government, but most of the data is not used in ways that can illuminate true progress toward sustainable outcomes or for identifying where greater efficiencies can be found. We need to build organizational and workforce capacity to more effectively utilize the data collected to ensure program quality, integrity, and efficiency.

The emergence of "interoperable technology" offers an unprecedented opportunity to connect systems across traditional boundaries and share information in exciting and rewarding ways. Moreover, data interoperability – technological and programmatic coordination that allows data and metrics to be shared across a variety of different programs and agencies at the local, state, and national levels – can help us address current barriers to service, and make it possible to develop new service models and approaches that will maximize positive outcomes for children, families and communities. This interconnectivity represents the cutting edge for development of new service models and approaches to maximize positive outcomes for children, families and communities.

In the case of accountability, health and human services leaders are seeking new ways to measure outcomes in ways that transcend the program silos that results from laws, regulation and funding, and recognize that services provided in one area may yield results in another area. Accountability is an indispensable component all government programs, in general, and H/HS programs, specifically, and reflects upon the commitment government have towards its citizens.

Health and human services leaders understand more than ever that to produce long-term, sustainable, and positive results requires a broad range of interventions—health, mental health, nutrition, housing, work, education, safety, juvenile justice, economic development, public safety—that cross government levels, departments, agencies, and programs. Thus, true program accountability and management requires a system reaching beyond a given siloed program and recognizing that the services provided in one area may have results that are realized in another.

The current broad scope of administrative data gathered by public agencies, most of which is collected under the broad label of program integrity and is used to meet process-based requirements, should continue as baseline metrics to ensure that service eligibility rules are enforced, benefit payments are timely and accurate, and cost-allocation rules are followed. However, advancements in research, data analytics, and technology can now provide us with the tools we need to transform these data into actionable insights that can open up new possibilities for redefining the impacts of H/HS. If integrated in relevant data sets rather than held in program silos, we can move beyond a strictly transactional business model to one that is also transformational. Together with an oversight feedback loop, this approach would enable effective evidence-based decision-making and continuous improvement in service delivery.

The Public Policy Solutions

To enable successful transformation, we need a Systems Approach that includes:

Expanded pilot and waiver demonstrations – especially across sectors and systems – to significantly broaden innovations in H/HS. Examples of the impact of demonstrations can be seen in initiatives like the Performance Partnership Pilots (P3) and the long-standing child welfare waivers, both of which are briefly described above. These pilot and demonstration programs can be structured to test alternative approaches and uses, particularly with the emergence of new research methodologies that apply behavioral science and allow for rapid cycle evaluations, while assuring that individuals and families continue to be adequately served.

Relaxing categorical federal funding rules and the array of program silos they have fostered would enable agencies to design data-informed services across departments that will work more effectively to address real needs and conditions. A streamlined funding framework would save substantial time, effort, and costs by directing funds where they can achieve the most effective social and financial returns.

Blended and braided funding options have been used in several sectors with increasing success, although they are seldom available for H/HS programs. Increasing blended or braided funding options across related programs and multiple service sectors will enable H/HS agencies to serve needs more holistically and efficiently, target high-priority performance goals, and streamline administrative requirements. Some jurisdictions, particularly at the local level, have successfully used available blended and braided funding, but federal categorical limitations severely limit taking this concept to scale.

Public-private partnerships would also ease some of the financial pressures that public agencies are facing. Private funding from philanthropies or partnerships with the private for-profit sector has historically been used in human service programs, usually as adjuncts to public health and H/HS efforts rather than as direct funding sources. But increased flexibility in the use of philanthropic or private for profit sector funds would go a long way to ensure that state and local H/HS programs have the

resources they need to generate the outcomes that are desired and move the system to its desired state. Specific methods include:

Social Innovation Funds (SIF) and Pay for Success (PFS) initiatives offer innovative ways for the public sector to partner with philanthropic and private sector investors to create incentives for service providers to deliver better outcomes at lower cost, producing the highest return on taxpayer investments. The concept is simple: pay providers after they have demonstrated success, not based on the promise of success. Similarly, Pay for Success financing is a mechanism for increasing investments in effective social interventions by changing the way government allocates and invests its resources – focusing on results and outcomes.³¹

Private businesses often work closely with workforce development programs to ensure training efforts align with available jobs and provide job opportunities to those who graduate from specific job training programs. While in training, private sector funds can be used for wage supplements. Once in a job, private sector funds can be used to fund “success coaches” who are able to direct workers to the support services they may need (child care, health care, etc.) without which it may be difficult for them to otherwise remain on the job.

Philanthropic foundations typically fund a variety of support activities that enhance or leverage programs, provide technical assistance, or support parallel efforts specifically directed toward serving particular population segments or outcomes. For example, the Casey Family Programs has, for many years, partnered with public child welfare agencies and a wide range of national and local child-serving organizations, political and civic leaders and has provided them with additional resources (fiscal and people) that enhance their capacity to apply evidence-informed programs and develop talent within the agency.

Federal policies and funding mechanisms should also take into account local and tribal agency funding. Local and tribal agencies typically contribute their own funds to most human service programs. They have the closest relationships both to clients and to community stakeholders, and have consistently developed some of the best and most innovative service and administrative models within the human service arena.

The federal government should create a new federal information technology (IT) support paradigm that can help simplify federal rules and cost-allocation requirements; actively encourage the adoption of the best IT systems and common templates; and support program integration and blended funding opportunities contained in recent legislation and federal administrative announcements. In addition, resources should be devoted to strengthening workforce capacity to analyze and leverage data to generate increased service and community impact.

This would entail new and redirected federal investments in technology, data warehouses, data sharing platforms, and business intelligence capabilities for data management and analysis. It would also require that the federal government help leverage data quality and data linkages to develop measures that address true outcomes for families, not simply outputs, and empower effective decision-making. Furthermore, there would be a need to aggregate the best research to identify state-specific, evidence-based programs, so that it is possible to estimate program impacts based on the states’ unique characteristics and resources. This holistic appraisal of impacts and benefits across sectors is central to measuring the value of and the social improvements realized by specific programs.

It would also require a review of privacy and confidentiality safeguards to ensure that legitimate safeguards are protected, but unnecessary regulations or practices are not allowed to hinder critically needed data sharing.

³¹ APHSA Innovation Center – Stories from the Field – Interactive Map

Successfully obtaining outcome performance data across programs and governmental sectors will require program integration or, at the least, data interoperability. This can be challenging since, historically, public agencies do not collect or analyze data in uniform ways. Many do not have the resources for updated technology that allows for interoperability, and real or perceived confidentiality and privacy laws are frequently seen as barriers (although there is increasing focus on how to achieve data sharing with appropriate protections). Nonetheless, state and local H/HS agencies are firmly committed to the value of accountability based on the principles of service integration and cross-program data that focuses on results. Health and human services leaders believe that policymakers should focus accountability on improved outcomes rather than compliance with process measures that do not tell us whether individuals and families are advancing toward greater capacity, independence, and well-being. The leaders are seeking the resources and technical assistance that public health and human service agencies need to illuminate the full impacts and sustainable results from our work.

CONCLUSION

America's H/HS system is increasingly becoming more responsive, innovative, and solution-oriented. This transformation is rooted in the understanding that for all of us to reach our full potential - no matter where we live - we must have the opportunity to develop a strong foundation of health and well-being capable of weathering life's storms.

In order to achieve this, strong support from the Administration and Congress is needed. That support has to be more than simply financial; it must be based on an awareness of the contributions a modernized system can make, the ways in which it can prevent "downstream" problems that are far more damaging and expensive to address, how it can fundamentally change the lives of many Americans, and how in this way it can fundamentally change America.

Implementing this new accountability paradigm will require intentional and proactive improvements on a broad scale and a federal-state partnership that is rooted in cooperation and continuous improvement. Joint federal-state workgroups are one method that could result in identifying "quick wins" through practical administrative changes that do not require regulations or statutory changes. Better and broader communications across governmental levels and across programs and specializations can also bring prompt and positive results.

Some of these ideas require legislative or regulatory changes, but many can begin with minimal adjustments to current policy and/or administrative actions. No matter what, this is an essential conversation that must take place if we are to identify sustainable solutions. Ultimately these issues depend on federal, state, and local governments working closely together with each other, and with other sectors, to share information, experience and insights, and to implement solutions to which everyone is fully committed.

If as a nation we wish to continue to have a modern and responsive H/HS system, the federal government, in particular, will need to continue to create new and important tools that can help move the system forward. These include a range of innovations around funding, programs, data, and accountability. The nation and H/HS leaders must also stay focused on what matters: child and family well-being, employment and economic well-being, and health.

With and through our members, the American Public Human Services Association has produced a series of papers that describe in further detail many of the concepts, issues, and ideas raised here to help illustrate how H/HS leaders are driving system transformation and the national policy changes needed to accelerate the transformation. Additional papers are forthcoming. We have also included a number of references to documents that are helpful in understanding the current and desired landscape for the nation's H/HS system.



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Center for Employment and Economic Well-Being: TANF at 20 - Time for Rational Changes

Including Integration with other Employment Programs and Expanded Work Supports



CEEWB

Center for Employment & Economic Well-Being



National Association of State TANF Administrators



American Public Human Services Association



NOVEMBER 2016



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TANF at 20 – Time for Rational Changes: Including Integration with other Employment Programs and Expanded Work Supports

Core Principles and Specific Suggestions

BACKGROUND OF APHSA’S PHILOSOPHY

After 20 years since the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), it is time for Temporary Assistance for Needy Families (TANF) to be modernized to better support 21st century children and families in achieving self-sufficiency. APHSA, through its members’ *Pathways* Initiative and our Center for Employment and Economic Well-Being (CEEWB) as well as its affiliate, the National Association of State TANF Administrators (NASTA), has consistently argued that greater emphasis on employment outcomes in TANF, rather than procedural compliance with a rigid and outdated work participation rate, is the next step in true welfare reform. Reauthorization of TANF must reflect the broad changes in the labor market and better prepare parents to obtain the necessary skills for meaningful employment that increases family economic security and well-being.

At the same time, TANF must remain nimble and responsive enough to support the well-being of both children and their families based on where they are collectively through a two-generation lens and with a keen eye towards family stabilization. To accomplish this requires the recognition that not all family circumstances fit precisely into artificial timeframes or one size fits all approaches. Cash assistance should be recognized as an important bridge to eventual self-sufficiency through employment or for individual heads of households who legitimately cannot work and are awaiting SSI/SSDI determinations.

Reimagining TANF is timely for several reasons: a growing recognition that there must be a path from an initial job to higher quality employment in order to achieve economic well-being; broad acknowledgment that skill deficits and other barriers

to employment exist and must be addressed to improve client employment prospects over time; and the timely opportunity presented for significant program improvement and better services for clients with the enactment of the Workforce Innovation and Opportunity Act (WIOA) in 2014.

The passage of WIOA in 2014 made TANF a mandatory partner with the American Job Centers (formerly one-stops). With this change, outcome measures for the programs must be better aligned. TANF is one of the only programs that relies on a process measure through a work participation rate (WPR) of 50 percent for all “work eligible” adults on the caseload (WPR) rather than employment-based outcome measures. WIOA, on the other hand, measures success through actual skills gains, certification achievement, job placement, and retention. Final WIOA regulations issued on June 30, 2016 reinforce the need for performance measure alignment and ongoing discussions between the Department of Health & Human Services and the Department of Labor, as well as the four other partner agencies to better serve clients in every setting and assist those who can work into the labor market and on a career pathway.

TANF has also become too complicated in regard to countable activities and stringent work verification procedures that divert state and local staff time away from helping “work-eligible adults” become employed. This undermines the original goals of allowing states to innovate within an overall goal of state flexibility and a set of four sub program goals enacted in 1996. There has not been a full reauthorization of the program since 2005 under the Deficit Reduction Act (DRA), and no additional

funds have been added to TANF over its now 20-year history, reducing the real dollar value of the block grant by 32.5 percent according to the Congressional Research Service.

It is time to reconsider the program’s purposes, what activities actually produce positive outcomes, and how the overall workforce system envisioned under WIOA can be further improved through thoughtful TANF Reauthorization in 2017.

Based on these realities, several core principles guide this specific set of recommendations.

- **TANF Is Complex with Interconnected Elements: State Flexibility Combined with Accountability is Vital to Serve Families and Children.** TANF has evolved into a more rigid and complex set of interconnected funding streams, rules, and mandates since the Deficit Reduction Act of 2005. The program should be modernized to allow additional approaches while holding states accountable for meaningful outcomes.
- **Innovative State Strategies Are the Best Avenue to Help Struggling Families.** Faced with inflexible participation mandates during the great recession, states developed innovative strategies to serve needy families while maintaining compliance with federal rules. Federal and state partners need to further employ a growing knowledge of what works effectively and better apply science, research and data for future success.
- **TANF Performance Measures Should Be Based on Positive Outcomes, Not Process.** The current Work Participation Rate (WPR) is outdated, does not properly measure client progress toward self-sufficiency, and fails to count partial effort or acknowledge the range of activities and skill-building necessary for families and their children to achieve economic well-being in a rapidly changing economy. Continuing to measure client engagement and including family stabilization efforts, even if not related directly to employment, in such measures is important, but future program success for “work eligible TANF adults should be determined based on employment not process related outcomes. Family stabilization measures under TANF must include addressing housing stability, access to nutrition through SNAP, securing child support, home visiting and case management related to teaching or improving executive functioning and parenting skills.
- **TANF and WIOA Should Be Better Aligned.** Although TANF and WIOA have similar goals and serve overlapping populations, certain TANF rules make their integration needlessly difficult. TANF clients should have access to WIOA services, but will also continue to need access to other targeted support services such as child-care and transportation as well as effective case management.
- **Penalties Should Take the Form of Required State Investment, Rather than a Reduction in Federal Funds.** The loss of federal funds related to penalties jeopardizes the states’ abilities to help TANF clients obtain employment and become self-sufficient. Shifting the penalty structure toward increased state Maintenance of Effort (MOE) expenditures will put more state resources into struggling programs.
- **Sufficient Time Should Be Allowed for States to Transition.** While the development of new reasonable, outcome-oriented performance measures in TANF focused on skill development, employment and retention for those who can work is meritorious, states will need at least five years to alter their laws and data systems for compliance with such new measures.

TANF HAS BECOME TOO COMPLEX AND HAS BEGUN TO STIFLE STATE INNOVATION – IT MUST BE MODERNIZED AND SIMPLIFIED TO PROMOTE MEANINGFUL OUTCOMES

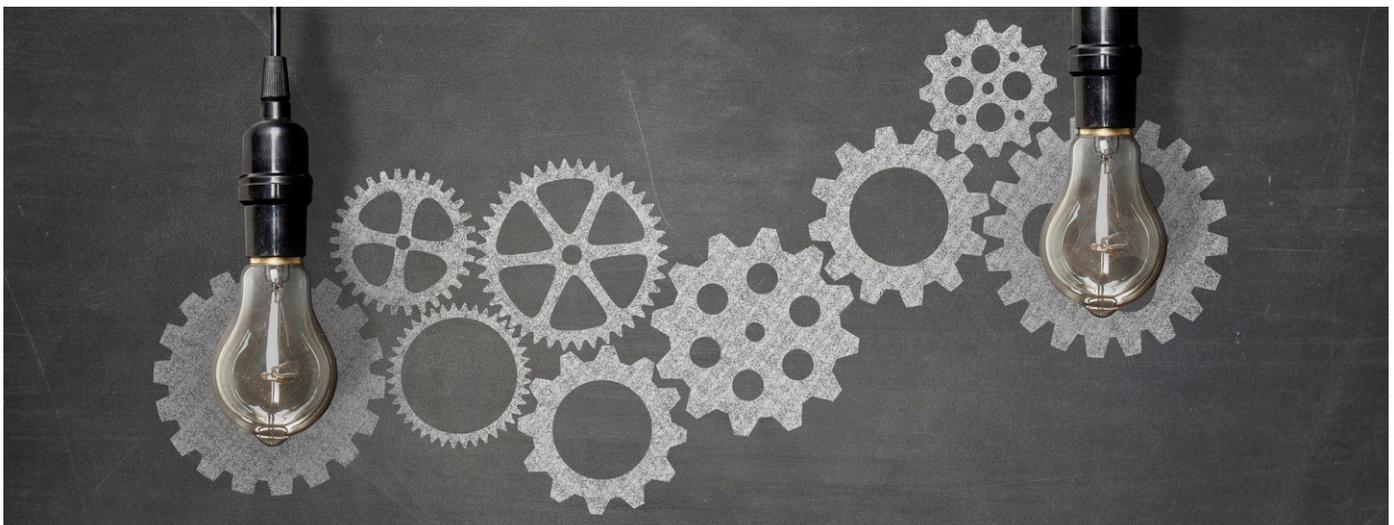
States strongly believe in the importance of work as the best avenue for establishing a career pathway towards self-sufficiency. But under TANF as currently constructed, a nominal 50 percent of “work-eligible” recipients must meet the weekly hourly requirements of the WPR.

The inflexibility of the WPR, the work verification procedures added in 2005, and the dwindling value of the block grant in inflation adjusted dollars make it difficult for states to make larger investments in the skill building, training, and work supports necessary for success because they often are not allowable activities or are limited as to how long they can be counted.

States already spend more funds on work-related activities than critics often cite as being only eight percent of overall federal and state MOE expenditures. This statistic fails to take into account other work-related expenditures. States transfer significant TANF funds to child care for the express purposes of adding subsidized child care slots and supporting work. Similarly, some states have used TANF funds for the creation or expansion of state Earned Income Tax Credits (EITC) to supplement the wages of those leaving TANF for employment. Most

states used enhanced earnings disregards as well to not immediately reduce cash benefits when clients find employment. These efforts do not get sufficient credit as being work-related activities and certainly do not fall into the realm of utilizing TANF funds for non-TANF related purposes.

Because of the rigidity of the WPR with its nine core and three non-core allowable activities, meeting the rate has required funding shifts and an ongoing emphasis on caseload reduction. Many states have been forced to transfer certain portions of their caseload to Solely State Funded Programs (such as programs serving two-parent households who under TANF rules must currently meet a virtually unattainable 90 percent WPR, post 60-month time limited cases and SSI pending cases). States have come under unfair criticism for these actions in spite of the fact that these SSF programs serve legitimate goals and do not mean that able-bodied adult recipients are not held to similar work requirements. Even with the growing complexity and shrinking value of TANF funding, states have still initiated some very successful practices and programs that could be scaled up if the TANF program was simplified and performance measures of success were changed (see Appendix I).





STATES ARE ALSO ENGAGING FAR MORE ADULTS IN WORK ACTIVITIES THAN STATED AND SHOULD RECEIVE PARTIAL CREDIT

Under the Claims Resolution Act of 2010, after a GAO report claiming either zero or very low rates of actual assigned work activities for able-bodied adults,¹ states were required to submit more extensive reports on engagement and participation in work related activities.² The two additional state reporting requirements measured: (1) work participation for families that currently do not meet the TANF program’s requirements to count toward state work participation rates; and (2) TANF spending in two broad categories known simply as “other non-assistance” and “authorized solely under prior law.”

The reports found that states get actual TANF credit for only a fraction of those who are actually engaged in work activities.

The ones for which they do not receive credit are either not meeting the required number of hours under TANF, are in an activity beyond the allowable time limit (job search, vocational education), or are participating full- or part-time in a non-core activity. While these reports have not been updated since 2011, the data is still available publicly and remains

predominantly accurate. It would be useful to update these reports to again demonstrate to policymakers that TANF clients are broadly engaged in various activities.

Given the clear results in the Claims Resolution Reports, it makes good policy sense—as a way to continue to measure broad engagement in work related activities—that states should receive proportional, partial credit for anyone engaged at least one-third time in such activities. This coupled with simplifying and expanding the allowable activities under TANF, eliminating the core/non-core distinction and lessening the excessively strict work verification rules will encourage and incentivize broader engagement and positive employment outcomes. Examples of highly successful family and child intervention programs that cannot be funded through TANF or can only count on a limited basis include the Nurse Partnership Program, home visiting programs, extended vocational education, certain skill- and credential-based attainment programs, job search as a partial ongoing activity, and others.

1 The May 2010 GAO report, *Temporary Assistance for Needy Families: Implications of Recent Legislative and Economic Changes for State Programs and Work Participation Rates* (GAO-10-525), can be accessed at www.gao.gov/assets/310/305122.pdf.

2 The July 2011 Office of Family Assistance report, *Engagement in Additional Work Activities and Expenditures for Other Benefits and Services, April-June 2011*, can be viewed at www.acf.hhs.gov/ofa/resource/cra-june2011.html.

BASE TANF PERFORMANCE MEASURES ON EMPLOYMENT-RELATED AND OTHER POSITIVE OUTCOMES – NOT PROCESS

Changes in the performance measures under TANF need to occur. The performance measurements put in place two decades ago will no longer work unless significantly changed.

The biggest problem is the focus of the Work Participation Rate (WPR) on measuring process instead of outcomes.

Some form of the WPR could remain as a measure of engagement, but changes are necessary as TANF transitions to outcome measures more akin to WIOA and the original goals of the TANF High Performance Bonus measures from the early 2000s.

Most importantly far more flexibility should be allowed under TANF regarding countable activities such as vocational education by increasing the current limit from one to two years, allowing job search and job readiness to count beyond current limitations, and eliminating the core/non-core distinction. Partial credit towards an altered WPR for hours less than the current 30-hour rule (20 hours if there is child under age 6) should also be allowed.

The nominal rate under the WPR is subject to reduction through various means that were intentionally created in statute by Congress and in regulation by HHS-ACF. Avenues to a lower effective WPR include caseload reduction from a base year (now 2005) and state spending over and above the required Maintenance of Effort (MOE) level of 75 percent if states meet the WPR and 80 percent if they do not (excess MOE provision in 1999 regulations put in place specifically to discourage state disinvestment). Some states have also used third party MOE, which are in-kind or cash contributions by non-governmental organizations to meet MOE requirements. This has become a controversial practice that has been proposed for elimination in the President's recent budgets requests. Recent House Committee action proposed freezing the use of third-

party MOE at its current levels, but the final House legislation did not include the provision.

States have utilized their legitimate flexibility out of necessity at varying levels to reduce their effective work rate, because of the rigidity of countable work activities under the WPR, the outdated distinction between hours of core and non-core activities and the time and caseload percentage limitations on the use of vocational education, job search and other activities that are essential to impart necessary skills for employment. The erosion of TANF funding, the ongoing remnants of the recession and a sluggish labor market have also contributed to necessary state choices.

With a reasonable employment-based outcome measure and a rethinking of what countable activities will actually work based on increased funding for research and evaluation, states would have more knowledge and ability to focus on real program goals rather than complying with a rigid process measure.

Additionally, the problems with the WPR were intensified with the passage of the 2005 Deficit Reduction Act (the last full reauthorization of TANF), which added layers of administrative reporting requirements through new work verification procedures (WVP) that require documentation of every hour of client participation. This has forced states to divert caseworker activities to compliance measures rather than actual time focused on getting people education, training and job placements. A study in Minnesota found that as much as 53 percent of caseworker time was taken up by verifying hours in activities rather than actually assisting in training, skill development and job placement.³ These verification procedures are also onerous for employers and community college programs where sector-based

³ The referenced report, *The Flexibility Myth: How Organizations Providing MFIP Services Are Faring Under New Federal Regulations*, can be viewed at www.aphsa.org/content/dam/NASTA/PDF/The%20Flexibility%20Myth%20Study%20on%20Job%20counselor%20hours.pdf.



employment training occurs, as they must spend time assisting in verifying hours under the WVP.

Both the WPR and WVP need to be made far less stringent so that a program focus on employment can be restored.

The WPR has also had the insidious effect over time of making it easier to reduce caseloads than to actually engage hard to serve clients in work activities that might move them into employment. Clients can also play a role in this reality in several ways: failing to comply with program rules, particularly in some large states with partial sanctions; legitimately misunderstanding the complicated work participation rules and assignments or by simply dropping out of the program, particularly in low benefit states; and living on a combination of other program benefits from SNAP, Medicaid, child support, episodic employment and informal help from relatives or friends. Some states have made efforts to re-engage sanctioned clients and to promote available job services with modest success, but there is inadequate caseworker time for such tasks due to the necessity of dealing with program compliance. Unfortunately, the result is that these clients remain disengaged from the program and excluded from availing themselves of employment and training services that could improve their economic well-being, opportunity for social interaction and the overall health and well-being of their family.

Client dynamics are not simple or homogenous. States are learning how to better understand and engage with clients in a meaningful way, getting at enablers and barriers through things like motivational interviewing that may uncover the root challenges that families face and create a more empowered client, teaching executive functioning skills to both parents and children and home visiting programs that provide family context that is critical to a whole family or two-generation (Two-Gen) approaches. Such approaches are of great value and diverting time away from them for process compliance is not a pathway to success for administrators or clients.

TANF, WIOA AND SNAP EMPLOYMENT & TRAINING MUST BE BETTER ALIGNED OVER TIME – CHANGES ARE NECESSARY FOR SUCCESS

Over time TANF, Department of Labor, and SNAP employment programs must have similar outcome-related measures including skill attainment, entries to employment and job retention. This transition to coordination must be gradual so as to allow time for readjusting policy, practice and systems to performance benchmarks. Initial steps in this direction have been taken in HR 2952 that recently passed the House Ways and Means Committee. The result of the continued misalignment is that in spite of the WIOA requirement to serve those most in need (which incidentally was a similar requirement under WIA), the rigidity of the WPR and the 30-hour rule still remain as disincentives for DOL to serve TANF participants. Despite statutory and regulatory language, barriers at the local level to successful implementation of WIOA remain and must be remedied. Movement over time away from procedural compliance requirements to similar outcome measurements between the programs is essential. Further study, through a recently released

RFP is soon to be conducted by HHS-ACF and the contractor, the Urban Institute, as to what should be the most reasonable and feasible employment-related outcomes under TANF.⁴

As this transition occurs, the 50 percent measure—as is nominally applied in the TANF WPR to measure engagement in activities—will have to be adjusted downward as TANF measures become more outcome-focused (job placement and retention) than process-focused, perhaps to an initial effective rate of 15-20 percent. States should also have the option for several transition years to be measured by either the WPR employment outcomes or some combination of the two before a full switch over to outcome-based measures. Outcome emphasis should be placed not only on job placement and retention outcomes, but also on employment preparatory activities and skill and credential attainment that are most likely to result in placement in available jobs with career ladders to self-sufficiency for hard-to-serve TANF recipients.

THE TANF PROGRAM PENALTY STRUCTURE MUST CHANGE

Currently when states fail to meet the WPR, they can be faced with both a loss of a percentage of their block grant funds as well as an increase in their own MOE contribution to make up the reduction. States do have the opportunity within a certain timeframe to correct the issue by meeting the WPR. The loss of TANF block grant funds, absent correction by the penalized state, starts at 5 percent and can go as high as 21 percent. This is unduly punitive. We suggest that there be no loss of federal TANF funds, but that the penalty, if applied, should be limited solely to an increase of state MOE funds. A number of states face penalties not necessarily because

they are not doing a good job in serving clients, but because the WPR is such a rigidly process-oriented measure that excludes or limits legitimate activities. The penalties do not incentive or lead to better employment outcomes, but rather reinforce process-focused efforts that too often have nothing to do with engaging participants into gainful, sustainable employment.

⁴ In the summer of 2016 the U.S. Department of Health & Human Services released a Request for Proposals. The purpose of this project is to explore the development of an employment-related performance outcomes approach for the TANF program. The Office of Planning, Research and Evaluation (OPRE) at the Administration for Children and Families (ACF) desires to summarize the experiences of programs using performance measures that aim to estimate reliable employment outcomes, including selected TANF programs. As a secondary purpose, the project will make recommendations on ways to improve the coordination between TANF and WIOA performance measurement systems. The project will explore the issues and options related to the development of an employment related outcome performance measurement system for the TANF program, including potential target groups, performance measures, performance standards, data needs, and accountability approaches.

THE EROSION OF TANF FUNDING IN REAL DOLLAR TERMS HAS GREATLY HINDERED INDIVIDUALIZED SERVICE PROVISION TO CLIENTS

The TANF block grant funding has not been adjusted at all since 1996 and according to the Congressional Research Service has consequently lost 32.5 percent of its real dollar value over the last 20 years.⁵ This reduction in the real dollar value of TANF funds has hamstrung states, as their capacity to both engage and serve more individuals has diminished.

TANF also has not allowed for investments or time spent in delivering services such as strong parenting skills, home visiting, motivational interviewing and case management or longer-term job readiness or treatment, even though those are the types of services that empower families to become self-sufficient.

Congress should increase funding to at least partially make up for inflation erosion, and in order to ensure a strong focus on employment related activities and basic assistance could restrict additional funds solely for broadly defined work-related activities, clear employment and job retention outcomes, cash assistance, one-time diversion payments and reinvigorated random assignment and other impact evaluation and research efforts that measure what truly works and what does not. The lack of clear

evaluation of TANF since its inception is problematic (most major research is pre-TANF and focused on state waiver programs), because in its absence it is difficult to determine which approaches yield the most success and should be replicated and brought to scale. The need for rigorous program evaluation, including use of modern research methodologies and tools that lead to more rapid results, (such as rapid-cycle evaluation) is a shared bipartisan goal in many other programs and should be a major emphasis in TANF reauthorization.

Also the recent passage of legislation by the House of Representatives of HR 5170 to allow the use of Social Impact Funding in TANF and increased resources for research evaluation as to what approaches work or do not work are welcome changes. But, these proposed changes do not address the vastly diminished value of the TANF block grant. Instead they transfer funds from the TANF Contingency Fund, which was designed as a buffer for economic downturns, to these efforts. Still, they represent important and innovative approaches to improving program performance and measuring success. Recommendations by DOL for sensible waivers for workforce innovations and evaluation would also be important additions to program reforms for both WIOA and TANF.⁶

⁵ See page 3 of *The Temporary Assistance for Needy Families (TANF) Block Grant: Responses to Frequently Asked Questions*, available at www.fas.org/sgp/crs/misc/RL32760.pdf.

⁶ The Workforce Innovation Fund (WIF) is one of several new Federal grant programs in which grantor agencies fund projects that seek to use evidence to design program strategies including innovative approaches. The Department of Labor's Employment & Training Administration (ETA) is seeking ways to remove administrative, statutory, and regulatory barriers to support greater coordination in the delivery of services, particularly among agencies and programs with overlapping missions and clients. Through the WIF, ETA seeks to support changes in structures and policies that enable a closer alignment and integration of workforce development, education, human services, social insurance, and economic development programs. So far, the ETA has announced three separate grant solicitations under the WIF. Information about the WIF can be found at www.doleta.gov/workforce_innovation/.



FEDERAL TRUST IN STATE INNOVATION GUIDED THE ORIGINAL TANF LEGISLATION

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act quite intentionally increased flexibility to states to accomplish four broadly stated purposes.

The specific language of the statute reads:

"Sec. 401. Purpose

"(a) In General – The purpose of this part is to increase the flexibility of States in operating a program designed to—

"(1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;

"(2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;

"(3) prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and

"(4) encourage the formation and maintenance of two-parent families."

The law has not changed but the attitude toward state flexibility has. A major issue for future success in TANF is renewed trust between federal and state partners.

Increasingly, since the original TANF legislation in 1996 and particularly in the last reauthorization under the Deficit Reduction Act in 2005, there has been a growing criticism of state actions that has led to unnecessary restrictions and an unproductive focus on process rather than improved outcomes for families. That is unfortunate, since states and localities are entrusted to follow and implement the law as effectively as possible, even with the declining value of TANF funds and stringent state budget requirements.

State and local eligibility workers and employment case managers are the troops on the ground, who

serve low-income clients daily under what has become an overly complicated and rigid program. States believe in the need to be held accountable to taxpayers for outcomes, but when they are forced to act in accordance with performance measures that are more process oriented, too much time is diverted from more constructive employment and retention goals. Again, a transition away from process to mutually agreed upon client success measures by federal and state partners over time and dedicated new funding under TANF aimed at reaching those outcome goals should be a major focus of reauthorization in 2017.

That trust and partnership between federal and state partners, particularly with the advent of WIOA and the focus on the shared goals of employment for those who can work and positive economic and social outcomes for families and children overall, has to be restored in order for success to be achieved.

Recommendations

The following are suggested legislative, regulatory and administrative recommendations for modernizing, improving the current TANF program to be more client- and family-centric and further integrating success measures with other workforce programs by phasing out the WPR over time and establishing a new outcome based measure including skill and certification attainment, job placement and job retention.

A. Make Changes in 2017 to Immediately Improve the Current TANF Program

1) Expand the number of countable activities under the TANF WPR to include broader approaches such as home visiting, motivational interviewing, and teaching executive functioning skills. Additionally, permit a longer, countable period for currently allowable activities such as vocational education beyond the current one-year limit and job-search/job-readiness

beyond the current six and twelve week limits. The following items can be achieved rapidly in 2017:

- Remove the current distinction between core and non-core hours of participation, which is both complicated and unnecessary;
- Allow proportional partial credit towards the WPR for those engaged in activities that are either not countable, do not fully meet the 30-hour weekly work requirement or where participants have surpassed current time limits in a countable activity such as vocational education, job search or job readiness. Such partial credit would be allowed for any work-eligible adult engaged in activities for at least ten hours weekly and calculated as a percentage of the 30-hour participation rule;
- Eliminate the virtually unattainable two-parent 90 percent WPR, which has forced most states to move this TANF population to solely state funded programs;
- Allow a 45-day grace period before a new TANF recipient is placed in the denominator for the WPR. It takes at least this amount of time to perform a thorough assessment and enroll a work eligible recipient in an appropriate activity (the law actually allows 90 days). After the 45 days the client should be in both the denominator and the numerator for TANF WPR purposes;
- Lessen the severity of the work verification requirement over the transition period for instance to a sample basis so caseworker time is not diverted away from the core skill attainment, job placement and job retention goals of TANF;
- Change the current penalty structure in TANF for failing to meet the WPR to one that solely requires states to increase their own MOE investments, but does not reduce the state share of federal funds under the block grant;
- Encourage broader use of sector-based, career pathway strategies that lead to job retention and, advancement. To further augment these efforts, the role of employers and community colleges

should be expanded in designing curriculum that teaches on the job skills. The use of shared caseworkers to assist multiple employers to help new employees should be expanded to navigate post job-placement issues, improve retention rates and assist with rapid re-employment after a job loss;

- Increase the coordination of TANF, WIOA and the SNAP E&T program service delivery to clients to avoid duplication, promote efficiency and provide better individualized client assistance.

B. Change the TANF Performance Measures over Time to Mutually Agreed-Upon Outcome Measures

1) Over a period of five years, transition the Work Participation Rate under TANF to a new national outcome based success measure focused on skill and credential attainment and job placement and retention akin to WIOA with a goal of building stronger families both economically and socially. During this transition period the WPR and the employment related outcome measure will operate side by side with suggested key modifications to the WPR. The WPR will decline each transition year and the employment related rate will increase at the same time annually. Federal and state partners should jointly negotiate the percent of each applicable rate annually. At the end of five years, a realistic percentage-based employment related outcome measure would replace the WPR as the measure of TANF program success. However, engagement in activities would continue to be measured and reported publicly for those not yet employed, utilizing the standards adopted in the 2011 Claims Resolution Act. Not only does this change move away from measuring process to measuring outcomes, it also moves towards integration of TANF with WIOA.

C. Expand funding under TANF Program

1) In order to compensate for at least part of the over 30 percent erosion in the block grant since 1996, additional funding should be added to the Block Grant. Congress could dedicate any new funding

solely for employment related activities including short-term subsidized employment that proved successful under the Emergency Contingency Fund in 2009-10; basic cash assistance, one-time payments that might avoid the need for ongoing assistance; enactment or expansion of state EITC's; and increased child care supply.

2) Maintain a strong contingency fund under TANF for use by states at times of economic downturns and high unemployment and make such funding more accessible to states by reducing the level of state matching funds needed to access them.

3) Expand funding for research and evaluation efforts, including application of behavioral economic and rapid cycle evaluations, to determine what activities actually work and integrate data sharing efforts between TANF and WIOA as a way to move towards a common client data base among partnering agencies that removes duplication of effort, increases program efficiency, and improves the delivery of client services.

4) Add separate new funding for state and locally designed, intensive employment training and job placement programs for non-custodial parents with child support orders in the Title IV-D program who are currently unable to meet their support obligations.

5) To increase the ability of states and local districts to propose innovative alternative approaches under TANF, issue a competitive Request for Proposals (RFP) to states allowing for and separately funding ten new pilot programs designed and focused on employment to be reviewed and launched in lieu of existing program components and measures. Include a rigorous, separate competitive evaluation proposal RFP that will measure pilot program success over time for possible replication on a broader scale. This concept was employed as part of the last Farm Bill through creating 10 state pilots for SNAP E&T and can hopefully yield important new policy and practice innovations in TANF.

D. Strengthen Related Work Incentive and Support Programs, Particularly Through a Two-Generation Lens

While not directly part of TANF reauthorization, both expanded child care availability and the work incentive and wage supplement effects of the EITC are critically important to helping and encouraging more work eligible adults to leave TANF for employment and to simultaneously support the overall well-being of parents and their children. Therefore, we make the following recommendations.

1) Increase available funding for the Child Care Development fund to expand the availability of subsidized child-care slots, assure the health and safety of care and promote the use of quality care. Consideration should also be given to assisting families who need non-traditional hours of care when traditional settings are not available and subsidies do not help. One avenue to accomplishing this would be to convert the current child and dependent care tax credit to a refundable credit for low and moderate income working households.

2) Expand the current federal Earned Income Tax Credit (EITC) in two specific fashions. First, increase the size of the maximum EITC for single individuals and childless couples both as a work incentive and a critical wage supplement. Specific and virtually identical legislation was proposed to accomplish this both by the Obama administration and House Speaker Paul Ryan in 2016. Second, encourage eligible households to save a portion of the annual EITC (up to 20 percent) as a "rainy day fund" (similar to an Individual Development Account or 401K account) by establishing a new matching program that would fully or partially match the household contribution. Such legislation was proposed in the Senate in 2016, introduced by Senator Booker (D-NJ) and Senator Moran (R-KS) as S. 2797, the Refund to Rainy Day Savings Act.

3) With discussion already beginning about the reauthorization of SNAP in 2018, it is important to maintain the integrity of SNAP as a work support, a nutrition program, and a ripe area to expand and

link E&T efforts to WIOA and TANF. Details on APHSA positions regarding SNAP reauthorization can be found in several policy documents on the APHSA website, www.aphsa.org.⁷

CONCLUSION

APHSA, as the association representing appointed state and local Commissioners of Human Services, offers these specific recommendations regarding TANF as a step toward rebuilding a healthy partnership between the federal government and its state and local partners. We strongly believe that these changes, suggested by the actual practitioners who deliver TANF benefits and related services, will result in a reinvigorated and successful TANF program for the future. TANF must be a program that not only moves families towards greater economic and social well-being through skill-building, work where possible, and critical work supports, but also through the provision of temporary cash assistance for those who cannot work, those awaiting a disability determination, and those who need a bridge support during economic hard times.

APHSA, through its Center for Employment and Economic Well-Being (CEEWB) and its National Association of State TANF Administrators (NASTA) affiliate, stands ready to work with the next Administration and Congress to build a better and more efficient TANF program for both clients and program administrators.

⁷ See APHSA's *Pathways Policy Brief Supplemental Nutrition Assistance Program: SNAP's Role and Potential in an Integrated Health and Human Services System* at www.aphsa.org/content/dam/aphsa/pdfs/Pathways/Briefs/Pathways%202.0%20Policy%20Brief%20-%20SNAP%20-%202017-22-15.pdf.





American Public Human Services Association

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January 24, 2017

The Honorable Kevin McCarthy
House Majority Leader
H-107, The Capitol
Washington DC 20515

The Honorable Kevin Brady
Chairman, House Committee on Ways and Means
301 Cannon Building
Washington DC, 20515

The Honorable Greg Walden
Chairman, House Committee on Energy and
Commerce
2185 Rayburn House Office Building
Washington, DC 20515

The Honorable Virginia Foxx
Chairman, House Committee on Education and
the Workforce
2262 Rayburn House Office Building
Washington, DC 20515

Dear Majority Leader McCarthy, Chairman Brady, Chairman Walden and Chairman Foxx:

The National Governors Association (NGA) appreciates your December 2nd letter to governors requesting feedback for potential changes to the Patient Protection and Affordable Care Act of 2010 (ACA). All governors and states have taken a different approach on improving access to high-quality and affordable healthcare. To date, 32 states, including the District of Columbia, have expanded Medicaid. As of February 2016, nearly 13 million Americans were enrolled in coverage through the health insurance exchanges. Governors share your goal of fostering a 21st century health care system that improves health outcomes and reduces the financial burden on families, businesses and government. By working together in a bipartisan manner, we can build a more efficient health care system that continues to put patients at the forefront and addresses the underlying factors driving unsustainable health care spending.

As Congress begins considering health care reform, governors request that you consider the following concepts:

- Governors lead the nation in driving value into the health care system and ensure access for their state residents. Congress should incorporate governors' suggestions throughout the legislative process. It is essential that Congress allows sufficient time for states to review and respond to proposed changes, build on current state efforts, ensure a smooth transition, and to minimize budgetary impacts to states.
- As Congress considers reforms to private health insurance, reforms must provide meaningful flexibility for states to shape the market based on the unique preferences and priorities of our residents.
- Support for vulnerable populations is a shared responsibility between the federal government and the states. In considering changes to Medicaid financing, it is critical that Congress continue to maintain a meaningful federal role in this partnership and does not shift costs to states. This includes the need for continued financial and programmatic

flexibility to innovate and improve the efficiency of our Medicaid programs through new and existing health care transformation initiatives.

- Any reform proposal should protect states from unforeseen financial risks – such as the recent economic downturn or higher costs due to new drugs, treatment or epidemics – that could result in a spike in Medicaid enrollment or increased per-beneficiary costs. Congress should also recognize and leverage the technological and administrative advancements already made and paid for under the ACA.
- As Congress considers health reform legislation, governors urge Congress to maintain predictability in federal programs while reforms are considered and not inadvertently lower the baseline for health spending during any interim period.
- Similarly, governors have created innovative health care programs that rely on federal funding. Continued federal support for these initiatives is critical to supporting the infrastructure for health care payment and delivery reforms that drive value into the health care system.

Governors commend congressional efforts to lower health care costs, improve access, enhance quality and improve the overall health of our nation. We share those same priorities. States are driving innovation in the delivery and payment of services by testing new models for health care transformation that aim to lower the trajectory of health care spending while improving quality and outcomes. As Congress begins debating new health care reforms, we urge you to maintain an open and robust dialogue with governors. It is critical that any changes to Medicaid and the private health insurance market reflect states' experience as major health care purchasers, regulators, and administrators who will be responsible for carrying out new reforms.

Governors stand ready to engage in a constructive and thoughtful dialogue with you to ensure the success of future reform efforts. We look forward to continued collaboration on these important issues.

Sincerely,

Governor Terry McAuliffe
Chair
National Governors Association

Governor Brian Sandoval
Vice Chair
National Governors Association

family driven

prevention oriented

holistic



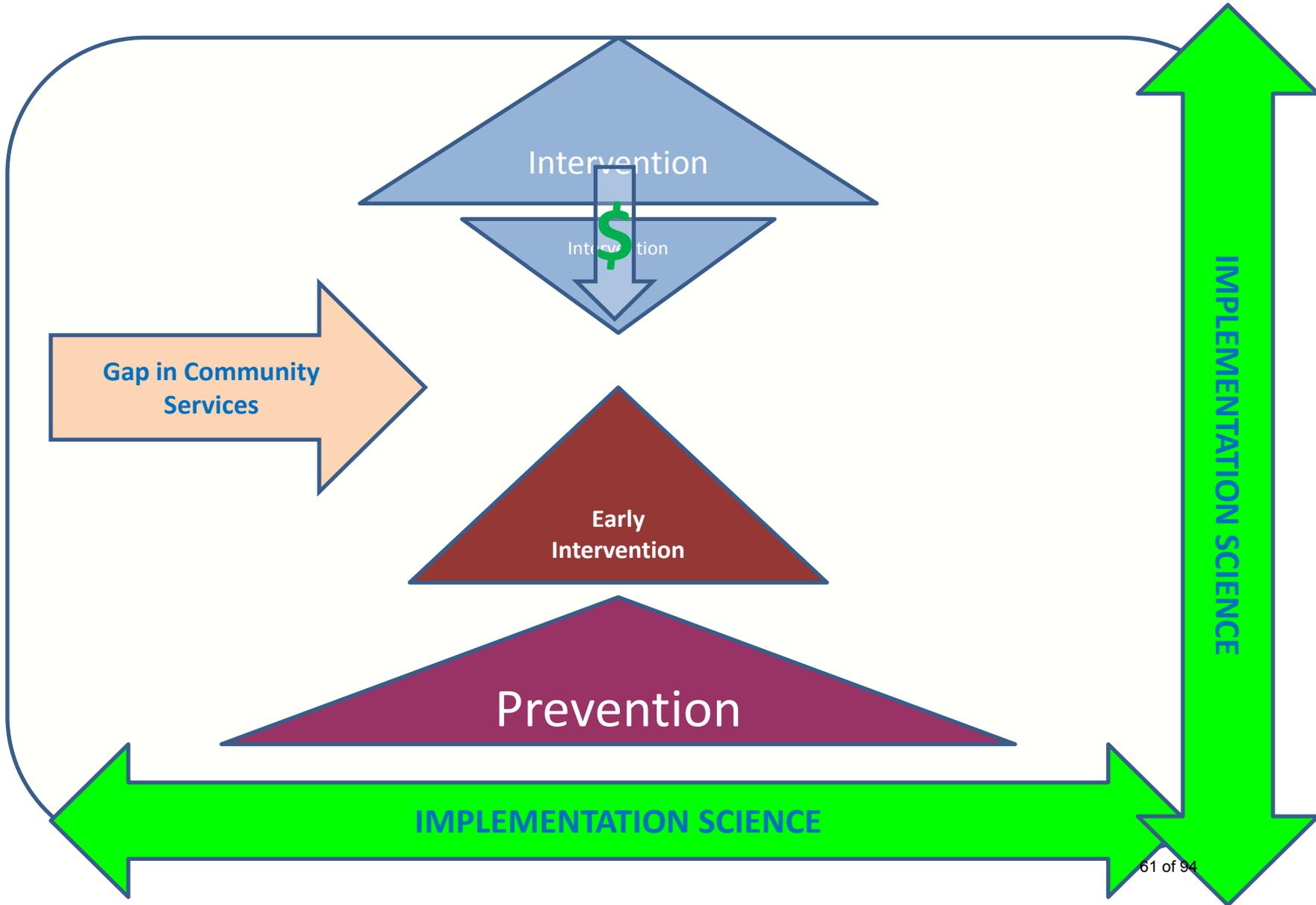
Boulder County Family Resource Framework



OUR OBJECTIVE for TODAY

- Review and discuss the **Who**, **What**, **When**, **Why**, and **How** of the Family Resource Framework.
- Decide and finalize HHSAC as FRF Regional Council.
- Decide on other key stakeholders to invite.

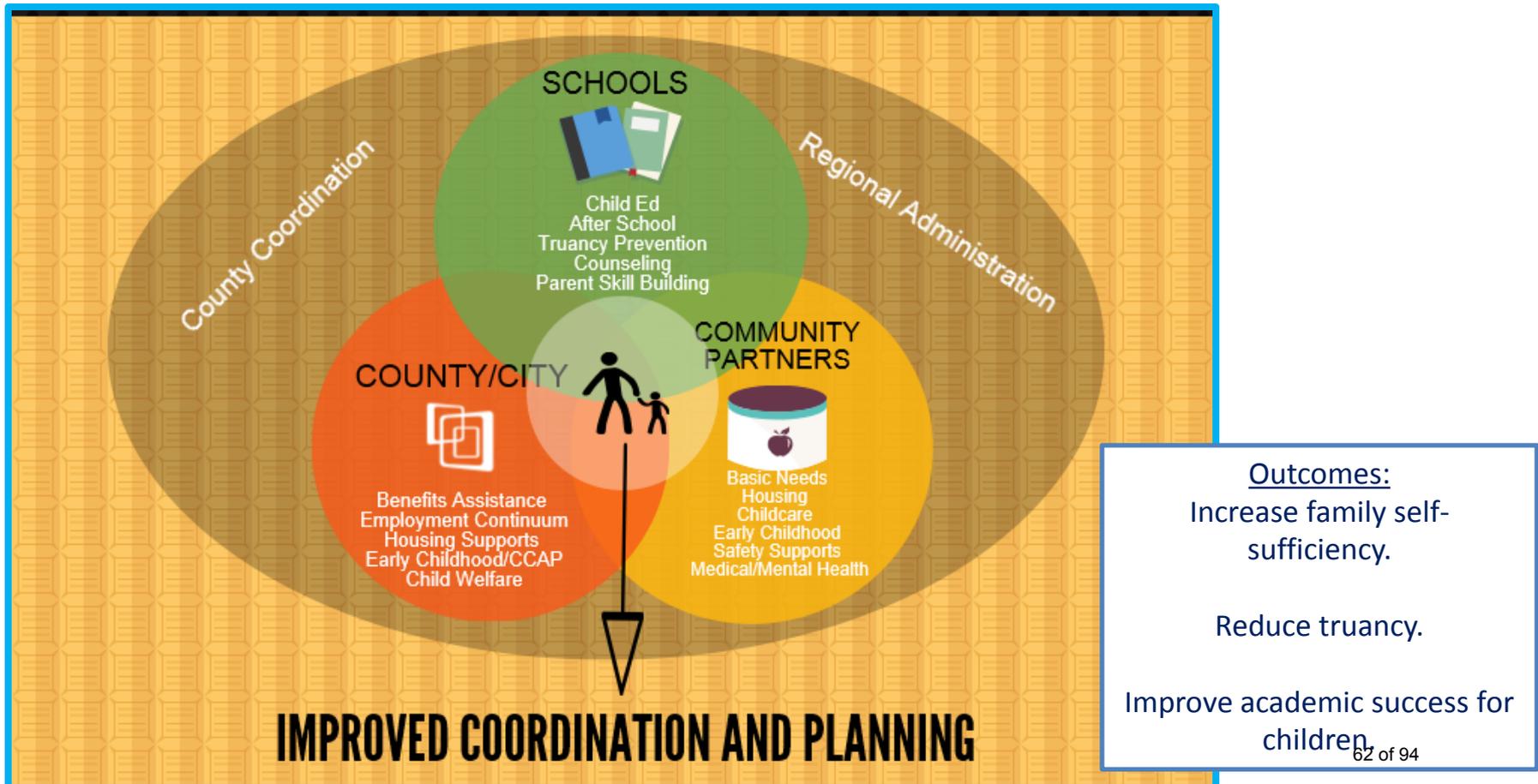
THE "WHY"



THE “WHAT”

Family Resource Framework

Based on a two generational approach, the FRF is a an integrated system of service delivery, organized through a county-wide governance structure comprised of **schools**, **community-based entities**, and **city/county government** aimed at increasing family self-sufficiency, reducing truancy, and improving academic success of children.



THE "HOW"



Entry – through Any Door



- Common Philosophy
- Universal Assessment and Practice



Common Data Systems



Sustainable Outcomes



FRF and Dream Big

Common Themes	Family Resource Framework	Dream Big
<p>Helping families, children and youth succeed</p>	<p>Increase family self-sufficiency, reduce truancy, and improve academic success of children.</p>	<p>Eliminate the opportunity and achievement gaps so all children in Boulder County are succeeding academically and reaching their full potential.</p>
<p>Emphasis on two-gen and early intervention</p>	<p>Based on a two generational approach engage families through common assessment and case planning grounded in the social determinants of health (housing, education, employment, etc.)</p>	<p>Engage children and families earlier by providing programming and support to parents with children ages 0-5.</p>
<p>Framework of key stakeholders</p>	<p>Develop an organized and integrated county-wide governance structure comprised of schools, community-based entities, and city/county government.</p>	<p>Develop a tight collaboration with BVSD to align and address all out-of-school and in-school factors for every low-income students,</p> <p>Facilitate deep and broad integrated services among the City, Schools, IHAD, non-profit and other agencies to ensure wraparound service.</p>

FRF and Dream Big

Structure	Family Resource Framework	Dream Big
Service Area	County-wide	City of Boulder (currently)
Approach	Grounded in Family Resource Model and Strengthening Families Competencies	Based on I Have a Dream model
Assessment and Practice	Universal Assessment (CFSA+) and case management practice model Services matched to assessment Various levels of intensity based on need	Assessment and case management practice not yet defined
Service Duration	Light to Heavy (1 visit to 30+ in a year) depending on assessed need	Heavy- follows family from early childhood through to career
Costs per family	\$100 - \$10,000+	Tens of thousands
Data and Systems	Universal, integrated data system and reporting structure accessed county-wide	Localized data system and reporting
Spectrum of Service Providers	30+ partners throughout the county supported through investments Vetted and provide best practices	Eight primary Boulder-based entities

Dream Big (using IHAD model)

Partnership with BHP and Aspinwall

Mentoring
Tutoring
Community Service Activities
Scholarship for college or vocational training

Pro-social after school activities,
family events, etc.

Pathways to College and Career



Family Resource Framework

Housing

- Rent and utility assistance
- Supportive housing programs
- Shelter and transitional housing

Education

- Before- and after-school child care
- After-school enrichment classes
- Truancy prevention services
- English as a Second Language classes
- GED classes and supports
- Achievement gap resources –tutoring & academic supports
- Evidence-based parent education programming

Health and Well-being

- Mental health services
- Medical/dental services
- Enrollment in public benefits
- Early childhood and childcare supports
- Pro-social activities, family events and activities
- Transportation assistance

Employment and Income Stability

- Job Readiness Training, Career Pathways and other employment supports
- Bridges Out of Poverty programming

Food and Nutrition

- Enrollment in food assistance, access to food banks, nutritional education

Safety

- Domestic violence and child abuse intervention and prevention
- Basic needs support

**Core
Services
Provided**

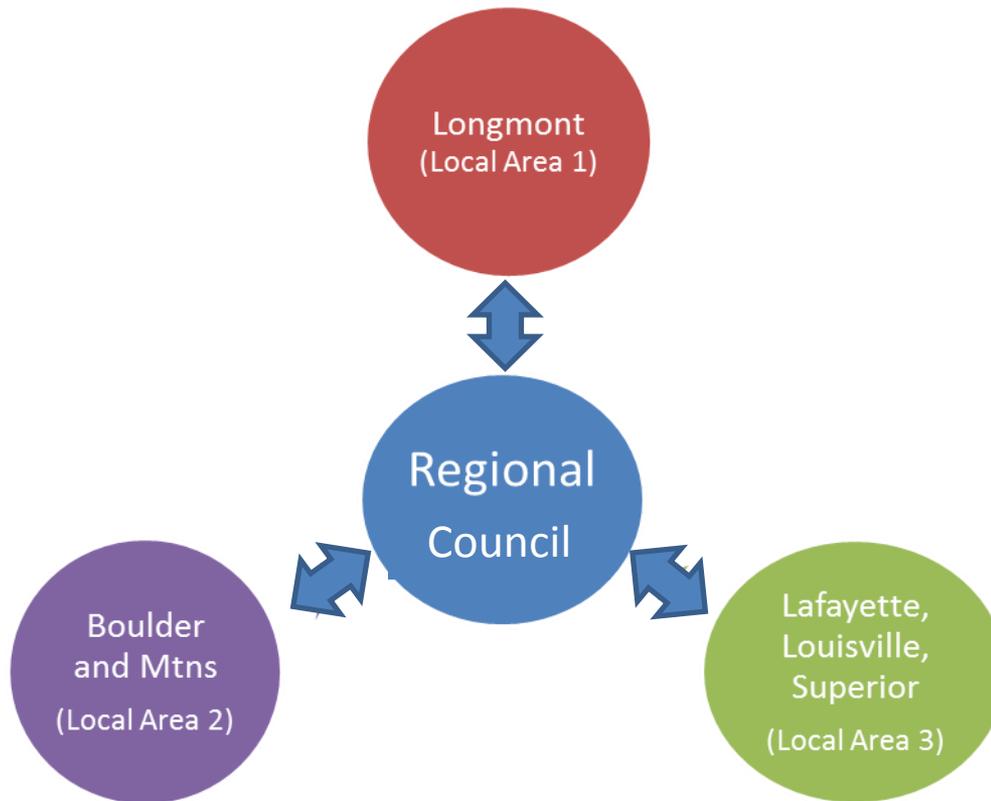
The “Who”

Family Resource Framework

GOVERNANCE



Governance Structure



Regional Council Role

- 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.
- Resource procurement and allocation
- Inform and support the Boulder County Integrated Services Delivery Model of Care.
- Review and approve recommendations from LACs.

Local Area Collaborative Role

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 analyze local data and reports on family resource programming;
- Implement referral, access and data quality improvement;
- Track progress on implementation of collective service outcomes;
- Establish and ensure participant programs adhere to standards outlined by the FRF, Quality Service Standards outlined by the Family Resource Center Association;
- Coordinate training and “communities of practice” within areas and collaborate between areas; and
- Inform and support the Boulder County Integrated Service Deliver Model of Care.

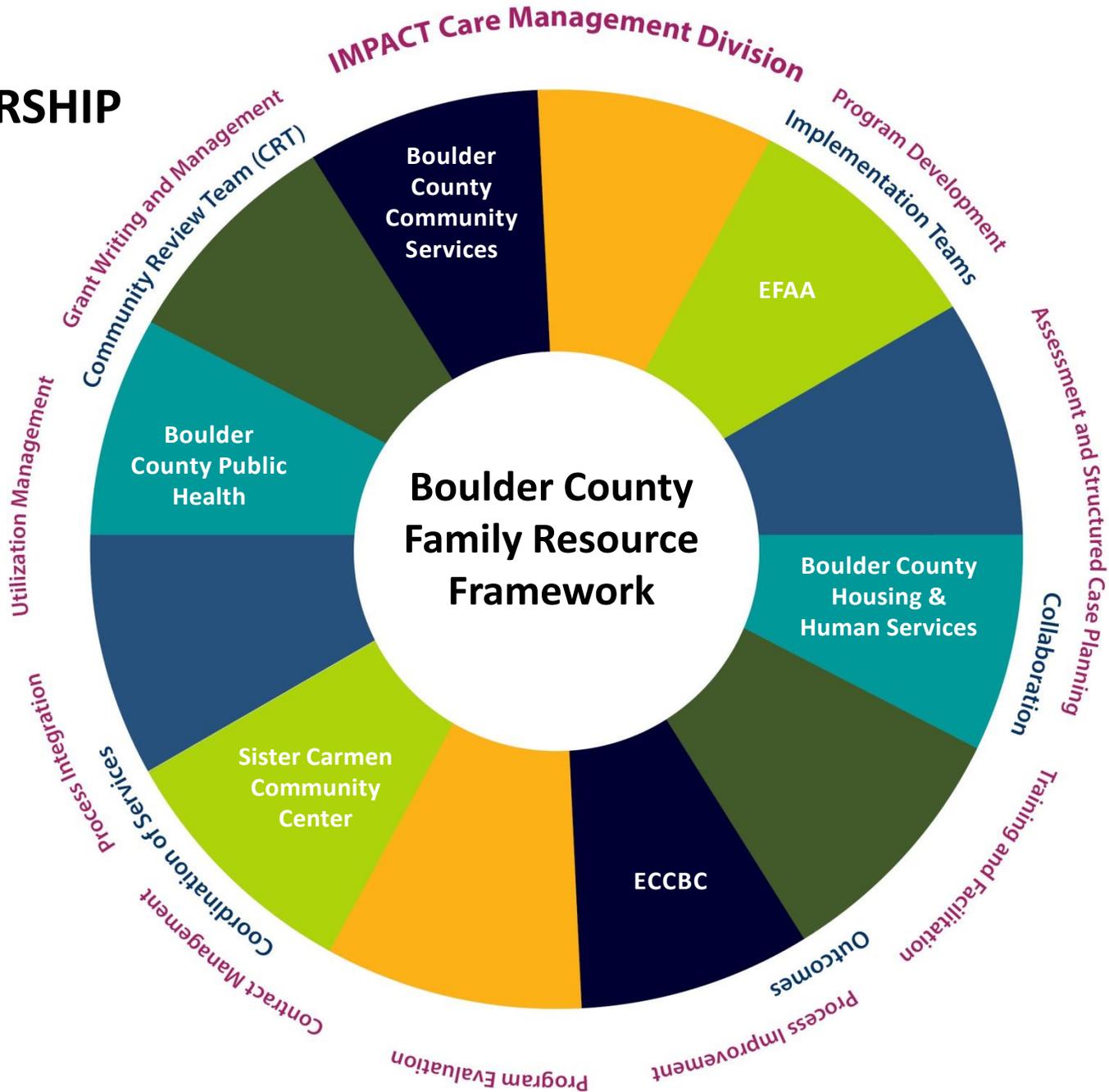
Staff Liaisons and Role

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

Local Area Collaborative Liaison (all 3)- IMPACT Strategic Initiatives
Coordinator (Whitney Wilcox)

Administrative and Program Support- IMPACT Strategic Initiatives
Specialist (Monica Serrato)

MEMBERSHIP



Regional Council Membership

SCHOOL

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

COUNTY/CITY GOVERNMENT

- Boulder County FRF Liaison
- 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

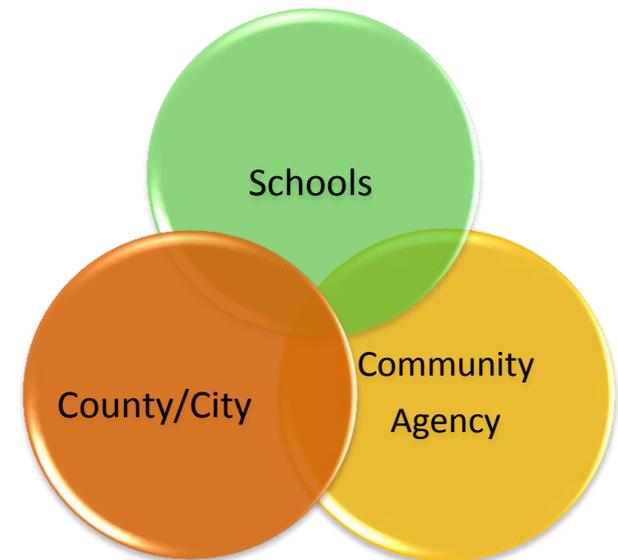
COMMUNITY-BASED AGENCY

- OUR Center Director (LAC 1)
- Sister Carmen Community Center Director (LAC 2)
- EFAA Director (LAC 3)
- Clinica Director
- ECCBC Director
- Boulder Housing Partners Director

Members at-large

Other considerations:

- Mental Health Partners Administrator
- Dream Big Director
- Foothills United Way Director



Local Area Collaborative Membership

SCHOOL

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

COUNTY/CITY GOVERNMENT

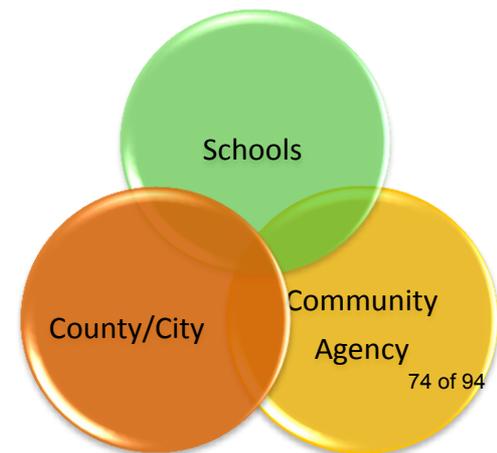
- Boulder County Housing and Human Services - FRF Liaison (attends all 3 LACs)
- BCDHHS Early Intervention Team Program Manager (attends all 3 LACs)
- Boulder County Community Services – Workforce Boulder County staff member (attends all 3 LACs)
- Boulder County Department of Public Health representative (attends all 3 LACs)
- City of Longmont- Children and Youth Center representative (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 staff
- Dream Big program staff
- ECCBC program staff
- Clinica program staff
- Boulder Housing Partners program staff



The “When”

Timeline 2017

Q1 2017

January

- Finalize Initial Governance Document and Membership
- Structure for Regional Council Meetings identified
- Begin Onboarding of FRF to Core Services and Initiatives
- FRF Implementation Team Formed (subcommittee of RC)

February

- Continue to onboard FRF Regional Council to Core Services and Initiatives
 - Overview of Core FRF Member Programs
 - SCCC, EFAA, OUR Center, City of Boulder FRS, Boulder FRC, etc., MHP services, etc.
 - Overview of Integrated Services Delivery Model of Care (ISDMC) as the foundation to service delivery
 - Overview of Truancy Project and its relation to FRF
 - Sharing of stories of Coordinated Services in Action
- Identify opportunities to align similar-efforts across the County with the FRF (i.e. Dream Big, Bringing School Home, FRCA work, etc.)

March

- Identification of Gaps and Needs by Local Area
- Formalize plan to align similar-efforts with the FRF
- Communications plan completed and begin implementation
- Plan for launch of LACs finalized

Timeline (cont'd)

Q2 2017

- Primary objectives for 2017-18 of FRF established and implemented (based on gaps/needs data and governance doc)
- Establish process and program metric and system needs to support the FRF functions
- Data sharing protocols created
- Training on Family Development Credential for all key partners and stakeholders completed
- Updates on Longmont FRC and Boulder FRC/EFAA

Q3 2017

- Data sharing agreements and systems in place for primary partners
- ISDMC Practice and Technology Alignment with FRF
- Implementation of ISDMC practice model in primary partner entities
- Investment planning for 2018

Q4 2017

- Evaluation of implementation of FRF process data
- Revisions to Framework made
- Final program metrics and investments plan for 2018 completed

Follow up on objectives

- Review and discuss the **Who**, **What**, **When**, **Why**, and **How** of the Family Resource Framework.

Any further clarifications needed?

- Decide and finalize HHSAC as FRF Regional Council.
- Decide on other key stakeholders to invite.

Next Steps

- Next Meeting – January 31, 2017 @ 3:30
- Action Item Review
- Proposed Agenda
 - Finalize initial governance document and membership
 - Identify structure for Regional Council meetings
 - Begin onboarding of FRF to Core Services and related initiatives
 - Form FRF Implementation Team (subcommittee of RC)

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. Serve in role as Family Resource Framework Regional Council member and serve as stewards per the FRF Regional Council Governance Guidelines—See Attachment A: FRF Governance Document.

B. 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.

C. 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.

- D. 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.
- E. Become more knowledgeable about other resources in the County and share appropriate information with the committee and the staff of the Department.
- F. Become familiar with County, State & Federal Human Services programs and policies.
- G. Become familiar with existing legislation at the County, State, and Federal levels and to contact legislators regarding pending and needed legislation.
- H. 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.

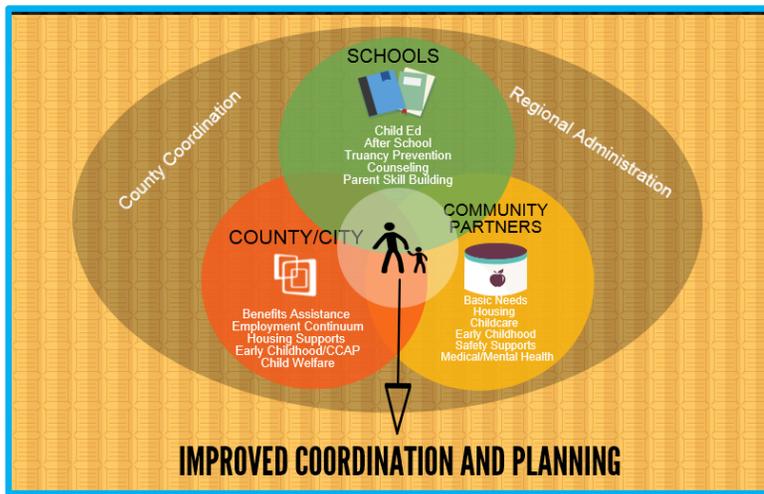
Family Resource Framework Governance Charter

Comment [FM1]: Change this to NETWORK?

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 for children.



The FRF Regional Council (RC)

The Boulder County Housing and Human Services Advisory Committee (HHSAC) will serve as the Family Resource Framework Regional Council (RC) 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 the following:

- communicating a shared vision;
- supporting progress on community-wide outcomes;
- advocating and informing on relevant local, state and federal policy;
- supporting and advising on program improvement;
- supporting coordinated and consistent processes;
- facilitating and approving formal agreements for operation of the Framework;
- facilitating resource procurement and allocation;

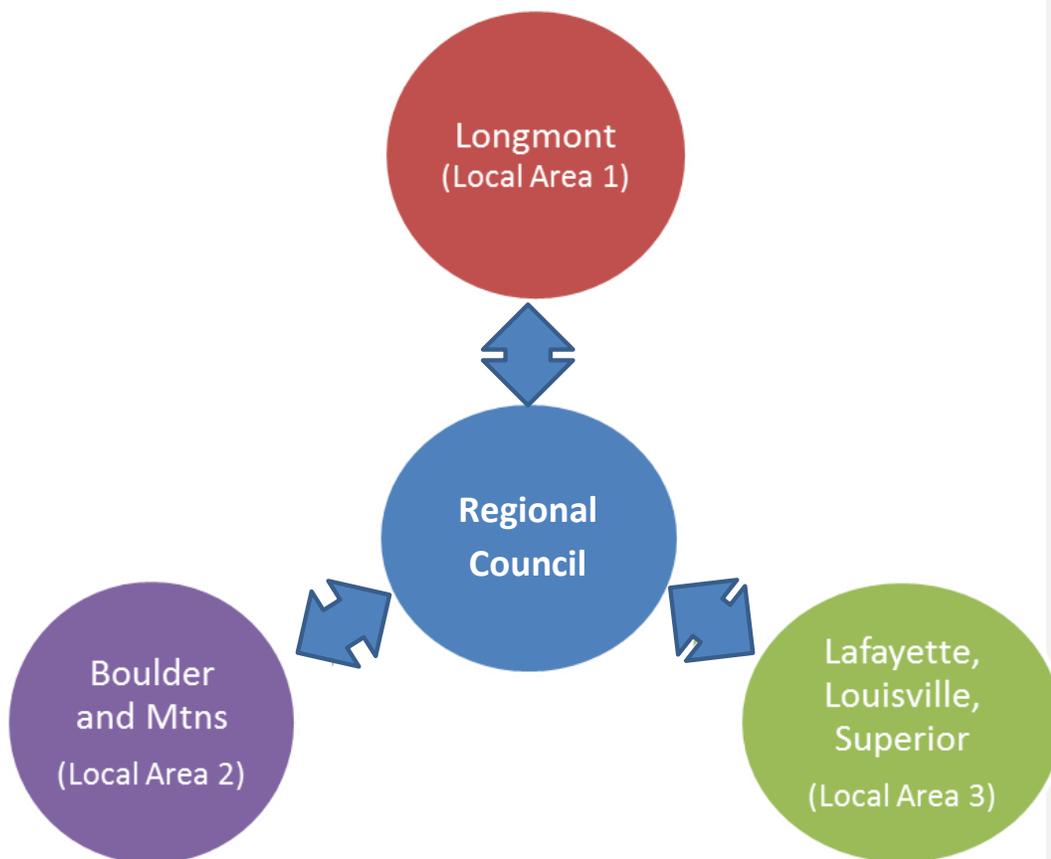
- informing and supporting the Boulder County Integrated Services Delivery Model of Care (ISDMC);
- reviewing and approving recommendations from Local Area Collaboratives (LACs)

Local Area Collaborative Groups

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 Collaborative (LACs) groups 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 plan;
- tracking progress on implementation of collective service outcomes;
- establishing and ensuring participant programs adhere to standards outlined by the FRF and Quality Service Standards by the Family Resource Center Association;
- coordinating training and “communities of practice” within areas and collaboration between areas;
- informing and supporting the Boulder County Integrated Service Delivery Model of Care.

Comment [FM2]: Consider adding a LAC 4 for the mountain communities



Boulder County Staff Roles

Two designated Boulder County staff will provide guidance, technical assistance and support to the Regional Council and the Local Area Collaborative entities (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 work as a fundamental basis for service delivery by FRF partners;
- Provides any pertinent fiscal reports (i.e. funding reports); and
- 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 reports to the 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 programs 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; and
- Serves as Regional Council Liaison in the absence of the Strategic Initiatives Manager.

Administrative Supports – IMPACT Strategic Initiatives Specialist (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; and

- 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 or designee
 Boulder Valley School District Assistant Superintendent or designee

Comment [FM3]: Melissa and Whitney are reaching out to Madeline Case and Karen Blough

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

Comment [FM4]: Reaching out to Karen Rahn and Christina Simms

COMMUNITY-BASED AGENCY

OUR Center Director (LAC 1)
 Sister Carmen Community Center Director (LAC 2)
 EFAA Director (LAC 3)
 Early Childhood Council of Boulder County Director (ECCBC)
 Clinica Director

MEMBERS AT-LARGE

Other considerations

Mental Health Partners Administrator
 Dream Big Director

Comment [FM5]: See notes from meeting with Lori. Still need to determine MHP rep

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 Collaborative

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.

Comment [FM6]: Based on decisions above, these section should mirror the RC agency representation

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 staff member(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)
- ECCBC program staff

Other Considerations

Mental Health Partners Program Manager

Dream Big program staff

Clinica program staff

Boulder Housing Partners program staff

3. SCOPE and ROLES

Regional Council

The Family Resource Framework Regional Council guides overarching governance of 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), finalizing an agreed upon logic model with tangible measures, and monitoring progress in achieving these outcomes.
- **Advocate and inform on relevant local, 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** – RC members will review the LAC process and program-related recommendations 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.
- **Facilitate 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** - This includes use of a common assessment and practice.
- **Review and approve recommendations from Local Area Collaborative entities**

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 included are listed below.

- **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 a referral process to support the family resource services in their area. Referrals will be linked to assessment and supported through a common data system (HHSC/Marketplace).
- **Review and analyze local data and reports** on family resource programming.
- **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**, to include Quality Service Standards by the Family Resource Center Association.
- **Coordinate training and “communities of practice”** within areas and collaborate between areas.

- **Inform and support the Boulder County Integrated Service Delivery Model of Care** (see attachment C).

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.

Comment [FM7]: Per ECCBC recommendation-add early childhood outcomes

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 outline 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). This document will assistance in development of the Boulder County FRF Outcomes to be completed per the FRF implementation work plan.

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

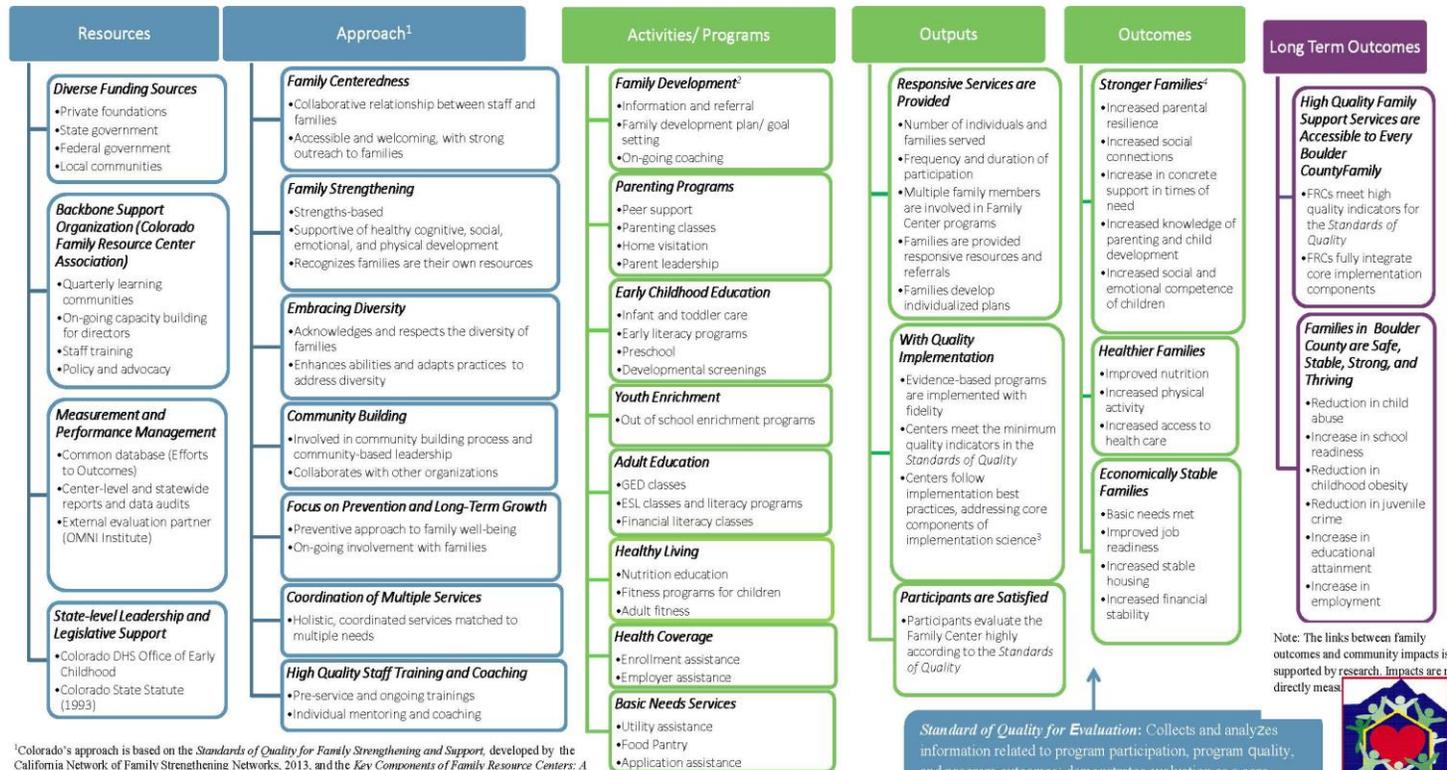
Date ratified _____

Revision _____

Revision _____

Colorado Family Resource Center Logic Model

(updated December)



Note: The links between family outcomes and community impacts is supported by research. Impacts are not directly measured.

Standard of Quality for Evaluation: Collects and analyzes information related to program participation, program quality, and program outcomes; demonstrates evaluation as a core component of programming.



¹Colorado's approach is based on the *Standards of Quality for Family Strengthening and Support*, developed by the California Network of Family Strengthening Networks, 2013, and the *Key Components of Family Resource Centers: A Review of the Literature*, funded by the FRCA.
²This is a required service under Colorado State Statute.
³Developed by the National Implementation Research Network <http://nimr.the.unc.edu/>.
⁴Strengthening Families Protective Factors Framework developed by the Center for the Study of Social Policy. <http://www.cssp.org/reform/strengthening-families>.

Note: Families receive an array of services based on local Family Center resources and family needs. Not all families receive all programs listed.

Boulder County Revision (orange box)

Short to Moderate Term Outcomes

Stronger Families

- Increased **parental resilience**
- Increased **social connections**
- Increase in **concrete support** in times of need
- Increased knowledge of **parenting and child development**
- Increased social and **emotional competence of children**

Healthier Families

- Improved **nutrition**
- Increased **physical activity**
- Increased **access to health care**

Economically Stable Families

- **Basic needs** met
- Improved **job readiness**
- Increased stable **housing**
- Increased **financial stability**

Success in School for Children and Youth

- Reduce truancy
- Improve academic success
- Improve behavioral outcomes

Long Term Outcomes

High Quality Family Support Services are Accessible to Every Boulder County Family

- FRCs meet high quality indicators for the *Standards of Quality*
- FRCs fully integrate core implementation components

Families in Boulder County are Safe, Stable, Strong, and Thriving

- Reduction in child abuse
- Increase in school readiness
- Reduction in childhood obesity
- Reduction in juvenile crime
- Increase in educational attainment
- Increase in employment

Attachment B

Stages of Development and Implementation for FRF Structure

Development Team

A Development Team comprised of members of the Regional Council (or designees 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 a new way of collaborating to support families.

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 positions 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 two-hour meetings per month to include monthly HHSAC meeting
- Plus an estimated two to four hours of additional work time per month

Attachment C

Integrated Services Delivery Model of Care Practice Model



Advance Planning Calendar for February – April 2017

Plan for February, 2017 Advisory Committee Meeting

- Finalize outstanding items from January Meeting
- Review of action items due
- Review and approve high level timeline and work plan for the Family Resource Framework
- Onboard FRF Regional Council to Core Services and Initiatives
 - Review of Integrated Services Delivery Model of Care (ISDMC) as the foundation to our service delivery.
 - Overview of Core FRF Member Programs-SCCC, EFAA, OUR Center, City of Boulder FRS, Boulder FRC
 - Overview of the Family Resource Center Association and relation to our FRF work
- Review of similar-efforts to the FRF across the County - Melissa will provide a map of initiatives for the group to review
- Review and finalize action items to be completed before next meeting.

Plan for March, 2017 Meeting

- Finalize outstanding items from February Meeting
- Review of action items due
- Continue onboarding of FRF Regional Council to Core Services and Initiatives
 - BHP- Bringing Schools Home
 - ECCBC- Strategies
 - TIP Project
- Discussion of recommendations to align similar efforts with the FRF- based on mapping exercise from March meeting
- Updates on implementation of LAC
- Updates on implementation of ISDMC and next steps with partners
- Review and approval of data template
- Review and finalize action items to be completed before next meeting.

Plans for April, 2017 Meeting

- Finalize outstanding items from March Meeting
- Review of action items due
- Updates from IHAD and partnership with SCCC and EFAA
- Updates on alignment efforts
- Updates on LAC implementation
- Data review



Hope for the future, help when you need it.

DHHS Advisory Committee

February 28, 2017

AGENDA..... 2-3

REVIEW OF MINUTES 4-

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FRN GOVERNANCE CHARTER -2

DHHS Advisory Committee
MONTHLY MEETING
Tuesday, February 28, 2017, 3:30-5:00 p.m.
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Objectives for Today:

- 1) Review of revised process for HHSAC – member recruitment and orientation, packet structure- updates, data, fiscal
- 2) Finalize the Membership and the Roles and Scope sections of the FRN Governance Charter
- 3) Identify and finalize additional members for HHSAC/FRN

- 1) **Introduction of Bobbie Watson as new HHSAC Chair-** (3:30-3:33) Frank
- 2) **Review and approval of today's agenda and above objectives** (3:33 – 3:35) Bobbie
- 3) **Review and approval of minutes and updates on action items from January 30th HHSAC meeting** (3:35 – 3:40) – Bobbie
[Decision point: Approval of minutes](#)
- 4) **Introduction of guests to today's meeting** (3:40-3:45)
- 5) **Review and discussion of revised meeting structure and process** (3:45-3:50)
Bobbie/Melissa

Member recruitment and orientation process; revised structure of packet including data and fiscal processes (see pages 10-12)

[Decision point: Finalize revised process](#)

- 6) **Discussion of work done by HHSAC in 2016 and transition to 2017 as FRN** (3:50-4:00)
Frank/Jim/Bobbie

Review of summary document.

- 7) **Discussion and edits to the FRF Governance Charter** (4:00-4:30)

Melissa

- Review revisions from Frank/APHSA
- Review and discuss Membership
- Review and discuss Scope – FRN Regional Council as primary function of HHSAC

- Discuss questions or concerns.

Decision points: Finalize the Membership and the Roles and Scope sections of the document.

Finalize all additions to document

Identify and finalize additional members to be invited to join

8) Partner updates and discussion (4:30-4:55)

- Review of public official outreach documents- talking points, letter template, strategies for engaging, etc. – All members led by Jim W.
- Update from Public Health on BUILD grant - Heather Matthews

9) Review of agenda for next meeting (4:55-5:00)

Bobbie/Melissa

- Introduction of prospective new members – Lori Canova, IHAD; Diane Lauer, SVVSD; Karen Roney, City of Longmont
- Onboard FRF Regional Council to Core Services and Initiatives
 - Review of Integrated Services Delivery Model of Care (ISDMC) as the foundation to our service delivery.
 - Overview of Core FRF Member Programs
 - SCCC, EFAA, OUR Center, City of Boulder FRS, Boulder FRC
 - Overview of the Family Resource Center Association and relation to our FRF work
- Review of similar efforts to the FRF across the County - Melissa will provide a map of initiatives for the group to review.
- Review and finalize action items to be completed before next meeting.

10) Adjourn



Department of Housing & Human Services

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Draft Meeting Minutes DHHS Advisory Committee January 31, 2017

Members Present: Robin Bohannon, Jeff Zayach, Julie Van Domelen, Suzanne Crawford, Dalia Dorta, Pat Heinz-Pribyl, Betsey Martens, Bobbie Watson, and Laura Kinder

Staff Present: Frank Alexander, Jim Williams, Melissa Frank-Williams, Susan Caskey, Darlene Bushue, Daphne McCabe, and Whitney Wilcox

Guest: Edwina Salazar

Meeting Action Items:

1. Committee members may send position papers, correspondence to clients and staff and other communication documents to Jim Williams. Staff will compile and post these documents to the HHSAC [Google Drive](#).
2. Staff will send committee members the notes from the meeting with Lori Canova/IHAD about alignment between the Family Resource Framework (FRF) and Dream Big.
3. Staff will connect with Canova about liaising with Dream Big partners to identify appropriate liaison to serve on HHSAC.
4. Staff will coordinate application process for new members.

Detailed Meeting 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 December 6, 2016 HHSAC meeting (3:33 – 3:35 p.m.)

Approved as written.

3) Recognition of Laura Kinder for her work with the committee (3:35-3:45)

The group recognized the contributions of Laura Kinder to HHSAC. F. Alexander announced that L. Kinder had decided to step down after six years serving on HHSAC that included her role as Chair. Alexander thanked her on behalf of the staff and recognized her immense contributions. Kinder was presented with a plaque for her year of service. She shared that she had enjoyed the work is always available to called upon.

Other committee members added their thank you and appreciation, including R. Bohannon, B. Martens, and B. Watson. Kinder expressed appreciation and reported that she is not leaving Longmont United Hospital and that her departure is intended to make room for other community members as HHSAC takes on governance of the Family Resource Framework (FRF).

4) Update on National Collaborative work, including future integration efforts, strategic planning work, and work with the new administration — Frank Alexander (3:45 – 4:30 p.m.)

Alexander wanted to orient committee members to the work of APHSA (American Public Human Services Association). He recently returned from Washington, DC from a meeting of the APHSA that convened its Locals Executive Committee members. APHSA is made up of local and state-based human services agencies. They are at the forefront of promoting integrated service delivery, had a large influence on implementation of the Affordable Care Act (ACA), and increasing data sharing and systems interoperability.

APHSA laid out three clear strategic goals, including establishing a work plan with key strategies and next steps for how to engage the new administration and Congress; clarifying how to make specific requests to the administration to keep the work moving forward, and developing common messages across sectors that address the uncertainty facing everyone. He wanted to share this work with HHSAC members and so included some examples of this work in the packet (*including National Collaborative for Integration of Health and Human Services: Promoting Greater Health and Well-Being, Creating a Modern and Responsive Health and Human Services System, and Center for Employment and Economic Well-Being: TANF at 20 – Time for Rational Changes*). Also included in the packet is a letter from the Chair and Vice-Chair of the National Governor’s Association responding on behalf of governors for feedback on changes to the ACA.

The group discussed the materials in the packet, which were described as transition documents. Alexander stressed that it’s important to re-ground ourselves in our core principals and to work across parties to do the work. He pointed to the packet documents for examples of concepts and work we have been engaged in locally. He said that APHSA had made commitments with other associations to work around common language and that we need to look for strategic opportunities. He said that our local community has had the experience of coming together around a common framing and language and that we had worked really well together to build the community safety net locally.

There was some discussion about Medicaid expansion. B. Watson asked what funding would look like if Medicaid was converted to a block grant. Alexander said we don’t currently have information on proposals and talked about lessons from TANF. He said that the funding amount was the same in 2016 as it was in 1996. He said the IV-E Waiver was better negotiated with better negotiating principles. He suggested that if Medicaid is converted to a block grant, states will work towards a positive outcome.

Alexander pointed to the National Governors Association letter in the packet as an example of the arena in which we are trying to work. Bohannon liked the letter and agreed it was important. She suggested using some time at next month’s HHSAC to talk more about local messaging and developing a uniform response to help address questions and concerns from clients and staff. Alexander agreed and said that state legislators are not hearing from local communities.

J. Van Domelen suggested planning for the worst case scenario – significant cuts and the dismantling of federal programs. She said the committee should be realistic about and share with the community the cost to families should programs be dismantled and funding reduced. She said this

would also help local funders think about how they will shift spending. Alexander responded that he's not in the position to make mitigation plans at the moment though that may be necessary in the future.

The group discussed sharing documents that its individual associations and/or organizations had created to communicate with clients, staff, and elected officials. These documents could be housed on the HHSAC Google Drive and help facilitate the creation of unified talking points locally. The group also discussed setting time aside during the next meeting to review and discuss.

5) Outcome of IHAD meeting with Lori Canova (4:30-4:40)

M. Frank-Williams reported that at the HHSAC meeting in December 2016, the committee agreed to convene a meeting with Lori Canova to share the scope of the FRF work and discuss alignment with Dream Big.

Frank-Williams reported that she and committee members met with Canova, that the meeting went well, and it created a mechanism for alignment around service delivery. There was agreement at the meeting to test some of the approaches around common assessment, service coordination, and data sharing with initiatives in early stages of development at BHP, EFAA and Sister Carmen. Bohannon asked for an example.

Van Domelen, S. Crawford, and Martens shared outcomes from the meeting. There was some discussion about extent to which next steps were concrete and operationalized, but the two pilots to be tested include the partnership between EFAA, BHP's Bringing School Home, and IHAD and the partnership between Sister Carmen, Sanchez Elementary, and IHAD. In both pilots, EFAA and Sister Carmen will administer the common assessment (the SSM or the CFSA+) to the pilot's participants. Frank-Williams agreed to send her notes from the meeting to committee members.

Canova was invited to attend the March meeting and Canova, Van Domelen, Martens and Crawford were invited to update the committee on the progress of these two pilots at the April meeting.

Martens said the meeting helped translate what has been more abstract into something more concrete. As part of this meeting, she was able to review the CFSA+, learn about how it is used, scored, and the frequency with which it is administered. She said that she loves theory and that seeing examples in practice, like the tool itself, is really helpful.

At this time, the group discussed the decision point: identify and agree on next steps with IHAD/Dream Big. Canova has been invited to join the committee. She will need to be nominated and, if accepted, go through County appointment process. Watson asked if Canova is the lead and/or if she would bring to the Dream Big steering committee to discuss with those members about who should be appointed to HHSAC. Frank Williams said she would want to make sure that the appointee is liaising with Dream Big members that are not attending HHSAC. Martens said that BHP's Rene Brodeur and Canova have been Dream Big Co-Chairs and that this is a question for Frank-Williams to follow-up with Canova on.

6) Discussion of Amendment to Bylaws to include FRF governance language (4:40-4:43)

Frank-Williams asked the committee if they wanted to change the FRF to Family Resource Network. She shared that the FRF model is being fed by some other work in California which also uses the work "Network." Alexander said it sounds more tactical and less abstract. Kinder asked if anyone had concerns, and none of the committee members did. The committee voted to officially change the name to Family Resource Network (FRN).

Frank-Williams shared the proposed amendment to the bylaws which would reflect the committee's role in overseeing the FRN. The committee voted to accept the change to the bylaws.

7) Discussion and voting on members (4:43-5:00)

Edwina Salazar, OUR Center Executive Director, was nominated to join the committee. Salazar said that she was excited to join the group and that OUR Center is very committed to the Family Resource Network. She added that the OUR Center board is excited to see how we all work together and that OUR Center has had a longstanding and strong partnership with Sister Carmen and EFAA. The committee voted unanimously in favor of adding Salazar to the board.

The committee discussed other individuals who may be appropriate for HHSAC. Alexander said the Commissioners wanted to make sure the committee has a strong community voice. Kinder asked if clients should participate on the committee. Salazar agreed with Kinder. She said the FRC model emphasizes the importance of client participation and leadership. Salazar said that this would be a good goal to have completed in the next six months (and if not six months she encouraged having some kind of timeframe for implementation). She said that given political climate, people seem more willing to participate.

Bohannon said it would be nice to recruit people that completed the People Engaged in Rising Leaders (PERL) training. Van Domelen asked if the committee should rely on an existing structure like the Head Start Parenting Committee for recruitment or if it's someone new that has accessed services from one of the community organizations. Bohannon said it could be a stretch for participants to go to both the Head Start policy council and also participate in another meeting.

Dalia said it's important for someone to participate on HHSAC that is independent of the Department and that does not need or want something from the Department of the larger committee – she added that the committee needs a participant who will speak up and out. Alexander suggested recruiting from the Community Foundation Leadership Fellows Program. He said he could follow-up with Elvira Ramos about this.

Martens asked about inviting a representative from MHP. Frank-Williams directed the committee to a powerpoint slide that identified recommendations from across the County. The recommendations included a representative from MHP, representatives from St. Vrain and Boulder Valley School Districts, and the cities of Longmont and Boulder. Frank-Williams asked for input from the committee on the recommendations.

J. Zayach said he was thinking about representation across the pillars and asked if there was representation from the safety and criminal justice work. Alexander said this was a good question for S. Caskey.

Martens said we should make sure a distinct housing voice is involved and that she didn't see her name/organization on the list. Frank-Williams apologized as this was an error and added her name.

Bohannon said the committee will need the right people at the table as we're looking at the systems work. She said there is an opportunity for a liaison role between this committee and other system groups. She suggested inviting SMEs to attend depending on the topic the committee would be addressing. She said she worries about meeting fatigue. Alexander said that S. Caskey and Dave Bonaiuto through Frank-Williams could provide updates on the truancy-related work. Zayach asked who from the committee could act as a liaison with the Human Services Alliance (HSA). Both Van Domelen and Crawford agreed to share this role.

P. Heinz-Pribyl said she didn't see someone from the City of Louisville identified for the committee. Bohannon said the challenge is that Louisville doesn't have a human services function in government and added that Lafayette doesn't have that function as much either. Alexander said that Heinz-Pribyl is the official representative from Louisville, per an agreement established when the housing authorities merged. Frank-Williams will add Heinz-Pribyl to the roster.

Van Domelen proposed the group consider officially adding a fourth region that would represent the Mountain communities. Frank Williams identified this as a discussion and decision point later on the agenda.

Kinder directed the committee to agenda item 8, **decide on the addition of a Local Area 4 for Mountain Communities and determine representation**. Alexander asked if Peak to Peak (P2P) could serve as a fourth local area collaborative, to which Van Domelen responded that the P2P is ready-made for that role. If the P2P is the fourth local collaborative, the committee wondered who the liaison would be. Van Domelen suggested the chair of the P2P could come to the HHSAC meetings, but there was a question from the group about sustained attendance. Van Domelen was proposed as a liaison along with HHS staff that currently attend P2P meetings. Zayach was concerned about capacity of staff in organizations serving the entire county if the same staff member needed to attend all four local area collaborative meetings as spelled out in the FRF document. There was discussion about how to resource this, with Alexander suggesting that it might not be necessary for the same person to go to all four meetings as long as representatives were bringing what they need to do to the HHSAC meetings. Frank-Williams said advanced agendas with clear topics could help facilitate this process.

Noting the time, Frank-Williams proposed moving the decision point identified in agenda item 8 to the February meeting. She also said staff will summarize action items and send out to the committee.

J. Williams asked about the time of the February meeting. An inquiry via email earlier in the week had surveyed committee members about their availability to meet 15-30 minutes earlier with the goal of lengthening the meeting. Williams reported that most people had conflicts and asked if committee members would be able to add time at the end of the meeting.

Alexander followed-up with the committee about how much time to dedicate to discussion about consistent talking points/messaging at the next meeting. After some discussion, the committee agreed that we would carve out time at the end of the meeting to discuss messaging and updates and focus the beginning of the meeting on the FRN work.

Dalia asked who would replace Kinder. Alexander said the committee would make a recommendation to the BOCC and then the person would have to apply. Kinder asked if someone from the committee was interested in stepping into the Chair role. Watson volunteered and was voted in by the committee. Watson asked that staff reach out to her with details of the role. Alexander and Williams will get the applications for Canova and for the recommendation from Dalia.

The committee thanked Kinder again for her work and leadership on the committee. The meeting was then adjourned.

Proposed Structure for HHSAC Packet Materials

In order to facilitate decision making during meetings, staff will provide the HHSAC packet 3-5 days prior to include:

- A detailed agenda with decision points identified;
- Minutes from the previous meeting;
- Action items from the previous meeting to be completed prior to the upcoming meeting;
- Pertinent materials to inform decisions;
- Relevant fiscal reports; and
- The data and outcomes report.

In addition, staff will provide the following documents for information purposes.

- A high level summary of updates relevant to the FRN such as “like initiatives”, FRC developments, Local Area Collaborative updates, and alignment related activities (one paragraph per item).
- Progress report on key milestones in the FRF timeline.

Only details relevant to any decisions to be made will be discussed during meetings.

Summary of Membership Process and Onboarding

Recruitment

Community members interested in becoming a part of the HHSAC Board come through two main channels- the open recruitment period posted on the Boulder County website's Boards and Commissions page and through solicitation by HHSAC members and/or staff.

- Maximum capacity of the HHSAC is fifteen.
- When seats become available, staff will inform the Chair and he/she will solicit nominations from the members. Staff will provide assistance when needed.
- Staff will also bring forward any applications that have come through the Board of County Commissioners (BOCC) office during the open recruitment period.
- Staff will facilitate outreach to prospective members to determine interest and invite them as a guest to a subsequent HHSAC meeting to observe and to provide an opportunity for them to talk about what they do in the community.
- Members will vote on prospective members to be recommended to the BOCC.
- Prospective members will fill out an application which will be submitted to the BOCC for formal approval.
- Prospective members will be formalized as members after the approval of the Commissioners. However, they may still attend and participate in HHSAC meetings as guests prior to approval.

Orientation and Onboarding

New members will receive a welcome letter from Frank and the Committee Chair along with a brief summary of the Committee's meeting time and place, the group's purpose, and current vision.

Staff will schedule a time to provide a full orientation to members which will include:

- Overview of the HHSAC by-laws and history
- Overview of member agencies and partners on HHSAC

- Overview of key outcomes and metrics, budget and investments (Community of Hope Report)
- Review of the Boulder County Integrated Services Delivery Model of Care
- Review of meeting structure and logistics
- Review of the Family Resource Network (FRN) and the Governance Charter
- Review of current work plan for the FRN
- Orientation to the Google drive with instructions for accessing the electronic “Board Binder” providing pertinent documents-
 - Copy of latest by-laws
 - Materials on member agencies and DHHS
 - Community of Hope Report
 - Copy of FRN Governance Charter
 - Updated list of current members, terms, and contact information
 - Communication Ethics
 - Confidentiality Statement

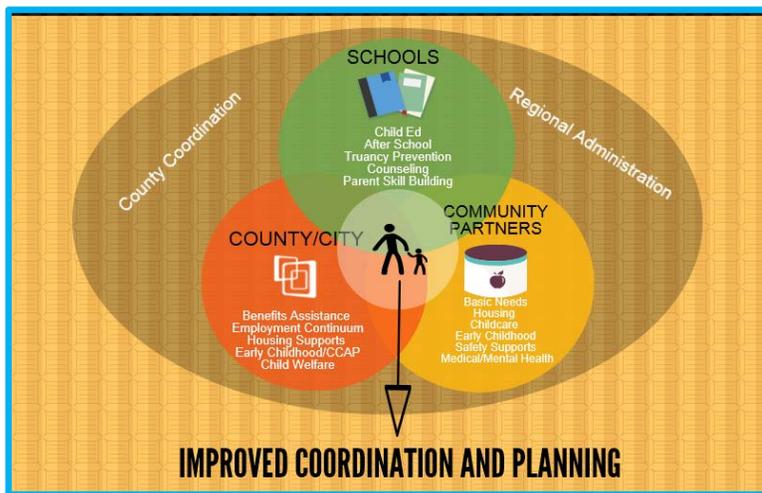
DRAFT 2/20/17

Family Resource Network Governance Charter

1. PURPOSE

Family Resource Network

Vision: Based on a two generational approach, create a fully integrated system of service delivery, organized through a county-wide governance structure comprised of schools, community-based entities, and city/county government aimed at increasing family self-sufficiency, reducing truancy, and improving academic success of children.



Full integration = a **holistic approach** to serving each consumer, using an **interoperable data exchange** to link the people, services, and information across systems and programs for robust **care coordination**, **integrated case planning**, **timely service delivery**, and **cross-system relationship management**.

The FRN Regional Council (RC)

The Regional Council is responsible for achieving a visionary, yet complex, large system-change process, aligning strategic direction and implementation consistent with the integration vision outlined above designed to produce the positive, long-term, sustainable outcomes for children, families, and individuals served throughout the community.

The Boulder County Housing and Human Services Advisory Committee (HHSAC) will serve as the Family Resource Network Regional Council (RC) and provide overarching governance to the Family Resource Network and achievement of collective service outcomes to improve overall well-being of Boulder County families. In this model, the Regional Council consists of high-level leaders with a stake in the outcome of the effort, people in a position to make significant policy decisions, break down barriers, and provide vision and strategic direction. It 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 the following:

- communicating a clear shared vision;
- define strategy and expected community-wide outcomes;
- monitor performance on key metrics
- advocating and informing on relevant local, state and federal policy;
- supporting and advising on program improvement;
- supporting coordinated and consistent processes, policies, and management of the FRF;
- facilitating and approving formal agreements for operation of the Network ;
- facilitating resource procurement and allocation;
- informing and supporting the Boulder County Integrated Services Delivery Model of Care (ISDMC);
- reviewing and approving recommendations from Local Area Collaboratives (LACs)
- increasing efficiency and collaboration among partners
- reducing duplication of services/efforts
- resolving conflict among FRN organizations
- making decisions required to assure success of the FRN

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Comment [FM1]: Additions from Bobbie

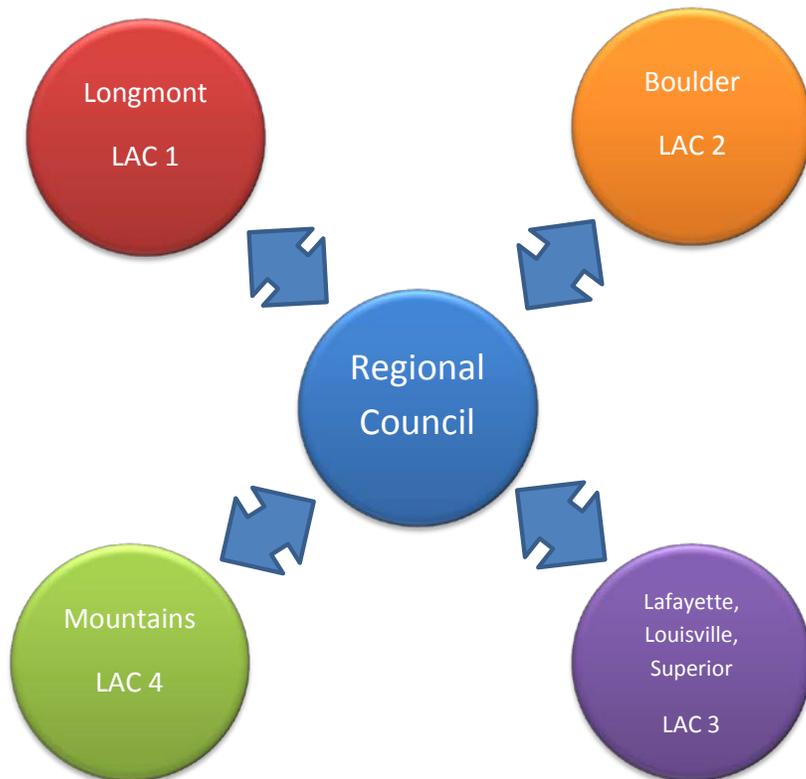
The FRF Regional Council will be responsible for ensuring focus on the vision and strategic direction and must monitor progress toward implementation in order to create the seamless that benefits both consumers and the community.

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Local Area Collaborative Groups

Given that a core principle of the Family Resource Network is that each community hub address the specific needs of the local area, Local Area Collaborative (LACs) groups will be created consisting of representatives in each of the four 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;
- identifying challenges and opportunities, helping the Regional Council leadership understand the barriers, working through them, and delivering on the vision;
- reviewing and analyzing local data and reports on family resource programming;
- implementing referral, access and data quality improvement plan;
- tracking progress on implementation of collective service outcomes;
- establishing and ensuring participant programs adhere to standards outlined by the FRF and Quality Service Standards by the Family Resource Center Association;
- coordinating training and “communities of practice” within areas and collaboration between areas;
- informing and supporting the Boulder County Integrated Service Delivery Model of Care.



Boulder County Staff Roles

Two designated Boulder County staff will provide guidance, technical assistance and support to the Regional Council and the Local Area Collaborative entities (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 work as a fundamental basis for service delivery by FRF partners;
- Provides any pertinent fiscal reports (i.e. funding reports); and

- 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 reports to the 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 programs 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; and
- Serves as Regional Council Liaison in the absence of the Strategic Initiatives Manager.

Administrative Supports – IMPACT Strategic Initiatives Specialist (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; and
- Provides summaries on pertinent related initiatives and investments (i.e. Truancy project, childcare contracts, etc.) for LACs and RC.

2. MEMBERSHIP

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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 or designee
 Boulder Valley School District Assistant Superintendent or designee

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 Louisville - Housing Representative](#)
 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)

The Early Childhood Council of Boulder County Director (ECCBC)
Clinica Director
Peak to Peak Representative
[Dream Big Director](#)

MEMBERS AT-LARGE

Other considerations

Mental Health Partners Administrator

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 Collaborative

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.

SCHOOL

- St. Vrain School District – TBD (attends for LAC 1)
- Boulder Valley School District – TBD (attends for LAC 2, 3 and 4)

COUNTY/CITY GOVERNMENT

- Boulder County Housing and Human Services - FRF Liaison (attends all 4 LACs)
- BCDHHS Early Intervention Team Program Manager (attends all 4 LACs)
- Boulder County Community Services – Workforce Boulder County staff member (attends all 4 LACs)
- Boulder County Department of Public Health representative (attends all 4 LACs)
- City of Longmont- Children and Youth Center staff member(LAC 1)
- City of Boulder – Family Resource Schools Administrator (LAC 2 and 3)

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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)
- [ECCBC Associate Director \(all 4 LACs\)](#)
- [Dream Big program staff \(all 4 LACs\)](#)
- [Clinica program staff \(all 4 LACs\)](#)
- [Boulder Housing Partners program staff \(LAC 3\)](#)
- Peak to Peak Representative (LAC 4)

Other Considerations

Mental Health Partners Program Manager

3. SCOPE and ROLES

Regional Council

The Family Resource Network Regional Council guides overarching governance of the Family Resource Network with support of the staff liaison.

- **Communicate a clear shared vision** - RC members will be responsible for formalizing and communicating the FRF vision and key objectives within their agencies and in the community.
- **Define strategy and expected community-wide outcomes**- The RC will be responsible for formalizing both process and collective program outcomes for the FRF (see attachments A and B), finalizing an agreed upon logic model with tangible measures, and monitoring progress in achieving these outcomes.
- **Monitor performance on key metrics – Using Transformational Collaborative Outcomes Management (TCOM) regularly monitor and report progress on outcomes across the Network .**
- **Advocate and inform on relevant local, 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** – RC members will review the LAC process and program-related recommendations 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 Network .
- **Support coordinated and consistent processes, policies and management of the FRF** - 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 Network** – This includes memorandums of understanding regarding service coordination, data sharing, etc.
- **Facilitate 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** - This includes use of a common assessment and practice.
- **Review and approve recommendations from Local Area Collaborative entities**
- **Increase efficiency and collaboration among partners – Identify and implement opportunities to streamline interagency effectiveness to include sharing of resources, optimizing data systems and best practices.**
- **Reduce duplication of services/efforts**

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Comment [FM2]: Is this covered in the bullet above?

- Resolve conflict among FRN organizations- members commit to a culture of transparency grounded in authentic leadership and practices. This includes promptly addressing conflict, engaging in difficult conversations, forming agreements and ensuring accountability to them.

- Make decisions required to assure success of the FRN

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 included are listed below.

- **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 a referral process to support the family resource services in their area. Referrals will be linked to assessment and supported through a common data system (HHSC/Marketplace).
- **Review and analyze local data and reports** on family resource programming.
- **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**, to include Quality Service Standards by the Family Resource Center Association.
- **Coordinate training and “communities of practice”** within areas and collaborate between areas.
- **Inform and support the Boulder County Integrated Service Delivery Model of Care** (see attachment C).

4. OUTCOMES

Development and Implementation of the Family Resource Network

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 Network 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 outline the changes anticipated as a result of the combined efforts of FRF partners in implementing the Network (see attachment A for the complete logic model; note that the outcomes in orange are additions from Boulder County). This document will assist in development of the Boulder County FRF Outcomes to be completed per the FRF implementation work plan.

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

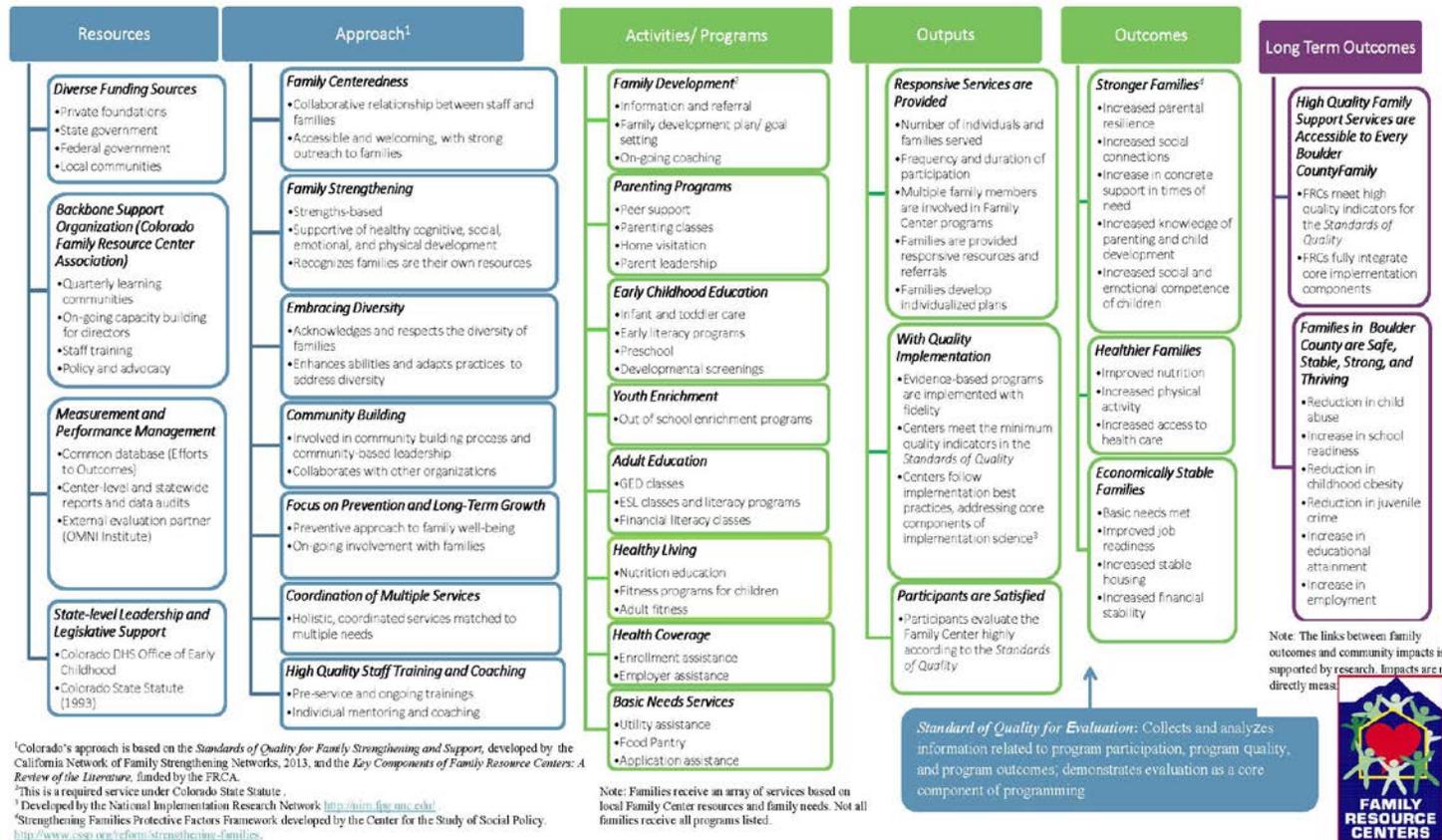
Date ratified _____

Revision _____

Revision _____

Colorado Family Resource Center Logic Model

updated December



Boulder County Revision (orange box)

Short to Moderate Term Outcomes

Stronger Families

- Increased **parental resilience**
- Increased **social connections**
- Increase in **concrete support** in times of need
- Increased knowledge of **parenting and child development**
- Increased social and **emotional competence of children**

Healthier Families

- Improved **nutrition**
- Increased **physical activity**
- Increased **access to health care**

Economically Stable Families

- **Basic needs** met
- Improved **job readiness**
- Increased stable **housing**
- Increased **financial stability**

Success in School for Children and Youth

- Reduce truancy
- Improve academic success
- Improve behavioral outcomes

Long Term Outcomes

High Quality Family Support Services are Accessible to Every Boulder County Family

- FRCs meet high quality indicators for the *Standards of Quality*
- FRCs fully integrate core implementation components

Families in Boulder County are Safe, Stable, Strong, and Thriving

- Reduction in child abuse
- Increase in school readiness
- Reduction in childhood obesity
- Reduction in juvenile crime
- Increase in educational attainment
- Increase in employment

Comment [FM3]: Per Bobbie- add early childhood outcome- "Improve quality, accessibility and affordability of early childhood programs and services"

Attachment B

Stages of Development and Implementation for FRF Structure

Development Team

A Development Team comprised of members of the Regional Council (or designees 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 Network , 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 Network 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 Network .

Installation

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

Initial Implementation

The Implementation Team will assess if the implementers have the skills, coaching, support, and resources needed to adopt the new Network 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 Network and to engage those who are in positions 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 two-hour meetings per month to include monthly HHSAC meeting
- Plus an estimated two to four hours of additional work time per month

Attachment C

Integrated Services Delivery Model of Care Practice Model





Hope for the future, help when you need it.

DHHS Advisory Committee

March 21, 2017

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DHHS Advisory Committee
MONTHLY MEETING
Tuesday, March 21, 2017, 3:30-5:00 p.m.

DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Objectives for Today:

- 1) Meet prospective new board members
- 2) Begin FRN Orientation process
 - a. Learn about Boulder County Family Resource Centers and the Family Resource Center Association
 - b. Learn about adjacent initiatives to the FRN and action steps
- 3) Finalize goals of FRN

- 1) **Review and approval of today's agenda and above objectives - (3:30-3:35)** Bobbie
- 2) **Review and approval of minutes and updates on action items from February 28th HHSAC meeting (3:35 – 3:40)** Bobbie
[Decision point: Approval of minutes](#)
- 3) **Introduction of guests to today's meeting (3:40-3:50)** Bobbie
 - Lori Canova, President and CEO, I Have a Dream
 - Diane Lauer, Assistant Superintendent, St Vrain Valley School District
- 4) **Discussion of goals of FRN (3:50-4:05)** – Melissa/Frank/Bobbie
High Level Process and Program Outcomes
- 5) **HHSAC Orientation Topic 1: Overview of Boulder County Family Resource Centers and the Colorado Family Resource Center Association (4:05-4:35)**
Suzanne, Julie, Edwina
 - Presentation (15 minutes)
 - Q and A (15 minutes)
- 6) **Partnership updates (4:35-4:45)**
 - Public Health Update
- 7) **Review of agenda for next meeting (4:45-5:00)** Bobbie/Melissa
 - Membership discussion
 - Finalize FRN Governance Charter
 - LAC Development and Implementation Discussion
 - HHSAC Orientation packet review
 - HHSAC Orientation Topic 2: ISDMC overview
 - Updates on IHAD, EFAA, BHP partnership
- 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:

[Boulder County Housing Authority Board Packets](#)

[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.

Draft Meeting Minutes
DHHS Advisory Committee
February 28, 2017

Members Present: Penny Hannigan, Robin Bohannon, Julie Van Domelen, Pat Heinz-Pribyl, Simon Smith, Jeff Zayach, and Bobbie Watson

Staff Present: Frank Alexander, Jim Williams, Melissa Frank-Williams, Susan Caskey, Darlene Bushue, Angela Lanci-Macris, Whitney Wilcox, and Monica Serrato

Guest: none

Meeting Action Items:

1. Staff will send out meeting minutes within a few days after the HHSAC so people have time to review.
2. Staff will post the partnership grid to the Google drive by **March 7** so people can make updates.
3. Staff will send the FRN Governance document by **March 7**, and the Committee will review and send feedback by **March 15** to ensure inclusion in the packet.
Revisions will include:
 - a. Edits to vision statement to ensure some behavioral or social-emotional are called out.
 - b. Under RC Role section, remove “resolving conflict among FRN organizations” or replace with “ensuring effective collaboration” AND add “identify gaps in services”.
 - c. Addition of role of participants throughout document
4. LACs: when identifying participation ensure to address “who is relevant” for each LAC- staff will propose a system
5. Staff will add an agenda item to future meeting to discuss the short and long term goals.
6. Staff will provide orientation/onboarding for next meeting.
7. Staff will compile a template for program and agency updates that will be provided in packets. Prior to the March meeting, staff will solicit updates from agencies which will be included in the packet.
8. Staff will add the Google drive link to HHSAC invite.
9. Staff will send out Google drive instructions by **March 7**.

Detailed Meeting Minutes

- 1) Introduction of Bobbie Watson as new HHSAC Chair- (3:30-3:33)
- 2) Review and approval of today’s agenda (3:33 – 3:35 p.m.)
Approved as written.

- 3) Review and approval of minutes from January 31, 2017 HHSAC meeting (3:35 – 3:40 p.m.)
Approved as written.

4) Introduction of Guests(3:40-3:45)

None

5) Review and discussion of revised meeting structure and process (3:45-3:50)

M Frank-Williams acknowledged that after some conversation with B Watson, it was decided to review member recruitment and orientation, as well as the addition of fiscal and data reports to the board packet. There would also be a program and services updates component which would include be a one-paragraph blurb around initiatives, new programs, activities, etc. relevant to the FRN. F Alexander asked if, for example, EFAA had an update, would that be in the packed. Frank-Williams said yes. J Van Domelen asked how would that be done, Frank-Williams said that there would be a call for updates. B Watson added that it would be helpful to get updates about things like the FHUW grant that EFAA was just awarded. Van Domelen stated that it would be helpful to receive a prompt in advance. J Williams mentioned that when the minutes go out for approval and are posted, that would be the time that a call is put out for the following month. Alexander asked if the minutes could go out within a few days of the meeting for review. The group agreed.

Watson added that she would like to really own the work of the group, and things like the timeline and structure and things members add would be how the group could do this. P. Hannigan noted that she read over the list of things for staff to do and thought that it was a lot. Van Domelen agreed. Frank-Williams stated that some groundwork had been done, that M. Serrato would be taking over from C. Campbell and that the group would have to try out this process and see how useful it is to the group.

Van Domelen said that it might be a challenge to share data and metrics every month. Melissa stated that she has had some preliminary conversations with BC MIS and it wouldn't be anything too robust right away. Right now there are three different sources, the FRCA work (logic model is at the end of the governance doc), the community-wide outcomes in alignment with strategic priorities, and the program level work that has been collected over the years. We will have to distill out the common pieces are and agree on common outcomes. Alexander mentioned that some of those reports are things that this group is well-attuned to, and they might work until things get more refined. Van Domelen noted that some reports are sensitive to a month vs a quarter. Watson added that we might not see movement from month to month to month. . The group agreed to consider revising the process to quarterly once it gets established. Frank-Williams said that the conversation with the BOSS division was around Sister Carmen, EFAA, and OUR Center, seeing what crosses our programs and mapping out what that looks like, then using that information to drill down. Williams pulled up graphics about BCHHS SNAP clients to show an example how data can be pulled out. Alexander added that a sample would be provided to the group of what is produced. Watson said that people around the table know a lot, but not every person knows individually what others may already know.

Frank-Williams redirected the conversation back to the membership process and onboarding- that it is almost official that the HHSAC will be a 15 member board. Alexander said that the commissioners did approve it in a PMI. Frank-Williams clarified that membership comes about in one of two ways- open recruitment or referral from a member or staff. Staff will reach out to the interested person, members will vote to make a recommendation to the BOCC, the prospective member will fill out the application and will be formalized after the commissioners approval. Then the orientation process would begin. Frank-Williams is working with Watson, W. Wilcox, and Serrato to put together a virtual binder in the google drive with orientation materials. Then Frank-Williams asked if there was interest in having current members do an orientation review over the next couple of months. P Heinz-Pribyl said it was a great idea. Frank-Williams said that a doodle poll would go out over the next few days to narrow down dates and times. Hannigan asked if there was enough interest in the open slots. Frank-Williams said yes. Watson asked for a decision point- approval of the member recruitment and orientation process, and the revised structure of the packed including data and fiscal processes. Smith moved, Hannigan seconded. Approved.

6) Discussion of work done by HHSAC in 2016 and transition to 2017 as FRN (3:50-4:00)

Williams opened by stating that this process began in 2015, the group started looking at projects based on the social determinants of health (SDOH) by partners at the table. There were a total of 7 projects. Some of the projects made more progress than others, and that is both due to staff as well as members. He noted that it was decided that the work around inclusivity would be taken on by the county which was taking on cultural responsiveness and inclusivity, and it would be brought back to the group at a later date. Watson said that she brought this topic up because she wanted to know what happened to some of these projects, particularly around the homeless project, as she is a few layers removed from that work. Williams asked if everyone had time to review the updates. Bohannon stated that she was particularly curious about Smith's update.

Smith said that he'd be happy to talk about the big unknown, Medicaid expansion. Things changed with the election, there was first a lot of rhetoric around repealing the ACA, then repeal and replace, then replace before repeal, and now its other words that get more to the notion of tinkering. The question is what are they going to do about the Medicaid expansion, some states have expanded and some haven't. More expansion happens in states with Republican governors. Smith thinks that there will be a bigger push toward broader autonomy for states. President Trump just acknowledged that healthcare is complicated. Smith is more confident that there won't be a total repeal, at least not until there's been a replacement with some tinkering. Health care exchanges frightened the insurance companies who threatened to pull out and there are also conversations around risk pools. Smith is cautiously optimistic. Clinica has done the math around what a rollback to pre-ACA revenues would be and how the 70% cut to community health center funding would impact them. The subsidized exchange plans impact to Clinica is negligible. People would have to pay \$5 or \$10 before their insurance would kick in, and once the insurance kicks back to Clinica they do not put their patients into collections. It would be a threat to catastrophic coverage but it doesn't really impact Clinica. However if they were to lose 70% of community health funding that would be about 6 million dollars. Pre- ACA rates would be about 4 million dollars. Clinica is collecting the data because that is important to share with the legislature. From a

community health center perspective, if you take away insurance you can't also take away community health funding. Primary care and behavioral health are fundamental. How do we shift to value based payment across all layers? J Zayach asked what is real and not real in conversations around reconciliations. Alexander stated that he thinks it's all up in the air right now. The pushback has been stronger than anticipated. SDOH need to be embedded into a practice that includes behavioral health. Hopefully there will not be too much constraint, but there will be some. Van Domelen said that it doesn't sound like this topic is one to check off and be done, and asked if it is a standing issue. Smith said that whatever is decided, there isn't adequate funding to do SDOH work right now. Van Domelen responded that they wouldn't do that anyway, and Smith agreed.

Alexander stated that for this group, using the SDOH lens, we know the overlap is very clear between our systems and the medical systems and that lens is important moving forward- asking clients "do you have health insurance, have you applied, how do you access care?" and that is a lot for people who are accessing healthcare for the first time in many years. We can shift the language into how it fits into the FRN.

Watson then stated that there is an update from ECCBC, an article is posted on the ECCBC website that says that frequent fliers can be determined by age 3. Something that ECCBC is doing with BCPH is a task force looking the size of early childhood mental health needs, which feeds into the greater work here. Reports should be done in April; it will be a deeper dive into the data.

Watson asked if there were any other projects, and if Bohannon could talk about the 10 year homeless initiative. Bohannon said that there was good alignment in Longmont and Boulder in how services are provided, piggybacking on HHSAC and IMPACT, ensuring accountability and leveraging the system. There's good data that's come out with the portal, HHS and homeless services agencies that tells us the focus needs to shift from crisis to long terms strategies. She is happy to answer any questions. Hannigan stated that Lee Hill has seen a decrease in visits to municipal courts. Bohannon said that the system shouldn't be based around one or two clients who draw everyone's attention or the crisis du jour. Hannigan mentioned that the HUD Regional Director toured Lee Hill.

Watson asked if Alexander wanted to talk about PHIP, and he deferred to Zayach. Zayach stated that there are mental health focus groups, 2 of 4 are primarily in Longmont. There is a workgroup that includes Longmont and the 7 surrounding areas. Mental Health First Aid is being offered in Longmont, with the goal of expanding to all partners in the county. Over 2,000 people will be targeted. A letter was sent to the JBC and there was a visit to discuss the 150 counselors in elementary and middle schools, funds that come from the marijuana tax, and community people took the lead on talking to the JBC. The last group is navigation, that group is just starting their work. There is a lot of work around behavioral health, coordination is a big piece across all the groups and there is a lot of time spent around coordination of services. There is a strong focus from the community justice management board on that. Lots of mental health work is happening. Watson thanked everyone for their updates.

7) Discussion and edits to the FRF Governance Charter (4:00-4:30)

Frank-Williams started with checking in with the group around the notion of the FRN being the primary function of HHSAC. She stated that her thought was that around 90% of the work would be focused on the FRN, and other pieces would be woven in. Where is the rest of the group on that idea? Van Domelen said that there are a lot of programs that are doing this work but we don't see them in the FRC model. Watson said that she sees HHSAC as a circle and the FRN is another circle, but the question is how big is the overlap, because she did not initially see the overlap as 90% as a committee member with 10% devoted to things like hot topics, so that is why the check in with the group. Van Domelen stated that she wasn't sure where the lines are- isn't access to health services in all of it? The work is informed by the FRN and SDOH. Worth Cause money might be of interest, and she thinks the group should be as inclusive as possible of topics that could help everyone. Zayach asked if the 10% outside of FRN work would be a separate group. Alexander answered that there might be issues to be grappled with that fall outside of the FRN work, but that would fall in the 10%, and all of the major players (along with additions) are already at this table. Watson reiterated that she wanted to bring the discussion to the group to be sure everyone was on the same page. Zayach said it would be more valuable to know if there are hot topics and to be sure that those conversations can happen. Frank-Williams added that if there were someone relevant who is not in the group, they could be brought into the conversation. The group agreed that the HHSAC would dedicate approximately 90% FRN activities.

Van Domelen said that the last sentence of the vision about truancy and academic success feels too narrow, could it be something broader? Frank-Williams said yes, that language can be worked on. Bohannon asked if there could be clarification around "resolving conflict", and Van Domelen suggested softening that language, or that "increasing efficiency" might cover it. Alexander acknowledged that the group knows that if, for example, there is funding available, those kinds of difficult conversations can be done in this group. Van Domelen asked if "identify gaps in services" could be added, and Frank-Williams agreed. Later in the document that is spelled out a little but more. The group discussed the roles of the LAC groups. Frank-Williams state that the LAC would also feed up how to the RC how implementation was going. Bohannon asked for clarification around the place for executive leadership- would that be in the RC but also in LACs? Frank-Williams responded that front line program staff would be in the LACs. Bohannon wanted to acknowledge that if there's a challenge or difference of opinion, there are some people who will be holding roles on both the RC and LAC. Would this be like how the ops board acts? Frank-Williams said that a program manager would attend the LAC and participate in discussing what's working and what's not.

Time limits prevented completion of this agenda item. Alexander asked that staff resend the documents to members to review, clean it up based on feedback, and then bring it back next month. He asked that it be sent out at least 10 days in advance of the next meeting. Smith asked if Clinica could participate in all four LACs, and Alexander responded it would not be necessary, that this group could liaise with him on any issue based activity. Smith responded that would feel less overwhelming. Frank- Williams reminded everyone that if

there was specific information needed, those people could be invited to the RC. She also pointed out that there was a fourth LAC for the mountains. Van Domelen thanked her.

Frank-Williams continued with the breakdown of suggested members- from SVVSD, Diane Lauer who is the Assistant Superintendent has expressed interest and there is a meeting later this week with her, she is planning to attend the March 21st meeting. If she does do the membership processes, this group would recommend her to the BOCC and she would submit her application.

Van Domelen stated that LACs should be people providing local services, “who is relevant to this area”. EFFA has active services in all 4 LAC areas. Hannagan asked if Betsey has weighed in on being the housing representative for the RC. Frank-Williams responded that she is the representative, and Alexander clarified that she would as a community based agency.

Watson asked that the logic model and outcomes be discussed. Moderate goals, long term goals- could the group do that? Frank-Williams responded that this goes on to the next agenda item. She provided some details regarding ISDMC and the use of the CFSA as a critical tool for measuring impact. This will be a topic of conversation for the March meeting.

8) Discussion and voting on members (4:43-5:00)

Alexander noted the time, and suggested that onboarding of new members could be the content of the next meeting, be sure that Edwina and Suzanne could be there and if they can't then we should reassess the time. Frank-Williams agreed, and that nuts and bolts could be done at another time. Frank-Williams reminded the group that Lori Canova (IHAD) would be at the next meeting. Karen Roney or Christina Pacheco-Sims (City of Longmont) would also be coming- it seems like Karen at the RC level and Christina at the LAC level would be a good fit, but they wanted to attend and decide that themselves. Hannigan asked where Lori would fit, and Frank-Williams responded that she would be at the RC level. Zayach asked if Roney and Pacheco-Sims would both be coming, and Frank-Williams responded that they would be letting her know. Bohannon asked about the City of Boulder and Frank- Williams said that the conversation hasn't been had with Karen Rahn yet. Bohannon asked who would be her “Christina” and Frank-Williams said that it would be Wanda. Frank-Williams mentioned that there is a meeting with Bobbie and Karen Rahn coming up and the group would discuss HHSAC then. For BVSD, Frank-Williams and Wilcox have a meeting with Madeleine case coming up and would ask for her guidance regarding participation on HHSAC. Zayach mentioned that the people who join the board need to be able to make decisions, and asked if that was a factor in selecting candidates. Frank-Williams affirmed that yes, assistant superintendents and directors for the RC, program directors and staff for the LACs.

Williams asked if everyone has been able to access the Google drive and indicated there will be an invitation sent out to everyone. The “information sharing folder” is what members have shared as of the last meeting. Please contact us if there are questions or if anyone needs help with the Google drive. Smith asked if there could be a link on the meeting invite for easier access. Alexander

reminded the group that the shift will be away from emailing out packets so that everyone will get used to using the Google drive.

Watson summarized that meeting minutes will be sent out in a few days and the March meeting would be onboarding and orientation.

The meeting was then adjourned.



Lori Canova, President and Chief Executive Officer, I Have a Dream

Foundation- Lori Canova has been the President and Chief Executive Officer of the "I Have a Dream" Foundation of Boulder County since 1997. Under her leadership, the organization has grown from 2 classes to 15, serving over 800 students, making the Boulder County affiliate one of the largest in the country. Lori helped start the local Mentors Matter group which focuses on recruitment of mentors, especially mentors of color. She also helped launch a county-wide collaborative school supply drive, Crayons to Calculators. Prior to

joining "I Have a Dream", Lori was the Program Director for Big Brothers of Metro Denver; a Program Director for the Mental Health Association of Colorado; the Director of SB94 Juvenile Diversion Program for Jefferson Center for Mental Health; and an Adolescent Counselor for Human Services, Inc. Lori has a Master of Social Work (MSW) from the University of Denver and completed her undergraduate work in Social Work at Colorado State University.



Diane Lauer, Assistant Superintendent of Priority Programs and Academic Supports, St Vrain Valley School District

Dr. Lauer has served St. Vrain Valley Schools for the past two years as the Executive Director of Professional Development & Assessment. Prior to that, Dr. Lauer worked for the Thompson School District for eighteen years, where she was an Executive Director of Instruction, Director of Curriculum & Instruction, Director of Instructional Coaches, Principal, Assistant Principal, Technology Staff Developer and Language Arts & Social Studies Teacher.

FRCA 101

An introduction to Family Resource Center Association



Overview

1.0 What is FRCA?

1.5 Who are the members?

**2.0 What Services does
FRCA provide?**



What is FRCA?



What is FRCA?

The Family Resource Center Association's mission is:

to provide public advocacy, capacity building, and resource development to strengthen our statewide network of family resource centers as they bring help and hope to Colorado families.



FRCA Timeline



Family Resource Center Association

1993 1998 1999-2000 2000-2007 2007 2009 2011 2012 2013 2015

- 1993: CDHS establishes 5-year pilot public-private initiative
- 1998: State funding sunsets, 21 existing family centers form FRCA
- 1999-2000: FRCA obtains 501(c)(3) status & hires first E.D.
- 2000-2007: FRCA focuses on finding pass-thru funding opportunities for centers
- 2007: Healthy Living Program area established and has first TCHF award and Program Staff are hired
- 2009: Strengthening Families Program area established and statewide effort to train centers on FDC begins
- 2011: Efforts To Outcomes database (ETO) is implemented statewide
- 2012: FRCA receives Promising Practice award from Poverty Reduction Task Force
- 2013: Quality Standards for Family Support adopted and work begins on FRC Model
- 2015: Upgraded CFSA 2.0 completed and Reliability Study published; FRC Model Implementation Tools created; State funding returns



Family Resource Center Association

What is a Family Resource Center?

Family Resource Centers are grassroots, community-based centers that reflect the culture and community of the people they serve.



Community Partnership FRC, Divide



Mountain Resource Center, Conifer



Focus Points Family Resource Center, Denver



Who are our Members?

Colorado

27
Member
Centers!

West/Northwest:

- Delta County Family Resource Center
- FRC of the Roaring Fork School District
- Mountain Family Center
- Family & Intercultural Resource Center
- Hilltop
- Valley Settlement Project

West/Southwest:

- The Pinon Project
- Fremont County Family Center
- Catholic Charities of the Diocese of Pueblo
- West End Family Link Center

Central:

- Mountain Resource Center
- Sister Carmen Community Center
- Focus Points Family Resource Center
- Families Forward Resource Center
- Denver Indian Family Resource Center
- Aurora Community Connections
- The Family Center/La Familia
- Catholic Charities of Central Colorado

East/Northeast:

- Rural Communities Resource Center
- Washington County Connections
- Morgan County Family Center
- Prairie Family Center

East/Southeast:

- Huerfano/Las Animas County FRC
- La Plata Family Centers Coalition
- La Llave Family Resource Center
- Tri County Family Care Center
- Community Partnership FRC



What do Family Resource Centers do?

Per state statute, Family Resource Centers should provide:

1. Family Development Work
2. Resource Information and Referral



Family Resource Centers continued...

Centers should follow Family Support Principles and Practices

(established by Family Support America)

1. Equality and respect
2. Affirm cultural identities
3. Work with the entire family
4. Work with families to identify and access resources
5. Recognize resources and strengths families bring to the table



Family Resource Centers continued...

Additionally, Family Resource Centers provide a myriad of other services:

- Access to Healthcare and Nutrition
- Early Childhood Education
- Parenting Programs
- Youth Development
- Emergency Assistance
- Adult Education
- Parent Leadership
- Financial Literacy
- Job Readiness
- Life Skills



Kids exercising at La Familia/The Family Center, Fort Collins



Benefits of FRCA Membership

- ✓ Networking with other family resource centers across the state, including statewide and regional meetings
- ✓ High quality training and technical assistance to increase center's organizational capacity and service delivery
- ✓ Representation of member centers and families they serve before the Colorado state legislature and other state agencies
- ✓ Eligibility to participate in FRCA funding opportunities
- ✓ Peer sharing of best practices in program and service delivery
- ✓ Use of group memberships, like MSEC
- ✓ ETO database usage and joint evaluation of selected programs





Families at Delta County Family Resource Center, Delta



FRCA Services

FRCA's core services center around strengthening centers to:

- work with families in setting and achieving transformative goals that help them become more self-reliant.
- support Family Resource Centers in building their long-term program excellence and organizational sustainability.



FRCA Services continued...

How do we support our centers?

- Tracking family progress in ETO
- Training in the Standards of Quality for Family Strengthening and Support
- Training in using of the Colorado Family Support Assessment 2.0 tool to assist with one-on-one work with families
- Member meetings and regional trainings to keep centers up-to-date on current trends and to promote peer sharing and networking
- Funding
- One-on-one trainings and technical assistance in programs, financial management, strategic planning, resource and board development
- Evaluation support – independent evaluation through OMNI Institute and ETO data tracking system to relate services and programs to family outcomes



Examples of Technical Assistance

- Updated Policies (by-laws, financial policy, employee handbook, etc.)
- Board short-term Goal-Setting (recruiting and retaining board members, understanding financial policies, creating succession plans, Moving from Advisory to Governing Board)
- Created Decision-Making Process for Program Expansion
- Building Key Collaborative Partnerships
- Rebuilding Funder Relationships
- Building new financial tracking systems





Cooking Matters for Kids, Prairie Family Center, Burlington





FRCA Membership Meeting at Mount Princeton, 2015



Membership Responsibilities

Administrative

1. Attend all quarterly meetings (Executive Director or senior management staff)
2. Pay membership dues (currently billed quarterly, based on 3.5% of pass-through funding awarded to center in previous fiscal year)
3. Submit grant reports and/or service information in required format in timely manner
4. Maintain current fiscal policies and adequate internal controls
5. Adhere to FRCA nondiscrimination policy
6. Annually submit:
 - Organizational Budget, Financial Statements, Audit or Financial Review
 - Quality Standards Program Self-Assessment (entered into ETO)
 - Annual Organizational Assessment (entered into ETO)



Membership Responsibilities Cont.

Programatic

1. Work towards the broader interests of the membership as a whole, recognizing that occasionally these broader interests may conflict with the interests of individual centers. Note: Individual requests may not be made to funders who fund the centers through FRCA, specifically Energy Outreach Colorado and The Colorado Health Foundation.
2. Acknowledge conflicts of interest and proactively communicate and seek constructive solutions to such conflicts
3. Follow the Principles and Practices of Family Support
4. Coordinate with FRCA any contacts with FRCA's pass-through funders to avoid confusion
5. Understand and fulfill your center's commitments and responsibilities related to grants funded through FRCA, including terms of subcontracts and ETO reports.



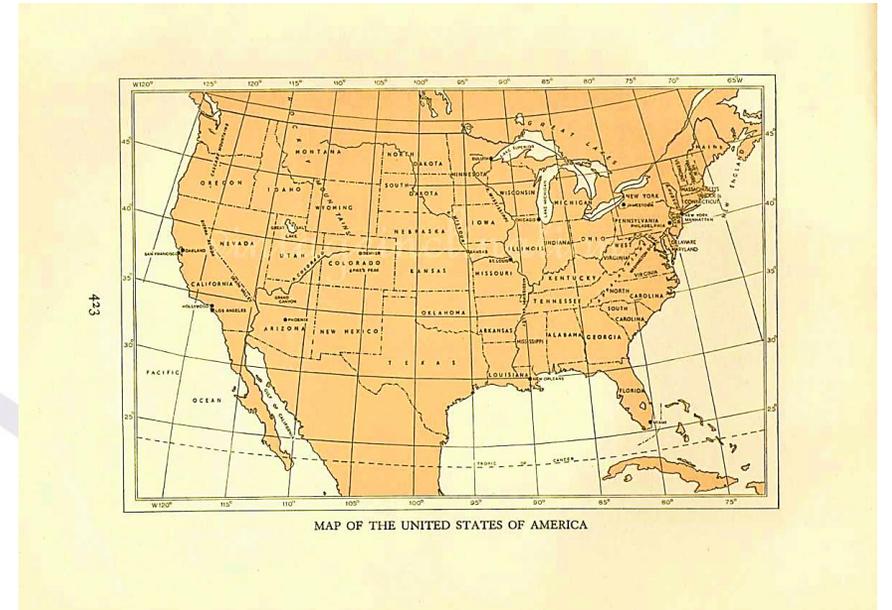
Bright Spots

- ✓ Named a Promising Practice to Reduce Poverty by CO Legislature
- ✓ Aspen Institute, Ascend Two-Gen Network Partner
- ✓ FRCA's manuscript "Reliability of Colorado Family Support Assessment: A Self-Sufficiency Matrix for Families" was published
- ✓ National Project Partner with Robert Wood Johnson Foundation to study national family support best practices



FRCA beyond Colorado

- FRCA co-founded The National Family Support Network for promoting best practices in family support services nationwide.
- FRCA started training other states on the use of the CFSA 2.0
- FRCA is working on a national-level survey of family support networks for the Robert Wood Johnson foundation.



Committees and Board

FRCA is run by a Board of Directors made up of center directors and community members. FRCA conducts much of its work through committees that report to the Board. The committees are smaller work-groups made up FRCA staff, center directors, center staff, community members and FRCA Board members.

Current Committees:

- Membership Committee
- Program and Evaluation Committee
- Development and Marketing Committee
- Finance Committee
- Executive Committee
- Other subcommittees as needed, like the Family Development Work Group



Family Resource Network (FRN) Update

March 2017

County-wide FRN Updates

- Partners and DHHS are working to implement a uniform case management practice model across the County. This practice will become an integral piece of the FRN.
- Community partners and DHHS staff are working to design and launch community-based partner access and interface with the DHHS data system, including sharing of improved case management and navigation functions.
- EFAA met with OUR Center staff to share LEAN processes implemented to improve services flow.
- OUR Center, EFAA, SCCC, and Broomfield FISH awarded funding from Foothills United Way for their Family Resource Center collaboration work.

Local Area Collaborative Groups

Although we have yet to officially launch our Local Area Collaborative (LAC) groups, we have some regional updates which are relevant to the FRN work. Once LAC groups are formed, reports directly from the collaborative groups will be provided here.

Local Area 1- Longmont

- OUR Center has received funding and support from Boulder County to implement its Family Resource Center in Longmont.
- The City of Boulder Children and Youth Center is partnering with OUR Center to provide on-site mental health counseling to individuals and families.

Local Area 2- Boulder

- EFAA has received funding and support from Boulder County to implement its Family Resource Center in Boulder. Discussions are currently underway to streamline Family Resource Center/Schools supports in Boulder.
- EFAA has met with the Family Resource Center Association regarding becoming a member FRC of the association.
- I Have a Dream Foundation, EFAA and Boulder Housing Partners (BHP) launching collaboration to provide assessment driven (CFSA) case planning and supports for families served at MHP.

Local Area 3- East County

- Sister Carmen is currently providing the Family Development Credential to case managers/service coordinators/advocates from across the county including HHS staff, EFAA and OUR Center.
- Sister Carmen has received approval from FRCA to attend the “train the trainer” workshop to provide Standards of Quality training (which is a foundational training for agencies working with families). They will then provide the training to local FRCs, DHHS, and affiliate service providers in the FRN. This is an exciting move in creating a central training hub for service providers working with families.

- I Have a Dream Foundation, Sister Carmen and Sanchez Elementary launching coordinated FRS/FRC supports for families. The group will update the FRN on their work at the April meeting.
- Melissa and Simon participated in the Sister Carmen's strategic planning meeting by serving on a facilitated panel. The group discussed challenges and opportunities in the community. The FRN was a part of the discussion.
- Melissa, Suzanne and Simon met with representatives from the Health Resources and Services Administration (HRSA) and Arrow Consulting to discuss the Lafayette Community Engagement (LCE) initiative and alignment opportunities with the FRN. The LCE is planning to develop a framework to support an integrated process for access to the spectrum of services that are available in the community, including a mechanism for on-going meaningful and authentic engagement of community residents. The potential health disparities areas of focus being explored are: 1) Increasing access to integrated health and social services and 2) Ensuring a medical home.

Given the parallels with the FRN, the LEC group will be working with the FRN Council members to ensure this work is in alignment with (and potentially "folds in to") the FRN and does not duplicate efforts. Melissa will be attending the next meeting of the LEC advisory in efforts to support the streamlining of our collective work.

Thanks to Suzanne and Simon for initiating this process of alignment.

- BUILD Health Challenge- Sister Carmen, Public Health, Centura Health and the Raising of America Partnership will be working to further community engagement. Suzanne and Jeff are serving as the FRN liaisons on this work and will continue to ensure alignment

Key objectives include-

- Increasing community dialog on family concerns.
- Increase the number of parent leaders and advocates in the 80026 zip code through improved coordination and marketing between parent education and leadership programs.
- Increase opportunities for parents to develop their leadership capacity by identifying gaps in the parent leadership pathway and seeking opportunities to fill them.
- Increase the number of community organizations prepared to incorporate authentic parent engagement into their efforts; improve the readiness of these organizations to do so authentically, beginning with our own partners.
- Increase the number of employers in the 80026 zip code that engage in assessment and implementation of family-friendly policies.

Local Area 4 – Mountain Communities

- Peak to Peak has been funded by Boulder County and Foothills United Way to support service coordination for the mountain communities.

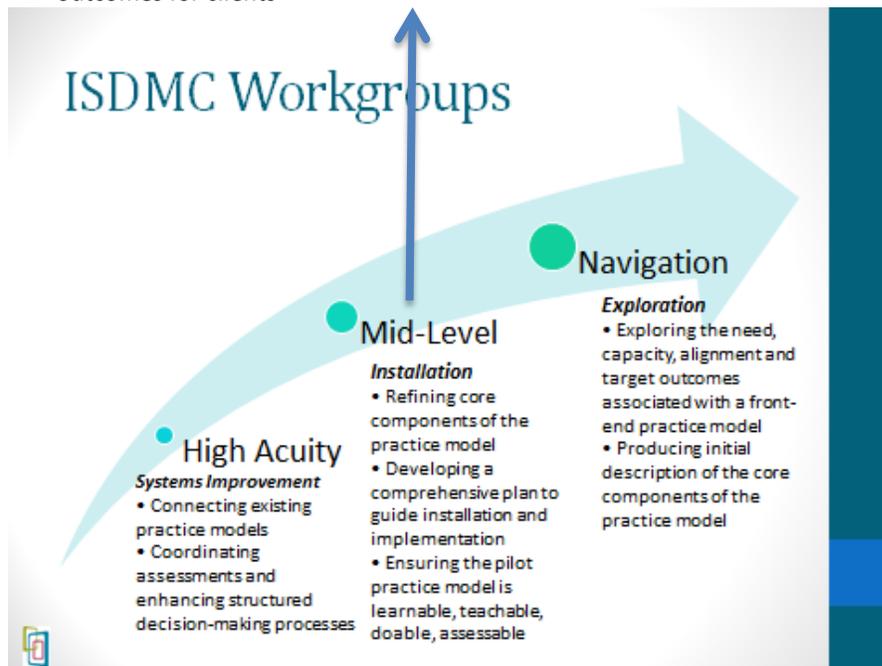
Whitney will be working with the Peak to Peak group and Julie to formalize a linkage to the FRN (via the LAC concept).

Integrated Services Delivery Model of Care (ISDMC)

The overarching goal of ISDMC is to transform the health and the well-being of the 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.

- There are three levels of work currently underway as demonstrated in the graphic below.
- The “mid-level” work is the most developed and will have significant overlap with the FRN by the end of the year.
- More information on ISDMC is to come.
- Here is a status update-
 - Implementation of a mid-level case management model is in development, with pilot teams scheduled to roll out the new model (using the CFSA) at the beginning of 2018
 - Sister Carmen, OUR Center, EFAA, and DHHS case management programs will be a part of the first phase of this roll out.
 - We are doing this refined approach to case management to increase consistency and sustainability of mid-level case management through:
 - Adequately resourcing the new practice model
 - Installing training and coaching supports
 - The mid-level case management model is meant to provide *support to implementers* as well as to ensure positive outcomes for clients



Data (data will be provided in April report for q1)

Fiscal Summary (to be provide in April report)

Partner Agency Updates

Boulder County Community Services

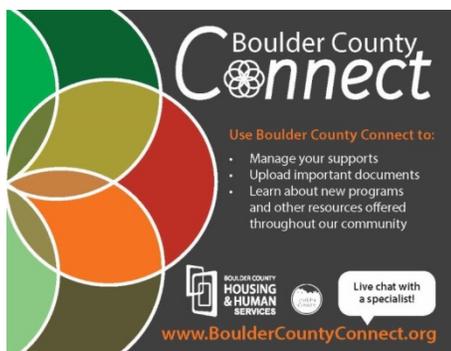
The Boulder County Community Services Department (CSD) provides services, in partnership with the community, that enhance quality of life, support and protect our county's diverse community of adults, children, families and elders, and promotes economic independence and self-sufficiency.

Boulder County Department of Housing and Human Services

We are building a healthy, connected community that empowers people and strengthens families by confronting the root causes of crisis and instability.

3-5 Year Strategic Goals

- **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.



The Boulder County Connect Challenge

1	9	2	7
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The Boulder County Connect challenge continues! Since last week, we saw a 40-account jump on our client portal (our biggest in several weeks!). We're currently at **1,927** Boulder County Connect client accounts. **We're trying to get to 2,000 accounts by April 1st!** How many can you generate?

If your staff have a few minutes and are sitting with a client, ask them to consider pointing them to the site, www.BoulderCountyConnect.org and getting them signed up. The client portal is a great resource to enhance their work with clients and give them more control over their own pathways to self-sufficiency. We have additional information, including sign-up instructions posted throughout our BCDHHS lobbies.

If you have questions about Boulder County Connect, please contact John Green, jgreen@bouldercounty.org with the DHHS BOSS Division.



Our Kestrel affordable housing community in Louisville will soon see its first residents!

Despite the setback recently on our proposal for an affordable housing community at Twin Lakes in Gunbarrel, we continue to make major progress on work to increase the supply of quality, permanently-affordable housing across Boulder County. As I'm sure you know, we are nearing move-in dates for the first phase of our Kestrel development in Louisville. In fact, in April and May of this year we will lease 42 of the affordable homes in that community to families accepted from our application list, with another 18 to follow in June. We've had over 500 applications so far for the 200 total homes in this community, and this is the result of limited, targeted outreach to those who've signed up for our interest lists and outreach through the Boulder Valley School District.

Boulder County Public Health

Boulder County Public Health shall protect, promote, and enhance the health and well-being of all people and the environment in Boulder County.

Boulder Housing Partners

Our mission is to provide quality, affordable housing, inspire vibrant communities, and create the opportunity for change in people's lives. We envision a diverse, inclusive and sustainable Boulder as a result of our efforts.

Clinica

To be the medical, behavioral health and dental care provider of choice for low-income and other underserved people in south Boulder, Broomfield and west Adams counties. Our care shall be culturally appropriate and prevention focused.

Early Childhood Council of Boulder County (ECCBC)

To expand and improve the comprehensive system of quality early childhood services for families in Boulder County Services: 1) the backbone organization for the Boulder County Early Childhood Collective Impact; 2) provide quality enhancement services to licensed childcare providers across Boulder County.

Update:

- Early Childhood Mental Health Task Force
- Looking to increase funding for early childhood mental health services across Boulder County;
- Dream Big Early Childhood Work Group
- Bobbie has been appointed to the Board of Health.

Emergency Family Assistance Association (EFAA)

EFAA helps those in our community whose immediate needs for food, shelter and other basic necessities cannot be adequately met by other means, and supports their efforts toward financial stability or self-sufficiency.

I Have a Dream Foundation

The mission of the "I Have a Dream" program is to motivate and empower children from low-income communities to reach their education and career goals by providing a long-term intervention program of mentoring, tutoring, and cultural enrichment. Upon graduation from high school, each Dreamer is eligible to receive a four-year tuition-assistance scholarship for college or vocational school.

OUR Center

The mission of the OUR Center is to unify community resources to help people in Longmont, Colorado and adjacent communities meet their individual basic needs and move toward self-sufficiency.

Sister Carmen Community Center

As a Family Resource Center we utilize a strength-based approach to address the many facets of a family in crisis. Our comprehensive three prong approach prevents homelessness, reduces food insecurity, increases access to health care, encourages self-reliance and strengthens families.

Entities and Updates to be added moving forward-

City of Louisville
City of Longmont
City of Boulder

Saint Vrain Valley School District
Boulder Valley School District



Hope for the future, help when you need it.

DHHS Advisory Committee

April 25, 2017

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BIOS..... 4-5

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REVIEW OF MINUTES 20-25

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FRN UPDATE REPORT44-49

**DHHS Advisory Committee
MONTHLY MEETING
Tuesday, April 25, 2017, 3:30-5:00 p.m.**

DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Objectives for Today:

- 1) Finalize the HHSAC Governance Charter**
- 2) Finalize high level FRN timeline and milestones for 2017**
- 3) Learn about ISDMC and its application to the FRN**
- 4) Learn about the HHS data system and plans to bring FRN partners onto it.**

- 1) Welcome and Introductions (3:30-3:40) Bobbie**
 - a. Diane Lauer, SVVSD
 - b. Karen Roney, City of Longmont
 - c. Christina Pacheco Sims, City of Longmont
 - d. Lane Volpe, BCDHHS
 - e. Jason McRoy, BCDHHS

- 2) Approval of the following Consent Agenda items (3:40-3:45) Bobbie**
 - a. Agenda for today
 - b. HHSAC Governance Charter
 - c. Minutes from March 21 meeting
 - d. One-page summary of FRN
 - e. Agenda items for next meeting
 - i. Local Area Collaborative Implementation Plan
 - ii. Prospective HHSAC members
 - iii. Process outcomes
 - iv. FRN Collective Services Outcomes Plan Discussion
 - v. FRN Orientation Topic 3 - ISDMC continued and partner overview

[Decision point- vote to approve the above](#)

- 3) Membership and Timeline Discussion (3:45-4:00) Melissa**
 - a. Membership (see attached)
 - b. FRN 2017 Timeline and Milestones- Review and discussion (see attached)

[Decision Point- vote to approve the milestones](#)

- 4) Boulder County Integrated Services Delivery Model of Care (ISDMC) (4:00-4:20) Lane, Melissa**
 - a. Overview – Lane Volpe
 - b. Role of ISDMC in the FRN - Melissa

5) Update on BC Connect and Client Data Access (4:20-4:30) – Jason McRoy

6) Group Q and A on Topics 4 and 5 - 4:30-5:00

7) Adjourn



Diane Lauer- Assistant Superintendent of Priority Programs and Academic Supports, St Vrain Valley School District

Dr. Lauer has served St. Vrain Valley Schools for the past two years as the Executive Director of Professional Development & Assessment. Prior to that, Dr. Lauer worked for the Thompson School District for eighteen years, where she was an Executive Director of Instruction, Director of Curriculum & Instruction, Director of Instructional Coaches, Principal, Assistant Principal, Technology Staff Developer and Language

Arts & Social Studies Teacher.



Karen Roney- Community Services Director, City of Longmont

Karen has served as the Community Services Director for the City of Longmont for nearly 27 years. Karen is responsible for the overall leadership and direction of seven divisions: Housing and Community Investment; Children, Youth and Families; Community and Neighborhood Resources; Library; Museum; Recreation and Golf; and Senior Services. She also manages the City's human service agency funding process. In her capacity, Karen is also responsible for coordinating and/or participating in communitywide and regional efforts that create collaborative responses to unmet and/or emerging

community needs, and for involving a diversity of community members in civic engagement opportunities. Some of these efforts have included: Longmont Multicultural Plan and Action Committee; the Dialogues on Inclusion and Involvement effort for Boulder County; LiveWell Longmont; the City's pilot poverty reduction initiative; the community-based initiative: Supporting Action for Mental Health; and Longmont Homeless Services Action Team. Karen partnered with citywide team members to establish Longmont's Community Engagement Model. She had a lead role in leading the City's Focus on Longmont Strategic Plan effort and introducing Appreciative Inquiry as an approach to municipal strategic planning and visioning. Karen has a Master's Degree in Social Work from the University of Iowa.



Christina Pacheco Sims- Division Manager, Children, Youth, and Families Division, City of Longmont

Christina is a Licensed Professional Counselor in the State of Colorado and has worked with children, youth and families in different capacities within the Longmont community for 22 years. Christina's career has been dedicated to the field of human services; She is bilingual (English/Spanish). Christina has had the opportunity to work in a variety of capacities such as Juvenile Court and Probation, Child Protection, School Districts and Children & Youth Services. She has a great deal of experience working with homeless and gang involved youth, providing

clinical supervision to masters level counselors, systems alignment and program development. Christina has been employed with the City of Longmont since 1999 and is currently Division Manager of Children, Youth and Families in the Community Services Department. The Children, Youth and Families Division focuses on 5 different areas: Counseling and Community Mental Health, Early Childhood, Gang Response Prevention and Intervention, Family Engagement and Youth Development.

Christina was born and raised in the San Luis Valley in Southern Colorado and comes from a family that has agricultural roots that date back 7 generations in Colorado and Northern New Mexico. She is the youngest of 8 children; all of whom pursued post-secondary education, many in human services and education. She has a Bachelor's Degree in Psychology, from the University of Colorado, with an emphasis on multicultural issues. She has a Master's Degree in Counseling Psychology from the University of Denver.

2017



BOULDER COUNTY FAMILY RESOURCE NETWORK

Governance Charter

April, 2017

A governing document of the Boulder County Housing and Human Services Advisory Committee (HHSAC)

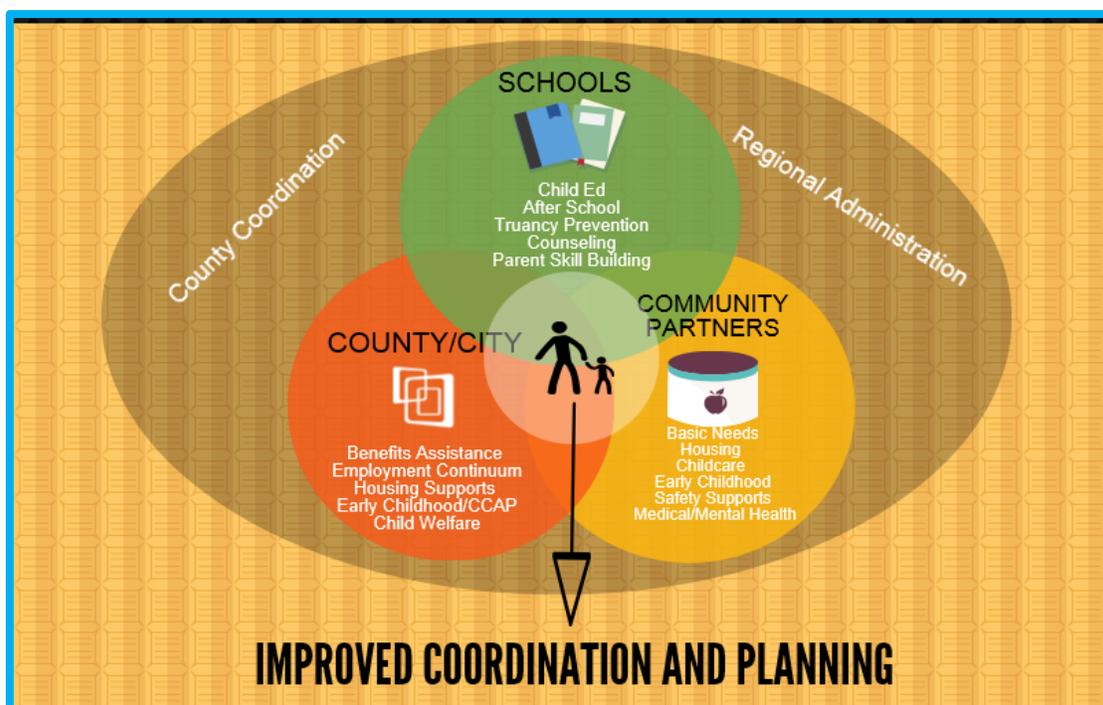
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1. Overview

A. Boulder County Family Resource Network (FRN)

Vision: Based on a two generational approach, create a fully integrated system* of service delivery, organized through a county-wide governance structure comprised of citizens, schools, community-based entities, and city/county government aimed at improving self-sufficiency of families and academic outcome for children and youth.



*A fully integrated system is a **holistic approach** to serving each consumer, using an **interoperable data exchange** to link the people, services, and information across systems and programs for robust **care coordination, integrated case planning, timely service delivery, and cross-system relationship management.**

B. The FRN Regional Council (RC)

The Regional Council is responsible for achieving a visionary, yet complex, large system-change process, aligning strategic direction and implementation consistent with the integration vision outlined above designed to produce the positive, long-term, sustainable outcomes for children, families, and individuals served throughout the community.

The Boulder County Housing and Human Services Advisory Committee (HHSAC) will serve as the Family Resource Network Regional Council (RC). This Governance Charter serves as a component to the HHSAC by-laws.

The Regional Council provides the overarching governance to the Family Resource Network and oversees achievement of collective service outcomes to improve overall well-being of Boulder County families. In this model, the Regional Council consists of high-level leaders with a stake in the outcome of the effort, people in a position to make significant policy decisions, break down barriers, and provide vision and strategic direction. It 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 the following:

- communicating a clear shared vision;
- defining strategy and expected community-wide outcomes;
- ensuring that the input by those being served by the FRN is guiding its direction;
- monitoring performance on key metrics;
- advocating and informing on relevant local, state and federal policy;
- supporting and advising on program improvement;
- supporting coordinated and consistent processes, policies, and management of the FRN;
- facilitating and approving formal agreements for operation of the Network ;
- facilitating resource procurement and allocation;
- informing and supporting the Boulder County Integrated Services Delivery Model of Care (ISDMC);
- reviewing and approving recommendations from Local Area Collaborative groups (LACs);
- increasing efficiency and collaboration among partners;
- reducing duplication of services/efforts and identify gaps; and
- making decisions required to assure success of the FRN.

The FRN Regional Council will be responsible for ensuring focus on the vision and strategic direction and must monitor progress toward implementation in order to create the seamless that benefits both consumers and the community.

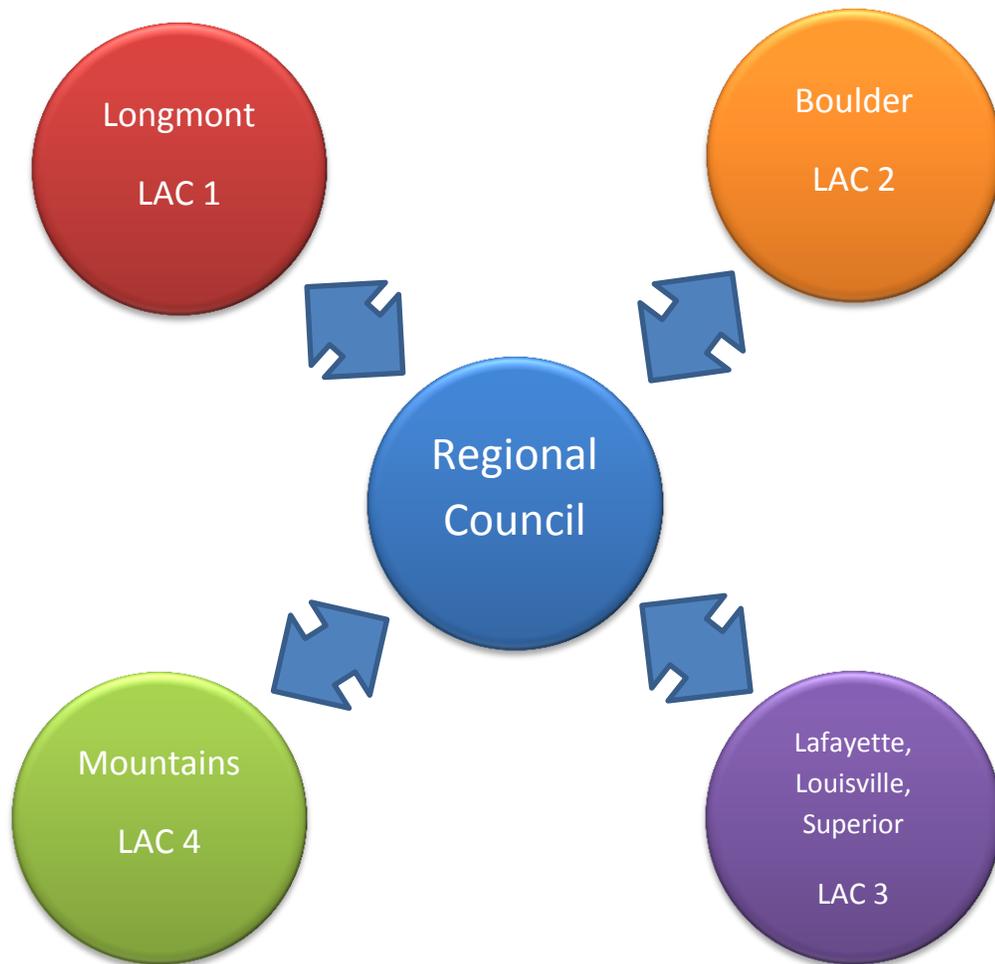
Note: The FRN does not take the place of any individual agency's Board of Directors.

C. Local Area Collaborative Groups

Given that a core principle of the Family Resource Network is that each community hub address the specific needs of the local area, Local Area Collaborative (LAC) groups will be created consisting of representatives in four regions (see page 4). Using data-informed practices, LACs are responsible for forming and overseeing the local "hubs" (networks of support) to include:

- reviewing access and referral processes;
- identifying challenges and opportunities, helping the Regional Council leadership understand the barriers, working through them, and delivering on the vision;
- ensuring that the input by those being served by the FRN is guiding its direction;
- reviewing and analyzing local data and reports on family resource programming;

- implementing referral, access and data quality improvement plan;
- tracking progress on implementation of collective service outcomes;
- establishing and ensuring participant programs adhere to standards outlined by the FRF and Quality Service Standards by the Family Resource Center Association;
- coordinating training and “communities of practice” within areas and collaboration between areas; and
- informing and supporting the Boulder County Integrated Service Delivery Model of Care.



D. Boulder County Staff Roles

Three designated Boulder County staff will provide guidance, technical assistance and support to the Regional Council and the Local Area Collaborative groups to achieve desired process and service outcomes.

Regional Council Liaison- IMPACT Strategic Initiatives Manager

Duties include:

- Leads monthly Regional Council (RC) meetings;
- Organizes meeting agendas, produces pertinent materials, identifies primary decision needed to advance the FRN, and responds to requests/needs of members;
- Provides recommendation to the RC necessary for making key decisions;
- Facilitates linkages between RC members and other key stakeholders to the FRN 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 FRN 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 work as a fundamental basis for service delivery by FRN partners;
- Provides any pertinent fiscal reports (i.e. funding reports); and
- Facilitates feedback on strategic investments.

Local Area Collaborative Liaison - The IMPACT Strategic Initiatives Coordinator

Duties include:

- Provides assistance with analysis of Local Area Collaborative data and outcomes and reports to the 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 programs 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; and
- Serves as Regional Council Liaison in the absence of the Strategic Initiatives Manager; and
- Oversees Boulder County Department of Human Services contract scopes and agreements with Family Resource Centers.

Administrative Support – IMPACT Strategic Initiatives Specialist

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

2. Membership

A. 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 or designee
Boulder Valley School District Assistant Superintendent or designee

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 Community Services Director
City of Louisville - Housing Representative
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)
The Early Childhood Council of Boulder County Director (ECCBC)
Clinica Director
Boulder Housing Partners Director
Peak to Peak Representative
I Have a Dream Foundation Director

Current or Previous Participant in FRC Services

MEMBERS AT-LARGE

Per the HHSAC by-laws-

- 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.

B. Local Area Collaborative Groups

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.

SCHOOL

- St. Vrain School District – TBD (attends for LAC 1)
- Boulder Valley School District – TBD (attends for LAC 2, 3 and 4)

COUNTY/CITY GOVERNMENT

- Boulder County Housing and Human Services - FRF Liaison (attends all 4 LACs)
- City of Longmont- Children and Youth Center staff member(LAC 1)
- City of Boulder – Family Resource Schools Administrator (LAC 2 and 3)

The following representatives will attend meetings as needed. An agenda for each monthly meeting will be sent in advance to the representative in order for the designated representative and the county liaison to determine if attendance is needed.

- BCDHHS Early Intervention Team Program Manager (attends all 4 LACs)
- Boulder County Community Services – Workforce Boulder County staff member (attends all 4 LACs)
- Boulder County Department of Public Health representative (attends all 4 LACs)

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)

The following representatives will attend meetings as needed. An agenda for each monthly meeting will be sent in advance in order for the representative and the county liaison to determine if attendance is needed.

- ECCBC Associate Director (all 4 LACs)
- I Have a Dream Foundation staff (all 4 LACs)
- Clinica program staff (all 4 LACs)
- Boulder Housing Partners program staff (LAC 3)
- Peak to Peak Representative (LAC 4)

Current or Previous Participant in FRC Services

3. Scope and Roles

A. Regional Council

The Family Resource Network Regional Council guides overarching governance of the Family Resource Network with support of the staff liaison. The RC will use key principles in the Standards of Quality and

ISDMC practices to guide implementation.

- **Communicate a clear shared vision** - RC members will be responsible for formalizing and communicating the FRN vision and key objectives within their agencies and in the community.
- **Define strategy and expected community-wide outcomes**- The RC will be responsible for formalizing both process and collective program outcomes for the FRN (see page 9), finalizing an agreed upon logic model with tangible measures, and monitoring progress in achieving these outcomes.
- **Ensure that the input by those being served by the FRN is guiding its direction**- Either through representation on the RC or LACs or through feedback provided by FRC Participant Advisory groups or related forums, ensure that guiding principles, policy, and service delivery are reflective of participant needs, input and guidance.
- **Monitor performance on key metrics** – Using Transformational Collaborative Outcomes Management (TCOM) regularly monitor and report progress on outcomes across the FRN.
- **Advocate and inform on relevant local, 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** – RC members will review the LAC process and program-related recommendations 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 Network .
- **Support coordinated and consistent processes, policies and management of the FRV** - 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 FRN** – This includes memorandums of understanding regarding service coordination, data sharing, etc.
- **Facilitate 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** – The RC will inform and stay apprised of ISDMC work and ensure adherence to the practice model.

- **Review and approve recommendations from Local Area Collaborative entities**
- **Increase efficiency and collaboration among partners** – Identify and implement opportunities to streamline interagency effectiveness to include sharing of resources, optimizing data systems and best practices.
- **Reduce duplication of services/efforts and identify gaps.**
- **Make decisions required to assure success of the FRN**

B. Local Area Collaborative Groups

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 FRN Regional Council, activities included are listed below. The RC will use key principles in the Standards of Quality and ISDMC practices to guide implementation.

- **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 a referral process to support the family resource services in their area. Referrals will be linked to assessment and supported through a common data system (HHSC/BC Connect).
- **Review and analyze local data and reports** on family resource programming.
- **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**, to include Quality Service Standards by the Family Resource Center Association.
- **Coordinate training and “communities of practice”** within areas and collaborate between areas.
- **Inform and support the Boulder County Integrated Service Delivery Model of Care** (see attachment B).

4. OUTCOMES

The FRN Regional Council and Local Area Collaborative Groups will be responsible for defining and tracking process measures and collective service outcomes.

A. Process Measures (Outputs) – The How

The process measures are the specific steps taken by the FRN to reach the desired collective service outcomes. Process measures will be defined by the FRN Regional Council and implemented and tracked by the LACs.

FRN process measures are related to the collective program outcomes which measure impact of services provided by FRN members at an “enterprise” or systems level. For example, a LAC will be responsible for defining the service network and role of each partner in that network. Once defined and a protocol is in place, a process measure would be to determine if programs within the LAC were following the steps outlined by the LAC. The improvement in service coordination is linked to improved outcomes in core areas of self-sufficiency.

B. Collective Service Outcomes

Collective Services Outcomes will be defined and agreed upon by the Regional Council. Implementation will be managed by the LACs.

Modeled after the Colorado Family Resource Center Association (FRCA) logic model, the collective service outcomes outline the changes anticipated as a result of the combined efforts of FRN partners in implementing the Network (see attachment A for the complete logic model; note that the outcomes on page 11 are additions suggested for Boulder County). This document will assist in development of the Boulder County FRN logic model to be completed per the FRN implementation work plan.

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

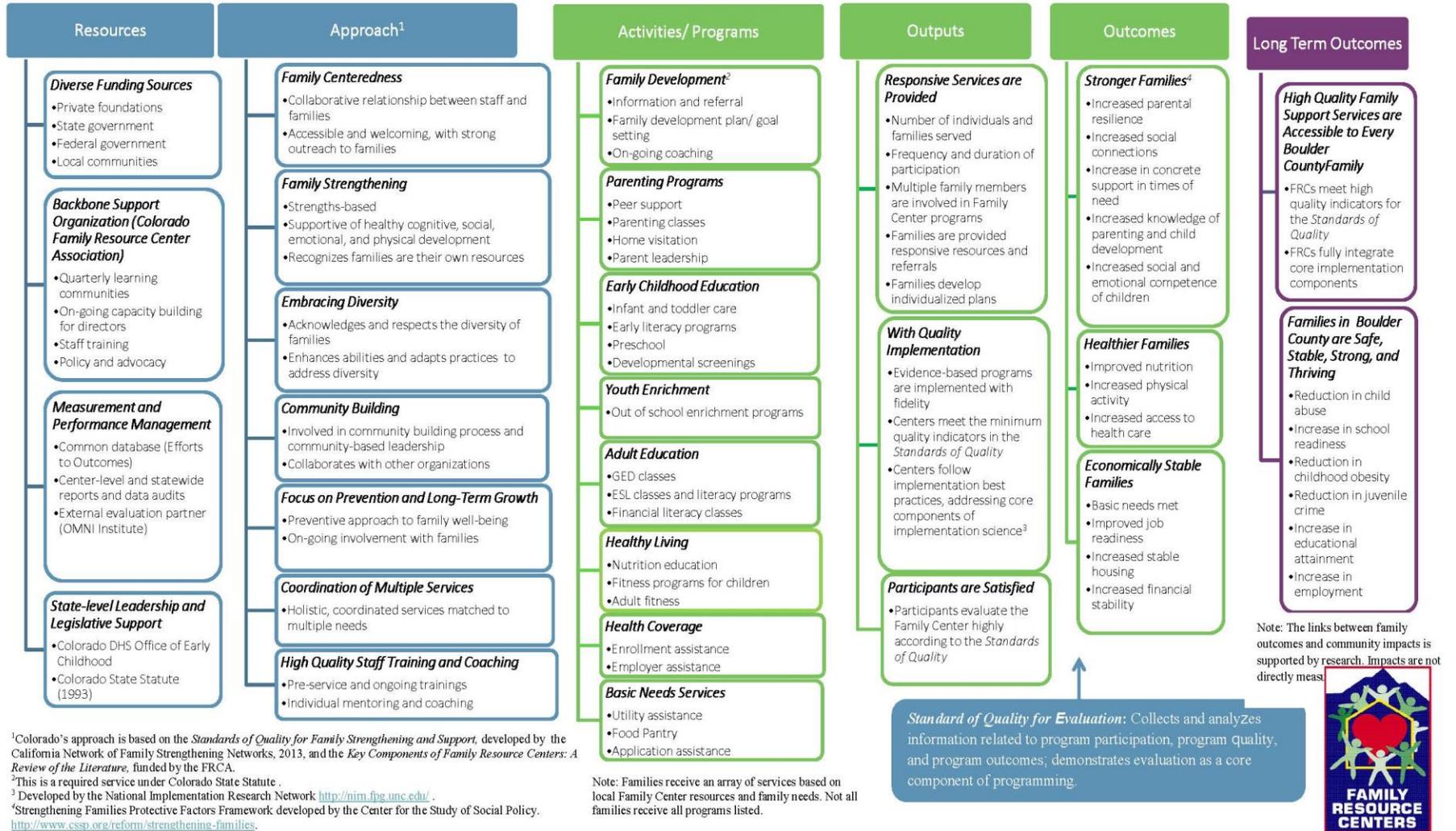
Date ratified _____

Revision _____

Attachment A

Colorado Family Resource Center Logic Model

(updated December)



¹Colorado's approach is based on the *Standards of Quality for Family Strengthening and Support*, developed by the California Network of Family Strengthening Networks, 2013, and the *Key Components of Family Resource Centers: A Review of the Literature*, funded by the FRCA.
²This is a required service under Colorado State Statute.
³Developed by the National Implementation Research Network <http://nim.fpg.unc.edu/>.
⁴Strengthening Families Protective Factors Framework, developed by the Center for the Study of Social Policy. <http://www.cssp.org/reform/strengthening-families>.

Boulder County Revision
(orange box)

Short to Moderate Term Outcomes

Stronger Families

- Increased **parental resilience**
- Increased **social connections**
- Increase in **concrete support** in times of need
- Increased knowledge of **parenting and child development**
- Increased social and **emotional competence of children**

Healthier Families

- Improved **nutrition**
- Increased **physical activity**
- Increased **access to health care**

Economically Stable Families

- **Basic needs** met
- Improved **job readiness**
- Increased stable **housing**
- Increased **financial stability**

Success in Early Childhood through Early Adulthood

Improve academic success of children and youth
 Improve behavioral outcomes for children and youth
 Improve quality, accessibility and affordability of early childhood programs and services.

Long Term Outcomes

High Quality Family Support Services are Accessible to Every Boulder County Family

- FRCs meet high quality indicators for the *Standards of Quality*
- FRCs fully integrate core implementation components

Families in Boulder County are Safe, Stable, Strong, and Thriving

- Reduction in child abuse
- Increase in school readiness
- Reduction in childhood obesity
- Reduction in juvenile crime
- Increase in educational attainment
- Increase in employment

Attachment B

Integrated Services Delivery Model of Care Practice Model





Department of Housing & Human Services

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Draft Meeting Minutes DHHS Advisory Committee March 21, 2017

Members Present: Bobbie Watson, Dalia Dorta, Suzanne Crawford, Betsey Martens, Julie Van Domelen

Staff Present: Frank Alexander, Melissa Frank-Williams, Susan Caskey, Whitney Wilcox, and Monica Serrato

Guests: Lori Canova, Edwina Salazar

Meeting Action Items:

- 1) **Review and approval of minutes to be consent item**
- 2) **Review and approval of agenda to be consent item**
- 3) **Review and approval of FRN document to be consent item- please send feedback to Melissa**
- 4) **HHSAC meetings to rotate between Longmont and Boulder starting in May. Monica will send out the revised calendar invitations to the group.**
- 5) **Revisions to the “one-pager” per Committee member recommendations will be made by Melissa and redistributed to the group by the next meeting.**

Detailed Meeting Minutes

- 1) **Review and approval of today’s agenda (3:33 – 3:35 p.m.)**
- 2) **Review and approval of minutes from February 28, 2017 HHSAC meeting (3:35 – 3:40 p.m.)**
Not enough members in attendance who were present at the last meeting, approval of minutes postponed until April.
- 3) **Introduction of today’s guests (3:40-3:50)**
Lori Canova introduced herself. She has been the CEO of the I Have a Dream Foundation (IHAD) for 20 years. IHAD works with low income youth starting in elementary school through college. The organization serves both the BVSD and SVVSD school districts, have 10 active “dreamer centers,” and have recently expanded to Carbon Valley. Lori is also the chair of Dream Big, a collaboration that includes Boulder Housing Partners, City of Boulder, the Community Foundation, and BVSD to reach more students in its work to close the achievement and opportunity gap. She looks forward to exploring how IHAD and Dream Big aligns with HHSAC/FRN and will share more information in future meetings. Melissa Frank-Williams responded that in the next meeting the group will be reviewing the governance document so that would be the best place for Canova to learn more about HHSAC/FRN, and there will be time in future meetings to share and learn more about partner’s work.

There was some discussion about membership status for both Canova and Edwina Salazar. Frank-Williams explained that the Commissioners are aware of their applications to join HHSAC and expects both applications to be approved by the Commissioners in time for the April meeting.

There was also some discussion about alternating HHSAC meetings between Boulder and Longmont. The group approved of the idea and agreed to share this update at the April meeting when additional members would be in attendance. It was requested that a very clear update is sent in the calendar invite and via email to remind members before that May meeting. M. Serrato will do this.

4) Discussion of goals of FRN (3:50-4:05)

Frank-Williams said that Watson requested the creation of a simple, one-page visual that could help HHSAC members in talking about the work of the FRN, something that could be used as an “elevator speech.” Frank-Williams shared the document with the group and invited feedback. She said the document should be helpful for communicating the FRN concept when people are onboarding to this work or when sharing it with members of the community. The following comments were shared during the review of the one-pager:

- Van Domelen shared that the vision isn’t the same as in the original document. Frank-Williams responded that the one-pager is meant to be a pared down version of the original.
- Van Domelen said it’s important to keep “self-sufficiency” in the pared down version.
- Dorta asked for clarification about Regional Council membership. Frank-Williams answered that in the last meeting, members decided that the HHSAC board responsibilities would stay the same, but that about 90% of the duties would be the Regional Council’s roles.
- Canova asked if the one-pager should include communication with the public as one of the roles of the Regional Council.
- There was discussion about using the phrase “shared governance structure” and some concerns about whether the Regional Council superseded the member organization’s boards. Members clarified that the Regional Council will oversee the governance of a system and not of individual member organizations.
- Martens said that she appreciates the document and that while she doesn’t believe any funding decisions have come to this group, in the future they will.
- Van Domelen asked if “funding decision” could be re-worded to “funding allocation.”
- Van Domelen added that family outcomes are different than social-emotional, family stability, and self-sufficiency. She added that an ongoing conversation at EFAA is if “self-sufficiency” is the right word. Salazar said that “self-reliance” is replacing “self-sufficiency” in the Family Resource Center model.
- Watson asked Van Domelen to share more about what an FRC would look like in the Mountain area where there is no brick and mortar location. Van Domelen said that while we usually think of a physical location, in the mountain area there won’t be any one agency where people will come to, it might be more of a “virtual” FRC. Alexander confirmed that it would be more virtual and that hopefully more people will be able to access services through the interconnectivity of the group. Van Domelen added that each LAC would look very different, more brick and mortar, but it would map out differently in each community.
- Salazar suggested adding continuing education or refreshing of practice as a standard for the group to hold itself to.

- Dorta suggested adding data sharing. She asked if all four LACs will have the same data system. Frank-Williams answered that with the exception of the mountain area, the other three LACs are currently part of a shared system (ETO) and will be migrating to a new system beginning this summer. There will be a phased approach with the first phase beginning in June that will include transitioning all current organizations using ETO to the new system. A second phase, that will include additional organizations, hasn't been decided yet but it is being discussed. Canova asked if school districts will be involved in the new system. Frank-Williams answered said that we have been working with the school districts around shared data, which included TBRA, a housing program that works in collaboration with the schools.

5) HHSAC Orientation Topic 1: Overview of Boulder County Family Resource Centers and the Colorado Family Resource Center Association (4:05-4:35)

FRC	FRCA (Family Resource Center Association)
Family Development	Public Advocacy
Resource and Referral	Resource Development
	Capacity Building

Suzanne Crawford provided an overview to the group about Family Resource Centers (FRC) and the Family Resource Center Association (FRCA). Though FRCs provide a range of services, Crawford explained that FRCs are only required to do family development work and resource and referrals. The strongest FRCAs are in Colorado and California. In 2011, Crawford, Frank-Williams, and Kathryn Coleman (City of Boulder) went to Monterrey, CA to learn more about the family support and development work in California. During this trip, the group discovered the Quality Standards for Family Strengthening and Support, which defines and promotes quality practice for families. Sister Carmen Community Center (SCCC) implemented them immediately and shared the Quality Standards with the FRCA in Colorado. The FRCA Program and Evaluation Committee was looking for a way to evaluate the work that FRCs around the state were doing and in 2013 adopted the Quality Standards and required that all the FRCs in the state use them to evaluate their services and practices annually.

Crawford said that FRCs all look different: some are rural and understaffed and undersupported, some are in schools, some are part of larger organizations (for example, Hilltop on the Western Slope). FRCs offer a range of services that may include parenting classes, child care, clothing, food banks, hot meal programs, residency programs for youth, financial assistance, health-related programs, and after school programs. Crawford said that all of these programs contribute to the well-being of the family as a whole.

Crawford shared some information about funding. She explained that the FRCA receives funding from multiple sources, including the state and the Colorado Health Foundation, and serves as a “pass through” to its membership. FRCs also receive funding from the Rose Foundation, which recently supported a collaboration with WorkLife Partnership to launch a pilot program in the Denver metro area. SCCC will have a coach on site once a week through this collaboration.

Watson asked for an example of a quality standard. Crawford said one example is that FRCs should be working with families in a culturally appropriate way. The Quality Standards are designed to be used as a tool and includes indicators for minimum to high quality. Suzanne believes that the tool encourages innovation within individual FRCs and allows staff to get creative with what will work within their individual communities. Frank-Williams forwarded the Standards to the group via email.

Susan Caskey asked what Crawford saw as the connection between the FRN and the FRCA. Crawford explained that the FRN is our local Boulder County network and the FRCA is the statewide association. She explained that in California, local networks have existed for years. SCCC currently serves as the liaison between the FRN and the FRCA to ensure alignment with reporting needs and case management practice. She added that EFAA and OUR Center have applied to become FRCA members and will also be able to serve in this capacity. Crawford mentioned that FRCA membership benefits including funding, access to training, and technical assistance. She said that there is an expectation that members are active in the FRCA and that Crawford serves on the board.

Watson asked if the FRCA has common outcomes and if SCCC shares their data with them. Crawford responded that they use the Colorado Family Support Assessment 2.0 (CFSA) which is very similar to the Self-Sufficiency Matrix (SSM) Boulder County has been using. Outcome data is pulled from this assessment which is entered into a common data system (ETO). Boulder County is moving to the CFSA in the next year. Crawford added that the work Boulder County is doing is ahead of many other counties in terms of the partnership between local government and non-profits. She said it's possible that Boulder County is leading the way in that regard.

Canova asked for clarification between Family Resource Schools (FRS) and Family Resource Centers (FRC). Frank-Williams replied that the main distinction is that the FRS specifically serves the families with a child attending the school in which it is located and the FRC serves any individual or family. The FRS doesn't currently offer the same depth of services as FRCs do and the FRS operates only when school is in session. Frank-Williams said that through the Boulder LAC, we will work to ensure seamless linkage and identify clear roles about who is providing what. She explained that part of the reason for the four LACs (as opposed to one operating board across the county) is to account for the specific needs of each community. Martens asked who oversees the FRS, to which Frank-Williams shared that the City of Boulder does. Alexander added that the county had been funding the FRS and the FRC at Manhattan Middle School. He said there's been a great amount of work that's been done but there are some holes: A kid at one school gets different services than a kid at a different school just by virtue of being at a different school. Do they wind up at EFAA or OUR Center or at a school? The group discussed that a core purpose of the FRN is to ensure Boulder County has a well-coordinated system of care whereby families are getting the right support at the right time regardless of their entry point into the system.

Martens asked if FRC certification is through the FRCA. Van Domelen said there is not currently a "certification" that establishes an organization as an FRC. She shared that EFAA spent a lot of time trying to decide if they were already an FRC. She said it was helpful to look at the Quality Standards, which helped them to determine where they were higher quality and where they were

meeting the minimum standards. Martens asked if someone emerged and said that they want to be a FRC, is HHSAC the body that the organization goes through? Crawford replied that any organization can call itself a FRC but not everyone can say they are a member of the FRCA. She said that should Sister Carmen, EFAA, and OUR Center all be FRCA members and someone in Boulder emerges and tries to join FRCA, it's unlikely they would be able to join because services are already being provided. Frank-Williams added that part of the work is alignment. She said that if there were someone who wanted to be an FRC, the role of the FRN/HHSAC members would be to reach out to that entity and bring it forward to determine how to proceed to ensure alignment and no service duplication. Salazar mentioned that The Family Garden in Longmont might move in that direction in the future.

Salazar said that the new OUR Center building has created new opportunities for programs and services, including a partnership with Dental Aid, a legal clinic, and adult basic education. She said that how (the philosophy and approach) services are provided is where the transformation is under the FRC model. Salazar added that the biggest change for OUR Center moving forward is to bring the strengths based/participatory approach to the work and including participants in decision-making.

Alexander added that we need to develop the common practice and surface the things that need to be worked on. He said we are struggling with the employment continuum. We went through a community collaboration and stabilization phase, and the system has gotten better at that, but how do we move people up and through so that they can free up resources, and how long do we need to support folks, that's where the FRN could make an impact. It creates a very different access point for people in the community than what we have now.

6) Partnership Updates (4:35-4:45) Frank-Williams reminded everyone that there are updates in the packet for members to review. She asked members to send any organizational updates they wanted to share with FRN/HHSAC members to Serrato. Frank-Williams reviewed the packet structure and said we would continue to use this format. She said that anything that has a decision attached to it would be brought to the meetings and that updates were for information only and would be included in the packet but not discussed at the meeting.

7) Review of agenda for next meeting (4:45-5:00)

Frank-Williams said that we will add in data and fiscal pieces to the packet for April's meeting. There will be an overview of the Integrated Services Delivery Model of Care (ISDMC), review of orientation materials, and a regrouping around IMPACT components we'd like to implement. We'll also approve the governance structure document. The governance document went out to everyone and is in the google drive. It is a work in progress, but we would like to finalize it knowing that we can always add updates and amendments later.

Frank-Williams shared that SVVSD's Diane Lauer will be at the April meeting, as well as Karen Roney and Christina Pacheco Sims from the City of Longmont. She said that staff, in partnership with Watson, are also connecting with BVSD leadership and working on having representation in May. Watson added that finalizing the governance document feels urgent and that it should be a consent item.

Martens reminded everyone to review the minutes, especially if you missed the meeting as it's

critical to be aware of what is going on. Alexander suggested members identify a “buddy” who was in attendance to review minutes with you if you missed a meeting.

8) Adjourn

The meeting was adjourned.

Boulder County Family Resource Network

Shared Governance Structure

A county-wide shared governance structure comprised of citizens, schools, community-based entities, and city/county government aimed at improving self-sufficiency of families and academic outcomes for children and youth.



Summary of HHSAC Membership Process

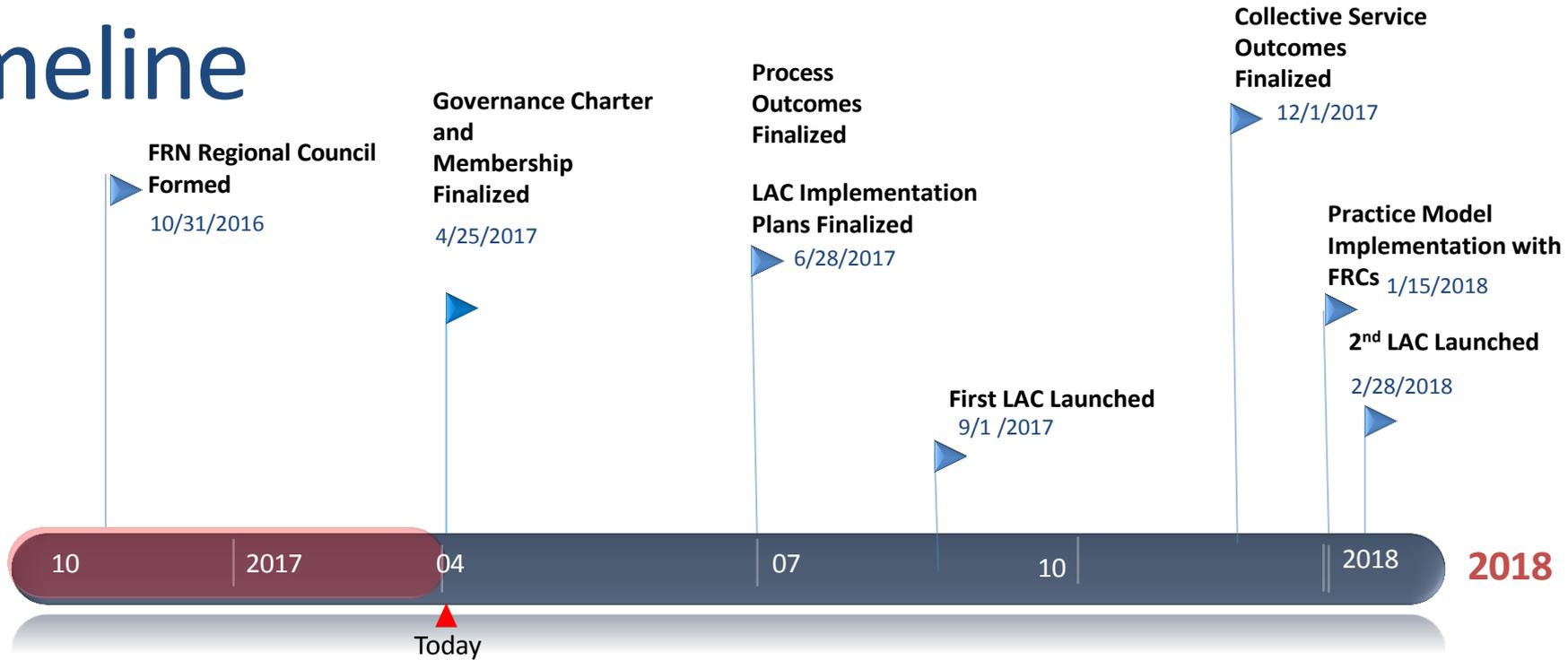
Recruitment

Community members interested in becoming a part of the HHSAC Board come through two main channels- the open recruitment period posted on the Boulder County website's Boards and Commissions page and through solicitation by HHSAC members and/or staff.

Maximum capacity of the HHSAC is fifteen.

1. When seats become available, staff will inform the Chair and he/she will solicit nominations from the members. Staff will provide assistance when needed.
2. An application will be provided to interested parties.
3. Staff will also bring forward any applications that have come through the Board of County Commissioners' (BOCC) office during the open recruitment period.
4. Staff and the Board Chair will schedule a meeting with interested parties to determine interest and fit.
5. Prospective members will be invited as guests to a subsequent HHSAC meeting to observe and to talk about their interests and role in the community.
6. Members will excuse the guest and vote on the prospective member to be recommended to the BOCC.
7. Recommendations and membership application will be forwarded by DHHS staff to the BOCC for formal approval at the next available business meeting.
8. Prospective members will be formalized as members after the approval of the Commissioners. BCDHHS staff will inform the members when they are approved.

Timeline



10/23/2016 - 3/28/2017



HHSAC established as FRN, governance document created, membership recruitment from schools and key agencies

10/23/2017 - 5/21/2017



FRN Regional Council Orientation and Onboarding

5/1/2017 - 6/28/2017



Finalize top process outcomes for FRN

5/1/2017 - 6/28/2017



LAC Guidelines completed, Readiness Assessment completed, identify first area to launch

6/28/17 - 9/1/2017



Coordinate first LAC to launch

6/28/17 - 12/1/2017

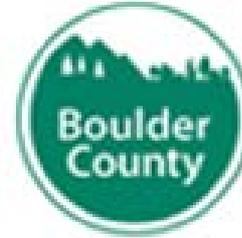


With ISDMC, identify collective service outcomes

10/1/2017-2/28/2018



Coordinate 2nd LAC to launch

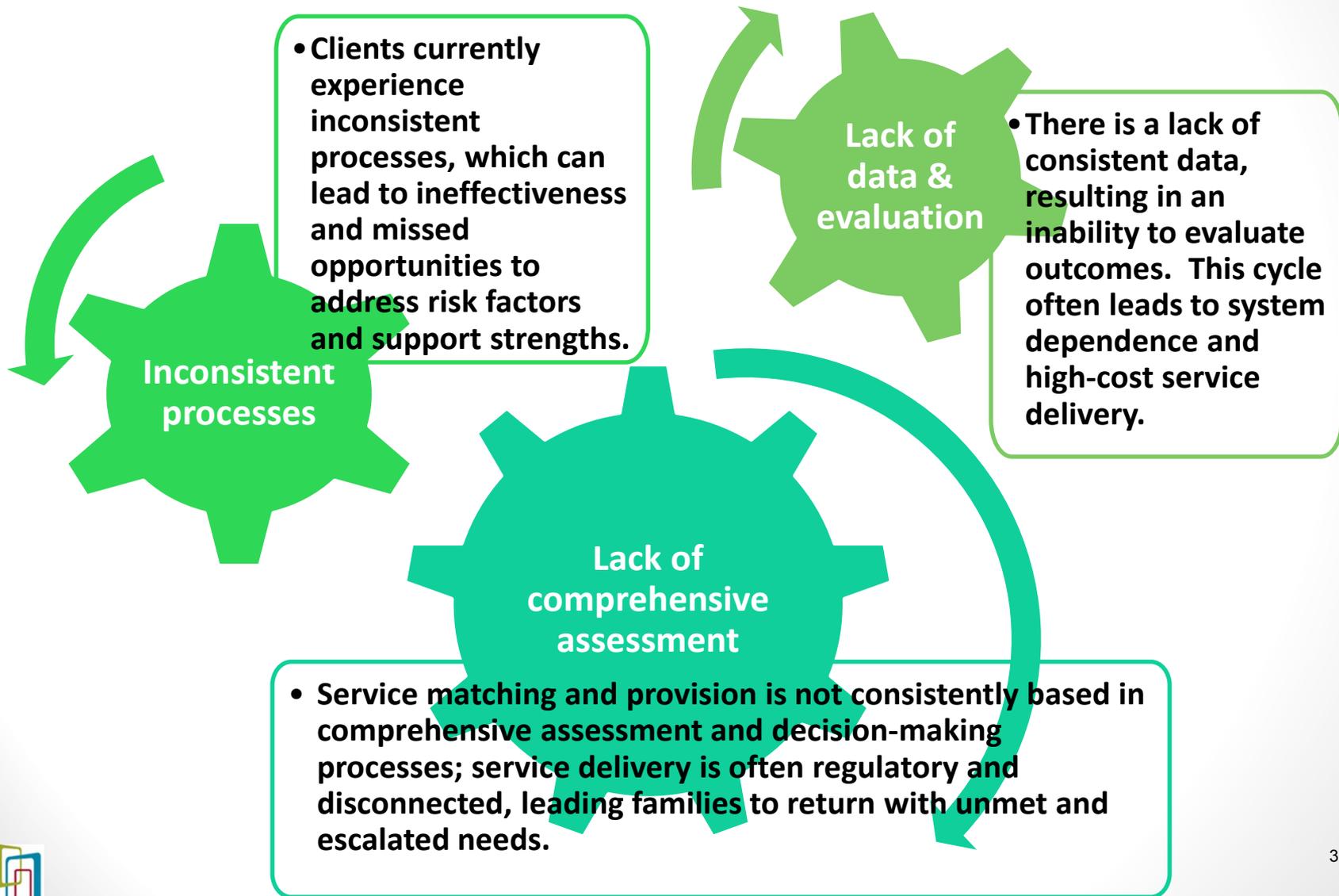


Hope for the future, help when you need it.

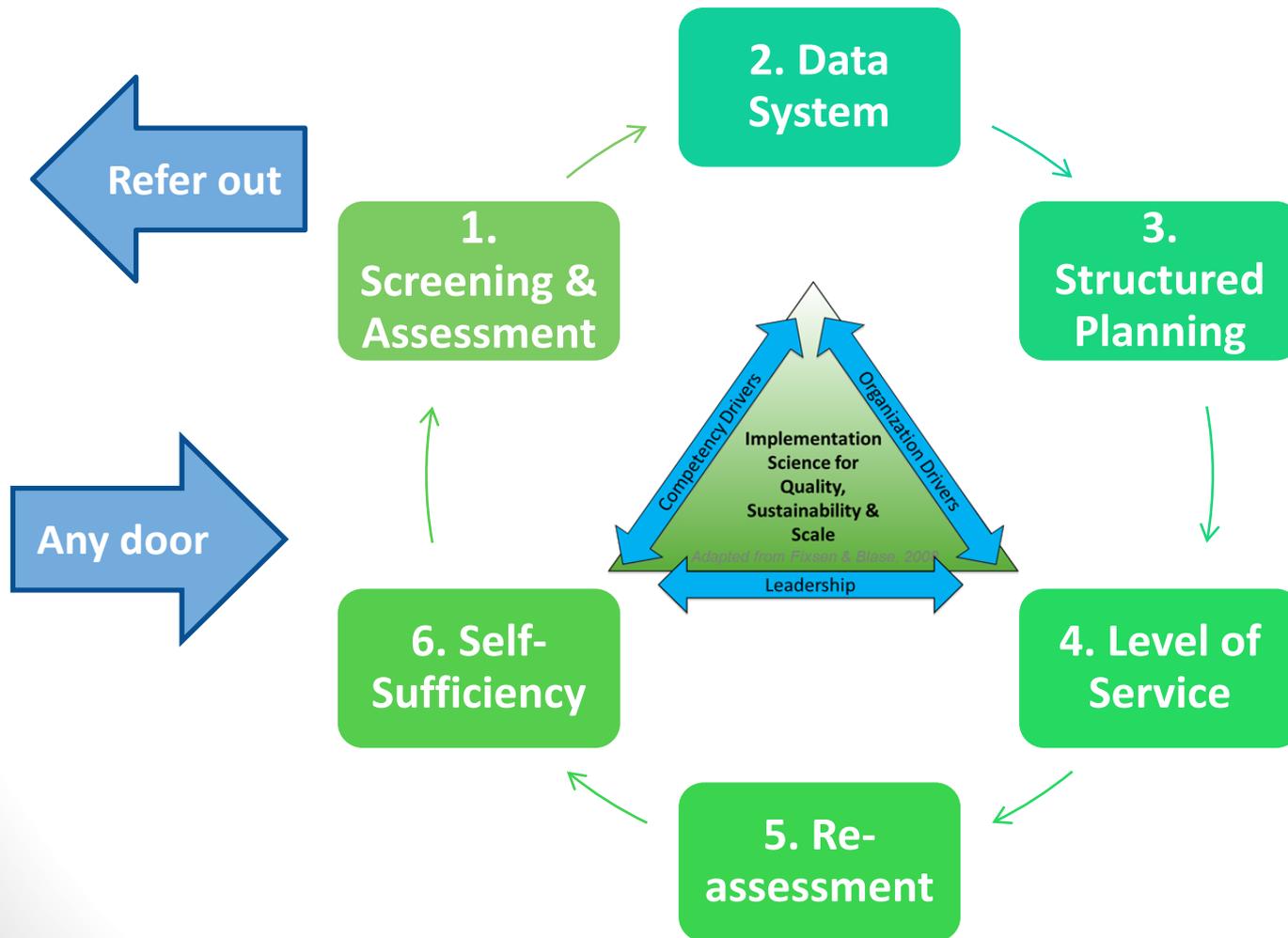
Integrated Services Delivery Model of Care (ISDMC)



ISDMC Problem Statement

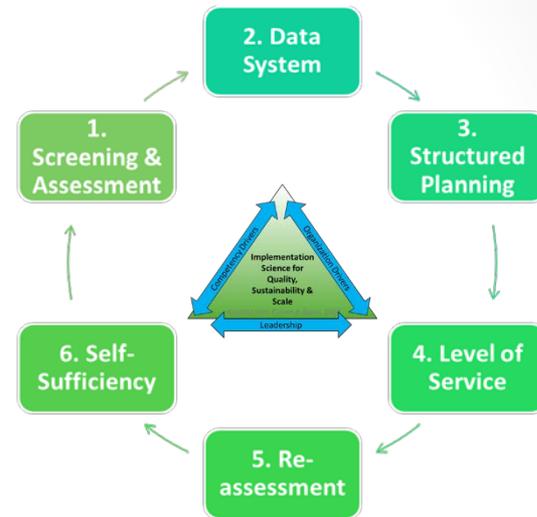


ISDMC Practice Model Core Components

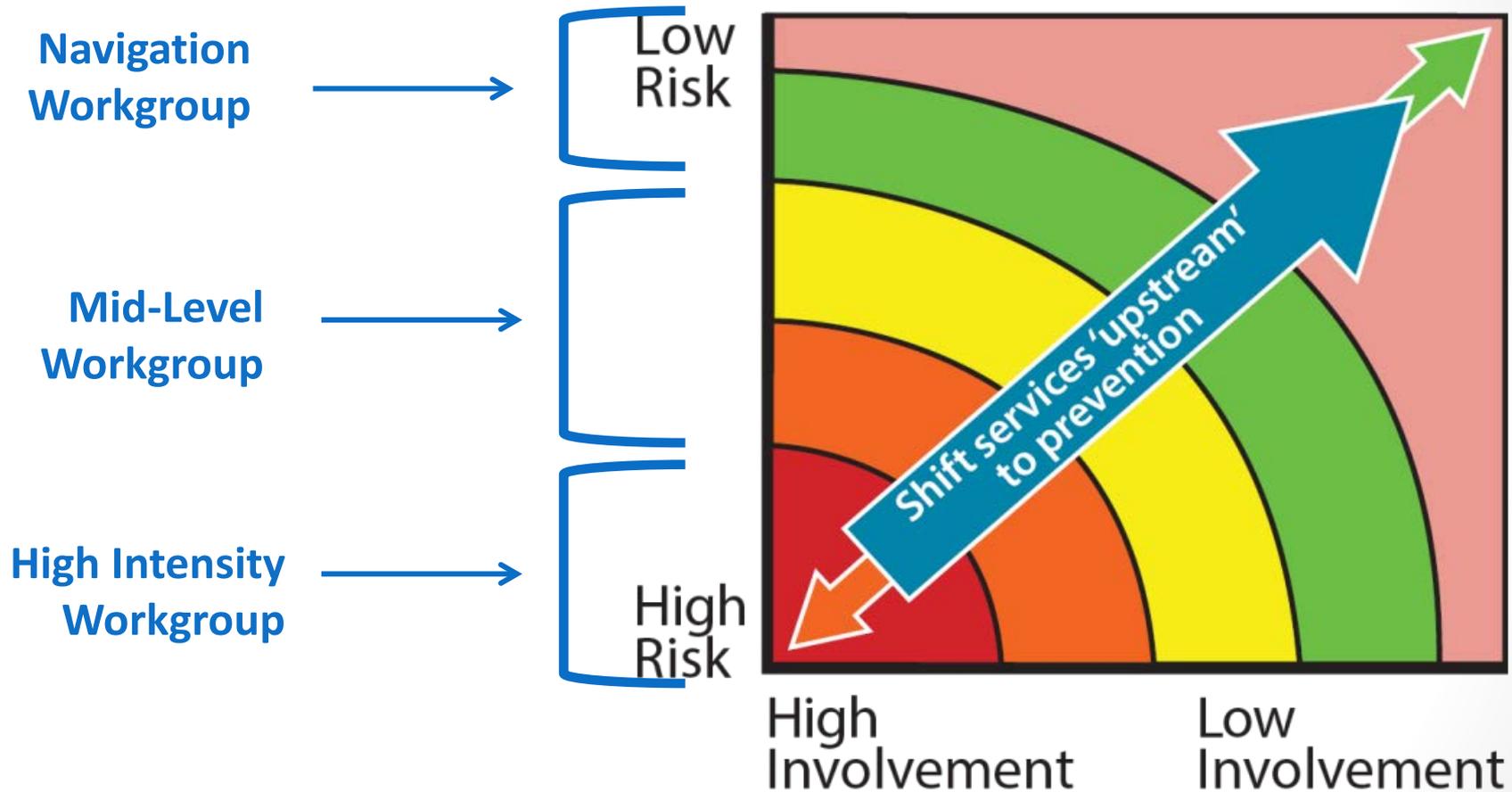


ISDMC Practice Model

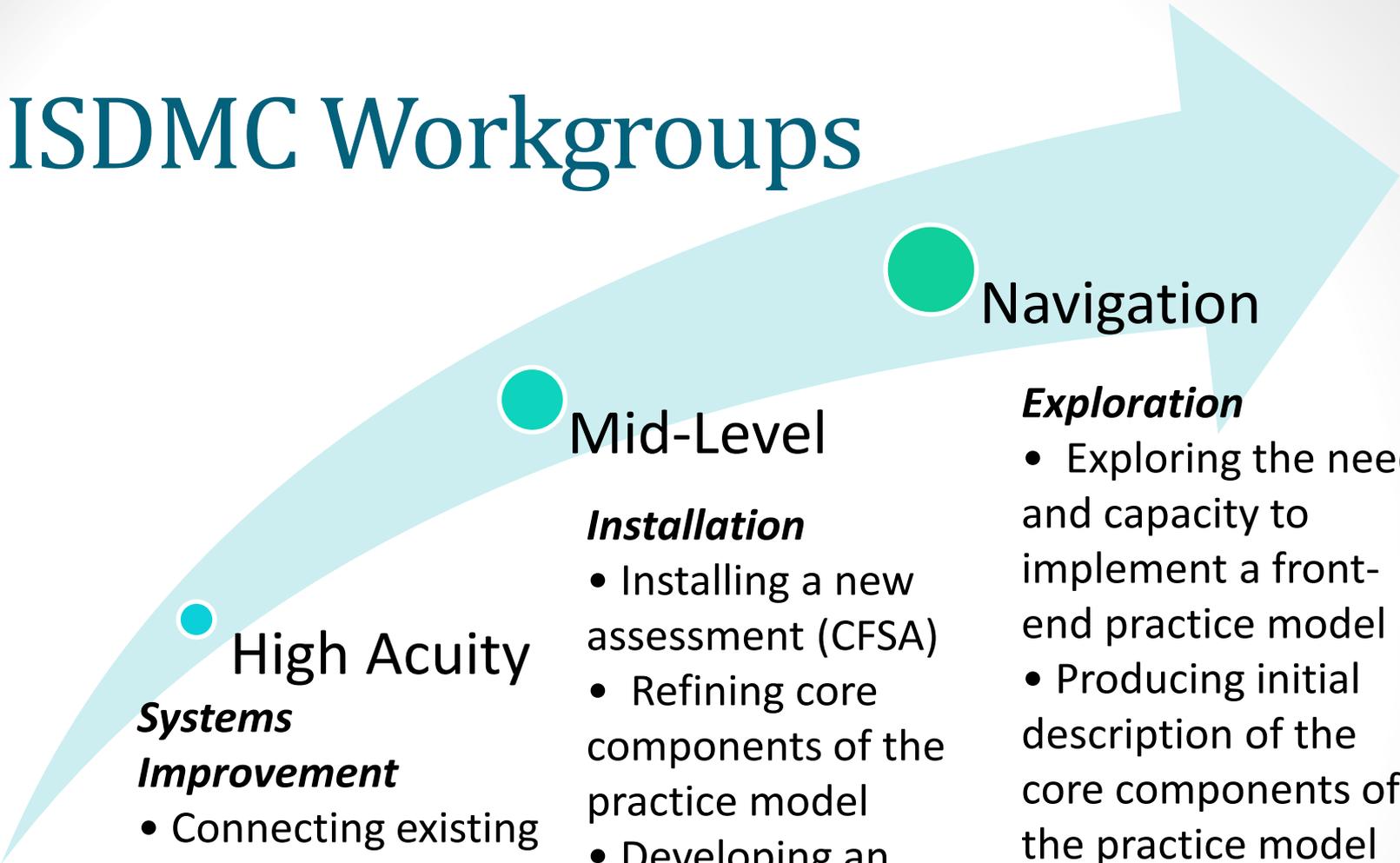
- The practice model means that how we **organize and coordinate** our programs and services is as important as what happens in each individual service



ISDMC Workgroups and the Client Continuum



ISDMC Workgroups



High Acuity *Systems*

Improvement

- Connecting existing practice models
- Coordinating assessments and enhancing structured decision-making processes

Mid-Level

Installation

- Installing a new assessment (CFSA)
- Refining core components of the practice model
- Developing an implementation plan
- Creating a coaching model to ensure ongoing support for CMs

Navigation

Exploration

- Exploring the need and capacity to implement a front-end practice model
- Producing initial description of the core components of the practice model
- Screening all clients for needs and indicators of risk at every point of entry



System Journey

Entry

Pregnant client applies for Medicaid.



- No screening is done for basic needs

Access

EFAA is trying to connect her to Mother House.



- Lack of coordinated referrals & tracking system

Event

Client delivers a month early.



- Housing is now a crisis instead of a need

Workaround

HHS convenes an ad hoc panel.



- Person-dependent solution
- No algorithm
- Disconnected services

Solution

HSP is approved, so Echo House is approved.



- Staff have secured a plan at the 11th hour

System Journey Under ISDMC

Entry

Pregnant client applies for Medicaid



- No screening is done for basic needs

Screening

Screening for needs/risks is administered



- Lack of coordinated referrals & tracking system

Referral

Referral to internal mid-level support



- Housing is now a crisis instead of a need

Coordination

Data system enables coordination

Services

Prevention-focused services in SDH



- Person-dependent solution
- No algorithm
- Disconnected services

Success

Re-assessments happen to monitor progress and client is on track to self-sufficiency



- Staff have secured a plan at the 11th hour

System Journey Under ISDMC

Entry

Pregnant client applies for Medicaid

Screening

Screening for other needs is administered

Referral

Referral to case management

Coordination

Data system enables coordination

Services

Prevention-focused services

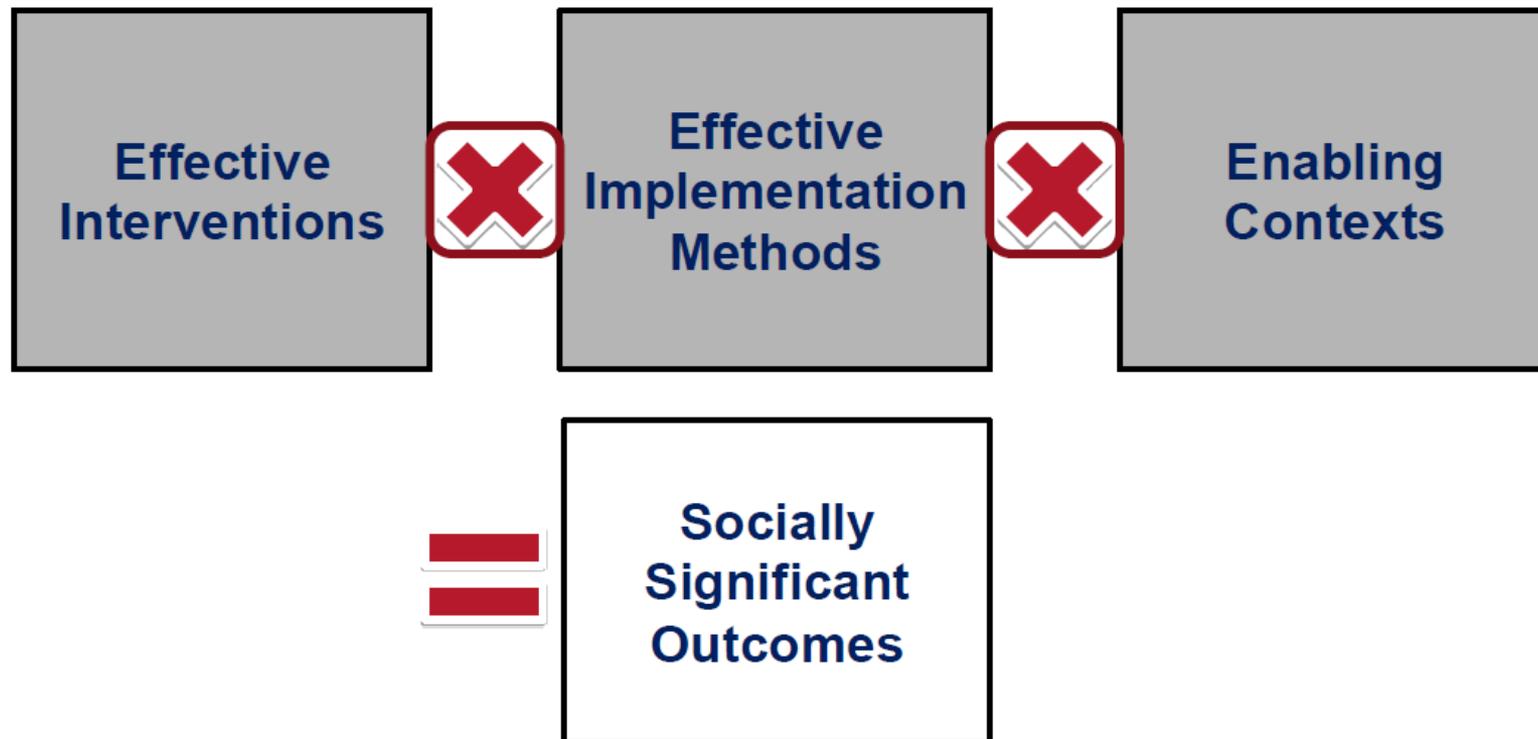
Success

Client is on track to self-sufficiency

Under ISDMC, these actions are:

- Proactive
- Screening- and/or Assessment-Driven
- Coordinated
- Timely
- Prevention-Oriented

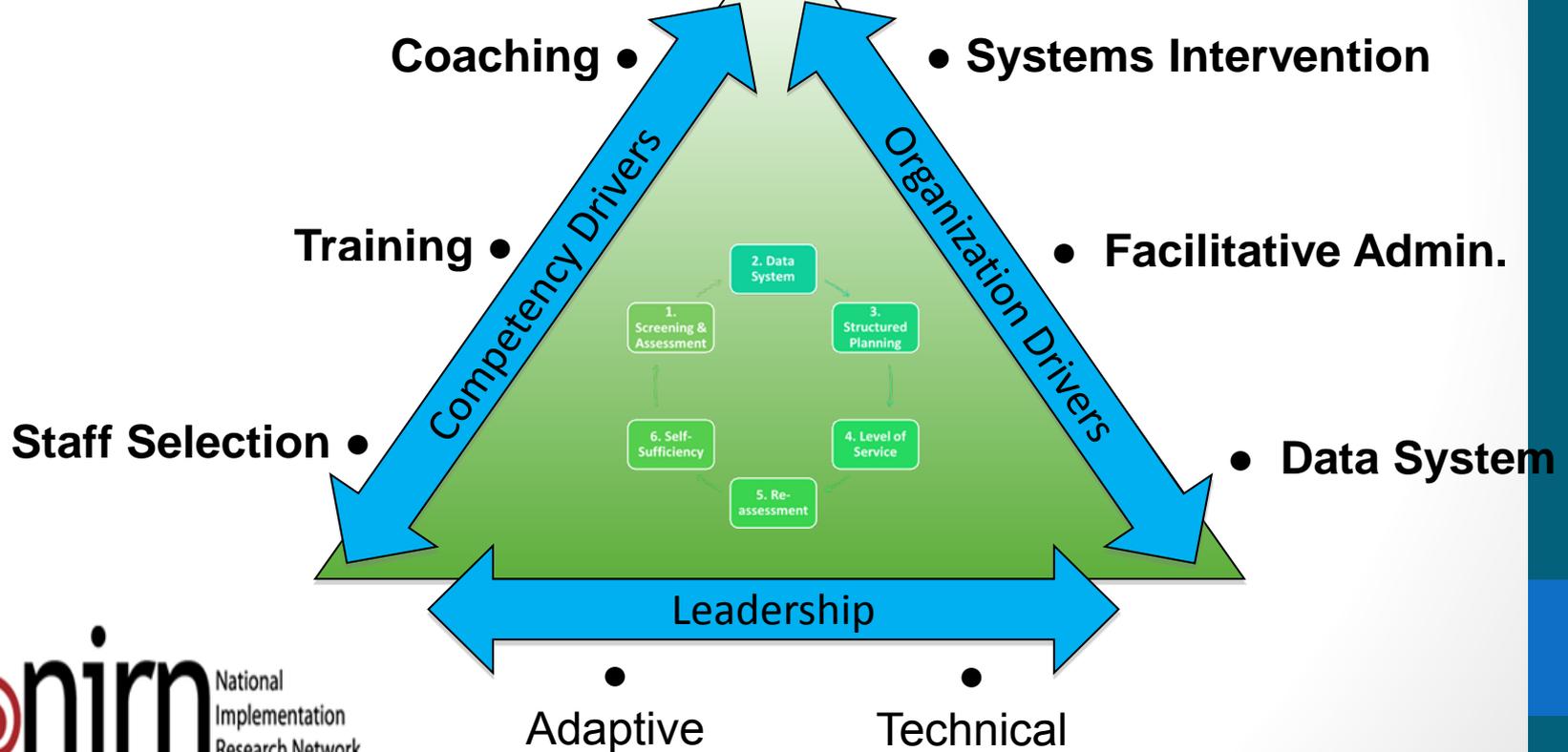
Implementation Science as a Framework for ISDMC



Improved Outcomes [Implementers, Clients, Families, Community]

Consistent, Effective Practices & Processes
[Quality, Sustainability, Scale]

Performance Assessment
Continuous assessment of drivers, performance



Implementation Science

		IMPLEMENTATION	
		Effective	Ineffective
INTERVENTION	Effective	Actual Benefits	
	Not Effective	Unpredictable or poor outcomes	

“. . . in some analyses, the quality with which the intervention is implemented has been as strongly related to recidivism effects as the type of program, so much so that a well-implemented intervention of an inherently less efficacious type can outperform a more efficacious one that is poorly implemented” (Lipsey 2009).

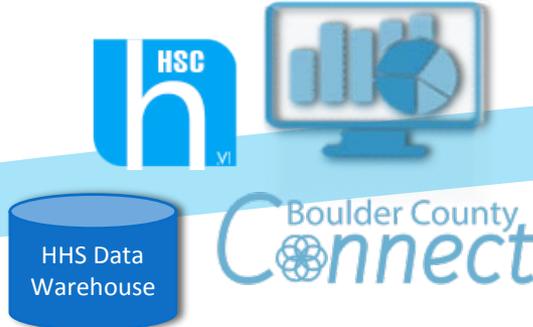
(Institute of Medicine, 2000; 2001; Commission on Mental Health and Excellence in Education, 1983; Services, 1999)



ISDMC in Action



Entry – through
Any Door



Common
Systems



Coordinated
Service Delivery

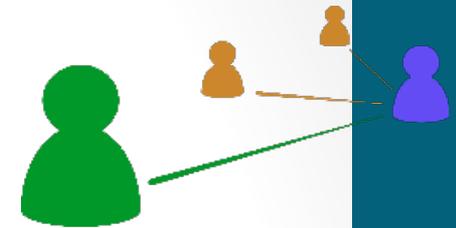
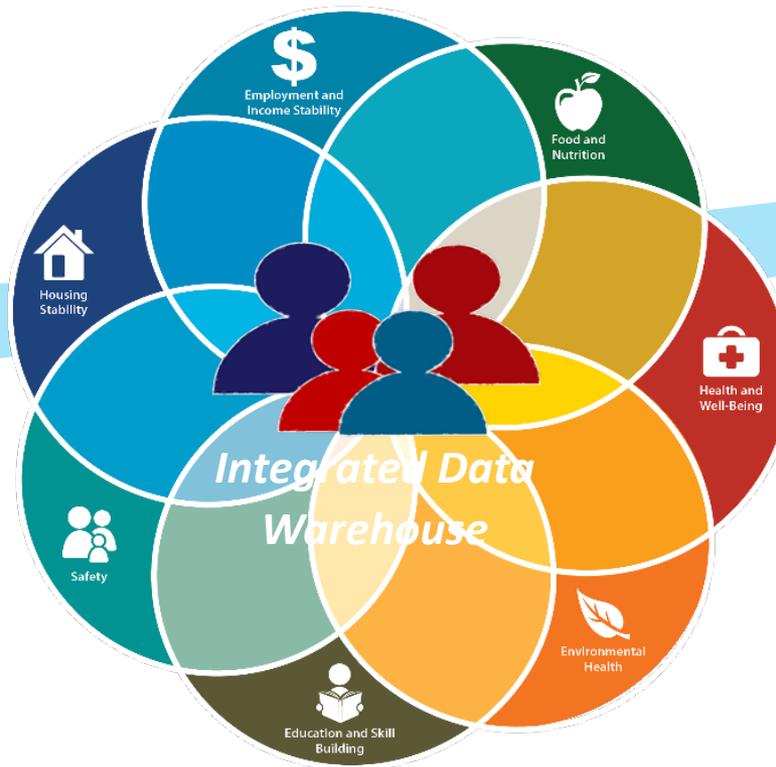


Sustainable
Outcomes



Integrated Data

- Benefits
- Child Welfare
- Housing
- Child Care
- Child Support
- Health
- Education
- Community Resources



Case Manager Tools



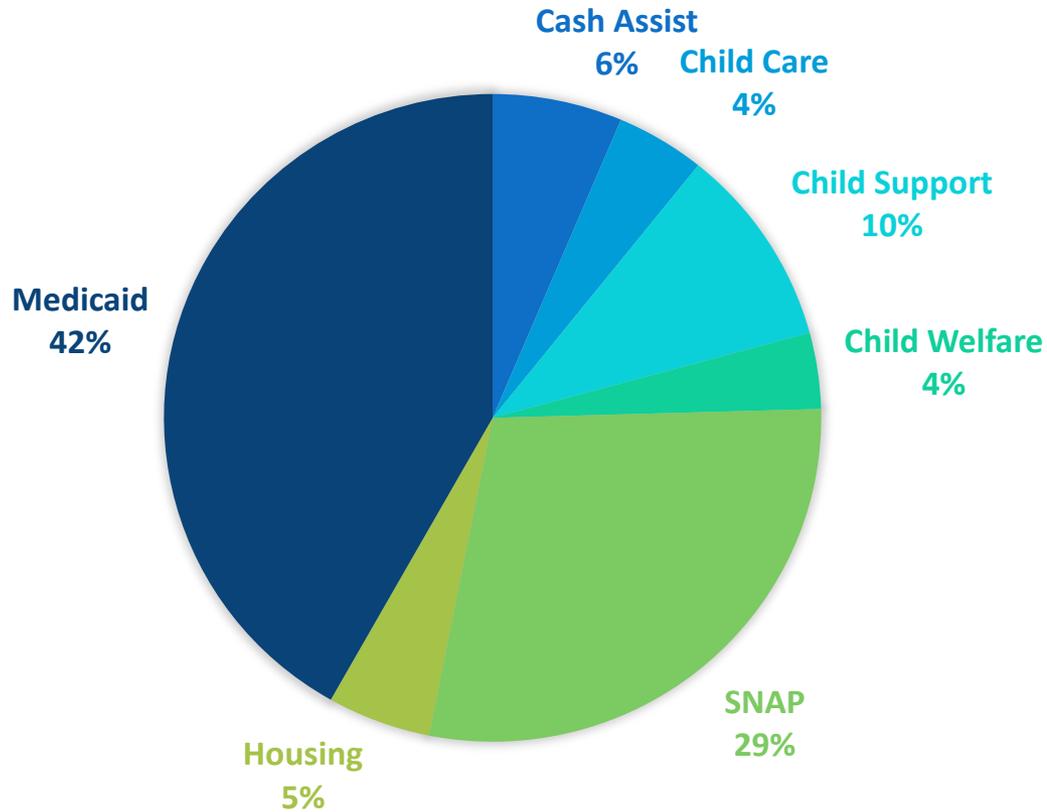
Client Data Profile



Analytics



2017 ETO ENROLLMENTS MATCHED TO HHS SERVICES



Family Resource Network (FRN) Update

April, 2017

County-wide FRN Updates

- Partners and DHHS are working to implement a uniform case management practice model across the County. This practice will become an integral piece of the FRN.
- Community partners and DHHS staff are working to design and launch community-based partner access and interface with the DHHS data system, including sharing of improved case management and navigation functions.
- SCCC and DHHS are working with FRCA and the Office of Early Childhood to align data and practice efforts.

Local Area Collaborative Groups

Local Area Collaborative readiness and planning work will commence in May. Whitney Wilcox will partner with our FRCs in each area in this process. Although we have yet to officially launch our Local Area Collaborative (LAC) groups, we have some regional updates which are relevant to the FRN work. Once LAC groups are formed, reports directly from the collaborative groups will be provided here.

Local Area 1- Longmont

- The City of Longmont is currently interviewing applicants for a Mental Health Counselor, which will be co-located at OUR Center to provide on-site supports to individuals and families. The counselor will be on-site as early as May.

Local Area 2- Boulder

- EFAA's Julie Van Domelen and Audrey DeBroux will be attending the National Family Support Network forum in Washington, DC May 17-18. Topics will include Family Resource Centers and 2-Generation approaches and the role of Family Resource Centers in preventing child abuse and neglect.

Local Area 3- East County

- Two Sister Carmen staff will attend The Standards of Quality for Family Strengthening and Support training in late April. This training will enable Sister Carmen to provide this training to organizations county-wide. The Standards training covers topics including family centeredness, family strengthening, embracing diversity, community building, and evaluation. Attached is an overview of the Standards and content of the training.
- I Have a Dream Foundation, Sister Carmen and Sanchez Elementary launching coordinated FRS/FRC supports for families. The group will update the FRN on their work at the April meeting.

- Melissa along with Suzanne and Simon presented the FRN to the Lafayette Community Engagement (LCE) group in efforts to further alignment opportunities. Members of this group included the Mayor Pro-Tem of Lafayette, HRSA representatives, Arrow Consulting group, and other representatives from the Lafayette Community. Suzanne and Simon are also members. The LCE is planning to develop a framework to support an integrated process for access to the spectrum of services that are available in the community, including a mechanism for on-going meaningful and authentic engagement of community residents. The potential health disparities areas of focus being explored are: 1) Increasing access to integrated health and social services and 2) Ensuring a medical home. As we move closer to forming FRN Local Area Collaborative we will circle back with this group.
- BUILD Health Challenge- Sister Carmen, Public Health, Centura Health and the Raising of America Partnership will be working to further community engagement. Suzanne and Jeff are serving as the FRN liaisons on this work and will continue to ensure alignment

Local Area 4 – Mountain Communities

- No additional updates at this time.

Whitney will be working with the Peak to Peak group and Julie to formalize a linkage to the FRN (via the LAC concept).

Integrated Services Delivery Model of Care (ISDMC)

ISDMC will be discussed in greater detail at the upcoming April HHSAC meeting. The slides for this presentation are in the HHSAC packet.

The overarching goal of ISDMC is to transform the health and the well-being of the 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.

Data (data will be provided in May report)

Fiscal Summary (to be provide in May report)

Partner Agency Updates

Boulder County Community Services

The Boulder County Community Services Department (CSD) provides services, in partnership with the community, that enhance quality of life, support and protect our county's diverse community of adults, children, families and elders, and promotes economic independence and self-sufficiency.

Boulder County Department of Housing and Human Services

We are building a healthy, connected community that empowers people and strengthens families by confronting the root causes of crisis and instability.

3-5 Year Strategic Goals

- **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.

Boulder County Pinnacle Award Winner

Boulder County Connect - Giving clients the tools they need to help manage their own path to self-sufficiency



A small portion of the Boulder County Connect Team with Commissioners

Launched in March 2016, Boulder County Connect (BCC) is an innovative web-based portal for HHS clients to use to manage their supports, learn about other supports, and connect with us when they have questions or need help. They can also use the portal to find out about some of the documents they need to provide and then upload them (this is a valuable service that allows clients to skip the often tough journey into our offices).

BCC has a "live chat" function where clients can get quick information directly from our call center staff. And there is information on the portal about services provided by partner organizations in the community. Boulder County Connect is helping us become a more effective provider of health, housing, and human services supports by helping remove barriers to those supports and by putting more control into the hands of our community members. BCC was recognized in 2016 with an award from the Center for Digital Government (CDG) for outstanding agency and department websites and apps. CDG expressed that "while each of the winning websites is unique, this year's winners generally embrace designs that are responsive, personalized, transparent, data-driven and offer a variety of ways to connect with citizens."



Senior Business Analyst John Green

Since its launch earlier this year, BCC has had over 2,000 clients sign up to use the platform. This more person-centered approach is undergirding a stronger, healthier, and more empowered Boulder County community and represents the best in public service.

2017 Pinnacle Award Finalists

- (In)Visible Boulder County
- 2016 Community of Hope Report
- Ambassador Program
- Boulder County Connect Client Portal
- Boulder County Storm Drainage Criteria Manual
- Casa de la Esperanza - Robotics Program
- Collaborative Fuels Reduction Project
- Flood Recovery Home Buyout Program
- Medical Waste and Sharps Disposal Program
- Partners for a Clean Environment (PACE)
- Permanent Flood Recovery Reconstruction of Lefthand Canyon Drive and Left Hand Creek Stream Restoration
- Preble's Meadow Jumping Mouse Post-Flood Monitoring
- Recycling at the HMMF
- Tax Lien Resolution Program
- The THRIVE Conference

Please visit the [Pinnacle InBC page](#) for summaries of each project. If you would like to watch the summary videos of each finalist project - you can [view the YouTube playlist](#) for the 2017 Pinnacle Awards. Also, you can [watch the webstream](#) of the ceremony online.

Boulder County Public Health

Boulder County Public Health shall protect, promote, and enhance the health and well-being of all people and the environment in Boulder County.

Boulder Housing Partners

Our mission is to provide quality, affordable housing, inspire vibrant communities, and create the opportunity for change in people's lives. We envision a diverse, inclusive and sustainable Boulder as a result of our efforts.

Clinica

To be the medical, behavioral health and dental care provider of choice for low-income and other underserved people in south Boulder, Broomfield and west Adams counties. Our care shall be culturally appropriate and prevention focused.

Early Childhood Council of Boulder County (ECCBC)

To expand and improve the comprehensive system of quality early childhood services for families in Boulder County Services: 1) the backbone organization for the Boulder County Early Childhood Collective Impact; 2) provide quality enhancement services to licensed childcare providers across Boulder County.

See ECCBC Vision, Goals and Strategies here

https://www.eccbouldercounty.org/wp-content/uploads/2016/05/AC-Strategies-One-Page-March-2017_3.pdf

Emergency Family Assistance Association (EFAA)

EFAA helps those in our community whose immediate needs for food, shelter and other basic necessities cannot be adequately met by other means, and supports their efforts toward financial stability or self-sufficiency.

Upcoming Event- Listen to Your Mother

Listen to Your Mother is a national series of live readings giving Mother's Day a microphone. Join us this Spring as 13 local writers share their stories in a celebration of Motherhood. Proceeds benefit EFAA.

Date: Saturday, April 29, 2017

Time: 7:00 - 9:00 pm

Where: Unity of Boulder at Folsom & Valmont

I Have a Dream Foundation

The mission of the "I Have a Dream" program is to motivate and empower children from low-income communities to reach their education and career goals by providing a long-term intervention program of mentoring, tutoring, and cultural enrichment. Upon graduation from high school, each Dreamer is eligible to receive a four-year tuition-assistance scholarship for college or vocational school.

OUR Center

The mission of the OUR Center is to unify community resources to help people in Longmont, Colorado and adjacent communities meet their individual basic needs and move toward self-sufficiency.

Sister Carmen Community Center

As a Family Resource Center we utilize a strength-based approach to address the many facets of a family in crisis. Our comprehensive three prong approach prevents homelessness, reduces food insecurity, increases access to health care, encourages self-reliance and strengthens families.



FAMILY LEADERSHIP TRAINING INSTITUTE

Through our membership with the Family Resource Center Association SCCC was selected to receive additional funding to host the Family Leadership Training Institute (FLTI). FLTI is a 20 week family civics program in which 25 participants receive 120 hours of evidence-based curriculum including personal and child development, leadership training, civic literacy and civic skills needed to become effective leaders in their communities.

SCCC is working to secure additional funding to continue this program into 2018 and to add a youth component. The goal is to empower the role of individuals and families as change agents within their community and local government by building confidence and their civic skills to advocate for change that will improve quality of life in their community.

Entities and Updates to be added moving forward-

City of Louisville
City of Longmont
City of Boulder

Saint Vrain Valley School District
Boulder Valley School District



DHHS Advisory Committee

August 29, 2017

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**DHHS Advisory Committee
MONTHLY MEETING
Tuesday, August 29, 2017, 3:30-5:00 p.m.**

DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Objectives for Today:

- 1) Approval of membership up to 20 members
- 2) Approval of minutes from April
- 3) Approval of Co-Chair
- 4) Review progress to date on 2017 FRN timeline and LAC implementation
- 5) Review updates on data system/reports
- 6) Approval of 2018 meeting schedule

1. **Review of Agenda and Consent Items- Bobbie (3:30- 3:40)**
 - a) Approval of minutes from April
 - b) Approval to membership to expand up to 20 members
 - c) Approval of Co-Chair
 - d) Approval of members to be added to the Regional Council upon expansion
 - Diane Lauer, SVVSD
 - Karen Rahn, City of Boulder
 - Christina Pacheco Sims, City of Longmont
 - Betsey Martens, Bringing Schools Home
2. **Intro to Marc Schaffer, BVSD, Assistant Superintendent of School Leadership- Susan (3:40-3:45)**
3. **Review of FRN timeline and status updates - Melissa (3:45- 3:55)**
4. **Update on Regional Council Sub Committee and LAC implementation –Whitney (3:55-4:10)**
5. **Practice model and data system roll out to FRN partners - Melissa (4:10-4:30)**
 - a. Review of ISDMC Mid-level Practice and status update
 - b. Updates on SCCC and CFS using live data system
 - c. FRN Data Structure Presentation
6. **Updates and Alignment Opportunities with FRN (4:30-4:50)**
 - a. Community Partner Meeting - Frank
 - b. FRC and Workforce Boulder County partnership opportunity - Robin
 - c. County-wide Family Homelessness Forum - Julie
 - d. Lafayette Community Engagement Group update – Suzanne
7. **2018 meeting schedule vote- Bobbie (4:50-4:55)**
8. **Proposed agenda for October- Bobbie (4:55-5:00)**
9. **Adjourn (5:00)**



Department of Housing & Human Services

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BCDHHS Advisory Committee

Meeting Minutes (DRAFT)

April 25, 2017

Members Present: Bobbie Watson, Robin Bohannan, Dalia Dorta, Betsey Martens, Julie Van Domelen, Suzanne Crawford, Lori Canova, Pat Heinz-Pribyl, Jeff Zayach

Staff Present: Angela Lanci-Macris, Susan Caskey, Melissa Frank-Williams, Whitney Wilcox, Monica Serrato

Guests: Christina Pacheco Sims, Karen Roney, Lane Volpe, Jason McRoy

Meeting Action Items

- Update roster with the addition of pillars
- Send out updated roster for membership review
- Survey Monkey to determine topics for review at orientation dinner
- Doodle poll to determine best date and time for orientation dinner
- Finalize vision statement

Detailed Meeting Minutes

1) Welcome and Introductions

Bobbie Watson opened the meeting by asking staff, members, and guests to introduce themselves. Christina Pacheco Sims and Karen Roney from the City of Longmont introduced themselves. Christina is the Division Manager for the Children, Youth, and Families Division and Karen is the Community Services Director. Both are interested in the integrated work of the Family Resource Network (FRN). A representative from the City of Longmont has been invited to join the board. Their attendance is to determine who would be the best fit before moving forward with the application process. Lane Volpe, Strategic Implementation Manager, and Jason McRoy, Division Director, Business Operations and System Support, both BCDHHS staff, introduced themselves. Lane and Jason are in attendance to provide an update on Integrated System Delivery Model of Care (ISDMC) and the data system connected to that work.

2) Approval of Consent Agenda Items- will be approving the entire packet, however will be looking at the vision statement

- **Agenda**
- **HHCSAC Charter**
- **Minutes**
- **One Page summary**
- **Agenda for May meeting**

Jeff moved to approve, Julie seconds.

3) Membership, Orientation, and Vision Statement Discussion

Discussion on the overview of the HHSAC membership process, an orientation dinner for all HHSAC members, and review of the proposed HHSAC Vision Statement.

- a. Membership-** Melissa shared the status of HHSAC board membership. There is still a goal of building membership in certain areas, for example the school districts and the City of Longmont (Christina and Karen), and the membership document summarizes the process by which this would happen.
- Bobbie said she was confused about who is on the board currently and who is possibly joining, but this document clarified those questions for her.
 - Betsey asked for clarification if everyone currently on the board is staying or if anyone would be dismissed. Melissa confirmed that there will be no changes to HHSAC membership other than additions as defined by the Governance Charter.
 - Julie asked if there are any set seats on the board. Melissa responded that there are specifications in the bylaws that oversee the FRN in general.
 - Betsey pointed out that there are more proposed members than seats outlined in the membership document. Melissa acknowledged this and stated that the board could approve the addition of more members and suggested a limit of 20 members.
 - Jeff asked if there should be representation for each of the Social Determinants of Health. Melissa said that the intent is to have representation from all of the Social Determinants of Health and if there is missing representation the board should discuss. Jeff followed up with asking if that should be formalized in any documents so that future HHSAC members know the importance of the representation. He added that it would be helpful to know who represents which pillars.
 - Dalia asked where she fits in, as a community member rather than representing a specific organization. Betsey responded that the members-at-large section seems fitting, and Melissa added that there could be more clarification around that in the by-laws. Dalia then asked which pillar she would fit into, and it was agreed that she would meet with Melissa to discuss further.
 - Angela asked if someone vacates a seat, and they represent, for example, early childhood, should that seat be filled with someone from early childhood. Jeff said yes.
 - Julie asked if we could map the current members to see which pillars are currently represented. Melissa said that yes, we can add that into the roster. It will be sent out before the next meeting and members should review and reply with their edits so that the final roster can be shared by next meeting.
 - Melissa asked if members were in favor of updating the bylaws to reflect a 20 person cap on membership. Julie suggested the membership have an odd number of representatives instead of an even number. Everyone present agreed to raise the limit, however a formal vote was not taken.
- b. Orientation Dinner-** Bobbie said it had become clear to her through multiple conversations with various members that there is a need to take a step back and get everyone oriented and on the same page as to HHSAC's role and responsibilities now that its primary function will be to provide oversight of the FRN. Bobbie proposed a 2 hour meeting over dinner that would be separate from the regular HHSAC meeting. This would be a foundational orientation covering topics such as the Community of Hope report, the pillars, and a philosophical and historical context of how the HHSAC has evolved so everyone is comfortable with governance around the FRN, and to discuss the path moving forward. Bobbie discussed

with Frank and he supports this idea. Staff will send a Survey Monkey out in the next couple of weeks to get feedback from members to determine the exact agenda for the meeting. There will also be a Doodle poll sent out to determine the date and time for this dinner.

- c. **Vision Statement-** Melissa presented two options for a vision statement. The consensus was that the statement needed to be simplified. Some suggestions include:
 - Keep under 30 words
 - Create a separate mission and vision statement
 - Consider using “valued, healthy, and thriving” as a value statement
 - Consider adding the phrase “Academic, social, emotional and life skills for children and youth”
 - Consider adding “increased self-sufficiency” or “greater self-reliance” for the mission statement
 - Consider using “well-being”
 - Create a “word-smith” committee to work on the details at a separate time and bring back to the larger group for review, discussion, and approval
- 4) **ISDMC- Lane Volpe** (see attached PowerPoint)
- a. **Overview-** Lane shared with the group information about the Integrated Service Delivery Model of Care (ISDMC) work, which evolved out of work done previously by the BCDHHS Integrated Case Management Committee (ICMC). ICMC looked into best practices and intersection points within the array of case management services provided across BCDHHS and in partnership with community organizations. Lane said that ISDMC takes this work forward by creating a model of care across BCDHHS with our partners that is rooted in comprehensive screening and assessment, structured case planning, and evidence-based services and supports. Among other things, Lane shared that this staff will increasingly be using common assessments across our work, and screenings will be done in as many circumstances (and as early) as possible. She also shared that through ISDMC, we expect to reduce service delivery costs, reduce client time navigating systems, and increase positive outcomes for clients. She said that there are three teams currently working on different aspects of ISDMC: Navigation, Mid-Level, and High Acuity (or High Intensity). Lane explained that this represents the three primary tiers clients fit into - low, medium, and high penetration of our systems. The Mid-Level group includes staff from Sister Carmen, EFAA, and OUR Center. See item 6, Q& A
 - b. **Role of ISDMC in FRN-** Briefly addressed in this meeting. It will be addressed in the future possibly as an orientation dinner topic.
- 5) **Update on BC Connects and Client Data Access- Jason McRoy-** Jason shared some updates on the new data system which included information on security and data access. Sister Carmen will be the first to roll on to the new data system, probably in June 2017. The data team is working to address issues of client confidentiality to ensure that it is protected while allowing the proper staff to have access to client data. Concerns include programs that require confidentiality due to safety issues, legal status, as well as staff members of agencies/programs who may be accessing services elsewhere. **See item 6, Q& A**
- 6) **Q and A**
- Betsey asked if the FRCs are involved in this work. Lane and Melissa answered yes, Mark from SCCC is a part of the mid-level team, as well as staff from EFAA and OUR Center. Staff from

BCDHHS and Sister Carmen are also meeting with FRCA staff, who is doing very similar work as well, so every effort is being made to ensure that the work is aligned.

- Betsey also wanted clarification on exactly what is the scale- when we say “any door is the right door”, what does that mean- how many doors are we talking about? Jason said that we’re trying to figure that out. He said there are about 70,000 people accessing services at the navigation level, 8-9,000 at the mid-level, and 2,000 at the high acuity level. He said we have access to about two dozen data points within the county.
 - Susan shared that while IMPACT falls in the high acuity level; the goal is to have seamless transition between all three levels. She said we don’t want the system to define the level of services, we want to use the assessment to define it.
 - Robin shared that this systems approach will be mirrored in the offender management system and the homeless system. The right assessment means the connection to the right services.
 - Navigation- Will the “any door” approach include partners other than Sister Carmen, EFAA, and OUR Center? Melissa and Jason responded that we are working toward that end. The Navigation group is in its exploration phase and a model is yet to be agreed upon and finalized. Partners will be involved in this effort. The navigation partners will have more robust access to data.
 - There were a number of questions from Suzanne and Julie about data sharing and the confidentiality of client information in the data system that they want to address prior to their organizations moving to the new data system. Members agreed that the discussion needed significantly more time to talk through the details and proposed that a smaller group meet to discuss further and update the larger HHSAC membership.
- 7) **Adjourn** - Bobbie closed the meeting and reminded members that between now and the next meeting, staff will send out a survey to help inform the agenda for the two hour meeting and will send out a Doodle poll to determine a date for the dinner. Confirmation of the next meeting’s location is to be determined (Boulder or Longmont). The meeting was then adjourned.



Dr. Marc Schaffer
Assistant Superintendent of School Leadership
720.561.5086
marc.schaffer@bvsd.org

As Assistant Superintendent of School Leadership for Secondary Schools, Dr. Schaffer is responsible for the supervision and leadership of the district's K-8, middle, and high schools and the principals. He also supervises and provides leadership to the Career and Technical Education Director. Marc serves on the Successful, Curious, Lifelong Learner Action Team for the BVSD Strategic Plan. Marc serves on the local YMCA board and supports the district by ensuring quality programming at the secondary level.

Prior to coming to the Boulder Valley School District, Marc served as the Director of Middle School Education with the Douglas County School District. Previously, he served as a middle school principal, assistant principal and teacher in the northern suburbs of Chicago. Marc also served as a high school Dean of Students in suburban Phoenix. In 2014, Dr. Schaffer was appointed as Assistant Superintendent in Boulder Valley. In addition to Marc's administrative experience, his 10 years of classroom practice at the middle and high school levels has enabled him to lead with conviction and expertise.

Education: Ed.D., Northern Illinois University; M.S.Ed., Northern Illinois University; B.A., Indiana University

Boulder County

Family Resource Network



August, 2017

FRN Work Plan Update



The FRN Road Map

Our destination

All FRN partners using the same screening, assessment and planning processes with families

Services to which navigators and advocates/case managers are referring are proven to work

We have common outcomes

We are all using the same data and reports to measure progress and make improvements

Roles

Executive

Regional Council

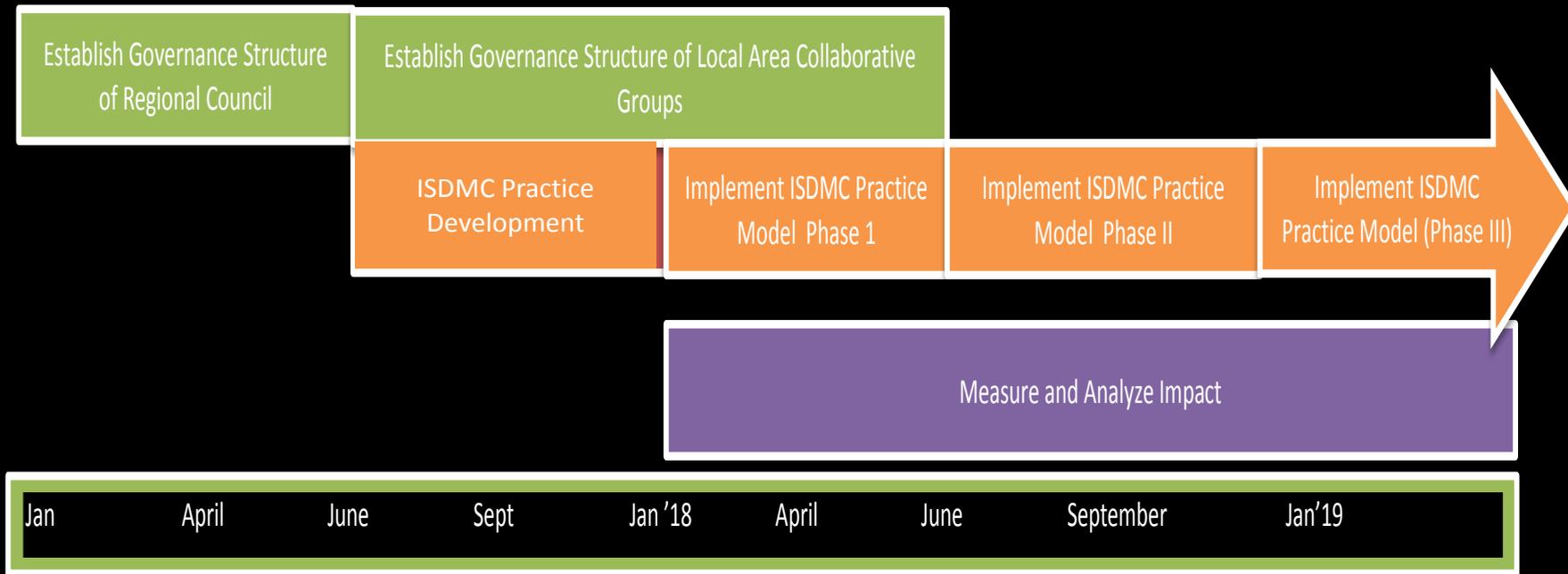
Set policy related to data, practice and service coordination and ensure
Define and monitor outcomes
Inform resource allocation
Information sharing
Communicate shared vision

Operations

LACs

Implement practice model
Ensure service coordination
Compile data-informed program recommendations
Peer coaching
Needs assessment and service mapping





Work Plan Updates

July 30-September 28

LAC plan development with agency directors

October 1-October 31

LAC work plan implementation begins

Agencies trained on data system and ISDMC practice model

October 31

HHSAC Regional Council – reviews LAC implementation progress, FRN metrics, and funding recommendations and provides feedback

PILOT ISDMC PRACTICE MODEL and DATA SYSTEM

Phase I Roll Out -October 2017-June 2018

FRCs

- Sister Carmen
- OUR Center
- EFAA

Phase II- August 2018- May 2019 (estimated)

Potential Participants- Schools, Community Services, Public Health, IHAD, BHP, Clinica

Phase III – August 2019-May 2020 (estimated)

TBD



Using a Common Data Structure

Implementing universal practices in data driven decision making through the FRN



Boulder County

Family Resource Network

WHAT: Proposed Data Structure

- ▶ 1) **Establishing needs** through data analysis
 - Reports compiled yearly for the FRN
- ▶ 2) **Define and measure** effective interventions through the FRN
 - Draft logic model created
- ▶ 3) Use the TCOM framework to **track progress** and facilitate outcome improvement through data.
 - Reports compiled quarterly

The above structure to be facilitated DHHS staff with engagement and guidance by the Subcommittee/LAC and RC over the next several months.

WHO and WHEN:

Phase I Roll Out –October 2017–June 2018

- ▶ Sister Carmen
- ▶ OUR Center
- ▶ EFAA
- ▶ All Boulder County Housing Case Mgt Programs (HSP, FSS, etc.)
- ▶ CO Works Case Management
- ▶ HHS Early Intervention Team (referred out Child Welfare cases)

Phase II– August 2018– May 2019 (estimated)

Potential Participants– Schools, Community Services, Public Health, IHAD/Dream Big, BHP, Clinica

Phase III – August 2019–May 2020 (estimated)

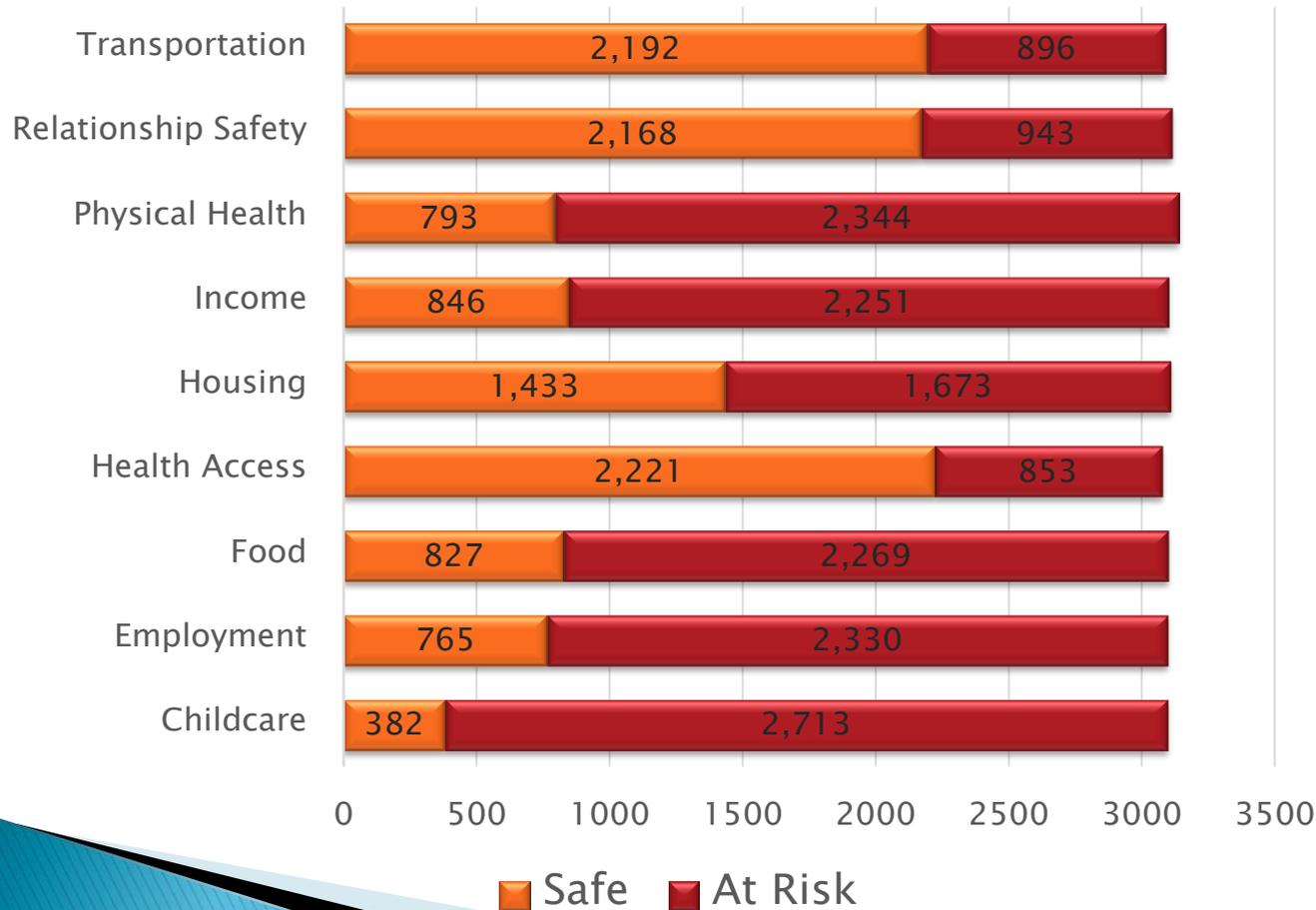
TBD

Establishing Needs

- ▶ Analysis across our systems yields highest areas of needs in the areas of:
 - Housing
 - Health (including Mental Health)
 - Income
 - Food
 - Employment
 - Child Care

Snapshot from our Housing Continuum

Baseline Self Sufficiency Risk Areas

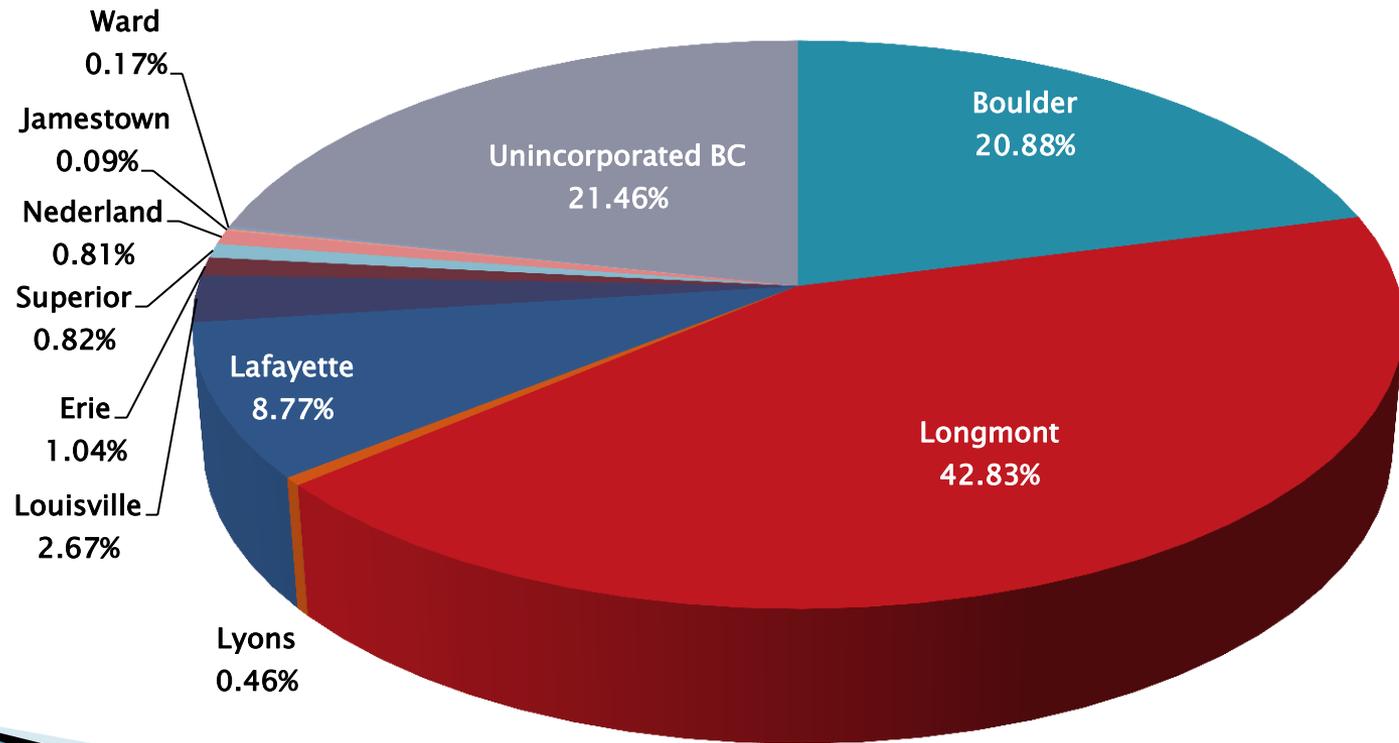


Two-Thirds of households assessed were at risk in areas of:

- Housing
- Health
- Income
- Food
- Employment
- Child Care

Distribution of Need – Food

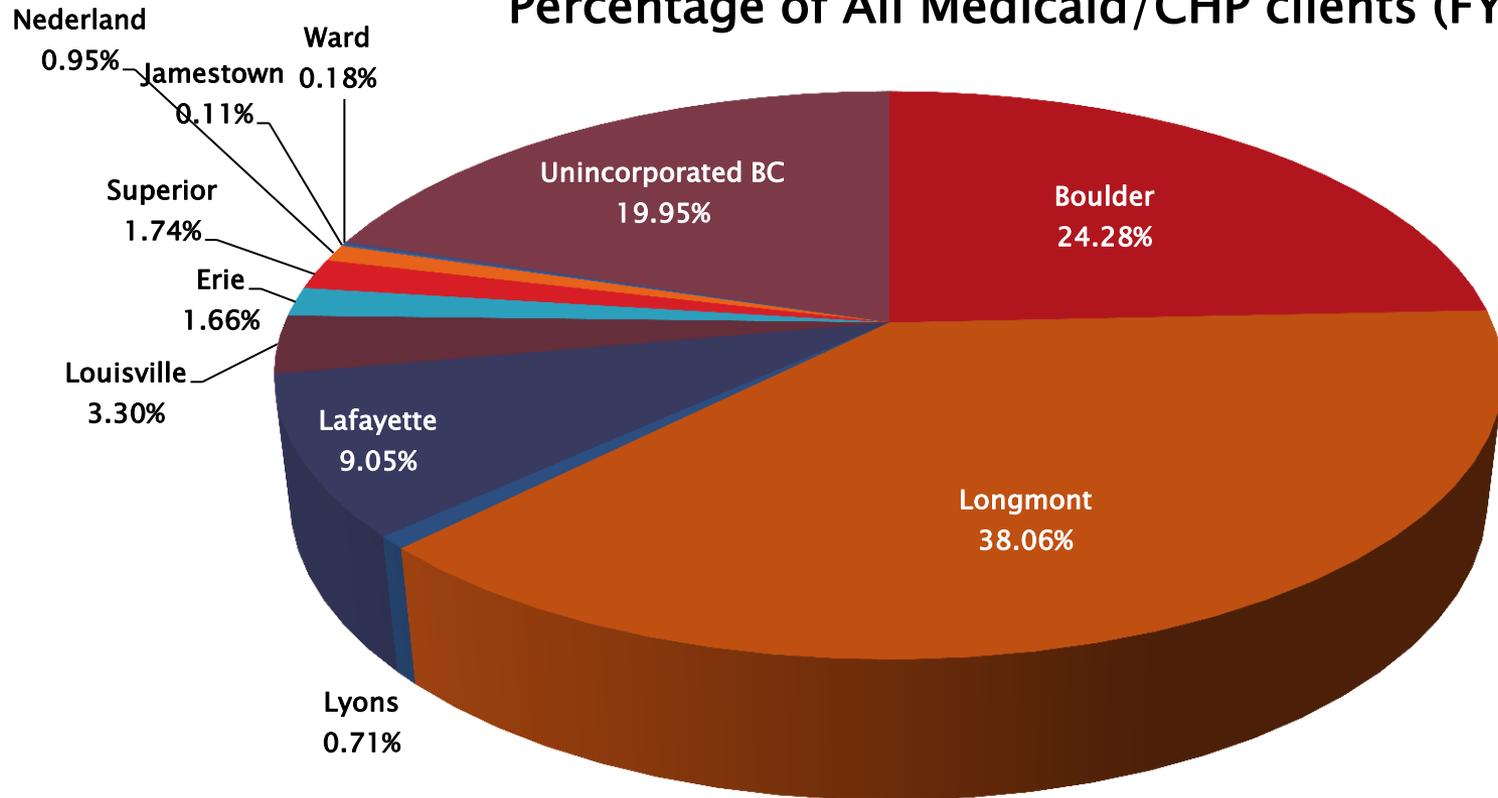
Percentage of All SNAP clients (FY 16)



Total=34,051

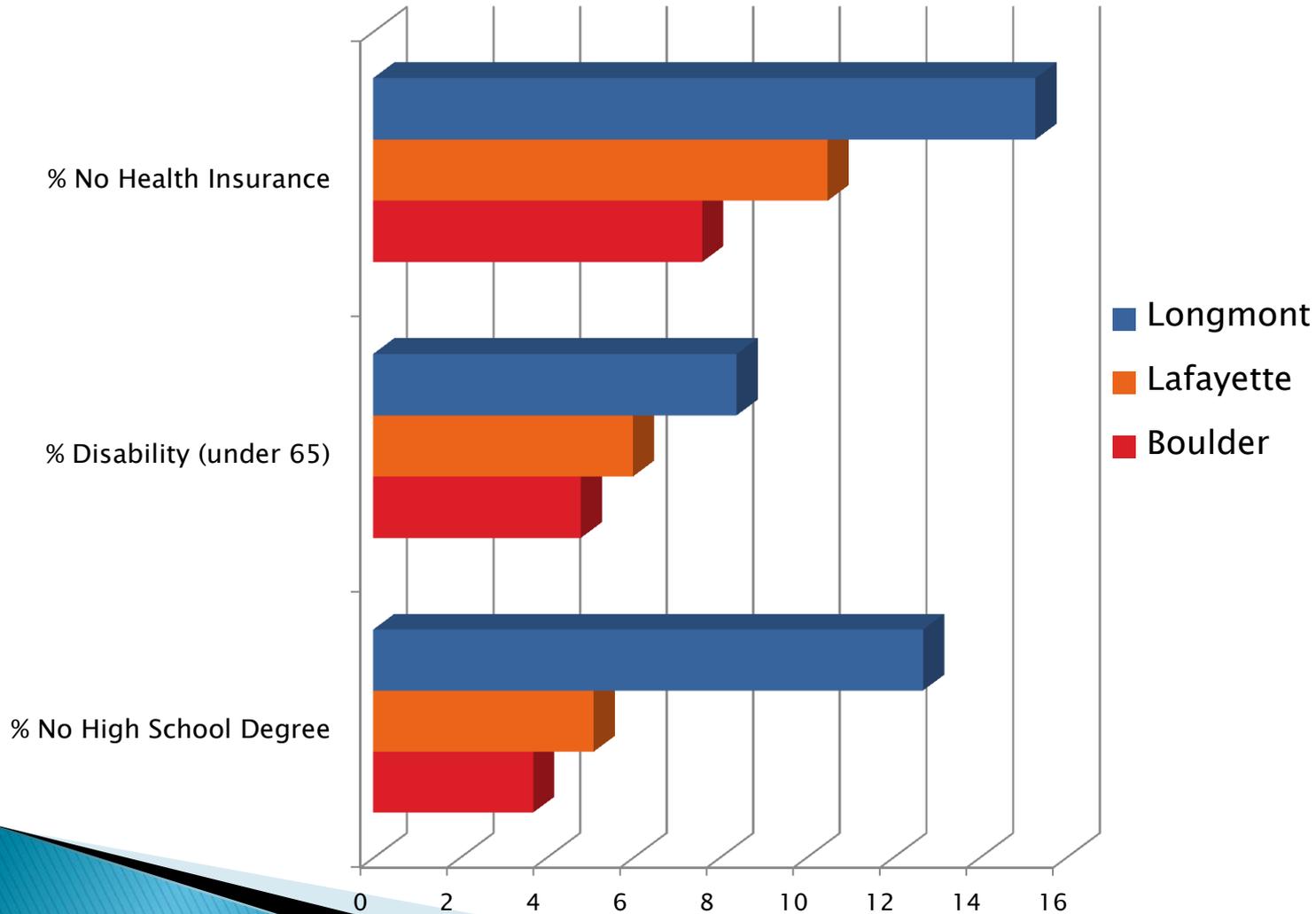
Distribution of Need – Health

Percentage of All Medicaid/CHP clients (FY 16)



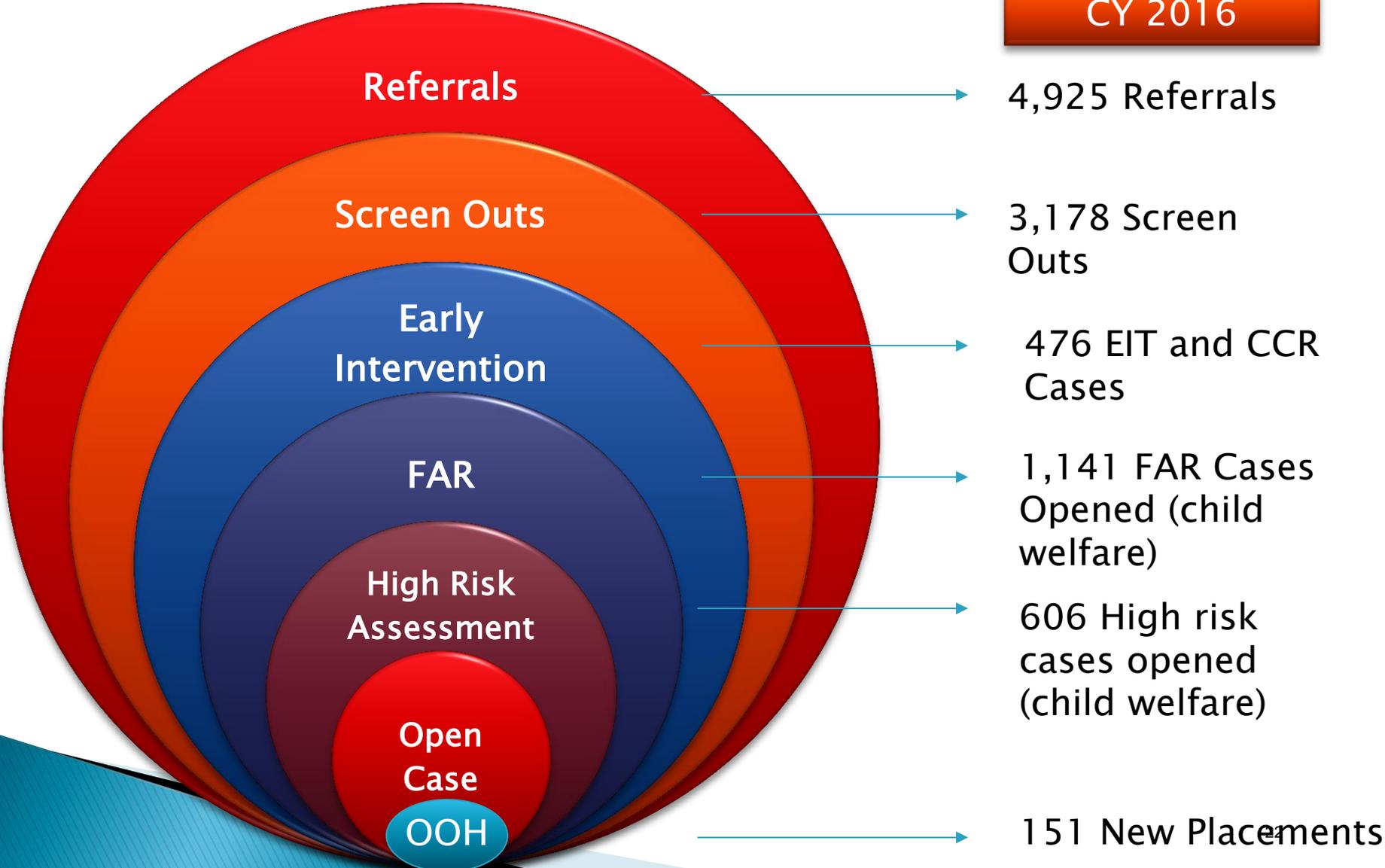
Total=89,681

Distribution of Need



Example of Early Intervention Opportunities

CY 2016



Tracking Progress Through TCOM

Provides a structure for reporting and analysis on these key factors

- ▶ **Transformational.** The priority of the system is supporting the personal change. This focus means impact must be understood as change in status, not a status at the end of services.
- ▶ **Collaborative.** We work towards a common goal and know that collaborations work only when there is a shared vision and purpose. Engagement, teaming, and system integration are all collaborative processes and should ultimately share the same vision.
- ▶ **Outcomes.** System management is based on impacting the personal change processes. Understanding the intended and unintended impacts of the system on the people we serve is fundamental to effective advocacy/case management, program management, and system management.
- ▶ **Management.** The collaborative focus on personal change is embedded in all aspects of the work and all levels of the system. This, along with maintaining the focus on the shared vision, makes it possible to manage effectiveness.

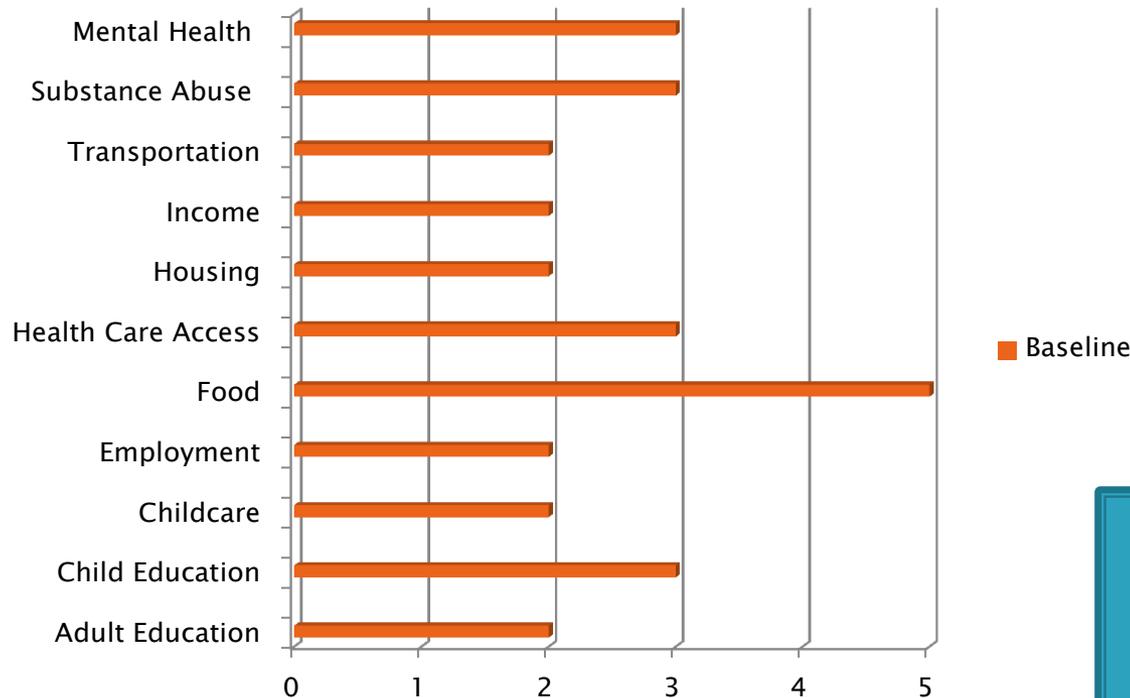
TCOM Grid

	Family & Youth	Program	System
Decision Support	Service planning Family engagement	Eligibility Step-down	Resource management Right-sizing
Outcome Monitoring	Reassessment and progress evaluation	Evaluation	Provider profiles Performance/ contracting
Quality Improvement	Case management Integrated care Supervision	Continuous Quality Improvement	Transformation Business model design

Service planning and family engagement using the CFSA

Participant: Lou Reid

Baseline



These are primary domains of the CFSA

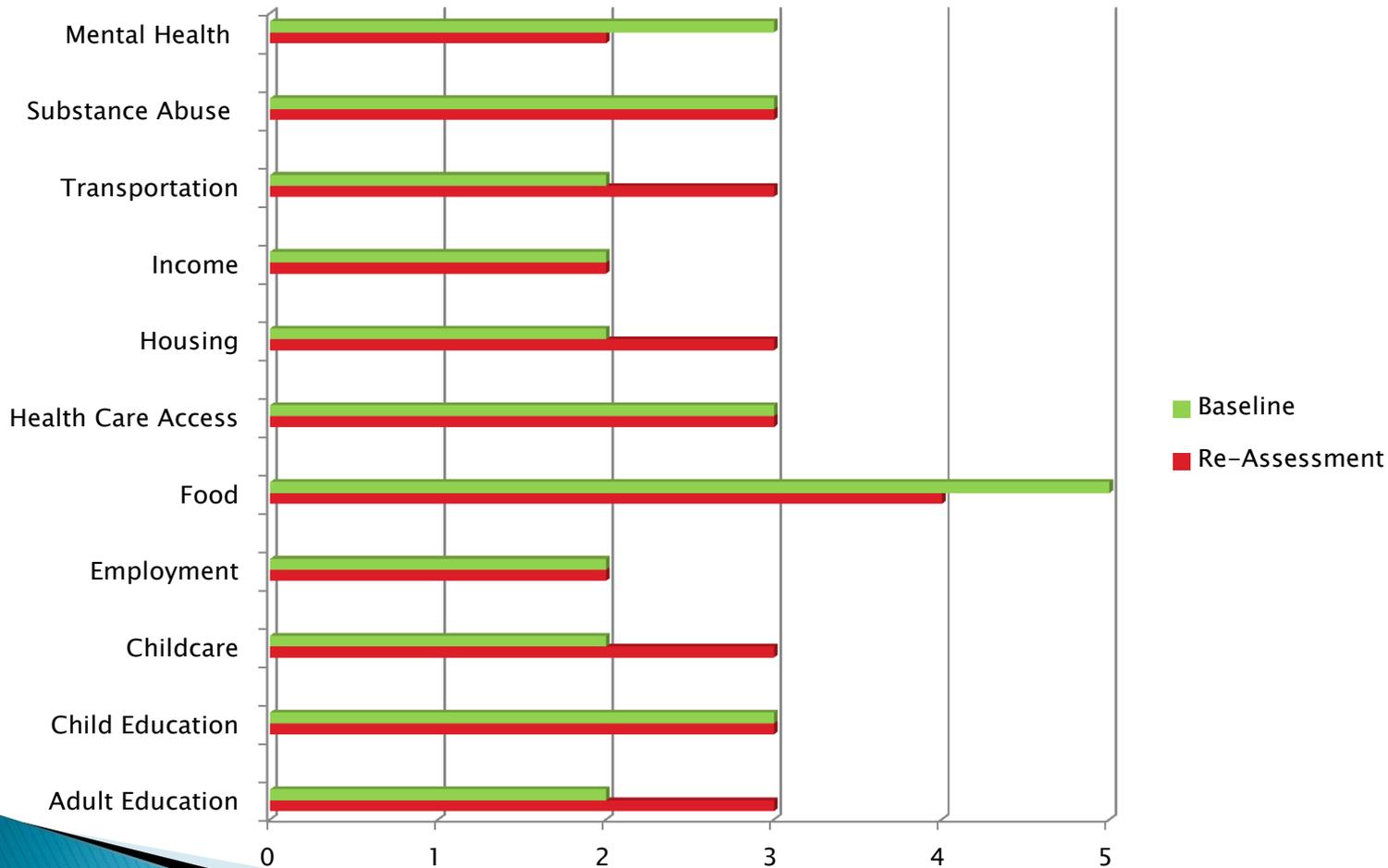
1 = in crisis
2 = vulnerable
3 = safe
4 = stable
5 = thriving

TCOM Grid

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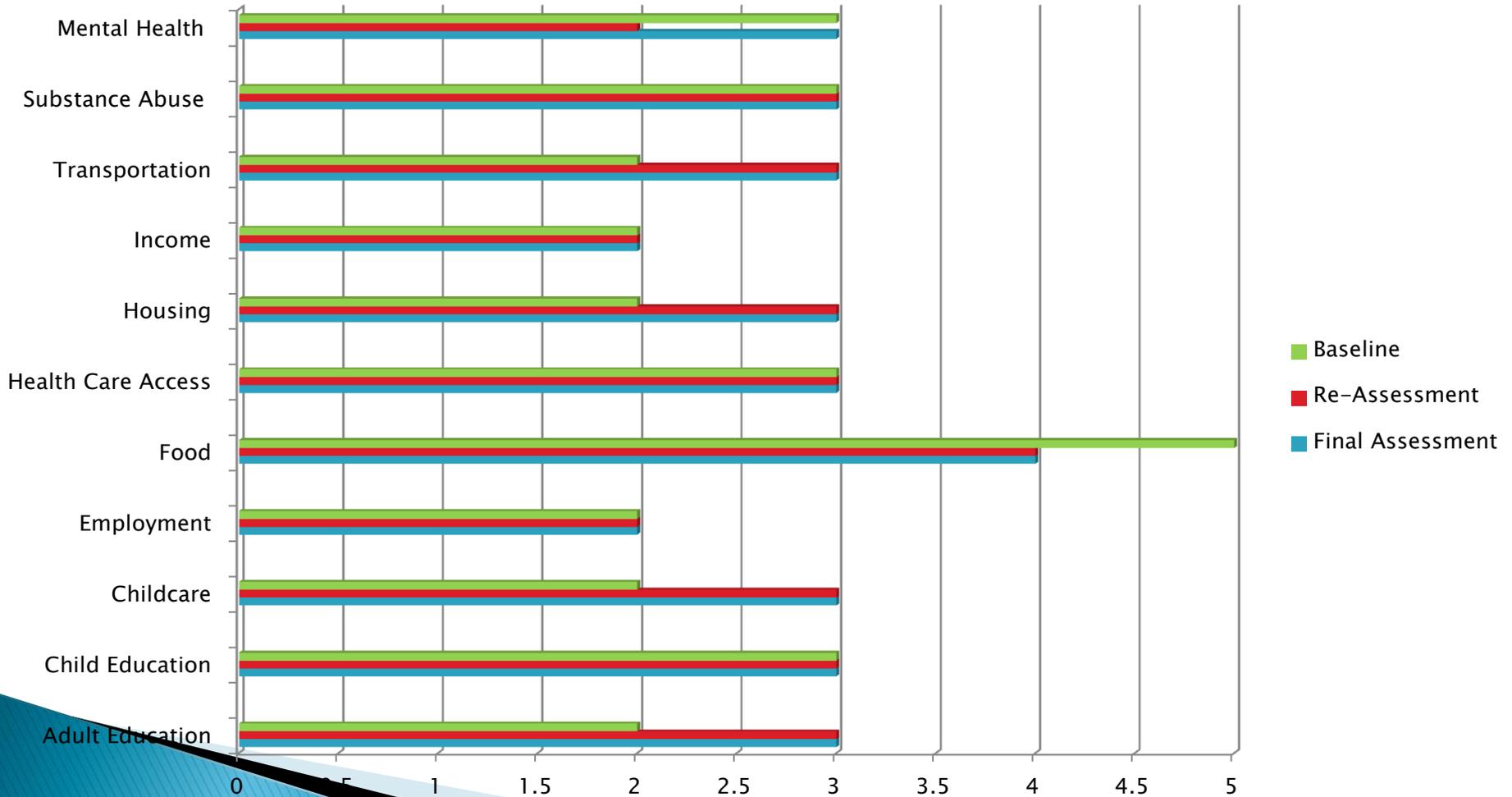
Reassessment and progress evaluation

Participant: Lou Reid



Closing and service transitions

Participant: Lou Reid

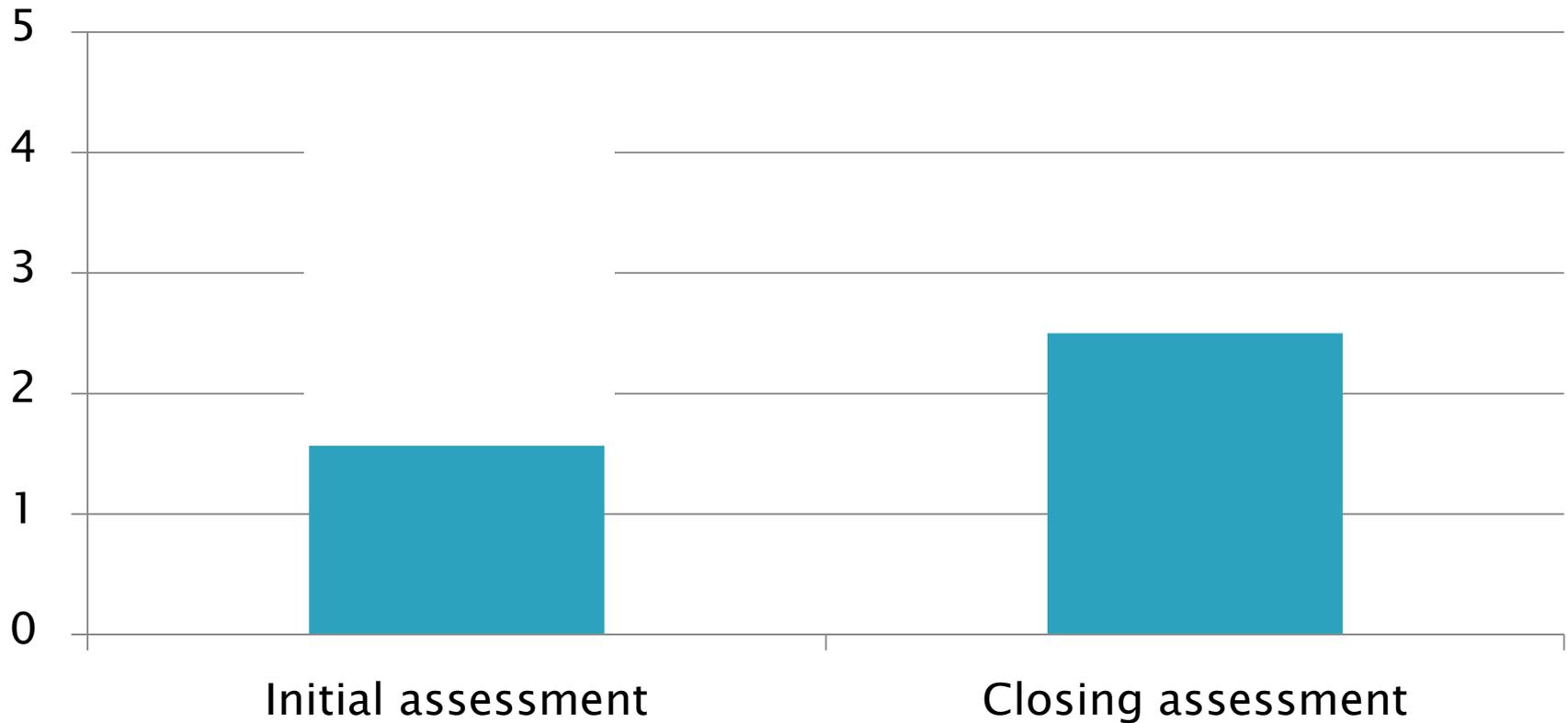


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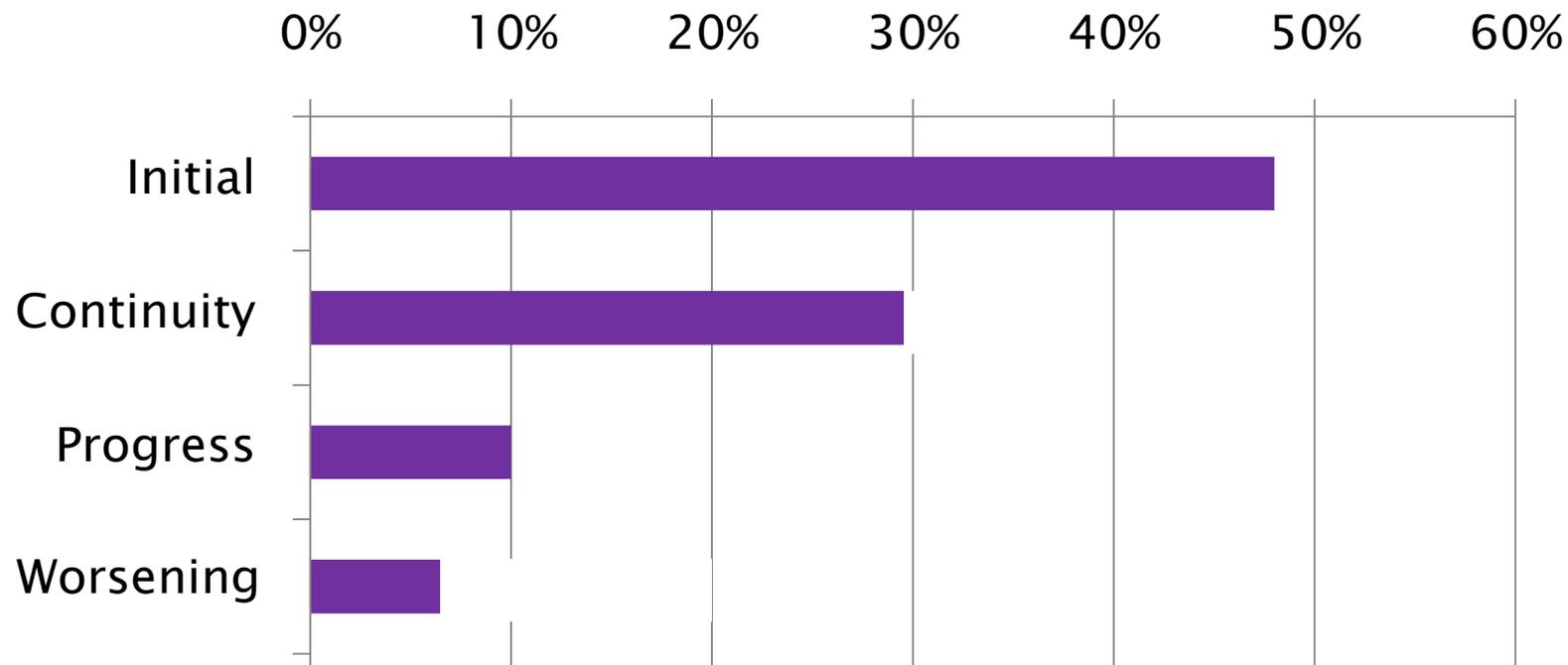
Program impact over time (SAMPLE)

Employment



Program progress report by Domain

Progress report: Employment

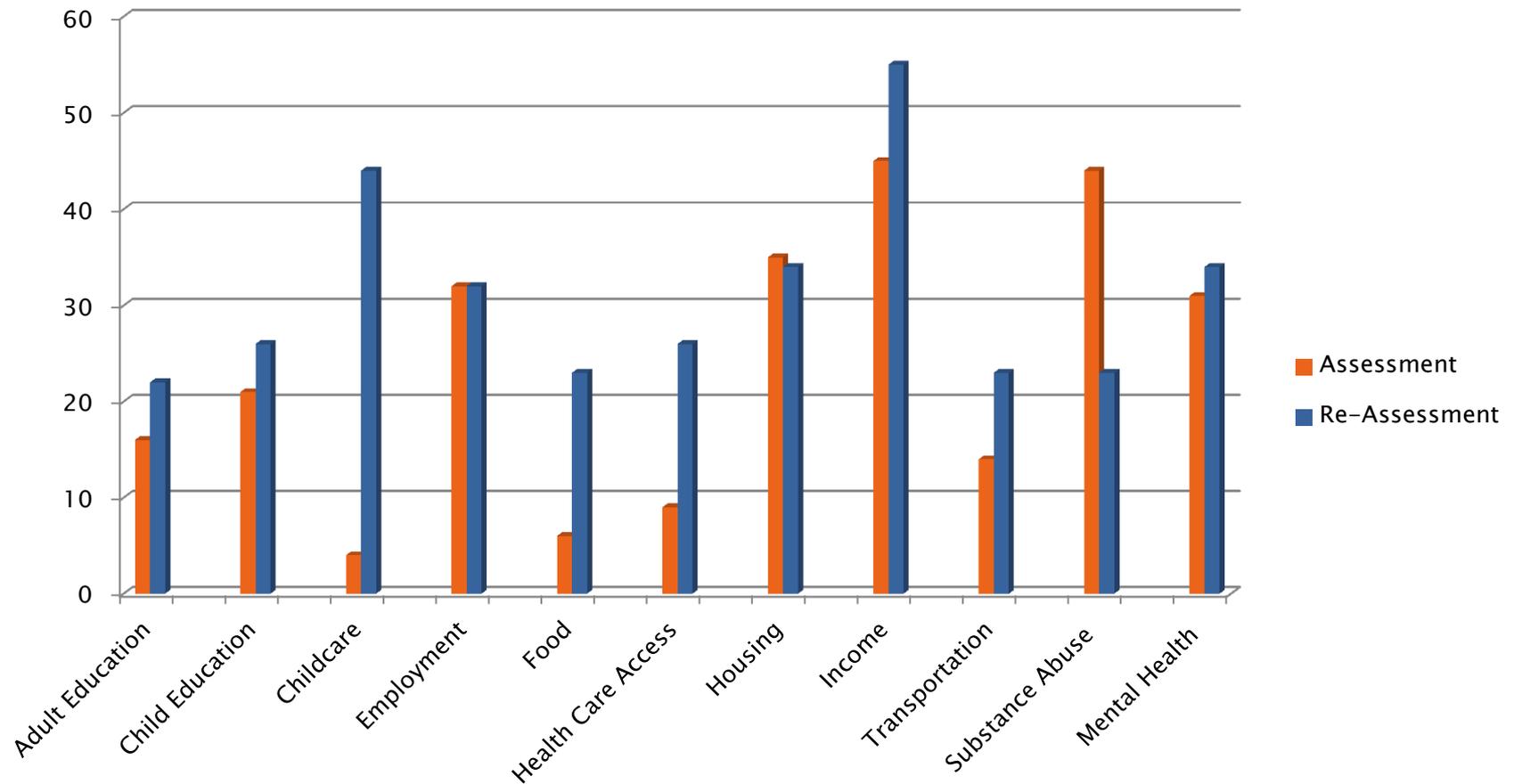


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Changes Over Time

Number who moved above prevention line in each domain

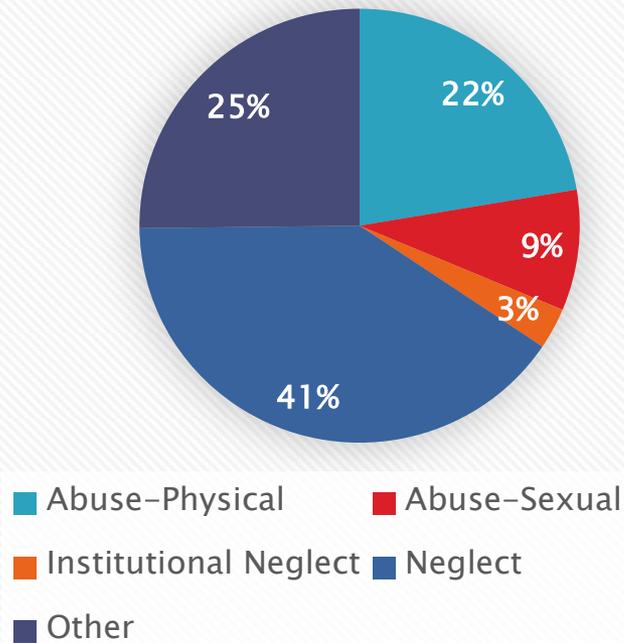


TCOM Grid

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Data Informed System and Program Refinements

Referral Reason Categories

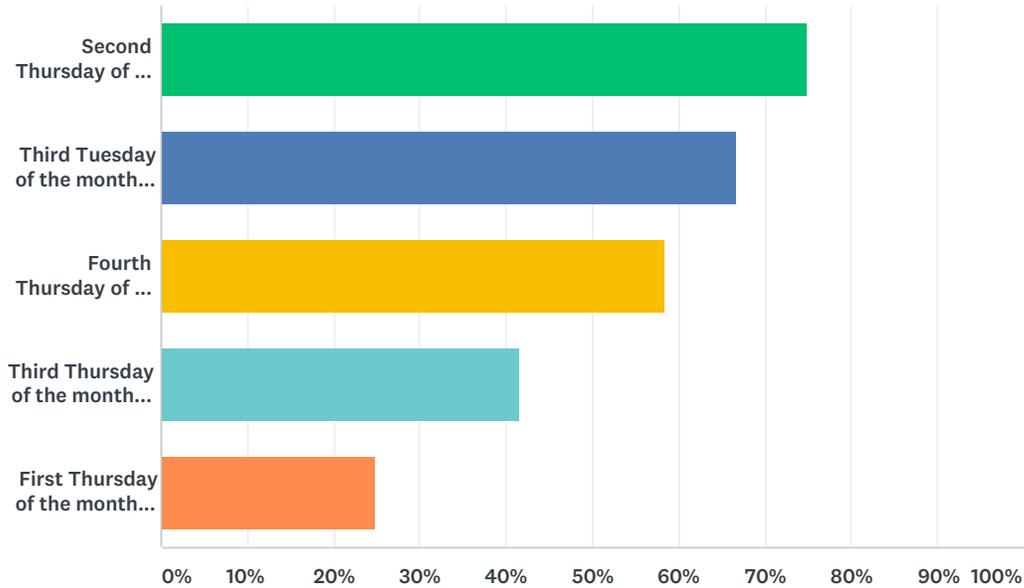


Data shows that
Agile Response = Improved Outcomes

- We see supportive housing (SH) programs applied most frequently to households working with issues related to neglect.
- Households involved with supportive housing and child welfare tend to be some of our more challenging to serve.
- We see 31% reduction in the child welfare case's length of service if the SH program begins within 3 months of the welfare case opening.
- For these cases we also see a 50% reduction in subsequent re-referral rates.

Q1 Please rank the following options for new meeting days and times. Please keep in mind that if alternating locations is something you are interested in, the two last options work to alternate between Longmont and Boulder. Please indicate the options that work for you.

Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES
Second Thursday of the month 3:00 PM- 4:30 PM in Longmont (HUB)	75.00% 9
Third Tuesday of the month 7:30 AM- 9:00 AM in Boulder (Kaiser)	66.67% 8
Fourth Thursday of the month 1:00 PM -2:30 PM in Longmont (HUB) OR Boulder (Kaiser)	58.33% 7
Third Thursday of the month 9:00 AM- 10:30 AM in Longmont (HUB) OR Boulder (Kaiser)	41.67% 5
First Thursday of the month 9:00 AM- 10:30 AM in Boulder (Kaiser)	25.00% 3
Total Respondents: 12	