# Department of Housing & Human Services

Housing Office: 2525 13th Street, Suite 204 • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax: 720.564.2283
Human Services: Boulder Office • 3400 Broadway • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax 303.441.1289
Longmont Office • 1921 Corporate Center Cir., Suite 3F • Longmont, Colorado 80501 • 303.441.1000

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, February 24, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Agenda:

1) **Approval of today's agenda 3:30-3:33pm**

2) **Approval of minutes from December 9, 2015 DHHS Advisory Committee meeting 3:33-3:35pm**

3) **DHHS Departmental updates: DHHS Senior Leadership Team strategic work—Frank Alexander (3:35 – 3:55 p.m.)**
   a) Refinement of DHHS strategic priority areas and priority projects
   b) Review of the master work plan and timelines
   c) Manager and Supervisor Meeting February 27, 2015
   d) All staff conference April 29, 2015

4) **Generative Human Services Safety Net concepts building on Community of Hope: Frank and Jeff Zayach (3:55-4:30pm)**
   a) Alignment efforts with Public Health and Community Services
      i. What we hope to achieve and why
      ii. Proposed Framework
   b) Connecting with the community to support integration and alignment efforts
      i. Feedback from the HHSAC
   c) Examples of projects:
      i. Medicaid expansion and capacity demand
      ii. Dream Big Project
      iii. Supportive Housing projects/Affordable Housing priority
      iv. Flood recovery housing developments in Lyons and Louisville
      v. BCHIC strategic priorities
      vi. SIB proposals

5) **Discussion of Advisory Committee Structure and role in the Community—Frank Alexander, Jeff Zayach (4:30 – 4:50 p.m.)**
   a) Discussion of areas of focus for the Committee
      i. Committee support to work toward the most effective structure
      ii. Community-wide alignment around vision for the safety net
         (a) Addressing special requests for support, staffing, funding
         (b) Movement toward Community indicators
      iii. Board function and critical role
   b) Bylaw review/discussion
      i. Committee purpose

ii. Committee membership

**6) Matters from the committee members for consideration**

**7) March agenda items:**

a) Continued Committee vision/governance structure discussion
b) Community of Hope update

**8) Next Meeting is Tuesday, March 31, 2014, 3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

**9) Adjourn**

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, December 09, 2014, 3:30 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Minutes

In attendance: Laura Kinder, Suzanne Crawford, Dalia Dorta, Penny Hannegan, Jeff Zayach, Frank Alexander, Will Kugel, Angela Lanci-Macris, Melissa Frank-Williams, Chris Campbell, Jim Williams

**1) Approval of today's agenda:**

Amending based on the attendance today. Will push off the budget discussion to another meeting.

**2) Approval of minutes from October 30, 2014 DHHS Advisory Committee meeting**

Approved

**3) Matters from the committee members for consideration**

None

**4) 2015 DHHS Budget Presentation—Will Kugel, Frank Alexander**
- **a) See DHHS Strategic priority: Revolutionizing the DHHS Workforce and Infrastructure**
  - (i) Comprehensive and Sustainable Economic Engine
- **b) BCHA Budget**
- **c) Human Services Budget**

Tabled

**5) 2014 Community of Hope Summit Action Items—Frank Alexander, Jim Williams, Chris Campbell**
- **a) Final Community of Hope Summit White Paper**
- **b) Discussion of next steps**

- Jim W—One of the focus during the summit was the Social Determinants of Health in the pillars of family stability—big part of the foundation of Community of Hope.
- Frank—we need advice from the Committee members today and in the coming months, we are trying to bring structure and guidance to our own department and with the greater community

to readjust and realign services on a more consistent basis. We get better with more feedback—constant feedback loop.
    - Constant feedback loop
    - Continuous learning environment
    - Common community indicators
    - Integration of Powerful Community Strategic plans
- **How do we build this structure so that we can better invest our time and resources
    - What kind of committees and forums already exist?
- Jim—Word clouds were developed from the 1300 statements that we received during the focus group sessions.
    - Family, collaboration, support, services, food, health, resources—what is working well. Will pull these out and work on in a more detailed way.
        - The task ahead of us is to start to drill down into the things that are working well and keep investing and honing them
    - Challenges—funding and housing
        - Not unknown to us but we will need to drill down deeper into these issues to come up with the strongest solutions
    - Opportunities—Education and Data:
        - Better understanding of the services that are available
        - Removal of barriers to data sharing
        - Use of data to determine what is working well
    - Action Items and Next Steps
        - Housing
        - Families
        - Data
        - Community
            - **Some of the lesser issues
                - Assessment issues
                - Landlords
                    - Engaging them
                - Undocumented families and individuals

Progress made thus far:

- The community of hope webpage is up and we have had decent traffic
- Great readership for the initial newsletter that went out
- White Paper summarizing the conference

NEXT STEPS: Structure: Frank, we are looking at a collective impact model, we have these types of models in specific areas, but now we are getting to a larger framework across multiple systems. Common agendas, common measurement structures, mutually reinforcing activities, etc.

Great opportunity and challenge is very common alignment of community need around core principles use this opportunity to align in many areas. RE: how does the public improvement process align with DHHS strategic priorities in a social determinants of health model.

How do we build the infrastructure to handle the various alignment processes. We are in an incredible position with the 15 year HSSN passage along with the alignment with the State

agencies and administrations to really move the work forward. **We need to develop really obvious and transparent process to advance the community agenda forward. Building the processes, collaborations and feedback loops to continue to move the community agenda.

Draft structure presented in the meeting—Angela Lanci Macris. Create a framework that so that we can actualize some of the opportunities that presented themselves at the community of hope summit.

Several community groups and plans exists, we will formalize this network and agree on community indicators. These groups would work on these goals. Housing goals, employment and income stability goals, food and nutrition goals, health and wellbeing goals, safety goals, education goals.

The generative human services safety net advisory committee would come out of this group and would funnel up an executive committee and ultimately the BOCC and other elected officials and city councils.

Frank—not only the bleeding edge is this in the early childhood realm, and this is the indicator we are trying to meet, but also other work groups that address issues (not just from a funding perspective). The draft structure here was meant to address the funding decision model needed but also the transparency

Jeff—first steps in the pillar areas to have agreement around objectives, goals and indicators. What role for each of the pillars does DHHS play versus the community partners.

Laura—idea is to break down some of the siloed decision making and look to integrated teams that are working across systems to make the ties between services.

Frank—From and DHHS perspective, we know that our work is most successful when it is integrated, evidence-based, front-end prevention, data driven focused. Goal is to create a 2 way feedback loop when working with partners.

Jeff—What becomes important is the backbone organization. How do we see this working in this model. Frank—the county would serve this role in many areas but it does depend on the scale of the work and the services offered.

Penny—United Way is very interested in the Collective Impact model along with City of Boulder, Community Foundation, and the United Way are working together on Early Childhood Education. How does it fit into this model? There are groups that are already moving ahead. Now would be the time to try to fit this into the larger governance model.

United Way is ready to work closely with us. Angela—smaller, subunit of the larger picture that we are working on with this model.

Folks want more of a bigger, collective impact model to work and to bring all of the siloed groups together to under a larger umbrella.

Jeff—funding decision group, who really needs to be in this group—funding collaborative is the one that drives this. Vets the community decisions and investments and makes general recommendations to the various funders.

Jeff—in terms of decision making authority around indicators, how does this play out? Angela—folks from the pillars tells us what is a gap, what is a need, where do we funnel funds but in order to get this, need to agree on larger community indicators. Bring in data analytics to drive toward these indicators. Frank—in some of the research we've done, that we must drive toward the discussion and agreement on common community indicators.

Angela—not an easy process however, we need to continue the conversation. How do we deploy resources to create this model? Town halls, open houses, go to each of the planning groups. 5-10 year process but do really want to build on the momentum of the Community of Hope.

Frank—IMPACT partnership, PHIP, ECCBC, 10 year plan, etc., need to bring all of these pieces together. What we really want help with is to bring a consistent frame and message out. Transparency about how we invest resources. Timeline is to start with something in the 1st quarter 2015. Set the calendar out for the year and set out key milestones. Significant progress should be made by June 2015 with the structure.

Laura—how does immigration reform fit into this picture? Dalia, this is really a short term solution however, they have very little access to services. Jeff, fits into each of the pillars in general.

**Action Item:** Who would we add to the Advisory Committee--United Way, appointee from each of the pillar groups (need to identify leaders from each of the areas).

Next steps is to start to reach out to the community—talking points around the structure, around the financial environment, 1st quarter 2015. Jeff, do a little more of a charter around each of the groups—working charter, description of the roles for each of the groups. Need to define the County's role as well. County will need to play a key role in coordination and facilitation. Frank—we are continuing to align internally with PH, CS and DHHS. That will clarify roles to the county.

Penny, just provide the structure and that would make significant strides.

Frank—Our system must integrate more with other systems and this take major work. Jeff—let the community know how we can support them—education. The more information about how agencies fit into this framework.

Suzanne, one of the struggles that United Way has gone through is shifting funding decisions. Need plenty of lead time to not surprise agencies. Frank, with the vast majority of money that we distribute, funding amounts won't change that much, just how we approach the work. Key!

Frank—10 year board, great minds, looking at data, we could have a liaison that can come from the county that can rely information, etc. Common input and transparency. Suzanne, may need to create some larger groups in the pillar areas—food and nutrition for example, EFAA, Sister Carmen, OUR Center do meet regularly but may need to expand this group.

Frank—Whatever structure that this committee has, this group can help immensely with transparency and communication, so need to build the structure around this. Liaison role will be key (feedback loop). Education is key as well—conversation today and then really move into the structure. Role of the Committee is to help carry the message, help solidify the feedback loops.

**Action Item**—The Committee will continue to focus on this. Educational sessions will continue, need to build some more sessions (Early Childhood Group for example)

When look at some of the other lead agencies from across the country, DHHS, Public Health and the United Way lead these types of structural efforts.

January 8 forum to discuss collaboration. Need to seize on this forum, if possible. Need some education on the generative framework—some back history.

Frame: Only thing that is being governed here is DHHS resources and staff along with the work the Public Health and Community Services.

Need to keep in mind the clients as well in this process!

Some community process that the group will need to help facilitate and host in the future.

6) **January agenda items:**
   - **a)** 2015 Planning Calendar
   - **b)** Continued Community of Hope action items

Tabled again for January meeting

7) **Next Meeting is Tuesday, January 27, 2014,** 3:30 p.m. Kaiser Large Conference Room, 2525 13th Street, Boulder

8) **Adjourn**

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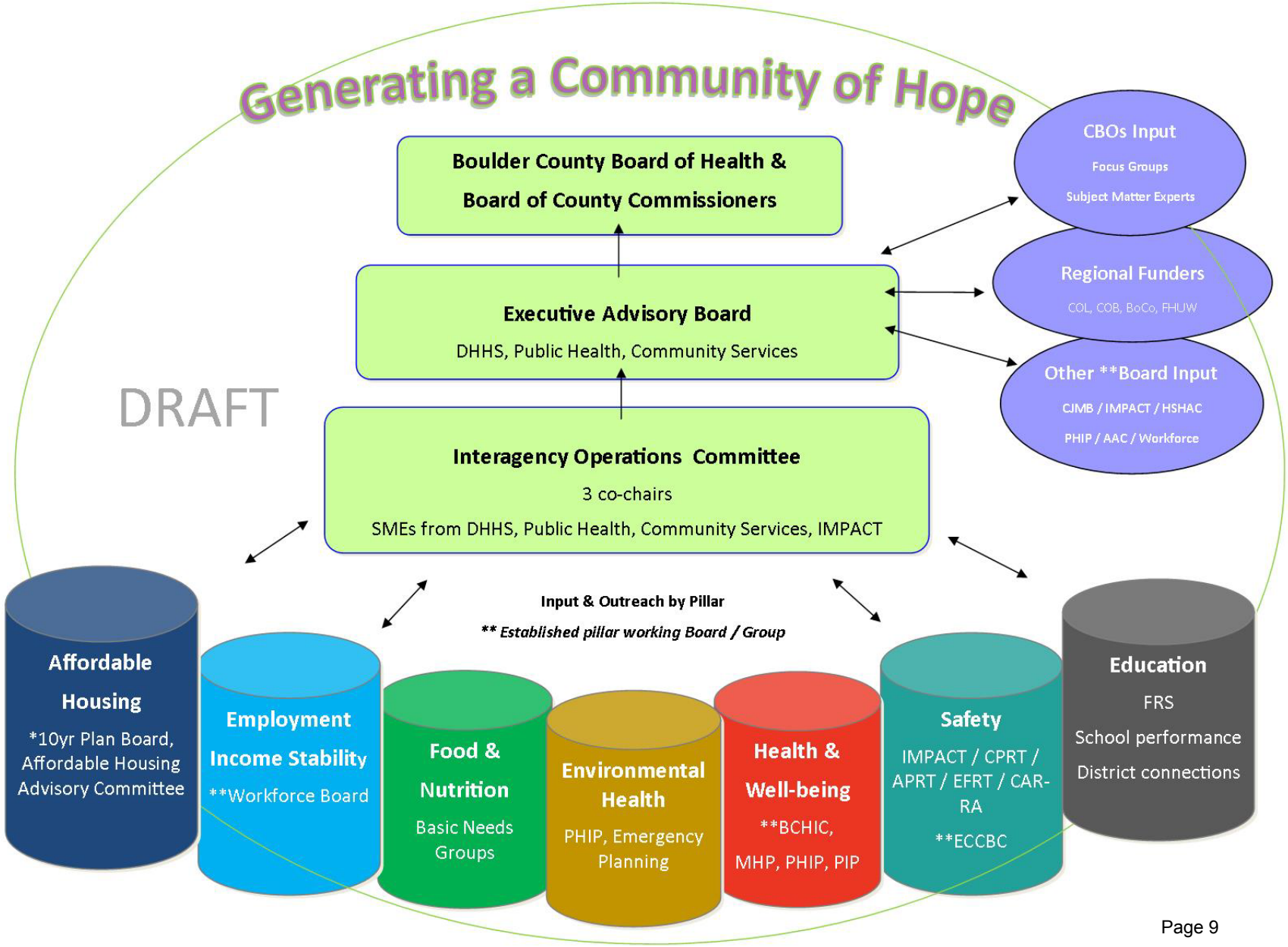
# Generative Human Services Safety Net—Boulder County Governance Framework



BYLAWS
BOULDER COUNTY DEPARTMENT OF HOUSING AND HUMAN SERVICES
COMMUNITY COUNCIL

## ARTICLE I – NAME

Section 1. Boulder County Housing and Human Services Community Council

## 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 is aligned with the needs of the Boulder County community

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

## ARTICLE III. – MEMBERSHIP

Section 1. Selection - Membership of the Community Council shall be composed of up to 15 members. They shall be those individuals who have the capacity to support the development of a county-wide, coordinated service delivery model that bolsters the performance of an integrated and accountable system to improve community outcomes associated with the pillars of health and well-being. Membership on the Council 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 Council members are:

A. Attend all meetings. If a member fails to attend three consecutive meetings, the Council may choose to remove the member.

B. Provide advice and consultation to the Department. One of the most critical roles of the community council 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. Community council members are in an important liaison role with the community and are positioned well to enhance and strengthen two-way communication between the department and various constituencies.

C. Actively participate in policy and program development of the Department. Participation may include but is not limited to: recommending modification of Department policies; evaluating the effectiveness of programs; other activities which would provide for citizen participation in assisting the Director and/or Board of Human Services in determining program and budgetary priorities.

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

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

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

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

Section 3. Appointment

A. Nominations to fill vacancies shall be presented to the Boulder County Board of Human Services in December of each year. Interested citizens are encouraged to make application. New members are to take office in January.

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 Council 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 Community Council to approve the extension of office; and when no new members are under consideration for appointment to replace that member's position on the Community Council.

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

## ARTICLE IV – OFFICERS

Section 1. The officers of the Council shall be Chairperson and Vice-Chairperson. The Department's Director and a subcommittee appointed by the Community Council will nominate persons to fill the positions of the Chairperson and Vice-Chairperson. Nominations will be submitted for approval to both the Community Council 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 Community Council and shall provide a backup administrator in his/her absence.

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

## ARTICLE V – SUBCOMMITTEES

Section 1. The Council shall act as a council 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 Council as a whole.

## ARTICLE VI – MEETINGS

Section 1. Regular meetings: There shall be at least nine monthly meetings during the year.

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

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

## ARTICLE VII – AMENDMENTS

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

## ARTICLE IX – RELATIONSHIP BETWEEN COMMITTEE AND DEPARTMENT

Section 1. Both the Department and Community Council shall attempt to maintain a constructive relationship which encourages open communication, trust, and mutual respect.

Revised 02/2015


# Boulder County Housing and Human Services Community Council (HHSCC) Member Expectations:

## About the HHSAC:

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

## Additional Background:

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

## Time Commitment:

The HHSAC meets once a month. Meetings last approximately 1 ½ hours. In addition to monthly meetings, members may be required to attend community dialogue meetings and other community events. Additional expectations include authoring letters to the editor, meeting with community partners, and assisting DHHS Senior Leadership with community outreach. **Approximate Monthly Time Commitment: 1 ½ hours to 5 hours per month.**

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, March 31, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
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## Agenda:

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

2) **Review and approval of minutes from February 24, 2015 DHHS Advisory Committee meeting (3:33-3:35 p.m.)**

3) **Update on Community of Hope and safety net alignment work—Frank Alexander (3:35 – 3:50 p.m.)**

4) **HHS Advisory Committee Proposed Support Activities—Frank Alexander and all (3:50 – 4:50 p.m.)**
   a) Areas for current support and advice from the HHSAC
      i. Summary of conversations to date
      ii. See attached PowerPoint (especially page 22)
      iii. See attached proposal by Frank Alexander for proposed areas needing member attention that will support DHHS strategic projects
   b) Discuss proposed timeline for report backs and discussion
      i. April meeting for interim questions, comments, and feedback
      ii. May meeting for member reports
   c) **Decision item:** Approval of proposed activities and timelines for Advisory Committee
   d) **Decision item:** Bylaw revision updated draft for discussion and approval by HHSAC
   e) **Decision item:** Proposal for additional Committee membership

5) **Matters from the committee members for consideration**

6) **April agenda items:**
   a) Update on Committee member activities
   b) Discuss staff attendance at the meeting
   c) Q/A

7) **Next Meeting is Tuesday, April 28, 2015**, **3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

8) **Adjourn**

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**MONTHLY MEETING**
**Tuesday, February 24, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building
Large Conference Room, 2525 13th Street, Boulder

## Minutes

In attendance: Bobbie Watson, Laura Kinder, Simon Smith, Dan Thomas, Penny Hannegan, Robin Bohannan, Jeff Zayach, Dalia Dorta

Staff: Frank Alexander, Chris Campbell, Jim Williams, Maggie Crosswy

1) **Approval of today's agenda 3:30-3:33pm**

   Approved as written

2) **Approval of minutes from December 9, 2015 DHHS Advisory Committee meeting 3:33-3:35pm**

   Approved as written

3) **DHHS Departmental updates: DHHS Senior Leadership Team strategic work—Frank Alexander (3:35 – 3:55 p.m.)**
   a) Refinement of DHHS strategic priority areas and priority projects
   b) Review of the master work plan and timelines
   c) Manager and Supervisor Meeting February 27, 2015
   d) All staff conference April 29, 2015

Frank led a discussion of the operational context that the agency has been working on for the last several years. This will allow us to consider the next steps for the Committee. PowerPoint is attached as part of these minutes.

Agenda for this section:

- HHS Operational Context and Integration Process:
- Social Determinants & Generative Model
- Community of Hope Findings
- Next Steps and HHSAC Evolution

DHHS Guiding Principles from 2009

- ❑ Focus on Early Intervention/Prevention
- ❑ Promoting Safety and Well Being
- ❑ Self-Sufficiency and Access to Benefits
- ❑ Integrated Services
- ❑ Community and Family Engagement
- ❑ Excellent Customer Service
- ❑ Communication, Transparency, Accountability
- ❑ Efficient Operations

2009: We've moved from a very reactive stage (funding issues, service delivery issues, staffing issues) to a much more proactive process. During this phase, we did start to work on shifting the system upstream.

2010: We had 12 rounds of budget cuts in this time. Layoffs, state takeover proposal, reduction in community funding. TSN was passed here.

2011: TSN investments expands. Focus on early intervention/prevention.

2012: Must more proactive approach. Community connections created here became very strong.

2013: ACA expansion was passed and was a huge shift. Generative model foundational work started.

2014: Community alignment process and state alignment processes.

This history created the foundation for the work we are taking on moving forward. We are more sophisticated in our approach in many areas. HSSN priorities are now becoming fine-tuned and focused.

- Expand on our ability to provide **food and financial assistance**
- Extend our ability to help with **housing and rent**
- Increase access to **health care**
- Provide more help for families to access **quality child care**
- Boost **job training** and **employment supports**
- Create and support community-based **Family Resource Centers**
- Increase access to **mental health** and **substance abuse services**

Social determinants of health are a primary focus of our work along with the generative model.

All of these decision making processes have been very reinforcing for us and has allowed for strong funding and decision making processes.

Community of Hope data is now shaping our decision making processing moving forward as well. We are covering this feedback and this history to spur the Committee's thinking around how we can best improve our system.

Housing, funding silos still exist. Better data coordination, better education, accelerate programming and collaboration activities—common assessment activities, integrated services models are some opportunities.

We started our strategic planning this year with a BHAG (Big Hairy Audacious Goal) from the Jim Collins research: *"Within 10 years, DHHS will transform of the health and the well-being of our community by shifting programming and funding upstream into prevention oriented and consumer driven cross-sector solutions that improve outcomes across the lifespan and significantly reduce high-cost institutional interventions within a social determinants of health framework."*

This has crystalized what we have learned over the past years and where our data/infrastructure has evolved and needs to go.

Strategic priorities have been recently honed through the lens of the BHAG. We honed down our strategic project to be more focused and realistic with our resources. Current work plan and infrastructure process, several projects emerged.

| Task Name | Start | Finish | Duration | Predecessors | Project Owner |
|---|---|---|---|---|---|
| CS Tracks and Staffing Plan Project | Tue 11/4/14 | Thu 12/31/15 | 303 days? | | **Grutzmacher** |
| Data Informed Management Practice | Mon 11/17/14 | Wed 9/30/15 | 228 days | | **Jason M** |
| Impact Planning post MHP | Thu 1/1/15 | Thu 4/30/15 | 86 days | | **Caskey** |
| St Vrain Building | Thu 1/1/15 | Wed 9/30/15 | 195 days | | **Jason M** |
| Housing Development Projects | Thu 1/1/15 | Mon 1/4/16 | 263 days | | **Willa W** |
| Community Investment Contract Process | Mon 12/1/14 | Fri 12/21/18 | 1060 days? | 205 | **Angela LM** |
| Flood Recovery – support rent assistance + rehab | Sat 11/14/15 | Tue 12/15/15 | | | **Willa W** |
| Flood Recovery: CDBG-DR Round II Funding | Thu 1/1/15 | Sun 5/31/15 | 108 days | | **Willa W** |
| HHS Competency Based Performance Framework | Mon 1/12/15 | Fri 1/1/16 | 255 days | | **Angela LM** |
| Integrated Case Management Projects | Mon 12/1/14 | Sat 12/31/16 | 545 days? | | **Kit T** |
| Strengthen Financial Analysis and Reporting tools and Systems (Human Services) | Mon 12/1/14 | Fri 1/15/16 | 295 days | | **Will K** |
| 2014/2015 State Fiscal Year Close | Mon 2/16/15 | Fri 7/31/15 | 120 days | | **Will K** |
| Housing Fiscal Team Meeting & Housing Financial Tools Enhancement | Mon 1/12/15 | Thu 12/31/15 | 254 days | | **Will K** |
| 2016 Budget Process & Multi-Year Forecasts | Mon 1/12/15 | Fri 12/18/15 | 245 days | | **Will K** |
| Hiring and Retention Plan | Fri 11/7/14 | Thu 12/31/15 | 300 days? | | **Susan G** |
| CCAP and HB1317 | Mon 12/1/14 | Wed 6/1/16 | 393 days? | | **Susan G** |

Project request examples that are coming in from the community: we can use input from this Committee on how to approach these better, with more transparency, and more efficiently.

In light of the community priorities, how do we weigh some of these decisions? How do we get ourselves organized so the requests do not come one off, and more meet the overall community need?

**Project Request Examples from the Community and Community-based Partners:**

- Medicaid Service Expansion Efforts: How do we effectively resource this?
- BCHIC priorities: Boulder County Health Improvement Collaborative. Need to align with this group.
- PHIP: Public Health Improvement Plan—need to align with their initiatives here as well.
- Dream Big Partnership
- Supportive Housing Projects/ Housing Stabilization Program
- Flood Recovery Housing
- Ten-Year Board to Reduce Homelessness Priorities Response/CW Prevention Supports ECCBC: Quality Improvement and Increased Access
- Social Impact Bonds
- IMPACT priorities
- Family Resource Centers/Resource Schools/PIP

We feel really excited with the alignment with our Organizational Development focus internally with the focus of the community/community partners—management/service delivery by data, integration,

Jeff-we've looked at a few different models—San Diego County, King County—see below.


Penny—Community indicators: how do we approach this—look at the data first and see what they tell us. Others know where we are at. The community assessments remain a high focus, we need to more effectively approach some of these areas.

Jeff—we have done a ton of legwork already, we need to draw from the work that has already has happened. Just need to bring it together under a framework.

Bobbie—Similar to ECCBC framework in Early Childhood (process to create this framework), have the BHAG, and bring together each of the groups to discuss. Outcomes under each pillar, work down from there. What are the strategies to reach these outcomes—and then pull these indicators. Need to define outcomes and strategies, and mutually reinforcing activities.

Frank—these groups already take responsibility in this work. Not all groups want to come together to go through a full strategic process. We need to get ourselves organized internally, we will know where each area/pillar is prioritizing and then we can approach them with our thoughts.

Penny—County is in a good position to be the catalyst to create dialogue in the pillar areas.

Robin: do we tee up the dialogue by doing some initial work on community indicators and then bring them to agencies. Real sweet spot.

Frank—more than ever, we know that this is the time for a more 2 way process to get to the right answer.

Simon—what are the avenues that the County wants to take to get to very precise issues? In various areas: Medicaid coverage, community health, etc. I have a strategic plan that has an integrated services model—Mental Health, Healthy living, utilization. Subject matter experts need to start to get down to real concrete examples. Specific off the shelf tools that we can start to utilize. There are opportunities here.

Frank—where we have come to the conclusion in our business unit, is that the public wants us to shift to front end prevention—integrate data, strategic approach, evidence-based approach, that is solution focused. Integrated fiscal models—pulling down Medicaid (leveraging) etc. Requests are not much more nuanced—we have met with our collaborative partners and we want to take this evidence-based approach. We now see off cycle requests, well thought out requests, now we feel we need to address these. Key is to pull all of the efforts together.

Robin: sometimes it's funding, sometimes it convening, sometimes it is leveraging need you to help in all of these areas.

Jeff—Need to break out of silos, and invest more intelligently.

Frank—want to build this team up here to support this work. Move this integrated service model forward.

4) **Generative Human Services Safety Net concepts building on Community of Hope: Frank and Jeff Zayach (3:55-4:30pm)**
    a) Alignment efforts with Public Health and Community Services
        i. What we hope to achieve and why:

Discussion has been: How do we deeply align the internal work within the county, framework for decision making, funding requests. Get us better prepared for the community work without duplication of efforts.

How do we focus on the pillars wellbeing that need more resource and investments.

ii. Proposed Framework:

Not an organizational chart, but a diagram of how the county agencies liaison with various community agency. The framework lays out how to connect/align our strategic work within the county and within the community.

Next steps are how to operationalize the alignment work, further deepen this activity.

See notes above…

b) Connecting with the community to support integration and alignment efforts
   i. Feedback from the HHSAC

See notes above:

c) Examples of projects:
   i. Medicaid expansion and capacity demand
   ii. Dream Big Project
   iii. Supportive Housing projects/Affordable Housing priority
   iv. Flood recovery housing developments in Lyons and Louisville
   v. BCHIC strategic priorities
   vi. SIB proposals

**5) Discussion of Advisory Committee Structure and role in the Community—Frank Alexander, Jeff Zayach (4:30 – 4:50 p.m.)**

a) Discussion of areas of focus for the Committee
   i. Committee support to work toward the most effective structure
   ii. Community-wide alignment around vision for the safety net
      (a) Addressing special requests for support, staffing, funding
      (b) Movement toward Community indicators
   iii. Board function and critical role
b) Bylaw review/discussion
   i. Committee purpose
   ii. Committee membership

**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 is aligned with the needs of the Boulder County community

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

Penny: Should we incorporate the Mission/Vision into the bylaws and also incorporate clients who we are serving?

Robin: can you serve 2 masters?—serve both DHHS/County Commissioners and the broader community?

Penny: is this an advisory group for the County alignment (PH, CS, DHHS) or just DHHS?

Simon: great question? This seems the direction that our strategic work is taking us. Social Determinants approach, actualizing these visions. The better this work links together, the more effective our agencies will be.

Frank—what we were starting with today, is where we are at. Incremental awareness and improvement in its current form is a good step. Iterative process. Want to continue the conversation.

Penny: should the Board be made up of reps from each of the Pillars?

Robin/Frank: not statutorily required to have a Committee?

Laura: do we need to vote on the bylaws in the next meeting? Frank—do not have to make any changes but we want to continue the conversation. Alignment is key. As of today, where you sit, where we are moving, what do you think? Does it make sense to have you oriented in this alignment?

**Action Item: All Committee Members—For next meeting, red line the bylaws and send to Jim and Chris**

Laura: onboarding—how do we bring members up to speed?

Jeff: Likes Penny's suggestion about having pillar representation.

Penny: more Longmont representation as well?

Frank—key is to have high-level systems thinkers that can see the big picture for the Boulder County Safety Net.

# Department of Housing & Human Services

Housing Office: 2525 13th Street, Suite 204 • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax: 720.564.2283
Human Services: Boulder Office • 3400 Broadway • Boulder, Colorado 80304 • Tel: 303.441.1000 Fax 303.441.1289
Longmont Office • 1921 Corporate Center Cir., Suite 3F • Longmont, Colorado 80501 • 303.441.1000

www.bouldercountyhhs.org



**Memo**

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

---

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

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

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

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

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

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

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

Once these sugggestions or others are adopted, I would recommend that the committee members come back to the April meeting with some basic sense of their targeted analysis, questions to help clarify the focus areas, and what will be required to provide some actionable recommendations that we can incorporate into our current work plan activities or begin to evaluate for our 2016 budget options. We can utilize the April meeting to have a wide-ranging discussion on the questions members have on their focus areas and we can collectively brainstorm next steps. We can also begin to set forth a calendar for May/June/July that will continue to support the presentation of these recommendations and help us think about our budgeting, planning, and strategic resources for the next 18 to 24 months.

# DHHS Advisory Committee Project Proposal Template

## Section 1: Overview of Project

| **Project Overview:** |
|---|
| [Insert project overview narrative here.] |
| **Current State:** |
| [Describe current state of project/process/activity.] |
| **Desired State:** |
| [Describe desired future state of project/process/activity.] |
| **Generative State:** |
| [Describe desired long-term generative state of project/process/activity. Note if the desired state and the generative state are the same, this section does not need to be completed.] |

## Section 2: Implementation Details

| **Outcome of Achieving Desired State:** |
|---|
| [Describe outcome of achieving the desired state.] |

| **Risk Factors in Achieving Desired State :** |
|---|
| [Describe the risk or challenges in achieving the desired state.] |

| **Interim Solutions/Resources :** |
|---|
| [Describe the steps that will be required to transition to the desired state. This may include an interim solution that is needed to ensure the primary tasks continue to be completed in a timely fashion. ] |

**Recommendations for HHS:**

[Describe the recommended actions for HHS. These may include policy positions, funding priorities, or allocation of departmental staffing or other resources that are needed to ensure the primary tasks continue to be completed in a timely fashion. ]

**Estimated Timeline for Project :**

[This section should provide an estimated timeline to complete the development and implementation of the project.]

**Committee Action Items:**

[Describe any action items needed from Advisory Committee members.]

**Estimated Cost of Project :**

[Estimation of the costs required to bring this project from development to implementation.]


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

**Boulder County Housing & Human Services Vision:**

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

**About the HHSAC:**

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

**Background:**

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

**Time Commitment:**

The HHSAC meets once a month. Meetings last approximately 1 ½ hours. In addition to monthly meetings, members may be required to attend and coordinate community dialogue meetings and other community events. Expectations also include authoring letters to the editor, providing analyses and recommendations for systems improvements and efficiencies, including evidence-based practice across the services continuum, and meeting with community partners and residents to support the department in effectively serving the community. Committee members are expected to attend 75% of **Approximate Monthly Time Commitment: 3 hours to 10 hours per month.**

BYLAWS
BOULDER COUNTY DEPARTMENT OF HOUSING AND HUMAN SERVICES
ADVISORY COMMITTEE

## ARTICLE I – NAME

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

## ARTICLE II. – PURPOSE

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

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

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

## ARTICLE III. – MEMBERSHIP

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

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

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

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

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

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

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

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

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

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

Section 3. Appointment

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

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

Section 4. Term of Office

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

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

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

## ARTICLE IV – OFFICERS

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

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

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

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

## ARTICLE V – SUBCOMMITTEES

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

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

## ARTICLE VI – MEETINGS

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

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

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

## ARTICLE VII – AMENDMENTS

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

## ARTICLE VIII – PARLIMENTARY LAW

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

## ARTICLE IX – RELATIONSHIP BETWEEN COMMITTEE AND DEPARTMENT

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

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 Human Services.

Section 2. Serve as a vehicle for education and communication with community leaders, Citizens and clients.

Section 3. Enable community leaders; volunteer within the Department, citizens and clients to make recommendations on improving the effectiveness of the Department.

## ARTICLE III. – MEMBERSHIP

Section 1. Selection - Membership of the Committee shall be composed of up to 10 members. They shall be those individuals who have shown an interest in the development of services to children, youth, adults and their families. The Committee shall reflect the ethnic and racial composition of Boulder County. It shall also reflect the geographic balance of the county. Membership on the Committee shall include balanced representation from community groups, human service agencies providing direct services to clients of the Boulder County Department of Human Services, vendors who contract services to the Boulder County Department of Human Services and individuals from the community at large. One position is to be filled by a foster parent and one position is to be filled by a current or former client of the Department of Human Services.

Section 2. Responsibilities – The responsibilities of the Committee members are:

A. Attend all meetings. If a member fails to attend three consecutive meetings, they will be removed. At the discretion of the Chair, this rule may be suspended.

B. Provide advice and consultation to the Department.

C. Actively participate in policy and program development of the Department. Participation may include but is not limited to: recommending modification of the Department policies; reviewing the Department's personnel system; evaluating the effectiveness of programs; reviewing the effectiveness of the grievance and appeals system; other activities which would provide for citizen participation in assisting the Director and/or Board of Human Services in determining program and budgetary priorities.

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

E. To learn about County, State & Federal Human Services programs.

F. To be aware of existing legislation at the County, State, and Federal levels and to contact legislators regarding pending and needed legislation.

G. To assist in clarifying misconceptions about Human Services.

H. Develop effective vehicles, which enable clients and volunteers with the Department, other individuals and groups to make recommendations to improve or recognize the achievements of 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.

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.

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

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## 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 Human Services Advisory Committee and the Board of Human Services will be notified.

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## ARTICLE IX – RELATIONSHIP BETWEEN COMMITTEE AND DEPARTMENT

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

Revised 12/2011

# HHS Advisory Committee

**February 24, 2015**


Hope for the future,
help when you need it.

BOULDER COUNTY
HOUSING & HUMAN SERVICES

Boulder County

# Agenda

- HHS Operational Context and Integration Process
- Social Determinants & Generative Model
- Community of Hope Findings
- Next Steps and HHSAC Evolution

# DHHS Guiding Principles 2009

- ❑ Focus on Early Intervention/Prevention
- ❑ Promoting Safety and Well Being
- ❑ Self-Sufficiency and Access to Benefits
- ❑ Integrated Services
- ❑ Community and Family Engagement
- ❑ Excellent Customer Service
- ❑ Communication, Transparency, Accountability
- ❑ Efficient Operations

# A Chronology of Progress

## 2009

- Departments Merged
- Service Integration Begins
- Financial Condition Assessed
- **Economic Downturn Begins**
- **SB-177 Impact**
- Casey Family Partnership
- Preventive/Front-end Services Emphasized
- Data-Driven Decision Making Emphasized
- Project Management Focus
- Consumer Benefits Expansion
- HSP Expansion

## 2010

- FCS Reorganization
- TSN Passes
- Financial Planning & Expertise
- Cross-Disciplinary Team Approach
- **State Administration Proposal**
- **State Budget Reductions**
- Customer Service Enhancement
- Enhanced Communications
- Outcome Measurement
- Family and Community Involvement
- **Four Mile Fire**

## 2011

- Early Intervention Team Formed
- TSN Priorities Established and Contracts Begin
- Josephine Commons Breaks Ground
- Data Emphasis Strengthens
- CBMS Redesign Starts
- FUP Award
- HB-1196 Passes
- State Child Welfare Redesign Begins
- Housing Stabilization Expansion

# A Chronology of Progress

## 2012

- CO Works Redesign
- Josephine Commons Completed
- CSTAT Begins
- CCAP In-House
- LHA/BCHA Consolidated
- Broomfield/Erie Properties Released
- Portfolio Refinance Begins
- TBRA Award
- VASH Award
- IV-E Waiver Approved
- ARRA Completed

## 2013

- Self Sufficiency Matrix Revamped
- ACA Health Care Expansion
- C4HC/HUB responsibilities
- JRT Training Starts
- Differential Response
- Aspinwall Breaks Ground
- Generative Approach Adopted
- Marketing Campaign
- Entire Portfolio Refinanced
- CMCO & CS Established
- Consolidated Contracts Moved to DHHS
- **2013 Floods**

## 2014

- Generative Approach and Social Determinants of Health Embraced
- Community of Hope Event
- Differential Response
- Alkonis (Louisville) Planning
- Lyons Planning
- CDBG-DR Flood Recovery Work Begun
- Aspinwall Completed and Fully Leased
- New, Integrated St. Vrain Building Construction Begun
- HHS Connection Implemented
- APS Mandatory Reporting
- Integrated Case Management Implemented
- HSSN Extended for 15 years

# Safety Net Collaborative Approach (HSSN)

Invest in families early, before they hit crisis

Strengthen early intervention and prevention

Invest in community-based safety net services

Promote individual and family stabilization

- Expand on our ability to provide **food and financial assistance**
- Extend our ability to help with **housing and rent**
- Increase access to **health care**
- Provide more help for families to access **quality child care**
- Boost **job training** and **employment supports**
- Create and support community-based **Family Resource Centers**
- Increase access to **mental health** and **substance abuse services**

# Transformation across systems

Mental Health

Public Health

Education

Human Services


BOULDER COUNTY HOUSING & HUMAN SERVICES

Boulder County

Hope for the future, help when you need it.

# Social Determinants of Health & Pillars of Family Stability


BOULDER COUNTY HOUSING & HUMAN SERVICES

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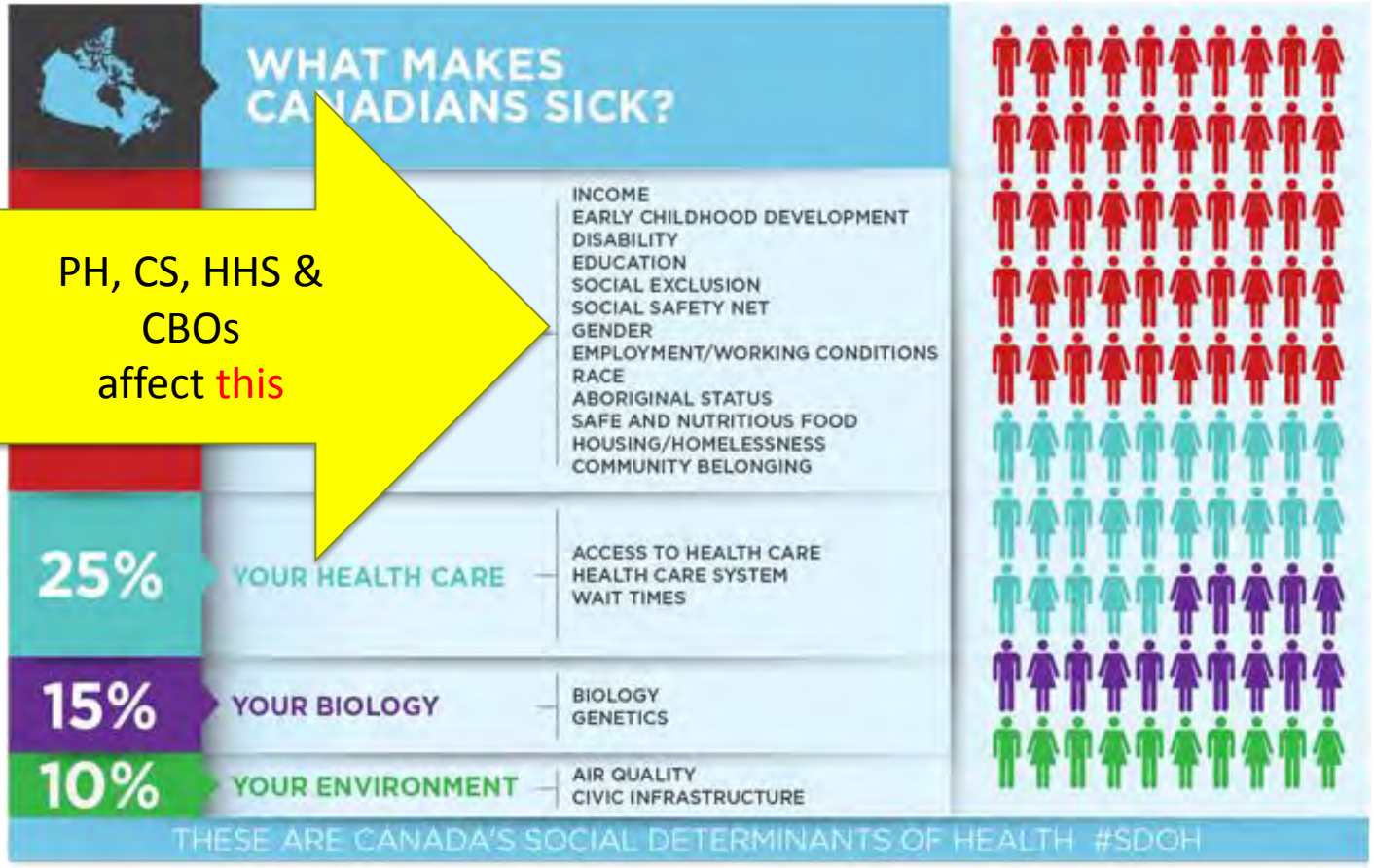
Hope for the future, help when you need it.

# Social Health Matters




## Safer and healthier communities invest in Social Health

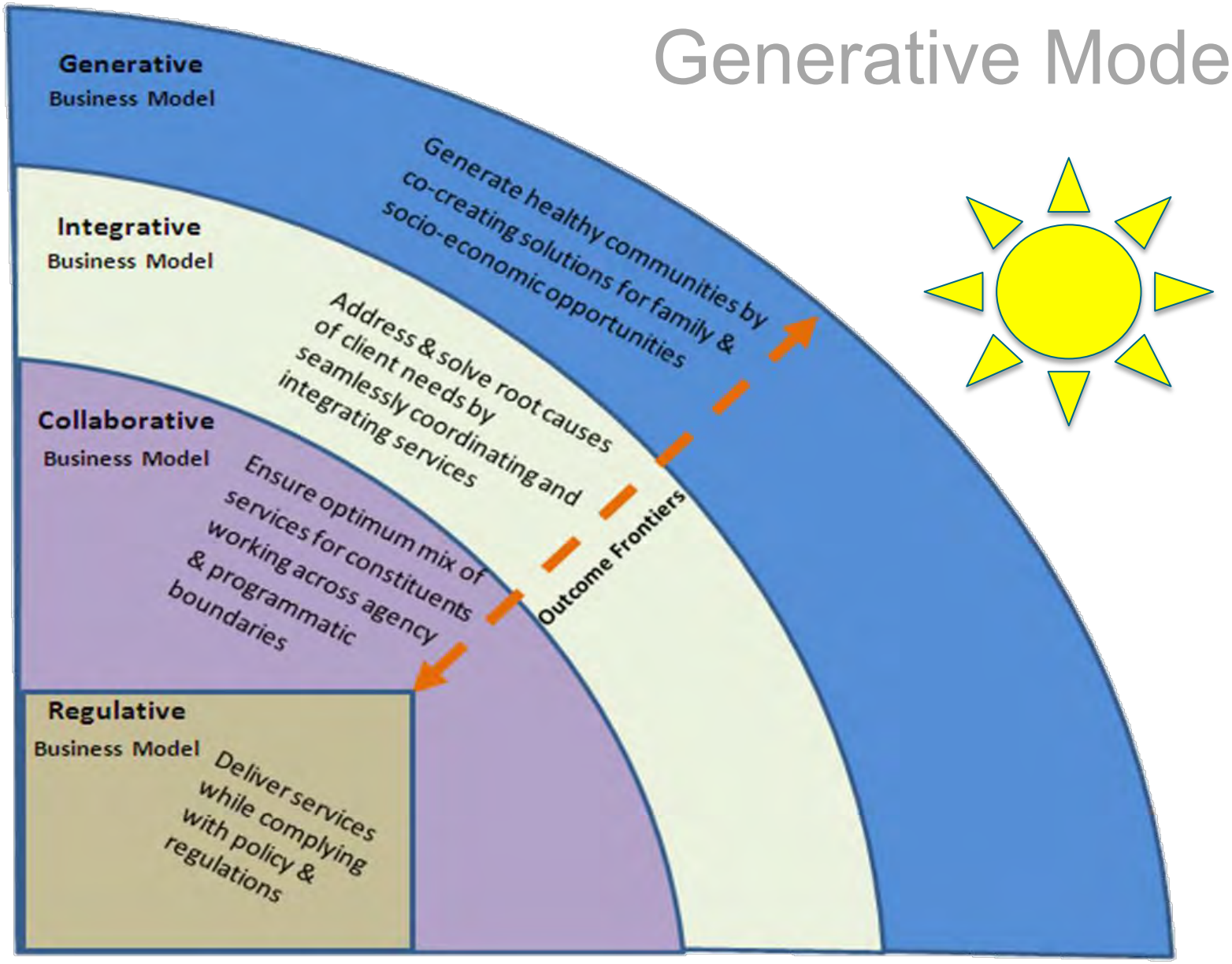
Ex: Reduced Child Welfare rates with increased pro-social programs

BOULDER COUNTY HOUSING & HUMAN SERVICES

Boulder County

Hope for the future, help when you need it.

# Generative Model






BOULDER COUNTY HOUSING & HUMAN SERVICES

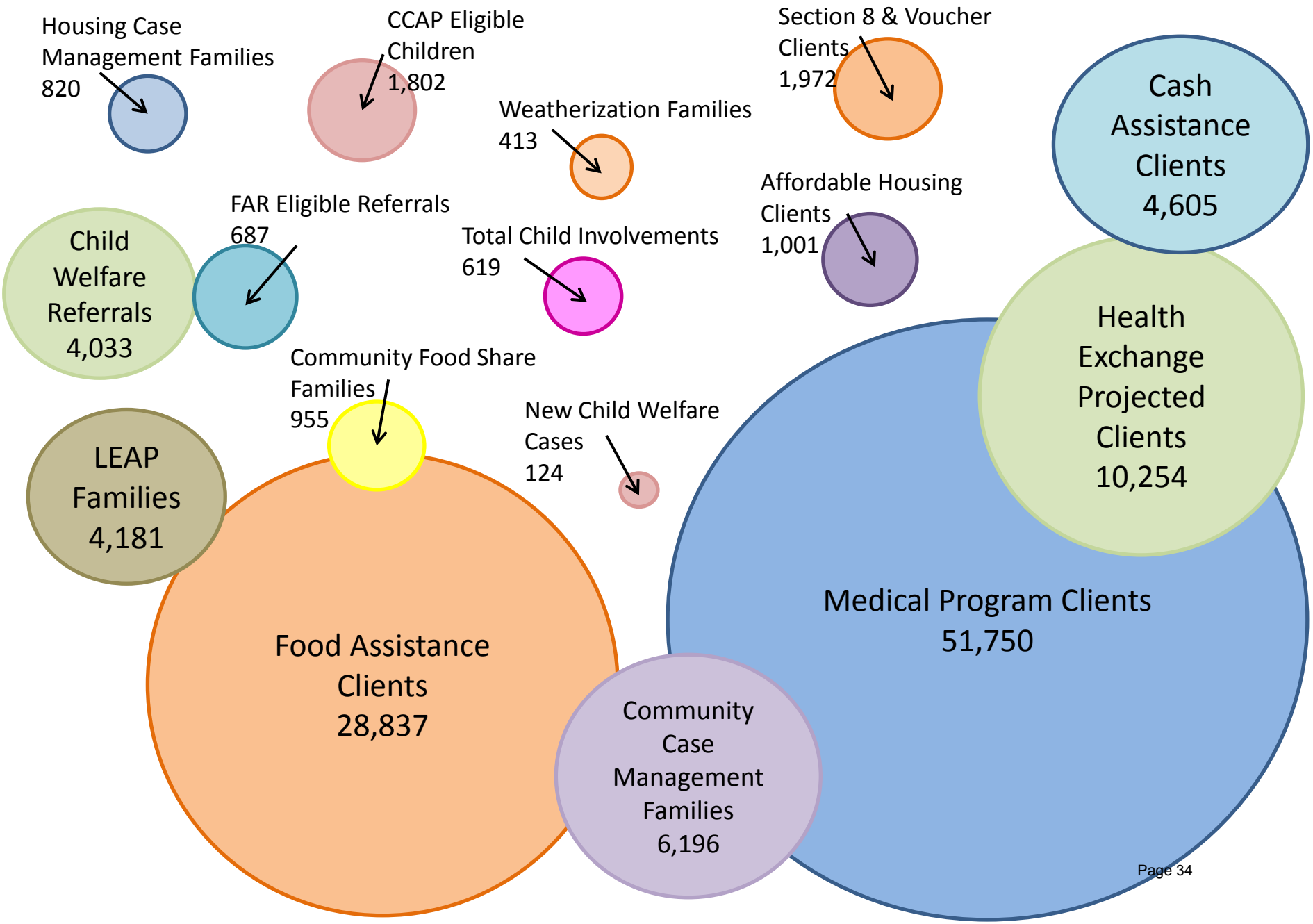
Boulder County

Hope for the future, help when you need it.

# Generative Checklist

| Priority Area | Description | How will priority be met? |
|---|---|---|
| **Improved Service Operations** | Improves service to customers by enhancing operations, workflow, delivery methods, access channels, customer experience or services offered. Program level improvements with cross-divisional implications are more valued. | |
| **Foster Integration** | Project links together services or staff across the department in attempt to better connect services and outcomes. | |
| **Include consumer in planning and service delivery** | Project implements strategies to allow consumers to be represented in the case planning process. | |
| **Fiscally Sustainable** | Project contributes to the department's overall plan for sustainability by maximizing match opportunities, trimming budgets or creating long term sources of revenue. | |
| **Improve outcomes, connect to community outcomes** | Project has clear outcomes that pertain to department and community level indicators. Potentially pertains to multiple program indicators. | |
| **Technology opportunity** | Project integrates with the enterprise vision for the agency and takes advantages of opportunities to leverage existing technologies or introduces potential new enterprise standards. | |

# HHS Service Populations: 9/2013 through 8/2014



# Boulder County: Community of Hope

## Summit: September 26, 2014

BOULDER COUNTY HOUSING & HUMAN SERVICES

Boulder County

Hope for the future, help when you need it.

# Focus Groups: **What's Working Well?**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# Focus Groups: **Challenges We Face**


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# Focus Groups: **Opportunities We Have**


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# Building Healthy Thriving Communities

- Constant Feedback Loop
- Continuous Learning Environment
- Common Community Indicators
- Integration Powerful Community Strategic Plans


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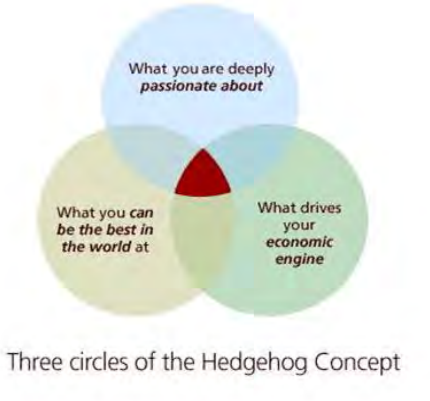
# Goal: Make our community's safety net more family driven, prevention oriented, and holistic.

## Why?

- **Boulder County's safety net is strong**
  - Excellent network of community partners
  - Visionary leadership
  - Supportive community

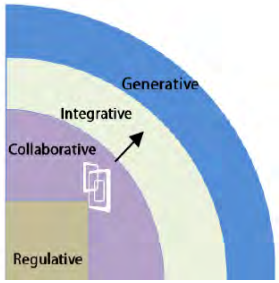
- **Boulder County's safety net can be much stronger**
  - Fully collaborative partnerships based on common goals
  - Use of data-driven common indicators to measure need and progress, funding tied to indicators
  - Funding and implementation system informed by community



Three circles of the Hedgehog Concept

# HHS BHAG

(Big Hairy Audacious Goal)




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

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# Honing of our strategic priorities and commitment to disciplined project management and pacing

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# Review of Master Project Plan

| Task Name | Start | Finish | Duration | Predecessors | Project Owner |
|---|---|---|---|---|---|
| CS Tracks and Staffing Plan Project | Tue 11/4/14 | Thu 12/31/15 | 303 days? | | **Grutzmacher** |
| Data Informed Management Practice | Mon 11/17/14 | Wed 9/30/15 | 228 days | | **Jason M** |
| Impact Planning post MHP | Thu 1/1/15 | Thu 4/30/15 | 86 days | | **Caskey** |
| St Vrain Building | Thu 1/1/15 | Wed 9/30/15 | 195 days | | **Jason M** |
| Housing Development Projects | Thu 1/1/15 | Mon 1/4/16 | 263 days | | **Willa W** |
| Community Investment Contract Process | Mon 12/1/14 | Fri 12/21/18 | 1060 days? | 205 | **Angela LM** |
| Flood Recovery – support rent assistance + rehab | Sat 11/14/15 | Tue 12/15/15 | | | **Willa W** |
| Flood Recovery: CDBG-DR Round II Funding | Thu 1/1/15 | Sun 5/31/15 | 108 days | | **Willa W** |
| HHS Competency Based Performance Framework | Mon 1/12/15 | Fri 1/1/16 | 255 days | | **Angela LM** |
| Integrated Case Management Projects | Mon 12/1/14 | Sat 12/31/16 | 545 days? | | **Kit T** |
| Strengthen Financial Analysis and Reporting tools and Systems (Human Services) | Mon 12/1/14 | Fri 1/15/16 | 295 days | | **Will K** |
| 2014/2015 State Fiscal Year Close | Mon 2/16/15 | Fri 7/31/15 | 120 days | | **Will K** |
| Housing Fiscal Team Meeting & Housing Financial Tools Enhancement | Mon 1/12/15 | Thu 12/31/15 | 254 days | | **Will K** |
| 2016 Budget Process & Multi-Year Forecasts | Mon 1/12/15 | Fri 12/18/15 | 245 days | | **Will K** |
| Hiring and Retention Plan | Fri 11/7/14 | Thu 12/31/15 | 300 days? | | **Susan G** |
| CCAP and HB1317 | Mon 12/1/14 | Wed 6/1/16 | 393 days? | | **Susan G** |


**Project Request Examples:**

Medicaid Service Expansion Efforts

BCHIC priorities

PHIP

Dream Big Partnership

Supportive Housing Projects/ Housing Stabilization Program

Flood Recovery Housing

Ten-Year Board to Reduce Homelessness Priorities

Response/CW Prevention Supports

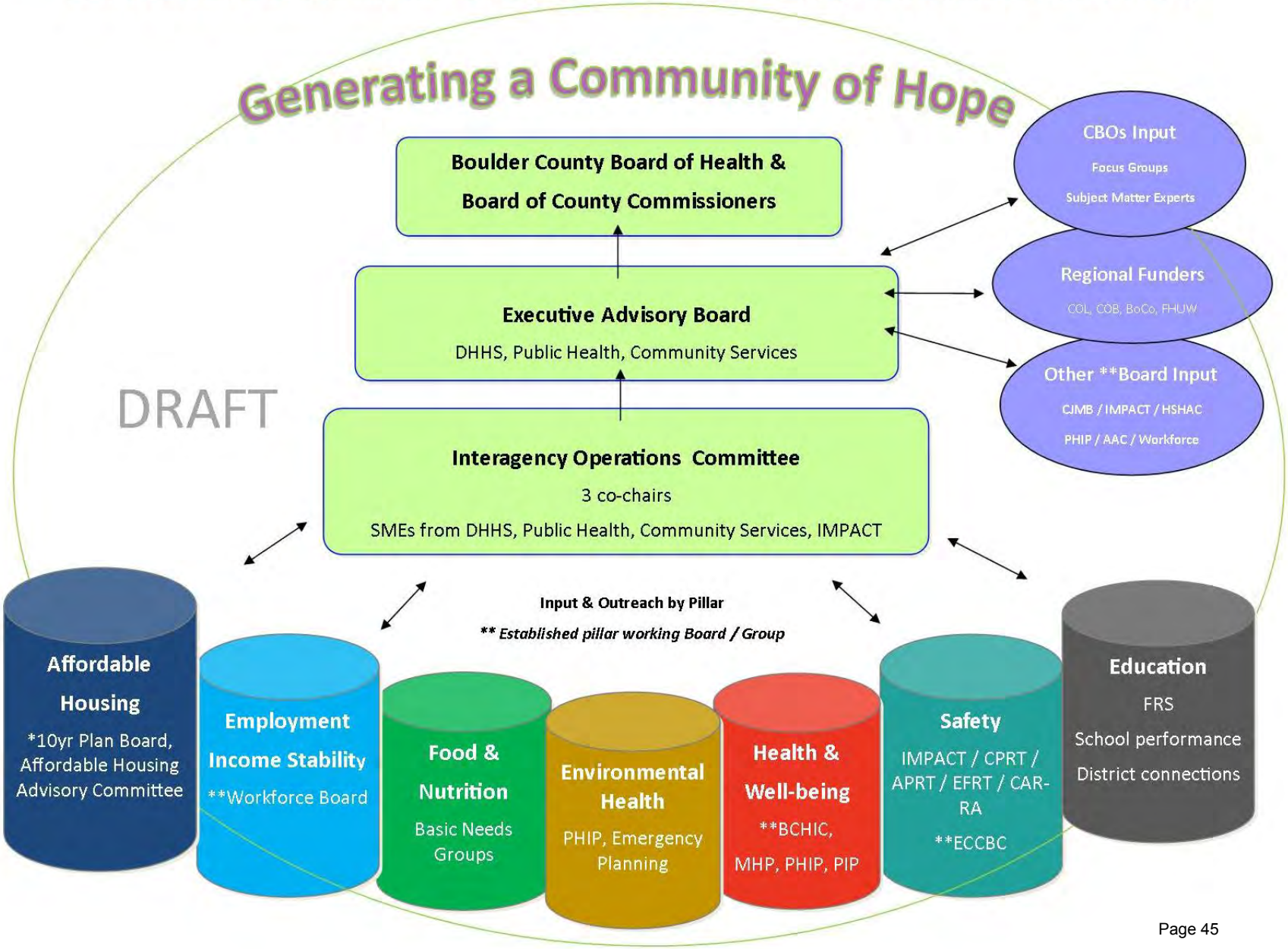
ECCBC: Quality Improvement and Increased Access

Social Impact Bonds

IMPACT priorities

Family Resource Centers/Resource Schools/PIP

# Generative Human Services Safety Net—Boulder County Governance Framework



# Next Steps:

## Compelling Vision


# Discussion:

How can the Advisory Committee most effectively help actualize and align the community's and the DHHS's Vision/Mission?

family driven

prevention oriented

holistic

# Department of Housing & Human Services

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, April 28, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Agenda:

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

2) **Review and approval of minutes from February 24, 2015 DHHS Advisory Committee meeting (3:33-3:35 p.m.)**

3) **HHS Advisory Committee Proposed Support Activities—Frank Alexander (3:35 – 4:55 p.m.)**
   a) **Update from members:** All members take time with your priority, then come back and talk about scope of what's needed to be successful; any questions, concerns, resource needs, actionable recommendations that we can incorporate into our current work plan activities or approaches to begin to evaluate for our 2016 budget options
   b) **April 28 meeting presenters:**
      1. Laura Kinder: **Community work with the Hospitals**—3:35 – 3:55 p.m.
      2. Dalia Dorta/Elvira Ramos: **Enhanced service delivery for the Latino community and strengthening recruitment and retention of bilingual and bicultural staff:** —3:55 – 4:15 p.m.
      3. Suzanne Crawford: **Family Resource Centers**—4:15 – 4:35 p.m.
      4. Jeff Zayach: **Evaluate PHIP priorities and HHS priorities for enhanced alignment** —4:35 – 4:55 p.m.

4) **Matters from the committee members for consideration**

5) **May agenda items:**

   a) Continued updates on Committee member activities
      1. **May 26 meeting:**
         (a) Simon Smith: **Medicaid Service Expansion Efforts**
         (b) Dan Thomas: **Financial and Budget Transparency and Communication to Community on Return on Investment**
         (c) Bobbie Watson: **Early Childhood Council of Boulder County: Quality Improvement and Increased Access**
         (d) Penny Hannegan: **Dream Big Project**
         (e) Robin Bohannan: **Ten-Year Board to End Homelessness Priorities:**

b) Question and answer session on support activities
   i. DHHS staff liaison attendance at committee meetings
   ii. Discussion of budgeting, planning, and strategic resources for the next 18 to 24 months.

**6) Next Meeting is Tuesday, May 26, 2015, 3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

**7) Adjourn**

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Boulder County

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, March 31, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Attending: Laura Kinder, Penny Hannegan, Dan Thomas, Dalia Dorta, Bobbie Watson, Jeff Zayach, Elvira Ramos, Jim Williams, Frank Alexander, Chris Campbell, Suzanne Crawford Judy Felan, Lydia Morgan Apartments – public observer

## Meeting Minutes

### Committee and Staff Action Items

**Committee:**

1. **Action Items—HHS Advisory Committee Proposed Support Activities:** All members take time with your priority, then come back and talk about scope of what's needed to be successful; Bring any questions, concerns, resource needs, and other items to the April and May meetings. **Frank Alexander (staff lead).**
    a. **April 28 meeting:** Laura, Dalia/Elvira, Jeff, Suzanne will present their proposals for support activities.
    b. **May 26 meeting:** Simon, Dan, Bobbie, Penny, Robin

2. **Action Item—Dream Big Proposal:** Post list of agencies in the collaboration along with additional information**. Penny Hannegan, Lead. By April meeting.**

3. **Action Item—Committee Membership:** Send any final suggestions for new committee members to Frank, Chris and Jim. We will compile a list, present to the Committee at April's meeting, and the Committee will make decisions on membership at that meeting. **Chris Campbell (staff lead). By April meeting**

**Staff:**

1. **Action Item:** Create location for all Committee documents to be posted and shared. Include committee roster, bylaws, expectations, etc. in this location. **Chris Campbell (staff lead). By April 3, 2015**

## Detailed Minutes

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

2) **Review and approval of minutes from February 24, 2015 DHHS Advisory Committee meeting (3:33-3:35 p.m.)**

Minutes approved unanimously

3) **Update on Community of Hope and safety net alignment work—Frank Alexander (3:35 – 3:50 p.m.)**
   - Frank – included in packet is last month's PPT. Continuing productive process in two arenas. We've agreed to move COH concept forward across all three departments to adopt common lens, Social Determinants, internal realignment work. Framework has been adopted. Established Executive Advisory Board – nine people including Robin, Frank, Jeff and two leadership members from each dept; draft work plan and membership for Interagency Operations Committee for work beginning at end of April. Aligning ourselves around the common operating framework – funding, policy, service delivery framework to align with community work across pillars, existing bodies doing this work in community. Questions – how do we make decisions, community indicators, priorities amongst equally valid areas of need, build cross disciplinary team that deepens work in agencies collectively to reduce separation and siloing? Iterative process moving forward. Jeff- efficiency wise we're all in different places. This framework will help us as much as the community. Frank – inventory of task groups, who was attending them, what they were saying at the groups, capacity to speak at a different level, able to align across different departments? Work is more complicated now too. Dan – any other depts or agencies we thought about bringing into this process? Frank – IMPACT board, otherwise no. EAB meets every two weeks for past two months. IOC will follow similar structure. Takes time to align around common vision, common pacing. Decision timelines we have today don't change (budget, staff resources realignment, data systems), this will take some time. We haven't had common agreement around strategic plans, informed by work we're doing in partnership with the community (naturally has been haphazard in the past in terms of advocating for what should be happening); we've not made a collective statement about our mission together in the past. HHSAC is on the side (board input). Might make sense down the road for HHSAC to govern more of COH process. This is still a draft document. IOC won't see this until Apr 30.
   - Bobbie – question about Dream Big – a different framework of looking at how we can move people through poverty, starting with cradle through college early childhood education; Penny – we have housing, how do we make sure they're getting educational support, early childhood, after school etc.; many partners – primary is I Have a Dream, but also BVSD involved; Randy could describe vision; research component as well, TechStars interested. System implications, philosophical impacts in terms of funding allocations. Group of people whose knowledgebase is growing. **Penny – send list of agencies involved to HHSAC members.** Lots of energy, BHP is the crucible that holds this. They've come to us for funding in the past. With some additional focus on this kind of issue (early intervention and prevention, supportive housing, etc.), let's not unintentionally miss things, let's figure out how to invest in top priorities.
   - FRCs, FRS, PIP – what do we mean by school based services, do we have a common philosophy? Need to have a common frame so pieces can support one another. What are the roles?

- Is BHAG shared with Public Health and Community Services? Jeff - No – but along with EAB context it's translated into our philosophy. Frank – doesn't mean this BHAG is all we do, but helps frame all kinds of questions around decisions that we make. PH – wording for us is similar. Guiding focus principle of our IMPACT partnership. Not just child-focused, for example, but focused on the whole family.
- Bobbie – funding of services 10 years ago – lots across the spectrum; looks to me like this is changing to deeper funding including the whole family – housing, social determinants, etc. Frank- what equals deep is that there's funding, blended dollars, service connection, additional resource, data, service integration, new business models – philosophy and infrastructure brought to an issue.

**4) HHS Advisory Committee Proposed Support Activities—Frank Alexander and all (3:50 – 4:50 p.m.)**

a) Areas for current support and advice from the HHSAC

i. Summary of conversations to date – questions from some members, meeting with Dalia; different iterations of this team over time; high profile needs in the community that are impacting us today, need a structure for addressing funding requests that come in; consider memo as work areas to define the committee's work going forward – funding, strategic priorities, social determinants piece, work amongst departments will be influenced by your work

ii. See attached PowerPoint (especially page 22)

iii. See attached proposal by Frank Alexander for proposed areas needing member attention that will support DHHS strategic projects

- Primary and secondaries pulling together folks for meetings to talk about these? Frank – maybe just gather thoughts, make a summary of what you think is happening, get feedback; then we think what we want to do – focus groups, bring in partners, look at multiple issues at once? You all tell me what would help you succeed in this?
- Penny will take Dream Big Partnership
- Frank, are you Jeff and Robin going to be helped by all this at the EAB level in decision making, funding decisions etc.; are we re-evaluating what you already know? Frank – we have our own big decisions that have to be made; alignment process with PH and CS, and role in community to be collaborative and iterative; can feel siloed; initiatives that come at us don't always have connections to other things we're working on; I need to make decisions in all of these areas, and this is an opportunity to be well-informed; are we serving the community well, making the right decisions about Medicaid expansions, 2016 budget? Does it match 10 Year Board priorities, Dream Big project, etc? We have to prioritize things, and you all need to have a more active role in guiding this. These felt like critical pieces. Dan's transparency assignment – very important that we're doing this right.
- Bobbie – you're looking for my orgs priorities/outcomes we'd like to see and recommended strategies to get you there? Frank - its' a sweet spot where things come together – recommendations based on linkages; how much into quality, how much into access – into wrapping families?
- April – deeper discussion on this? Take this back, digest it – what can you do each in relation to request – what info and support from committee do you need? Draft template of how to think through your issue. Make recommendations of how long things will take; resource questions.
- Laura – are staff aware of liaisons? No, mostly not yet. All individuals are involved in these priorities and know you generally. **Dream Big – Whitney will be liaison**?
- Dalia – Cultural awareness crosses boundaries of all projects, for example – Medicaid expansion, housing, customer service access, transparency, all this informs our work across all of these

areas. These will all be less complicated if they take advantage of the work that's happened. We need consistency o0f deployment and scaling within a common context.

- Taking a part of each meeting to talk about these things? You all tell me how you want to run the meetings, how long you want to take with each issue. Bring early findings, requests for more info, risks you've identified, etc. Could also impact HHS/PH alignment around early childhood, for example – and what does this mean for staff needs to serve the need?
- Bobbie - Social Impact bonds – within early childhood or just innovative funding for homelessness, etc? Frank – I didn't pick it yet because I thought it might come out of your work. Pay for Success framework – trying to make it an operating framework for TANF, other investments.
- 10 Year Plan document example – what's the relative priority of all these issues? How would you resource the plan?
- Dalia - Area Agency on Aging – don't see them much – good suggestions to inform work.
- Reduce average length of stay in affordable housing by 20%, you've just created 20% more affordable housing
- What are we doing/not doing to support seniors living independently in the community and how is it connected to the work we are or aren't doing?
- **Frank – everyone take time with your priority, then come back and talk about scope of what's needed to be successful; schedule out next few months from there. Maybe discuss three per meeting? May want to shift gears based on your first evaluation? 3 to 4 people could be priorities. Dalia, Jeff, Penny, Suzanne.**
- **Penny needs a staff liaison for Dream Big**
- Send materials in advance – put them in Google Drive folder
- Contacting staff liaison – we'll update liaisons by tomorrow.
- Laura – this is exciting, why we're all here
- We hope to get meeting minutes out more quickly to this group, Google Docs drive;

b) Discuss proposed timeline for report backs and discussion
   i. April meeting for interim questions, comments, and feedback
   ii. May meeting for member reports

c) **Decision item:** Approval of proposed activities and timelines for Advisory Committee

- Article 4, Section 1 – nominations for chair/vice chair submitted to both HHSAC and board of commissioners notified? Delete the word "both"
- Jeff –motion to approve with Dan's change; unanimously approved.
- **Put list of members on the Google Drive**

d) **Decision item:** Bylaw revision updated draft for discussion and approval by HHSAC

e) **Decision item:** Proposal for additional Committee membership

More aging population representation, health care, Longmont representation? We can add when we need to. Frank – what does the committee want in terms of #s? Yes, someone in Aging. Dalia – Guio Bravo - Latina who works with AAA and lives in Longmont – Dalia will get resume to DHHS. Julie Van Domelen (EFAA) is interested in joining. New director of MHP? Lena from VIA? What about Workforce? Connection to employment base, workforce center, job development in community? Penny will talk to Heather about Dream Big. Frank Bruno now with BCH – feet in many different places.

When do we want to bring the new members on? Next few months. We'll discuss the list and what we've found next time.

5) **Matters from the committee members for consideration**
   - Laura will send letter to anyone who might represent you at your organization to say what a valued member you've been of the HHSAC so they know. Let Laura know by email who the letter should go to and what contact info (email, mailing address) and I'll get them out by the end of April
   - New Trends out mid-September
   - Dalia - Promotores grant finished in May –frustrating to see funds go away – came from Latino Age Wave - $25k per year. Grants were only for 2 years. AAA considering taking on Promotores. Money goes through Latino Task Force.
   - Penny – BHP made a video (on their website) about Lee Hill community – project has been nominated for Impact Award, we're up against Union Station – very impressive!
   - Suzanne - New director of programs started today – Mark - very excited about him

6) **April agenda items:**
   a) Update on Committee member activities
   b) Discuss staff attendance at the meeting
   c) Q/A

7) **Next Meeting is Tuesday, April 28, 2015**, **3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

8) **Adjourn**

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**Memo**

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

---

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

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

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

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

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

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

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

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

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

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   a) **Update from members:** All members take time with your priority, then come back and talk about scope of what's needed to be successful; any questions, concerns, resource needs, actionable recommendations that we can incorporate into our current work plan activities or approaches to begin to evaluate for our 2016 budget options

   b) **May 26 meeting presenters:**

| May 26, 2015 Meeting | | |
|---|---|---|
| | | |
| **1. Simon Smith** | **Medicaid Service Expansion Efforts** | **3:35 – 4:05 p.m.** |
| | | |
| **2. Laura Kinder** | **Community work with the Hospitals** | **4:05 – 4:35 p.m.** |
| | | |
| **3. Penny Hannegan** | **Dream Big Project** | **4:35 – 5:00 p.m.** |
| | | |

4) **Matters from the committee members for consideration**

5) **June agenda items:**

   a) Continued updates on Committee member activities

| June 30, 2015 Meeting | |
|---|---|
| | |
| 1. **Bobbie Watson** | **Early Childhood Council of Boulder County: Quality Improvement and Increased Access** |
| | |
| 2. **Robin Bohannan** | **Ten-Year Board to End Homelessness Priorities** |
| | |
| 3. **Dan Thomas** | **Financial and Budget Transparency and Communication to Community on Return on Investment** |
| | |

b) Question and answer session on support activities
   i. Discussion of budgeting, planning, and strategic resources for the next 18 to 24 months.

6) **Next Meeting is Tuesday, June 30, 2015**, **3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

7) **Adjourn**

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Boulder County

# Department of Housing & Human Services

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Longmont Office • 1921 Corporate Center Cir., Suite 3F • Longmont, Colorado 80501 • 303.441.1000

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, April 28, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Members Present: Penny Hannegan, Suzanne Crawford, Jeff Zayach, Dalia Dorta, Simon Smith, Robin Bohannan

Staff Present: Frank Alexander, Whitney Wilcox, Angela Lanci-Macris, Summer Laws, Melissa Frank-Williams, Chris Campbell, Jim Williams

## Minutes

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

2) **Review and approval of minutes from February 24, 2015 DHHS Advisory Committee meeting (3:33-3:35 p.m.)**

Addition: Penny's action item from the previous minutes: she will send information for the Dream Big Initiative.

3) **HHS Advisory Committee Proposed Support Activities—Frank Alexander (3:35 – 4:55 p.m.)**
   a) **Update from members:** All members take time with your priority, then come back and talk about scope of what's needed to be successful; any questions, concerns, resource needs, actionable recommendations that we can incorporate into our current work plan activities or approaches to begin to evaluate for our 2016 budget options

Frank introduction—coming out of the community of hope work, the integration work with PH and CS we wanted to take the opportunity to take the Committee to another level. What we are hoping will surface from this interdisciplinary group is to help support linkages with our community partners and more coordinated service delivery with our community partners.

Over the next couple of months, we will start to map out how these activities will be approached. This will drive our work plan as a team over the next year. For example, we get a very specific funding request, this group will measure how the request fits into the community needs, community priorities, etc.

b) **April 28 meeting presenters:**

1. Laura Kinder: **Community work with the Hospitals**—3:35 – 3:55 p.m.

Tabled until the next meeting

2. Dalia Dorta/Elvira Ramos: **Enhanced service delivery for the Latino community and strengthening recruitment and retention of bilingual and bicultural staff:** —3:55 – 4:15 p.m.

Focus was from Dalia's experience with the Promatores program. The following is the proposal from Dalia and Elvira:

## DHHS Advisory Committee Project Proposal

**Enhanced service delivery for the Latino community and strengthening recruitment and retention of bilingual and bicultural staff**

### Section 1: Overview of Project

| **Project Overview:** |
|---|
| Considering the experiences of Latinos interviewed by the Promotoras between November 2013 and March 2015 regarding the barriers to access services and the actual services received, it became clear that frontline staff is a barrier second only to client lack of knowledge of services. |
| **Current State:** |
| There are inconsistencies on customer services that rely, in many cases, on one person, usually a Spanish speaking person, to take care of all non-English speaking clients, or in some cases on a written script. Current perception of services tends to suggest that there is more emphasis on numbers to comply than quality of service. This has a direct impact on people's trust or reliability of services or even willingness to use services until crisis presents. |
| **Desired State:** |
| To have well trained personnel on customer service and cultural awareness, capable of understanding and developing rapport with service users/clients/customers. |
| **Generative State:** |
| Same as above |

### Section 2: Implementation Details

| **Outcome of Achieving Desired State:** |
|---|
| 1. Increasing the number of clients that attend preventive services.<br>2. Support and enhance the work of cultural diverse personnel.<br>3. Increase potential synergies among agencies |

4. Improve services across the board in the County.

**Risk Factors in Achieving Desired State :**

1. Assuming only one single person within a department or organization can take on the task of serving diverse users.
2. Assuming a Latino associate will automatically serve well the Latino population.
3. Management resistance to undertake cultural awareness strategies and consequently permeate them.
4. Weight of quantitative goals over qualitative goals

**Interim Solutions/Resources :**

1. Confirming Promotoras first findings: Implement "mystery shoppers" strategy to evaluate your customer services throughout the county. Starting by choosing some critical, high sensitive receptions or front-end services.
2. Benchmarking units' performance could show weakness as well as strengths in areas; as well as being able to develop best practices.
3. Recognize and validate best practices already being implemented

**Recommendations for HHS:**

Customer service, which tightly includes cultural awareness, should be included in the training of all levels of personnel. Once this becomes a priority and management is committed and engaged, results in quality service will show.
Definition of objectives regarding quality in service should be included.
Continuous qualitative evaluation should be implemented by client surveys, focus groups, employee surveys, and other agencies feedback on referrals.

**Estimated Timeline for Project :**

One (1) year project:
Six (8) months to evaluate and benchmark
Six (4) months to define guidelines and implement continuous evaluation.

**Committee Action Items:**

1. Share current guidelines on customer service, including evaluation and best practices
2. Provide feedback on referrals services in qualitative terms
3. Define points of agreement on customer services and cultural awareness.

**Estimated Cost of Project :**

TBD

Comments from the Committee: Elvira—relevant as it pertains to the Promotoras group and their needs in the future. Will need to more evaluate the current state within DHHS and where we are at during this point. Tough to know where DHHS is now—need more data/demographic data along with pay differential data. Frank—this was done a bit with the Latino Task Force and the DHHS Advisory Committee in the past—Action Item: will bring this data back to the project team.

Summer—Health equity is strong goal for Public Health. Continuous quality improvement piece that we need to focus on. Frank—would be helpful to have some concrete ideas on how to improve in terms of service delivery.

Frank—the Promotoras group was helping seniors to get access to all community services across the spectrum.

Angela—the countywide diversity group (Cultural Competency Group) is currently working on some of these issues. Recently done some survey work. Love the "mystery shopper" concept. Use this as a training opportunity for our staff—feedback from the shoppers.

Next Steps/Action item: meet with Myriam and Chris C to look at data and start to hone the project and start to formulate what the county is doing currently.

Action Item: Angela Lanci-Macris—will work to send the past "'Mystery Shopper" data from a past project to the committee.

Action Item: Robin B: the Area Agency on Aging will continue the Promotoras work. CS and DHHS Staff want to improve given the feedback from the Promotoras client experience.

3. Suzanne Crawford: **Family Resource Centers**—4:15 – 4:35 p.m.

Suzanne: Started from the overview approach, meeting with staff liaisons to get the lay of the land. They have yet to put together a proposal but plan on building on the plan that DHHS has in place. See the information sheet that has some definitions of what a FRC is and how they function.

Frank—Some background: when the first TSN was passed, FRC became a framework/best practice to fill some of the service gaps that were found in the safety net. A RFP was issued and Sister Carmen and Boulder Family Resource School were chosen for funding. DHHS has been working with these agencies for the past 5 years and will continue to work with them.

## What is a Family Resource Center?

Family Resource Centers provide a safe, accessible place for families to connect with comprehensive, coordinated services that help them strengthen their families and become more self-reliant. Programs at each center are tailored to the culture, resources, and needs of the community they serve and focus on building on the strengths of each family and individual.

Family Resource Centers which are members of the Family Resource Center Association of Colorado adhere to the Principles and Practices of Family Support established by Family Support America and at a minimum provide Family Development services and Resource Information and Referral, as well as other core services as appropriate to their communities. Not all programs and agencies which call themselves Family Resource Centers are members of the FRCA and FRCs which are not a part of FRCA may or may not adhere to the Principles and Practices of Family Support.

What is the difference between a Family Resource Center and a Family Resource School? A Family Resource School generally serves only families with a child attending the school. Programs and services offered at the FRS *may* be more limited than at an FRC.

**Family Development and Self Reliance**

Through this program, family development workers work one-on-one with families to help them set and achieve transformative goals in their lives and help them become more self-reliant. The framework, a research-based approach known as the family development approach, focuses on helping families build from their strengths, take charge of their lives, and access resources that are available in their communities. Note: Family Development workers are workers trained in a 90-hour Family Development Credential program developed by Cornell University, in partnership with Colorado State University Extension.

Parenting programs, home visiting programs, and/or parent support groups complement the one-on-one work of Family Development workers, promote positive parenting skills, and prevent child abuse. Financial literacy courses support families in managing and strengthening their family finances. These programs use curricula that have shown strong evidence of success with families over time.

## Principles and Premises of Family Support

**Premises of Family Support Programs**

- Primary responsibility for the development and well-being of children lies within the family, and all segments of society must support families as they rear their children.
- Assuring the well-being of all families is the cornerstone of a healthy society and requires universal access to support programs and services.
- Children and families exist as part of an ecological system.
- Child-rearing patterns are influenced by parents' understandings of child development and of their children's unique characteristics, personal sense of competence, and cultural and community traditions and mores.
- Enabling families to build on their own strengths and capacities promotes the healthy development of children.
- The developmental processes that make up parenthood and family life create needs that are unique at each stage in the life span.
- Families are empowered when they have access to information and other resources and take action to improve the well-being of children, families and communities.

**Principles of Family Support Practice**

- Staff and families work together in relationships based on equality and respect.
- Staff enhance families' capacity to support the growth and development of all family members — adults, youth and children.

- Families are resources to their own members, to other families, to programs, and to communities.
- Policies and practices affirm and strengthen families' ethnic, racial and linguistic identities and enhance their ability to function in a multicultural society.
- Programs are embedded in their communities and contribute to the community-building process.
- Programs advocate with families for services and systems that are fair, responsive and accountable to the families served.
- Practitioners work with families to mobilize formal and informal resources to support family development.
- Programs are flexible and continually responsive to family and community issues.
- Principles of family support are modeled in all program activities, including planning, governance and administration.

We put together some information about the FRC Consortium that may be helpful for this afternoon's conversation. This group has been meeting since 2013. FRC Consortium membership includes representatives from Sister Carmen Community Center, City of Boulder FRC, OUR Center, City of Longmont, Boulder County HHS (CMCO & FCS representation), and Community Services. Membership in this group expanded in 2014 to include partners administering parent education programs. Since 2014, we've focused specifically on objectives outlined below:

1. **Standardizing and Implementing Parent Education across Boulder County**
    a. A subset of the consortium have been meeting to more closely coordinate Nurturing Parenting programs which are now being administered by Community Services, City of Longmont, and Sister Carmen Community Center. All three organizations are working to identify and implement processes to help ensure families have access to the programs regardless of residency. Nurturing Parenting programs are tentatively scheduled to take place at Timberline, Lafayette, Sanchez, and Casey schools; City of Longmont Youth Center; OUR Center; Sister Carmen; Boulder Housing Partners; St. Vrain Main St. School; Boulder County Jail; SPAN; and City of Boulder FRC. This group will continue to meet to strengthen opportunities to more closely coordinate referrals, registration, and outreach. Note: It's unclear if Community Services will receive funding to continue administration of Nurturing Parenting, may know in early May.
2. **Identify implementation plan and best practices for FRCs and formalize FRC/FRS partnership model**
    a. HHS staff met with City of Boulder FRC and SCCC staff to document the implementation of the FRC in Boulder and Lafayette. Staff are working on preparing a paper to include:
        i. Boulder County definitions of FRC and FRS.
        ii. Core components of the Boulder County FRC and FRS models
        iii. Summary of best practice research and resources
        iv. Recommendations for expanding FRC model to Longmont
        v. Timeline and next steps
3. **Strengthen partnerships between HHS and FRC/Parent Ed providers**

Consortium members brainstormed ideas to strengthen relationships between HHS and community partner case managers that also provided opportunities to learn more about each other's programs and resources. The idea that emerged is very similar to HHS June 10th event. The group will continue to explore this idea in conversation with ICMC and CORE groups through 2016.

**Comment from the Committee:

Elvira is cultural competency/cultural awareness a focus of FRC work? Yes, absolutely is a pillar of the FRC model.

Simon: Is motivational interviewing available to case workers in general in the county? This creates as skillset that reinforces cultural competencies.

Suzanne—one goal of the project will be consistency of service delivery from all of the providers in the county. Provide trainings to all agencies in the County—FRCA type training

FRS/FRC relationship can be supported and strengthened. Jeff—we've started to engage SVVSD in the conversation around being a FRS, would the FRC cover families adequately? Suzanne, there is a lot of overlap with families. Frank—Key is the consistent and common development of services (re: Allegheny County model with school-based services) between all of the agencies—this is the edge currently. Need significant coordination with these agencies. We are supporting this evolution now. The sophistication of the entire safety net still needs to evolve. FRC model is fabulous at this—great container for all types of supports.

Suzanne: Conversations between FRCs/FRSs/SVVSD/BVSD and the County agencies are crucial moving forward.

Action Item: please put all documents on Google Drive in the future so all members can access.

4. Jeff Zayach: **Evaluate PHIP priorities and HHS priorities for enhanced alignment** —4:35 – 4:55 p.m.

See the attachments sent by Jeff, including the Public Health Improvement Plan

Programming that we are talking about are really focused on the social determinants of health and the pillars of self-sufficiency.

Prevention and Health Promotion

- Health Equity
  - Support child development and healthy and intended pregnancy
  - Enhance and increase protective factors for children, youth, families
  - Social determinants of health framework
- Health Promotion
  - Healthy Eating and Active Living (PHIP)
  - Mental Health (PHIP)
  - Reduce Substance abuse (PHIP)
  - Reduce tobacco use
- Health Systems
  - Maximize opportunities through the Affordable Care Act
- Addiction Recovery

- Integrate substance use, mental health and primary care

**Where are we Working Together Now**

- Community of HOPE
- Public Health Improvement Plan (PHIP)
  - Reducing Substance Abuse Coalition
  - HEAL
- Healthy Youth Alliance
- IMPACT
- Boulder County Health Improvement Collaborative (BCHIC)
- Prevention and Intervention Program (PIP)
- Affordable Care Act
  - Enrollment and service provision
- Space and service integration Longmont
- Parent Infant Advisory Board
  - Community Infant Program (CIP)
- Data expansion and integration assessment
  - Hospitals
  - BVSD and SVVSD data
  - RCCO including MHP and Clinics
  - CHORDS (including Salud and Clinica)

Other Near Term Opportunities

- Children, youth, families
  - Primary prevention and PHIP
    - Positive youth and family development
    - LGBT
  - FRS and data expansion SVVSD
  - PIP
  - Early childhood development
  - Early Home Visitation Programs
  - CIP
  - IMPACT
  - Healthy and Intended Pregnancy
  - GENESIS and GENESISTER*
  - WIC
- Mental Health & Substance Abuse
- Housing
- Education
- Family Resource School expansion - SVVSD
- Hospitals
- BCHIC
  - Specialty care now, but still interest in mental health

- More focused and coordinated policy work
- Service integration and referral
- Data expansion and coordination
- Centralized Community Health Dashboard

**High Priority Immediate Need/Gaps from Public Health

- Healthy and Intended Pregnancy
  - ***Primary prevention GENESISTER program funding ending in 2016***
  - ***LARC expansion***
  - Potential GENESIS pilot with Clinica – space integration
  - Conversation with Salud about GENESIS type approach
  - Conversation between Clinics and Boulder Valley Women's Health Center

Comments from the Committee:

Frank—what we need to remember that this is an iterative process and all we are trying to do is try to get better as a community. It is never a final process and we always need to learn and get stronger/better. Significant roots in social equity—how do we as a community get at root causes. These are very complex questions that will take time to discuss and formulate strategies to approach.

What do people feel like with opening dialogues like this. Will need to expand the conversations to two meetings from now. As we engage in the dialogues, what would productive action items look like?

4) **Matters from the committee members for consideration**

5) **Next Meeting is Tuesday, May 26, 2015**, **3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

6) **Adjourn**

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| Activity/Project | Committee Member(s) | Staff Liaison(s) |
|---|---|---|
| | | |
| **Community work with the Hospitals** | Laura Kinder, Primary<br>Simon Smith, Secondary | Stephanie Arenales-<br>sarenales@bouldercounty.org |
| | | |
| **Enhanced service delivery for the Latino community and strengthening recruitment and retention of bilingual and bicultural staff** | Dalia Dorta, Primary<br>Elvira Ramos, Secondary | Myriam McDowell-<br>mmcdowell@bouldercounty.org<br>Chris Campbell-<br>ccampbell@bouldercounty.org |
| | | |
| **Family Resource Centers** | Suzanne Crawford, Primary<br>Bobbie Watson, Secondary | Melissa Frank-Williams-<br>mfrankwilliams@bouldercounty.org |
| | | |
| **Evaluate PHIP priorities and HHS priorities for enhanced alignment** | Jeff Zayach, Primary | Summer Laws-<br>slaws@bouldercounty.org<br>Angela Lanci-Macris<br>alanci-macris@bouldercounty.org |
| | | |
| **Medicaid Service Expansion Efforts** | Simon Smith, Primary<br>Jeff Zayach, Secondary | Frank Alexander-<br>falexander@bouldercounty.org |
| | | |
| **Financial and Budget Transparency and Communication to Community on Return on Investment** | Dan Thomas, Primary<br>Simon Smith, Secondary | Jim Williams<br>jcwilliams@bouldercounty.org |
| | | |
| **Early Childhood Council of Boulder County: Quality Improvement and Increased Access** | Bobbie Watson, Primary<br>Suzanne Crawford, Secondary | Terri Albohn-<br>talbohn@bouldercounty.org<br>Susan Grutzmacher-<br>sgrutzmacher@bouldercounty.org |
| | | |
| **Dream Big Project** | Penny Hannegan, Primary<br>Robin Bohannan, Secondary | Whitney Wilcox-<br>wwilcox@bouldercounty.org |
| | | |
| **Ten-Year Board to End Homelessness Priorities** | Robin Bohannan, Primary<br>Penny Hannegan, Secondary | Daphne McCabe-<br>dmccabe@bouldercounty.org |
| | | |

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, June 30, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Agenda

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

2) **Review and approval of minutes from May 26, 2015 DHHS Advisory Committee meeting (3:33-3:35 p.m.)**

3) **HHS Advisory Committee Proposed Support Activities—Frank Alexander (3:35 – 4:55 p.m.)**
   a) **Update from members:** All members take time with your priority, then come back and talk about scope of what's needed to be successful; any questions, concerns, resource needs, actionable recommendations that we can incorporate into our current work plan activities or approaches to begin to evaluate for our 2016 budget options

   b) **June 30 meeting presenters:**

| **June 30, 2015 Meeting** | | |
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| | | |
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| **2. Simon Smith** | **Medicaid Service Expansion Efforts** | **4:15 – 4:55 p.m.** |
| | | |

4) **Matters from the committee members for consideration**

5) **July agenda items:**

a) Continued updates on Committee member activities

| July 28, 2015 Meeting | |
|---|---|
| | |
| **1. Robin Bohannan** | **Ten-Year Board to End Homelessness Priorities** |
| | |
| **2. Dan Thomas** | **Financial and Budget Transparency and Communication to Community on Return on Investment** |
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b) Question and answer session on support activities
   i. Discussion of budgeting, planning, and strategic resources for the next 18 to 24 months.

**6) Next Meeting is Tuesday, July 28, 2015, 3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

**7) Adjourn**

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**DHHS Advisory Committee discussion schedule: Remaining Committee member activity discussions**
(updated 6-22-2015)

| May 26, 2015 Meeting--**Completed | |
|---|---|
| | |
| 1. Laura Kinder | Community work with the Hospitals |
| | |
| 2. Penny Hannegan | Dream Big Project |
| | |

| June 30, 2015 Meeting | |
|---|---|
| | |
| 1. Bobbie Watson | Early Childhood Council of Boulder County: Quality Improvement and Increased Access |
| | |
| 2. Simon Smith | Medicaid Service Expansion Efforts |
| | |

| July 28, 2015 Meeting | |
|---|---|
| | |
| 1. Robin Bohannan | Ten-Year Board to End Homelessness Priorities |
| | |
| 2. Dan Thomas | Financial and Budget Transparency and Communication to Community on Return on Investment |
| | |

**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, May 26, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

Members Present: Penny Hannegan, Jeff Zayach, Dalia Dorta, Dan Thomas, Laura Kinder, Bobbie Watson

DHHS Staff Present: Frank Alexander, Whitney Wilcox, Chris Campbell, Jim Williams

Community Partners Present: Rene Brodeur (BHP), Lori Canova (I Have a Dream Foundation), Betsey Martens (BHP)

## Minutes

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

**Approved**

**2) Review and approval of minutes from April 28, 2015 DHHS Advisory Committee meeting (3:33-3:35 p.m.)**

**Approved as written**

**3) HHS Advisory Committee Proposed Support Activities—Frank Alexander (3:35 – 4:55 p.m.)**

a) **Update from members:** All members take time with your priority, then come back and talk about scope of what's needed to be successful; any questions, concerns, resource needs, actionable recommendations that we can incorporate into our current work plan activities or approaches to begin to evaluate for our 2016 budget options

b) **May 26 meeting presenters:**

| **May 26, 2015 Meeting** | | |
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| **1. Penny Hannegan** | **Dream Big Project** | **3:30 – 4:30 p.m.** |
| | | |
| **2. Laura Kinder** | **Community work with the Hospitals** | **4:30 – 5:00 p.m.** |
| | | |

| | | |
|---|---|---|
| **3. Simon Smith** | **Medicaid Service Expansion Efforts** | **Tabled until next meeting** |

Frank—Goal of the tasks/projects we are looking at as a Committee: We are really trying to have the committee operationalize some of the projects and requests that come to us—Healthcare system, prevention-based healthcare, early childhood efforts, population-based health outcomes (Public Health), School Districts, etc. When these initiatives are launching, how do we ensure that resources are coordinated and how do we assess the impacts to systems across the spectrum.

Frank and Jeff—Short update on the **Medicaid Service Expansion Efforts** since Simon is unavailable for today's meeting: Tremendous increase in enrollment 52,000 in Medicaid today. This is putting a large strain on the system infrastructure—office space, staffing, etc. Additionally, reimbursement rates are not high enough to cover costs currently—this is an issue that is still being fleshed out at the state level. We are working together to support infrastructure during this interim time by releasing an RFP in June to put some relief into the system. We are looking to this board to help us prioritize the gap and expansion funding needs in this interim space.

**Dream Big Project Overview and discussion**

Penny Hannegan, Betsey Martens, Rene Brodeur, Lori Canova presenters

See copy of Betsey's White Paper on Dream Big as part of a National Research demonstration.

See copy of PowerPoint presentation as well.

- Since the summer of 2014, a group of community stakeholders has been collaborating and meeting with a commitment to improve the educational outcomes for children in the City and eventually the entire County of Boulder.
- We have been engaged in developing a collective impact initiative – referred to as Dream Big.
- Through integrating and expanding services to more low-income/at-risk youth, our long term goal is to eliminate the achievement and opportunity gaps in Boulder County.
- Over the next few months we will continue to engage in a process to create a strong collective impact infrastructure to support this initiative with initial focus in the City of Boulder.
- It is our hope that over time Dream Big will positively affect all low-income and at risk youth and their families throughout Boulder County.

Dream Big Summary

Since July 2014, a group of community stakeholders committed to improving educational outcomes for children in Boulder County has been engaged in developing a collective impact strategic plan – referred to as Dream Big. Through integrating and expanding services to more low-income/at-risk youth in Boulder County our goal is to eliminate the achievement and opportunity gap.

*Phase I*

Arrow Performance Group was hired last September to lead and facilitate Phase 1 of the Dream Big strategic planning process, with funding provided by the Nonprofit Cultivation Center, the "I Have a Dream" Foundation of Boulder County, and Boulder Housing Partners. The community partners who meet regularly as a part of the Dream Big Design Team are:

- Lori Canova (co-chair) and Cathie Williamson, "I Have a Dream" Foundation of Boulder County ("I Have a Dream")
- Rene Brodeur (co-chair) and Karin Stayton, Boulder Housing Partners (BHP)
- Ron Cabrera, Boulder Valley School District (BVSD) and Fran Ryan, Impact on Education
- Kathryn Coleman, City of Boulder, Children, Youth, and Families Division (including Family Resource Schools, FRS)
- Alison Rhodes, City of Boulder Parks and Recreation Department (including the Youth Services Initiative, YSI)
- Whitney Wilcox, Boulder County Housing and Human Services
- Joe Mendyka and Doug Yeiser, Foothills United Way
- Jane McConnell and Chris Barge, Community Foundation Serving Boulder
- Claudia Sanchez and Ruben Garcia, Dream Big Parent Advisory Committee

The overarching objective of Dream Big is to increase Boulder's collective commitment to eliminate the opportunity and achievement gaps so that by 2040, all children in Boulder County are succeeding academically and reaching their full potential. Dream Big seeks to:

- Expand the successful "I Have a Dream" model, which includes having a Program Director follow and work with a cohort of students as they travel through their educational journey from elementary school through college and career;
- Develop a tight collaboration with BVSD to align and address all out-of-school and in-school factors for every low-income student and create a network of elementary, middle and high schools in the feeder school system;
- Facilitate deep and broad integrated services among the City of Boulder, Boulder County, "I Have a Dream," BVSD, BHP, and other non-profit and social service agencies to ensure wraparound service provision;
- Engage children and families earlier by providing programming and support to parents with children ages 0-5, recognizing that parents are their child's first teachers, and empowering them as prime partners in their child's education and ensuring that all younger children are enrolled in a preschool or early childhood education program.

*Deliverables and Accomplishments:*

We have completed Phase 1 of the 18 week Dream Big Collective Impact Conceptual Design Project. We held five strategy sessions facilitated by the Arrow Performance Group Consultants to produce the following deliverables:

- Identified membership for a leadership team and developed an accountability structure.
- Applied for the Strive Together Cradle to Career Network as an Exploring Community and participated in monthly webinars and conference calls.
- Outlined a preliminary problem statement, common agenda, vision, mission, goals and objectives for the Dream Big Collective Impact Project.
- Started initial work to develop shared measures and benchmarks.
- Drafted key messages to effectively communicate the work of the Dream Big Collective Impact Project to internal and external audiences.

- Applied for and received a Colorado Opportunities Scholarship Initiative Grant to pilot the pre-collegiate program.
- Started the discussion and feasibility of a sustainability plan and outlined key roles needed to accomplish this work.

*Dream Big Pilots*

As the Dream Big strategic planning process continues there are two pilot projects underway. The upcoming work of these two pilot groups, including creating a shared agenda, mutually reinforcing activities, a process for continuous communication, and shared measurement, will continue to inform the Dream Big Design Team as it seeks to align community partners, transform current practices, and expand programming to reach more children – cradle to career.

*Pilot #1: Oak Class* - The February 2015 launch of the "I Have a Dream" Oak Class provides an opportunity to implement new practices in collaboration and service delivery. The Oak Class will include 2nd and 3rd graders from north-central BHP housing sites as well as other 2nd grade low-income children who attend Columbine Elementary – a total of 80 students, which is 60% more than previous Dreamer Classes, due to this Dream Big Collective Impact Project. Many of these families are currently being served by FRS, YSI, and BHP, and the opportunity for children to become Dreamers will greatly increase their academic success, giving them the greatest chance to break the cycle of poverty. Initial meetings with partners in the Dream Big Oak Pilot have shown the potential for shifting current practices to be able to:

- serve more children in "I Have a Dream" by redefining roles and responsibilities of current staff from the participating organizations;
- align "I Have a Dream," FRS, YSI, and other after-school programming goals and schedules to reduce duplication and maximize student participation;
- reach more families earlier with an emphasis on early intervention and prevention;
- serve families more effectively by increasing collaboration, communication, and the use of shared measurement tools.

*Pilot #2: Pathways to College and Career* – This pilot, which will launch in February 2015, will create a college and career pipeline for 360 middle and high school aged low-income youth who have demographic or economic factors that indicate susceptibility towards succumbing to the achievement gap. The "I Have a Dream" Foundation of Boulder County, Boulder Housing Partners, Boulder Valley School District, Front Range Community College, the University of Colorado at Boulder, Workforce Boulder County and Boulder Rotary will work together to support these students on the path to and through college and into the workforce.

The goal is to ensure that more and more students in BHP and Boulder County will have the opportunity to graduate from high school, attend college, graduate with minimal debt, and continue on to gainful employment, addressing workforce readiness, the degree attainment gap, and affordability issues that put a college degree out of reach.

*Phase II*

During Phase II (over the next 9-12 months), community partners will continue to engage in a process to create a strong infrastructure that will ensure low-income children, youth, and families are getting the education programming and supportive services they need. Some of the deliverables will include:

- Identify a backbone structure for Dream Big;
- Finalize benchmarks and theory of action;

- Define the continuum of integrated services that will serve families;
- Develop partnership agreements to outline each partner's roles and responsibilities;
- Start to develop funding resources for sustainability;
- Create data-sharing agreements.

In summary, as Dream Big's problem statement reflects, we cannot do it alone: "There exists a seemingly intractable academic achievement and opportunity gap for low-income, at-risk children in Boulder County that prevents future meaningful employment and successful resiliency as adults. The problem is greater than any one organization can resolve by itself."

****Comments from the Committee on the Dream Big Project****

Laura Kinder: How are you able to follow your dreamers? Lori: Using the Americorps resources to work with students. They start working with students in high school and follow them through college. Goal is to also have graduates come back as mentors for new enrollees into the project.

Dalia Dorta: How do you approach the language gap for some students particularly in early elementary? Additionally, how are the barriers addressed in the School Systems? Lori: we are excited that the school system is at the table so that we can identify the barriers and how do we address them at the systemic level. Beginning those conversations now. Also focusing on recruiting bilingual staff and partners.

Bobbie: need for a backbone. Critically important. Need to recognize that this is someone that is an entrusted member of the community but not part of the collaborative. Major function of the backbone is also to bring funding into the collaborative.

Dan: 2040 goal is that 100% of all kids reach academic success and full potential. How is this defined? Lori: individualized for all students—could be college or vocational training.

Betsey: how important is the role of housing. Stable, well-located, healthy housing is a foundation piece to achieving goals and self-sufficiency. Lens could be: what if the housing is the quarterback? Focus of her research. We have an intimate relationship with families that are in our housing.

Birth and 18 years of age, schools have contact with kids 9% of the time (low amount of touches). I have a dream takes it to 16%. When housing sits at the table, and reinforces that education is a goal, then what have we have touch kids much more often.

Jeff: when you think about the criteria for kids before pre-school, what percentage come through housing. Betsey: about 1 in 4 kids come through housing. Leading to charge that it is a universal, capitated system (voucher system).

Bobbie: military system and families have pretty strong outcomes. Have wrap-around services (folks move a lot). Institutionalized mobility. Housing supports could play this same wrap-around role.

Penny: United Way is moving toward a collective impact type of model. They are therefore interested in the Dream Big Initiative.

Frank: Some things to consider—how do you determine the targeting of the resources across systems? The core of what you are saying is an issue that we are grappling with safety net wide. Families are

touching the safety net in multiple systems. From the cradle to college, what are the appropriate amount of resources—appropriate amount of business scaling. More of a concentric circle model for how you support families and kids?

**Laura Kinder: Community work with the Hospitals**

(need to get documents from Laura)

Jeff—Boulder County Health Improvement Collaborative (BCHIC) strategic focus is on how to get better access to specialty care for lower income families and individuals.

Jeff—Longmont Community of Health Network—trying to keep folks out of the hospitals/emergency rooms—medical home (Salud) or in home care is the goal.

Dan—do we have Medicaid intake in LUH? Yes, but not full time DHHS staff for enrollment.

Frank—there are things that the hospitals can do to help us and there are a lot of things that we can to do to help the hospitals. Need to get the right folks in the rooms. Targeted enrollment is key based on data, prepopulated applications—refresh this collaborative approach. How do you get a system that was used to working with uninsured populations to shifting the system to more preventative services—medical home and in home care. Education as well (not coming in for an ear ache for example).

**Next Steps for the Committee regarding the activities:**

Frank—map out the Committee's work plan over the next 18-24 months. Also discuss funding recommendations as a group. Look at the common threads in these projects and pull those. Family preservation model: common assessment and case management tools across systems is key. We're taking people/families/kids that are at risk and finding them a streamlined pathway. What is difficult is who is the quarterback and how to you titrate resources.

Jeff—Committee members can connect with each other on all of the projects. Frank—Follow up conversations are very important. Not sure how to best do that part.

**Matters from the committee members for consideration**

None

**4) June agenda items:**

a) Continued updates on Committee member activities

b) Question and answer session on support activities
   i. Discussion of budgeting, planning, and strategic resources for the next 18 to 24 months.

**5) Next Meeting is Tuesday, June 30, 2015, 3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

**6) 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.

# BoCo DHHS Advisory Council

Bobbie Watson

Executive Director

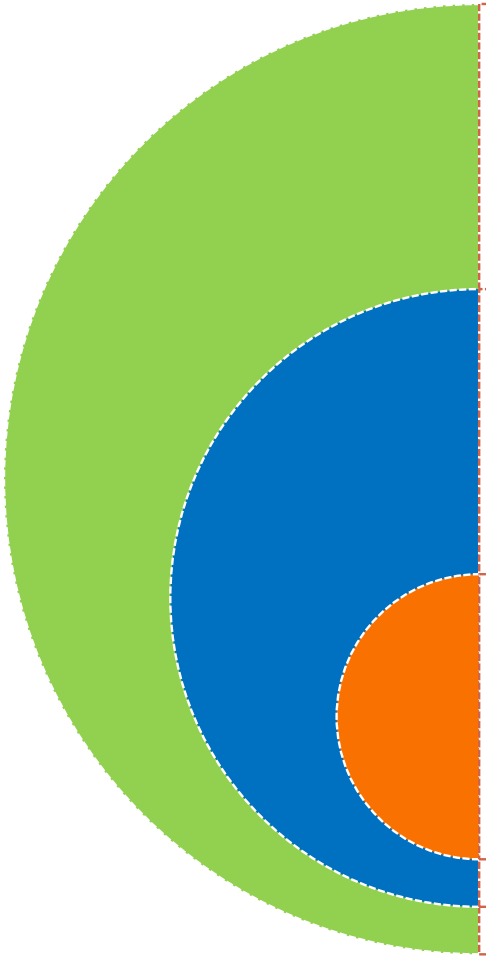
The Early Childhood
Council of Boulder County

# ECCBC Vision and Mission

- Our *Vision* is to ensure that all young children across Boulder County arrive at kindergarten ready to succeed in school and in life

- Our *Mission* is to expand and improve the comprehensive system of quality early childhood services for families in Boulder County

# Council responsibilities



## Impacting Services

- Professional Development
- Childcare quality, affordability and accessibility
- Family support services

## Building Foundations

- Impacting Policies
- Partnerships Developed
- Cross-system alignments
- Align Strategic Priorities

## Creating Internal Capacity

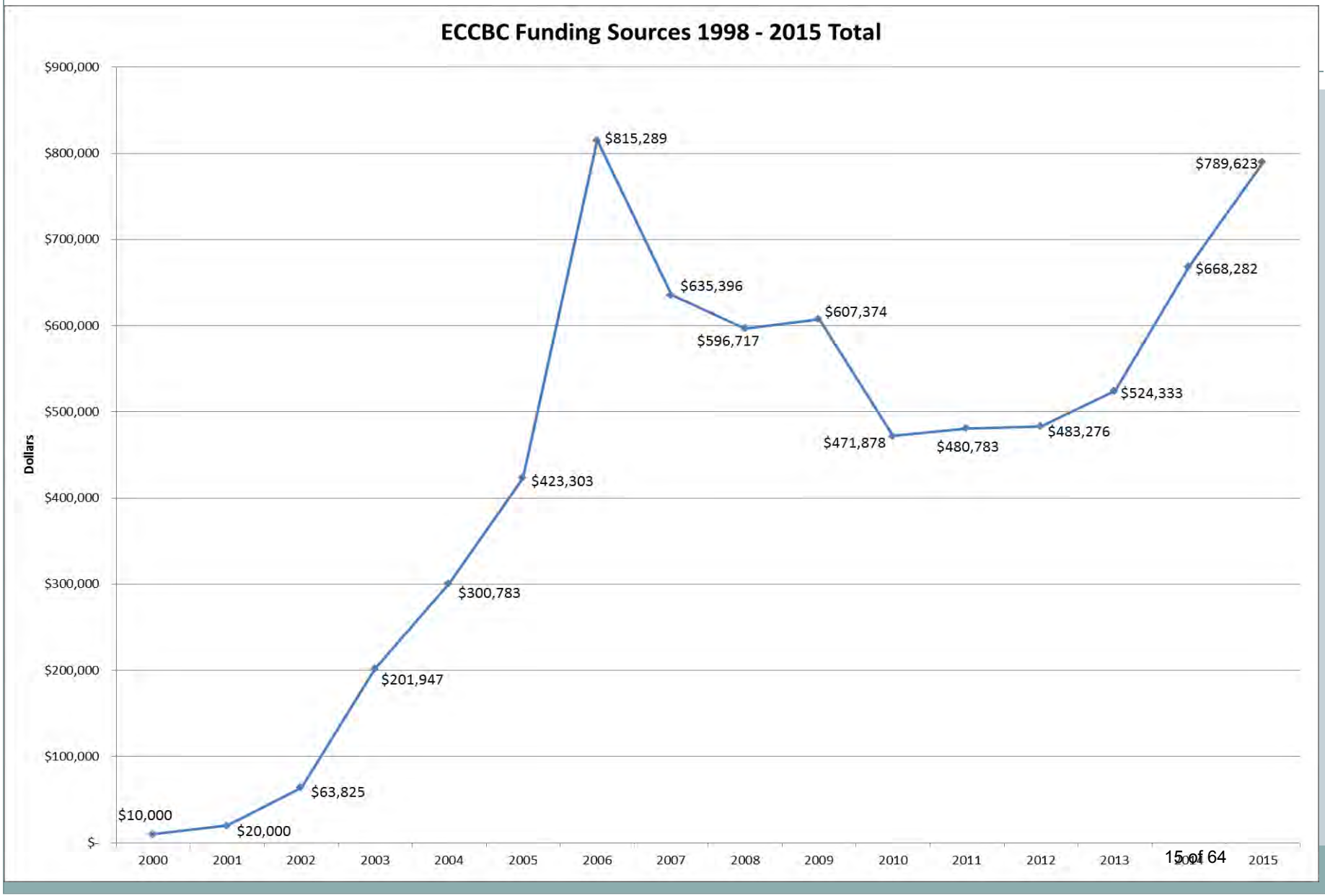
- Staff capacity
- Membership: BOD + AC
- Framework
- Sustainable funding
- Data Collection

# Guiding Principals

## From Neutrons to Neighborhoods, IOM 2000

- Human Development is shaped by dynamic and continuous interaction between biology and experience
- Growth of self-regulation is a cornerstone of EC development that cuts across all domains of behavior
- Children are active participants in their own environment
- Human relationships are the building block of healthy development
- The course of EC development can be altered by effective interventions that change the balance between risk & prevention
- The timing of experiences does matter

# ECCBC Funding History



# ECCBC Program focus

- Early Childhood Collective Impact
  - ECCBC acts as the backbone organization for the EC Collective Impact Collaboration in Boulder County
- Professional Development: *individuals*
  - Monthly PD training Calendar
  - Touchpoints Team
  - EQIT
  - Scholarships
- Quality Improvement: *licensed facilities*
  - Infant Toddler Quality and Availability Program

# Collective Impact

"…..the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem."

John Kania and Mark Kramer

Stanford Innovation Review, 2011

# Collective Impact

"…..committed to a common agenda"

- ECCBC Early Childhood Framework

"…. for solving a specific social problem."

- kindergarten readiness across Boulder County

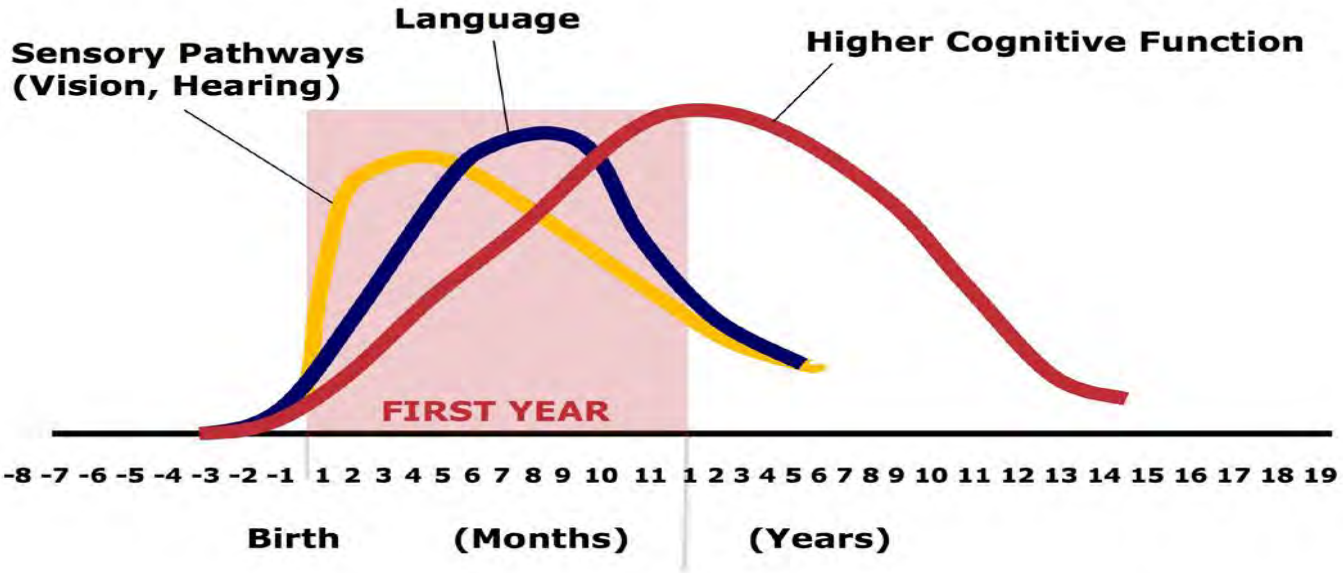
➢ data suggests that at least 1 out of 3 children entering kindergarten are not prepared to learn

# Why we do what we do……..

Center on the Developing Child
HARVARD UNIVERSITY

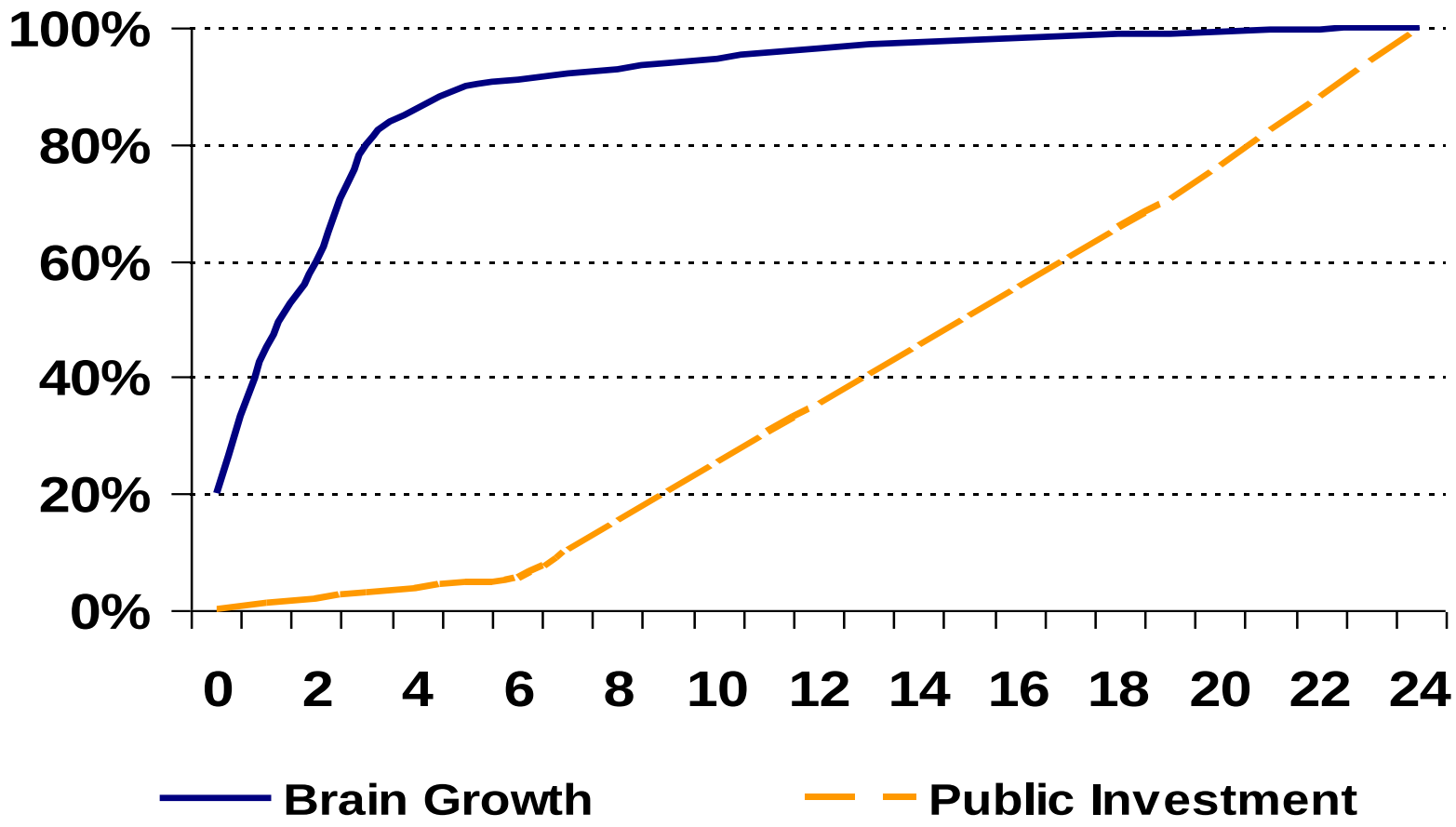
## Human Brain Development

**Neural Connections for Different Functions Develop Sequentially**




Source: C.A. Nelson (2000)

# Brain Growth and Colorado Public Education Investments by Child Age (2012)



# Collective Impact

## *5 critical components*

- Common Agenda (defined by the collective)
- Mutually Reinforcing Activities
- Continuous Communication
- Shared Measurement System
- Backbone Support Organization

# Common Agenda

"All participants have a shared vision for change, including a common understanding of the problem and a joint approach to solving it through agreed upon actions."

Collective Impact Forum Spring 2014

# ECCBC Framework


EARLY CHILDHOOD FRAMEWORK FOR BOULDER COUNTY / FEBRUARY 2014

# Common Agenda

- **READY CHILDREN**: Children arrive ready for school: healthy, well-adjusted, and having been exposed to the fundamentals of learning.

# Common Agenda

- **READY FAMILIES**: Families are empowered to nurture their child's healthy growth and development as their child's first and best teacher.

# Common Agenda

- **READY EARLY CARE and EDUCATION**: Early childhood professionals have the knowledge, skills, and supports to work effectively with and on behalf of children and their families.

# Common Agenda

- **READY COMMUNITY**: The community recognizes the importance of early childhood as integral to the quality of life in Boulder County and as a critical part of the continuum of social equity.

# Mutually Reinforcing Activities

" The power of collective action comes not from the sheer number of participants or the uniformity of their efforts, but from the coordination of their differentiated activities through a mutually reinforcing plan of action."

Collective Impact Forum 2014

# Mutually reinforcing activities

strategies

## EARLY LEARNING

- Advocate at the local, state and federal levels for increased/universal access to high-quality early childhood programs
- Expand publicly funded comprehensive early childhood programs for infants and toddlers
- Promote cultural understanding between early childhood professionals and parents and families
- Explore incentives for early childhood professionals to serve infants and toddlers and children with special needs
- Support the ongoing development and practice of new skills and knowledge such as on-site coaching and mentoring
- Promote increased quality of early childhood professional staff education, program quality and environment quality
- Sustain availability of community resources and support networks for early childhood professionals
- Remove barriers to formal education for the early childhood workforce
- Pursue opportunities for partnerships to make trainings available to more early childhood professionals in Boulder County
- Increase training opportunities and ongoing support for early childhood professionals serving children with special needs
- Convene an early childhood professionals' compensation package taskforce
- Increase outreach and training to unlicensed child care workforce and families

## FAMILY SUPPORT AND EDUCATION

- Expand referrals and consultation for target populations
- Provide information to families to facilitate connection to services and support
- Improve access to adult education and family literacy
- Provide a system-wide approach to measuring and promoting quality that includes and is accessible to low-income families
- Consider incentives for professionals and assistance for families such as differential reimbursement based on quality standards
- Provide parent education, consultations and appropriate referrals aligned with Child Care Aware standards
- Provide wraparound services for part-time programs
- Analyze CCCAP utilization to identify program strengths and barriers and develop appropriate policy recommendations
- Provide subsidy payments that are at least 100% of the average market rate
- Monitor market rates, community trends and CCCAP polices and rates to ensure access for low-income families and capacity of providers to serve them
- Provide easy-to-use developmental tools and information on how to screen and how to obtain assessments and interventions
- Expand system for interagency referrals with multiple means of access to information
- Promote partnerships between a child's parents and early childhood professionals to work with other service providers to meet the child's specific needs
- Provide tools and information to families to strengthen their involvement in their children's lives
- Expand outreach to parents of newborns; home visitations to include all four domains
- Encourage participation in training that strengthens and supports family leadership
- Educate community and legislature regarding factors that promote healthy brain development during the first year of life
- Develop a cost-benefit model to support at-home option for the first year of life

## SOCIAL, EMOTIONAL, AND MENTAL HEALTH

- Broaden implementation of prevention-based programs promoting healthy development that are delivered in early childhood programs
- Increase utilization of standardized assessments for determining social-emotional competency
- Identify, assess and address intensive family concerns, including familial and community trauma
- Expand family support and parenting programs to include services in the social-emotional and mental health domain
- Increase the number of mental health professionals with specific training in early childhood mental health who accept Medicaid, CHP+ or other insurance
- Educate early childhood professionals about mental health resources available to children and families
- Increase the availability and usage of tools that measure nurturing interactions in classrooms
- Train program administrators about workplace environments that foster professional relationships for the benefit of young children's social-emotional health
- Promote specialized coursework for early childhood professionals focused on promotion, prevention and intervention within the social-emotional domain
- Make the continuum of support available to early childhood professionals (spanning brief consultation, on-site consultation, mentoring and coaching)
- Educate the public about the social-emotional needs and potential of young children

## HEALTH

- Implement the Assuring Better Child Health and Development (ABCD) Project
- Increase access to hearing, vision, developmental and dental screenings and treatment
- Improve and expand health education to all parents, including fathers
- Promote preventive and comprehensive medical and dental care for all children
- Support community efforts to enroll and renew children in Medicaid, CHP+ or other insurance programs
- Partner with state-level organizations to implement policies that increase Medicaid reimbursement rates and decrease administrative burdens
- Promote and support use of standards for a Medical Home approach
- Support Boulder County efforts to increase immunization rates
- Educate early childhood professionals to promote health for staff and families
- Expand and increase public awareness of public health and community programs
- Increase public awareness of the importance of healthy behaviors before conception and prenatally

# Continuous Communication

- ECCBC  Advisory Council
- Boulder County Public Health Improvement
- BoCo DHHS Advisory Council
- SVVSD Early Childhood Council:  CPP
- BVSD  Early Childhood Council: CPP
- State Early Childhood Partnership
- Early Childhood Legislative Summit
- Front Range Community College Advisory

# Continuous Communication

- School Readiness Quality Improvement Partnership
- The Wild Plum Board of Directors
- ABCD Task Force
- AAE Association of Agency Executives
- Human Services Alliance
- Professional Development Committee
- Infant Toddler Quality and Availability Work Group

# Shared Measurement System

"Agreement on a common agenda is illusory without agreement on the ways success will be measured and reported."

Collective Impact Forum 2014

# Success Indicators

indicators

## EARLY LEARNING

- Number and type of licensed early childhood programs
- Percentage of rated/accredited early childhood programs
- Number of licensed early childhood programs for infants, toddlers, and preschoolers accepting subsidies, by funding stream
- Percentage of licensed early childhood program participants achieving kindergarten school readiness
- Percentage of third graders achieving proficiency on state-mandated standardized tests
- Number and type of Colorado Early Childhood Credentials obtained by early childhood professionals
- Average hourly wage for early childhood professionals

- *Percentage of licensed early childhood programs by QRIS level*
- *Number of fluent and bi-cultural Spanish-speaking early childhood professionals*
- *Number and type of degrees obtained by early childhood professionals*
- *Number of early childhood professionals with training and/or experience serving children with special needs*

## FAMILY SUPPORT AND EDUCATION

- Number of families receiving Child Care Resource and Referral Services (i.e., homeless, non-English speaking, special needs and challenging behaviors)
- Average weekly price of care (center and family child care home) for infants, toddlers and preschoolers
- Comparison of CCCAP and market reimbursement rates and CCCAP eligibility levels
- Number of public dollars spent to subsidize early childhood programs, by funding stream
- Number of public dollars spent to subsidize early childhood programs serving children with special needs
- Number of children eligible but not enrolled in public subsidy programs
- TANF, WIC and affordable housing rates
- Number of children (with suspected disabilities) referred, screened, evaluated and recommended for treatment by community-based agencies
- Number of parents completing family advocacy or leadership programs

- *Number of parents attending English language classes*
- *Number of children with social-emotional difficulties, referred, screened, evaluated and recommended for treatment by community-based agencies*
- *Number of families receiving education regarding child development and early care and education*
- *Number of opportunities for parent education and support for families in Boulder County*
- *Number of families benefitting from support with parenting a child through the first year of life*

## SOCIAL, EMOTIONAL AND MENTAL HEALTH

- Child maltreatment rates
- Out-of-home placement rates
- Number of allied professionals (home visitors, mental health providers, nurses, human services) with Infant Mental Health Endorsement
- Number of mental health professionals accepting Medicaid, CHP+ or other insurance
- Preschool expulsions and challenging behavior rates
- Number of early childhood professionals with Colorado Department of Education Social Emotional Credential or the Infant Mental Health Endorsement

- *Percentage of children screened for social-emotional developmental milestones*
- *Percentage of children meeting developmental milestones in the social-emotional domain*
- *Percentage of families with young children receiving services for social-emotional or mental health concerns*
- *Percentage of children with emotional, developmental or behavior problems needing treatment or counseling, according to parent report*
- *Rates of maternal depression*
- *Rates of parents experiencing mental health issues*
- *Number of classrooms meeting minimum standards on accepted tools, including tracking of environments, interactions and relationships that support children's social-emotional well-being*
- *Percentage of early childhood professionals with training in social-emotional development*
- *Percentage of early childhood professionals with training in responding to children with challenging behaviors*

## HEALTH

- Number of children eligible, but not enrolled in WIC
- Percentage of children enrolled in WIC with iron deficiency anemia
- Percentages of children who are overweight and obese
- Number of children eligible for but not enrolled in Medicaid, CHP+ or other insurance
- Number of providers (doctors and dentists) who accept Medicaid and CHP+
- Percentage of pregnancies that are unintended
- Percentage of women receiving early prenatal care
- Percentages of babies born with low birth weight and very low birth weight
- Percentages of children ever breastfed and those breastfed at six months

- *Number of children receiving health and developmental evaluations and treatment*
- *Percentage of children with untreated tooth decay*
- *Percentage of third graders who have dental sealants in place*
- *Percentage of children having a dental visit by age one*
- *Percentage of children receiving fluoride varnishes at least two times per year*
- *Number of children undergoing major dental surgery at Children's Hospital due to decay*
- *Percentage of families with children from birth through age five years reporting food insecurity*
- *Number of uninsured children not eligible for publicly funded health/dental insurance*
- *Percentage of children receiving a Medical Home approach*
- *Immunization rates*
- *Number of early childhood programs receiving 5210 recognition*
- *Number of early childhood programs serving infants certified as Breast-Feeding Friendly*

**Note**: Indicators in italics are *emerging*, meaning they have been deemed important but are not currently being measured.

# Shared Measurement System

- ECCBC Indicators Report to the Community
- Indicators *developed by the collaboration*
- 2009, 2010, 2011, 2013
- www.eccbouldercounty.org

# Backbone Organization

- Dedicated staff
- Independent of member organizations
- Highly structured process
- Adaptive leadership
  - Focus on common agenda
    - Create sense of urgency
  - Frame issues as opportunities

# ECCBC Role in the Community

- Act as the Backbone for the Collective Impact
- Funding Strategies
- Impact policy
- Build public awareness
- Accountability
- Improve quality

# Alignment with Boulder County ***Strategic Priorities***

*Prevention and early intervention are key*

- ***Community Integration***

  *ECCBC Early Childhood Framework*

  *Safety Net Advocacy*

  *Working across the 4 domains of early childhood*

- ***Building the pillars to self-sufficiency***

  *increase access to high quality childcare*

  *increase quality of childcare services*

- ***Revolutionizing DHHS workforce/infrastructure***

  *integrate ECCBC quality & access work with DHHS goals*

# Alignment with Boulder County

*Shared goals:*

- strengthen community safety net
- create/implement a robust early childhood plan
- improve access to high quality, affordable childcare
- boost educational/employment development

# Strategies which align with DHHS

*Shared outcomes*:

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

# Alignment with BoCo Public Health

*Prevention and early intervention are key*

## Health Equity:

- Develop/enhance prevention & intervention that support child development
- Enhance & increase protective factors for children and families

## Health Promotion:

- Focus health promotion efforts on improving healthy eating, active living
- Improve access to mental health services for children and families

# Alignment with BoCo Public Health

*Prevention and early intervention are key*

- Focus on lifelong health impacts of early childhood experiences
- Critical importance of breastfeeding and HEAL
- Continuous surveillance of physical, fine motor and emotional development
- Early referral to appropriate intervention, referral and follow up
- Access to medical and dental home
- Continued emphasis on social/emotional development
- Continued emphasis on maternal depression
- Expand home visitation to at risk families

# Strategy alignment with BoCo Public Health

- Improved overall health status for children: oral, visual, auditory, developmental, weight, and children with special needs
- Consistent access to medical and dental homes
- Increased % infants breastfed for 6 months
- Work with Early Intervention to ensure that all children receive timely developmental screenings with appropriate evaluation, referral and treatment

# Alignment with FRC

*Prevention and early intervention are key*

- Primary responsibility for the development and well-being of children lies within the family
- Child rearing patterns are influenced by parents' understanding of child development
- Collaboratively involved in issues impacting family stability and self-sufficiency
- Access to high quality childcare
- Work jointly with parenting programs, home visiting programs and parent support groups

# Aligned strategies with FRC

- Improved access to family and community services
- Increased % of eligible families using subsidies to access childcare, housing, transportation and other basic needs
- Increased use of community navigators
- Increased family advocacy at the program, community and policy levels
- Improved parenting skills

# A Parent's Role:

**Parents are a child's <u>first</u> and <u>best</u> teacher.**


**Early Care and Education programs and services exist to *<u>assist</u>* parents in this critical work.**

# ECCBC Strategic Priorities

- the **birth through three year** old population
- the **at-risk population** of young children
- programs that provide **parent support/education**
- increasing access to **high quality childcare**

# *BHAG* (Big Hairy Audacious Goal)

## Recommendations for DHHS staff support & funding

1. Continued support for Early Childhood Collective Impact
2. Pilot CCAP program which ties enhanced reimbursement to staff career ladder to improve staff recruitment/retention
3. Pilot for contracting for CCAP slots
4. Pay for Success : expansion of CIP
5. Support the Lafayette Community School
6. Funding for ECE needs assessment + supply/demand model
7. Long term support for Quality Improvement Initiatives

# Strategies which align with DHHS

*Shared outcomes*:

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

# A Thought for the Day

"What the best and wisest parent wants for his own child, that must be what the community wants for all its children."

- John Dewey (1859-1952)
US Educator, Philosopher and Psychologist

# Early Childhood Framework

# Boulder County

**A COLLECTIVE VISION ON BEHALF OF BOULDER COUNTY'S YOUNG CHILDREN AND THEIR FAMILIES**

**KEY LEADERS FROM THE FOLLOWING EARLY CHILDHOOD GROUPS CREATED, REVIEWED AND SUPPORTED THE EARLY CHILDHOOD FRAMEWORK FOR BOULDER COUNTY:**

The Acorn School for Early Childhood Development
Boulder County Department of Community Services
Boulder County Department of Housing and Human Services
Boulder County Head Start
Boulder County Movement for Children
Boulder County Public Health
Boulder Day Nursery Association
Boulder Institute for Psychotherapy and Research
Boulder Journey School
Boulder Valley School District
City of Boulder, Department of Human Services, Children, Youth and Families
City of Lafayette
City of Longmont—Bright Eyes Coalition
The Peoples' Clinic
Colorado Department of Education
Colorado Department of Human Services
Colorado Office of Early Childhood
Congregation Har HaShem
Foothills United Way
Front Range Community College
Imagine!
Mental Health Partners
Play Therapy Institute
Representatives of parents with children under age five years
Rose Community Foundation
Sister Carmen Community Center
St. Vrain Valley School District
Temple Hoyne Buell Foundation
TLC Learning Center
University of Colorado Boulder
Wild Plum Center for Young Children and Families
Wilderness Place Partnership
Wolf Family Foundation

**For more information contact**
**www.eccbouldercounty.org**

**Early Childhood Council of Boulder County**
1285 Cimarron Drive, Suite 201, Lafayette, CO 80026
Council Staff: Bobbie Watson-Executive Director, Danielle Butler-Programs Director.

Printed on 100% recycled paper.

*This version is adapted from the Early Childhood Colorado Framework*

## GOALS

### READY COMMUNITY

The community recognizes the importance of early childhood as integral to the quality of life in Boulder County and as a critical part of the continuum of social equity. The community implements policies that support all families with young children throughout the county.

### READY EARLY CARE AND EDUCATION

Early childhood professionals have the knowledge, skills and support to work effectively with and on behalf of families and children.

### READY FAMILIES

Families are empowered to nurture their children's healthy growth and development as their children's first and best teachers. Families have access to programs and services to support their children's development and can advocate effectively for their children.

### READY CHILDREN

Children arrive ready for school: healthy, well adjusted and having been exposed to the fundamentals of learning.

## outcomes

### EARLY LEARNING

- Increased capacity and number of high-quality early childhood programs for infants, toddlers and preschoolers
- Increased access to high-quality early childhood programs for infants, toddlers and preschoolers
- Increased percentage of children meeting developmental milestones to demonstrate school readiness
- Decreased gaps in school readiness and academic achievement between populations of children
- Increased percentage of early childhood professionals accessing formal education and professional development opportunities
- Increased compensation packages for early childhood professionals commensurate with experience and education
- Increased services and support for appropriately identified children with special needs

Note: Infants and toddlers are birth through age three years; preschoolers are ages four and five years.

### FAMILY SUPPORT AND EDUCATION

- Improved access to family and community information to support participation in early childhood services
- Increased affordable, high-quality, culturally competent early childhood programs
- Increased percentage of eligible families using financial assistance to access high-quality, culturally competent child care, early childhood programs, housing, transportation and other basic needs
- Increased agency collaboration to provide services for children who are at risk or have special needs
- Increased opportunities for family and community education regarding optimal child development
- Increased family advocacy and leadership at program, community and policy levels
- Public policies developed that would allow a parent to remain home during the child's first year of life

### SOCIAL, EMOTIONAL AND MENTAL HEALTH

- Increased social-emotional competence in young children
- Decreased rate of child maltreatment and need for out-of-home placement
- Increased knowledge and practice of supportive, nurturing behaviors within families
- Increased access to mental health services for all children and families
- Increased nurturing classroom interactions that promote children's healthy social-emotional development
- Increased number of early childhood professionals with training in social-emotional development and possessing the skills and strategies for serving children's social-emotional needs
- Increased community awareness about the importance of healthy social-emotional development and resiliency in children

### HEALTH

- Improved overall health status of children, including: Oral , Visual, Auditory, Developmental, Weight and Children with special needs
- All children covered by consistent health and dental insurance
- Increased percentage of health care providers (primary care physicians, dentists, ophthalmologists, optometrists, other specialists) who accept Medicaid and CHP+
- Increased percentage of children who receive a Medical Home approach (comprehensive, coordinated care)
- Increased percentage of children who are fully immunized
- Early childhood programs increase their support of children's health
- Increased percentage of women who have pregnancies that are intended
- Increased percentage of women giving birth with timely, appropriate prenatal care, including dental care and healthy birth outcomes
- Increased percentage of infants breastfed for at least six months

## ECCBC

| Countywide Convener | Develop Funding Strategies | Impact Policy | Build Public Awareness | Promote Accountability | Improve Quality |
|---|---|---|---|---|---|

## THIS WORK IS GUIDED BY THE FOLLOWING PRINCIPLES:

- **Comprehensive and Inclusive** in its design to meet the needs of all children and families.
- **Family and child-centered** in a way that values the uniqueness of each child and each family, builds on family strengths and is responsive to unique needs.
- **Focused on prevention** through promotion of physical, social-emotional, cognitive and language development of children; and early identification and intervention services for children with special health care needs, mental health concerns, disabilities, or developmental delays.
- **Affordable, accessible and available** to ensure that parents have choices in utilizing high quality, culturally competent services for their children.
- **Coordinated and Integrated** to promote seamless and flexible service delivery, prevent gaps and duplication, maximize resources and leverage the strengths of the existing system.
- **Accountable** to the community and funders through monitoring of outcomes and indicators and a commitment to continuous quality improvement.
- **Sustainable** through stable funding mechanisms, governance and infrastructure for services.

# Strategies

## EARLY LEARNING

- Advocate at the local, state and federal levels for increased/universal access to high-quality early childhood programs
- Expand publicly funded comprehensive early childhood programs for infants and toddlers
- Promote cultural understanding between early childhood professionals and parents and families
- Explore incentives for early childhood professionals to serve infants and toddlers and children with special needs
- Support the ongoing development and practice of new skills and knowledge such as on-site coaching and mentoring
- Promote increased quality of early childhood professional staff education, program quality and environment quality
- Sustain availability of community resources and support networks for early childhood professionals
- Remove barriers to formal education for the early childhood workforce
- Pursue opportunities for partnerships to make trainings available to more early childhood professionals in Boulder County
- Increase training opportunities and ongoing support for early childhood professionals serving children with special needs
- Convene an early childhood professionals' compensation package taskforce
- Increase outreach and training to unlicensed child care workforce and families

## FAMILY SUPPORT AND EDUCATION

- Expand referrals and consultation for target populations
- Provide information to families to facilitate connection to services and support
- Improve access to adult education and family literacy
- Provide a system-wide approach to measuring and promoting quality that includes and is accessible to low-income families
- Consider incentives for professionals and assistance for families such as differential reimbursement based on quality standards
- Provide parent education, consultations and appropriate referrals aligned with Child Care Aware standards
- Provide wraparound services for part-time programs
- Analyze CCCAP utilization to identify program strengths and barriers and develop appropriate policy recommendations
- Provide subsidy payments that are at least 100% of the average market rate
- Monitor market rates, community trends and CCCAP polices and rates to ensure access for low-income families and capacity of providers to serve them
- Provide easy-to-use developmental tools and information on how to screen and how to obtain assessments and interventions
- Expand system for interagency referrals with multiple means of access to information
- Promote partnerships between a child's parents and early childhood professionals to work with other service providers to meet the child's specific needs
- Provide tools and information to families to strengthen their involvement in their children's lives
- Expand outreach to parents of newborns; home visitations to include all four domains
- Encourage participation in training that strengthens and supports family leadership
- Educate community and legislature regarding factors that promote healthy brain development during the first year of life
- Develop a cost-benefit model to support at-home option for the first year of life

## SOCIAL, EMOTIONAL, AND MENTAL HEALTH

- Broaden implementation of prevention-based programs promoting healthy development that are delivered in early childhood programs
- Increase utilization of standardized assessments for determining social-emotional competency
- Identify, assess and address intensive family concerns, including familial and community trauma
- Expand family support and parenting programs to include services in the social-emotional and mental health domain
- Increase the number of mental health professionals with specific training in early childhood mental health who accept Medicaid, CHP+ or other insurance
- Educate early childhood professionals about mental health resources available to children and families
- Increase the availability and usage of tools that measure nurturing interactions in classrooms
- Train program administrators about workplace environments that foster professional relationships for the benefit of young children's social-emotional health
- Promote specialized coursework for early childhood professionals focused on promotion, prevention and intervention within the social-emotional domain
- Make the continuum of support available to early childhood professionals (spanning brief consultation, on-site consultation, mentoring and coaching)
- Educate the public about the social-emotional needs and potential of young children

## HEALTH

- Implement the Assuring Better Child Health and Development (ABCD) Project
- Increase access to hearing, vision, developmental and dental screenings and treatment
- Improve and expand health education to all parents, including fathers
- Promote preventive and comprehensive medical and dental care for all children
- Support community efforts to enroll and renew children in Medicaid, CHP+ or other insurance programs
- Partner with state-level organizations to implement policies that increase Medicaid reimbursement rates and decrease administrative burdens
- Promote and support use of standards for a Medical Home approach
- Support Boulder County efforts to increase immunization rates
- Educate early childhood professionals to promote health for staff and families
- Expand and increase public awareness of public health and community programs
- Increase public awareness of the importance of healthy behaviors before conception and prenatally

CUT LINE

CUT LINE

# indicators

## EARLY LEARNING

- Number and type of licensed early childhood programs
- Percentage of rated/accredited early childhood programs
- Number of licensed early childhood programs for infants, toddlers, and preschoolers accepting subsidies, by funding stream
- Percentage of licensed early childhood program participants achieving kindergarten school readiness
- Percentage of third graders achieving proficiency on state-mandated standardized tests
- Number and type of Colorado Early Childhood Credentials obtained by early childhood professionals
- Average hourly wage for early childhood professionals

- *Percentage of licensed early childhood programs by QRIS level*
- *Number of fluent and bi-cultural Spanish-speaking early childhood professionals*
- *Number and type of degrees obtained by early childhood professionals*
- *Number of early childhood professionals with training and/or experience serving children with special needs*

## FAMILY SUPPORT AND EDUCATION

- Number of families receiving Child Care Resource and Referral Services (i.e., homeless, non-English speaking, special needs and challenging behaviors)
- Average weekly price of care (center and family child care home) for infants, toddlers and preschoolers
- Comparison of CCCAP and market reimbursement rates and CCCAP eligibility levels
- Number of public dollars spent to subsidize early childhood programs, by funding stream
- Number of public dollars spent to subsidize early childhood programs serving children with special needs
- Number of children eligible but not enrolled in public subsidy programs
- TANF, WIC and affordable housing rates
- Number of children (with suspected disabilities) referred, screened, evaluated and recommended for treatment by community-based agencies
- Number of parents completing family advocacy or leadership programs

- *Number of parents attending English language classes*
- *Number of children with social-emotional difficulties, referred, screened, evaluated and recommended for treatment by community-based agencies*
- *Number of families receiving education regarding child development and early care and education*
- *Number of opportunities for parent education and support for families in Boulder County*
- *Number of families benefitting from support with parenting a child through the first year of life*

## SOCIAL, EMOTIONAL AND MENTAL HEALTH

- Child maltreatment rates
- Out-of-home placement rates
- Number of allied professionals (home visitors, mental health providers, nurses, human services) with Infant Mental Health Endorsement
- Number of mental health professionals accepting Medicaid, CHP+ or other insurance
- Preschool expulsions and challenging behavior rates
- Number of early childhood professionals with Colorado Department of Education Social Emotional Credential or the Infant Mental Health Endorsement

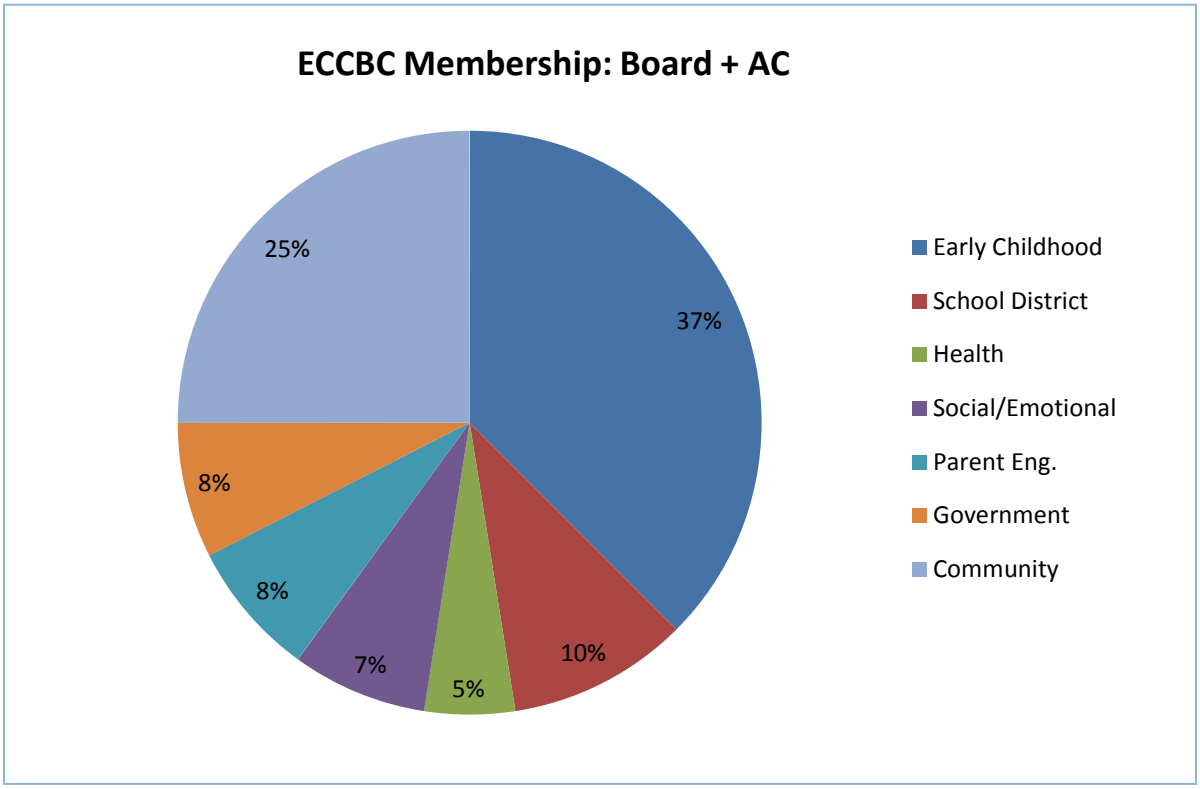
- *Percentage of children screened for social-emotional developmental milestones*
- *Percentage of children meeting developmental milestones in the social-emotional domain*
- *Percentage of families with young children receiving services for social-emotional or mental health concerns*
- *Percentage of children with emotional, developmental or behavior problems needing treatment or counseling, according to parent report*
- *Rates of maternal depression*
- *Rates of parents experiencing mental health issues*
- *Number of classrooms meeting minimum standards on accepted tools, including tracking of environments, interactions and relationships that support children's social-emotional well-being*
- *Percentage of early childhood professionals with training in social-emotional development*
- *Percentage of early childhood professionals with training in responding to children with challenging behaviors*

## HEALTH

- Number of children eligible, but not enrolled in WIC
- Percentage of children enrolled in WIC with iron deficiency anemia
- Percentages of children who are overweight and obese
- Number of children eligible for but not enrolled in Medicaid, CHP+ or other insurance
- Number of providers (doctors and dentists) who accept Medicaid and CHP+
- Percentage of pregnancies that are unintended
- Percentage of women receiving early prenatal care
- Percentages of babies born with low birth weight and very low birth weight
- Percentages of children ever breastfed and those breastfed at six months

- *Number of children receiving health and developmental evaluations and treatment*
- *Percentage of children with untreated tooth decay*
- *Percentage of third graders who have dental sealants in place*
- *Percentage of children having a dental visit by age one*
- *Percentage of children receiving fluoride varnishes at least two times per year*
- *Number of children undergoing major dental surgery at Children's Hospital due to decay*
- *Percentage of families with children from birth through age five years reporting food insecurity*
- *Number of uninsured children not eligible for publicly funded health/dental insurance*
- *Percentage of children receiving a Medical Home approach*
- *Immunization rates*
- *Number of early childhood programs receiving 5210 recognition*
- *Number of early childhood programs serving infants certified as Breast-Feeding Friendly*

**Note**: Indicators in italics are *emerging*, meaning they have been deemed important but are not currently being measured.

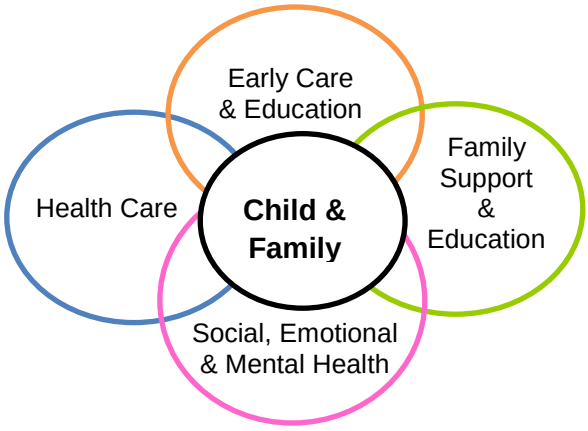



Explanation of Categories:

- Early Childhood: includes Head Start, The Wild Plum Center, CU, Front Range Community College, EC providers, Programs Serving Children with Special Needs,
- School District: BVSD + SVVSD preschool Directors
- Health: BoCo Public Health (Child Health Promotion, Early Intervention), Nurse Family Partnership; pediatrician, Dental Aid
- Social/Emotional: The Mental Health Partners (Kids Connects), Boulder Institute for Psychotherapy and Research (BIPR); The Play Therapy Institute
- Parents: includes Parents of children <5; foster/adopt parents
- Government: City of Boulder, City of Longmont, Boulder County DHHS
- Community: Sister Carmen, United Way, private individuals

Following the Colorado General Assembly's establishment of legislation titled *Consolidated Early Childhood Pilots* in 1996, several communities committed to strengthen local early childhood systems and better serve young children with a primary focus of increased access and availability of childcare for low income families. The Early Care and Education Council of Boulder County (ECECBC) was one of the original pilot communities. Over time, more communities joined this effort, ultimately leading to legislation in 2006 which established the Early Childhood Councils (HB07-1062). Currently there are 30 Early Childhood Councils serving 55 out of 64 Colorado counties. The charge of the Councils is to positively impact services for young children and families by building an effective and responsive local early childhood system. ECECBC changed its name to The Early Childhood Council of Boulder County (ECCBC) and reorganized as a 501c3 in 2009.

Formerly, there was not a coordinated system to ensure that Boulder County's youngest children had access to the quality services and supports needed to be successful in school and life. ECCBC now provides the mechanism for "connecting the dots" between initiatives, programs, services and policies to create a system that is seamless for children and families. Because parents don't typically access just one type of service for their child, coordination is necessary across fields and services. As a result, ECCBC focuses attention across four domains of early childhood: early learning; family support and education; social emotional and mental health; and health.




ECCBC develops the internal capacity to do this work by establishing and maintaining council governance, building a communication mechanism, developing evaluation and assessment tools, engaging in strategic planning and developing sustainable resources. Council members include a broad representation of local community stakeholders, including policy makers, business leaders, early childhood professionals, representatives from both school districts, parent consumers and advocates. ECCBC receives funding from the Federal Child Care and Development Block Grant administered by the State of Colorado through the Office of Early Childhood, the Colorado Department of Human Services as well as the Colorado Department of Education. However, these grants do not fully fund Council work. ECCBC addresses this shortfall by leveraging funds from other sources and fostering local partnerships to support the building of this early childhood system.

The ultimate goal of ECCBC is to improve the quality, access and equity of services across all four domains by building the foundations of a strong system, using the *Early Childhood Framework*

*Boulder County* as a guide. These six foundations are listed below, along with examples of system building strategies adopted by ECCBC.

### County Wide Convener

- Convene Advisory Council and participate in other county wide partnerships
- Facilitate communications and resource leveraging across all 4 domains and county partnering agencies
- Ensure coordination between ECCBC Comprehensive Plan, Human Services Master Plan, and other county wide strategic planning efforts

### Develop Funding Strategies

- Support community efforts to identify, acquire, leverage and maximize resources
- Work with Boulder County to develop and implement a tiered reimbursement system for early childhood programs and services
- Actively research new sources and uses of local, state and federal funding

### Impact Policy

- Convene policy development coalitions to influence early childhood policies
- Participate in county wide policy discussions and forums
- Meet regularly with local and state legislators
- Develop an early childhood policy agenda in collaboration with county wide partners

### Build Public Awareness

- Raise community awareness about the critical importance of early childhood to the quality of life in Boulder County
- Raise awareness in the business community of the importance of early childhood as a business development strategy
- Convene community forums

### Accountability

- Produce annual indicators report
- Identify, collect, and share data on local trends to inform comprehensive childhood plans, programs, and policies
- Provide updated early childhood needs assessment and analysis every 5 years
- Act as Boulder County clearinghouse for early childhood related data and issues

### Improve Quality

- Increase number and scope of school readiness project sites
- Increase professional development opportunities and scholarship funding
- Work with county partners to implement a quality rating system
- Act as program incubator for emerging best practice programs

Building these foundations of a local early childhood system is the key to impacting services for all children. By coordinating and leveraging existing early childhood services across domains, ECCBC does something unique by: reducing duplication in the system, facilitating access to available services, and maximizing the use of a broad array of community resources. These efforts support increased communication and collaboration across the early learning, family support, mental health, and health domains, resulting in increased access, quality and equity of services for all children and families.

# Early Childhood Investments Substantially Boost Adult Health

Frances Campbell,[1] Gabriella Conti,[2] James J. Heckman,[3,4,5]* Seong Hyeok Moon,[3] Rodrigo Pinto,[3] Elizabeth Pungello,[1] Yi Pan[1]

High-quality early childhood programs have been shown to have substantial benefits in reducing crime, raising earnings, and promoting education. Much less is known about their benefits for adult health. We report on the long-term health effects of one of the oldest and most heavily cited early childhood interventions with long-term follow-up evaluated by the method of randomization: the Carolina Abecedarian Project (ABC). Using recently collected biomedical data, we find that disadvantaged children randomly assigned to treatment have significantly lower prevalence of risk factors for cardiovascular and metabolic diseases in their mid-30s. The evidence is especially strong for males. The mean systolic blood pressure among the control males is 143 millimeters of mercury (mm Hg), whereas it is only 126 mm Hg among the treated. One in four males in the control group is affected by metabolic syndrome, whereas none in the treatment group are affected. To reach these conclusions, we address several statistical challenges. We use exact permutation tests to account for small sample sizes and conduct a parallel bootstrap confidence interval analysis to confirm the permutation analysis. We adjust inference to account for the multiple hypotheses tested and for nonrandom attrition. Our evidence shows the potential of early life interventions for preventing disease and promoting health.

Noncommunicable diseases are responsible for roughly two-thirds of worldwide deaths (*1*). Most policies that combat disease currently focus on treatment after disease occurs and on reducing risk factors in adult life. Recent discussions of effective ways of controlling the soaring costs of the U.S. health care system emphasize tertiary prevention—that is, reducing the worsening of the conditions of those already ill [see, e.g., (*2*)] and "bending the cost curve" for such treatments (*2*–*5*).

A complementary approach is to prevent disease or to delay its onset. A large body of evidence shows that adult illnesses are more prevalent and problematic among those who have experienced adverse early life conditions (*6*, *7*). The exact mechanisms through which early life experiences translate into later life health are being actively investigated (*8*, *9*).

This paper shows that high-quality, intensive interventions in the early years can be effective in preventing, or at least delaying, the onset of adult disease. The recent literature establishes that interventions that enrich the environments of disadvantaged children have substantial impacts on a variety of outcomes throughout their lives [see, e.g., (*10*–*12*)]. However, little is known about their benefits on health [see, e.g., (*13*)].

We study the long-term health effects of one of the oldest and most cited early childhood programs: the Carolina Abecedarian Project (ABC). ABC was designed as a social experiment to investigate whether a stimulating early childhood environment could prevent the development of mild mental retardation in disadvantaged children. The study was conducted on four cohorts of disadvantaged children born between 1972 and 1977 who were living in or near Chapel Hill, North Carolina. The base sample included 109 families (111 children). Of these 111 children, 57 were assigned to treatment status and 54 were assigned to control status. The intervention consisted of a two-stage treatment targeted to different segments of child life cycles: an early childhood stage (from birth through age 5) and a subsequent school-age stage (from age 6 through 8). The first stage of the intervention involved periods of cognitive and social stimulation interspersed with caregiving and supervised play throughout a full 8-hour day for the first 5 years. The stimulation component was based on a curriculum that emphasized development of language, emotional regulation, and cognitive skills (*14*, *15*). The second stage of the intervention focused on improving early math and reading skills through having "home-school resource teachers" customize learning activities based on materials being covered at school and then deliver these materials to the parents to use at home. The treatment and control groups from the first stage were randomly assigned to treatment and control groups in the second stage. We analyzed data on treatment and control groups created by the first-stage randomization. We found no evidence of any treatment effect on adult health from the second-stage randomization. The treatment effects are much smaller in magnitude than those estimated for the first-stage treatment and fail to achieve statistical significance at conventional levels. See the supplementary materials, section F, for evidence on this issue. References (*16*–*18*) show that for most outcomes the early educational intervention had much stronger effects than the school-age treatment. Additionally, previous work has also shown no health effects from a school-age (as compared with a preschool) educational intervention (*19*). The available evidence on interventions to prevent obesity points to the years 0 through 5 as a critical period (as compared with after 5 years) [see, e.g., (*20*–*22*)].

The ABC intervention also had a nutritional and health care component during the first stage. Treated children had two meals and a snack at the childcare center. They were offered primary pediatric care (both well- and ill-child care), with periodic check-ups and daily screening. More details on the intervention are given in the supplementary materials, section A.

## Data

Data were collected on both treated and control cases from the beginning of their participation in the study, using surveys administered to children, parents, and teachers, as well as direct assessments. Before the intervention started, baseline information was gathered on parental characteristics, family structure, socioeconomic status, and birth circumstances. For both treated and control cases, data on cognition, personality, health, achievement, and behavior were then collected at multiple stages from birth until the end of school-age treatment. At the end of the second stage of treatment, participants were followed up at ages 12, 15, 21, 30, and in the mid-30s. Details on the outcomes and covariates used in this analysis are provided in the supplementary materials, section B.

A biomedical survey of cardiovascular and metabolic risk factors was conducted when participants were in their mid-30s. Information on biomeasures was collected from two sources. The first source was a physical exam carried out by a local physician in the Chapel Hill Internal Medicine practice, in which the same doctor (blind to treatment status) examined all subjects. In this exam, measurements were collected on weight (pounds), height (inches), waist (inches), hips (inches), and systolic and diastolic blood pressure (bp). The physician also checked the status of several body systems. The physician carried out a complete physical exam and checked whether there was abnormality in relation to the following systems: skin, HEENT (head, ear, eye, nose, and throat), neck, chest, lung, breast, cardiovascular, abdomen, neurologic, muscle strength and tone, musculoskeletal, and lymphatic. The second source was laboratory tests, based on nonfasting venous blood collected from the subjects during the medical visit (the phlebotomist was blind to treatment status, and the blood samples were sent out to another facility for analysis and report preparation).

Several issues arise in evaluating the health effects of the ABC intervention. First, the sample size is small. Conventional testing approaches that rely on large-sample properties of test statistics

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may be inappropriate. To surmount this problem, we use exact (small-sample) block permutation tests. We show in tables S25 and S26 that when we use bootstrap methods that have a large sample justification, we obtain the same inference about treatment effects. Bootstrapping has the additional benefit of producing confidence intervals to gauge the uncertainty inherent in our estimates.

Second, numerous treatment effects are analyzed. This creates an opportunity for "cherry picking"—finding spurious treatment effects merely by chance if conventional one-hypothesis-at-a-time approaches to testing are used. We account for the multiplicity of the hypotheses being tested using recently developed stepdown procedures (*23*).

Third, information is missing due to nonrandom attrition from the survey, potentially undermining the validity of inference. We investigate the causes of missing information and correct for potential bias using inverse probability weighting (IPW) (*24*, *25*). More information on the methodology and a detailed analysis of the attrition patterns is presented in the supplementary materials, sections C, D, and H.

## Results

### *Physical Health*

Estimated treatment effects and associated test statistics are given in Tables 1 (males) and 2 (females). Throughout the paper, we report one-sided single-hypothesis block permutation *P* values associated with the IPW treatment effect estimates; multiple hypothesis stepdown *P* values are reported in Tables 1 and 2. We first report the experimental results on the biomarkers of cardiovascular functioning. On average, treated males have lower values of both systolic and diastolic bp. This difference amounts to 13.5 mm Hg for diastolic bp ($P = 0.024$) and 17.5 mm Hg for systolic bp ($P = 0.018$). Treated females are less likely to be prehypertensive. The prevalence of prehypertension (systolic bp ≥ 120 or diastolic bp ≥ 80) (*26*) is 0.909 in the control group and 0.667 in the treatment group, and the difference is statistically significant ($P = 0.042$). Using two different definitions of hypertension [systolic bp ≥ 140 and diastolic bp ≥ 90 (*27*) and systolic bp ≥ 140 or diastolic bp ≥ 90 (*26*)], treated males are less likely to fall into the stage 1 hypertension category (a prevalence of only 0.105 or 0.211) as compared with a much higher prevalence observed in the control group (0.444 and 0.556). Both treatment effects are statistically significant ($P = 0.010$ and $P = 0.038$) (*28*).

**Table 1. ABC intervention, males: main health results, biomedical sweep.** This table presents the inference and descriptive statistics of selected outcomes of the ABC intervention. The first column describes the outcome analyzed. The remaining six columns present the statistical analysis. The columns present the following information: (i) Control mean. (ii) Treatment mean. (iii) Unconditional difference in means across treatment and control groups. We multiply the difference in means by (−1) when a higher value of the variable in the raw data represents a worse outcome so that all outcomes are normalized in a favorable direction (but are not restricted to be positive). (iv) Conditional treatment effect controlling for cohort, number of siblings, mother's IQ, and high-risk index at birth, and accounting for attrition using IPW. Probabilities of IPW are estimated using the following variables: prematurity (gestational age < 37 weeks), a dichotomous indicator for not having an exam for illness or injury in the past 2 years at age 30, Achenbach DSM attention-deficit/hyperactivity (AD/H) problems scale at age 30, and Achenbach substance abuse scale at age 30. The selection of covariates for IPW is based on the lowest Akaike Information Criteria (AIC) among models examining all combinations of covariates that present statistically significant imbalance between attriters and nonattriters. See supplementary materials section C and table S1 for details. (v) One-sided single-hypothesis block permutation *P* value associated with the IPW treatment effect estimate. By block permutation, we mean that permutations are done within strata defined by the preprogram variables used in the randomization protocol: cohort, gender, number of siblings, mother's IQ, and high-risk index. (vi) Multiple hypothesis stepdown *P* values associated with (v). The multiple hypothesis testing is applied to blocks of outcomes. Blocks of variables that are tested jointly using the stepdown algorithm are delineated by horizontal lines. *P* values ≤ 0.10 are in bold type. HbA1C, glycosylated hemoglobin; NCEP, National Cholesterol Education Program. See table S11 for complete estimation results.

| Variable | Control mean | Treatment mean | Difference in means | Conditional treatment effect | Block *P* value | Stepdown *P* value |
|---|---|---|---|---|---|---|
| | | | *Blood pressure* | | | |
| Diastolic blood pressure (mm Hg) | 92.000 | 78.526 | 13.474 | 19.220 | **0.024** | **0.024** |
| Systolic blood pressure (mm Hg) | 143.333 | 125.789 | 17.544 | 24.828 | **0.018** | **0.029** |
| Prehypertension (systolic bp ≥ 120 and diastolic bp ≥ 80) | 0.667 | 0.421 | 0.246 | 0.321 | 0.119 | 0.172 |
| Prehypertension (systolic bp ≥ 120 or diastolic bp ≥ 80) | 0.778 | 0.684 | 0.094 | 0.096 | 0.235 | 0.235 |
| Hypertension (systolic bp ≥ 140 and diastolic bp ≥ 90) | 0.444 | 0.105 | 0.339 | 0.537 | **0.010** | **0.018** |
| Hypertension (systolic bp ≥ 140 or diastolic bp ≥ 90) | 0.556 | 0.211 | 0.345 | 0.404 | **0.038** | **0.038** |
| | | | *Laboratory tests* | | | |
| High-density lipoprotein (HDL) cholesterol (mg/dL) | 42.000 | 53.211 | 11.211 | 11.720 | **0.066** | 0.110 |
| Dyslipidemia (HDL < 40 mg/dL) | 0.417 | 0.106 | 0.311 | 0.255 | 0.179 | 0.179 |
| Prediabetes (HbA1C ≥ 5.7%) | 0.583 | 0.473 | 0.110 | 0.043 | 0.426 | 0.426 |
| Vitamin D deficiency (<20 ng/mL) | 0.750 | 0.368 | 0.382 | 0.435 | **0.021** | **0.021** |
| | | | *Obesity* | | | |
| Overweight (BMI ≥ 25) | 0.750 | 0.722 | 0.028 | 0.190 | 0.239 | 0.239 |
| Obese (BMI ≥ 30) | 0.625 | 0.556 | 0.069 | 0.211 | 0.233 | 0.345 |
| Severely obese (BMI ≥ 35) | 0.375 | 0.111 | 0.264 | 0.404 | 0.115 | 0.232 |
| Waist-hip ratio (WHR) | 0.962 | 0.937 | 0.025 | 0.045 | 0.293 | 0.293 |
| Abdominal obesity (WHR > 0.9) | 0.875 | 0.647 | 0.228 | 0.294 | 0.137 | 0.218 |
| | | | *Multiple risk factors* | | | |
| Obesity and hypertension | 0.500 | 0.111 | 0.389 | 0.529 | **0.016** | **0.016** |
| Severe obesity and hypertension | 0.375 | 0.000 | 0.375 | 0.502 | **0.005** | **0.012** |
| Hypertension and dyslipidemia | 0.333 | 0.000 | 0.333 | 0.435 | **0.006** | **0.012** |
| Metabolic syndrome (NCEP definition) | 0.250 | 0.000 | 0.250 | 0.465 | **0.007** | **0.014** |
| Framingham risk score (*34*) | 7.043 | 4.889 | 2.154 | 3.253 | **0.038** | **0.038** |

Biomarkers of metabolic activity from blood tests (lipid panel) show that treated individuals have higher levels of high-density lipoprotein cholesterol (HDL-C)—"good" cholesterol. The magnitude of the difference between treated and control groups is larger for males. The control males have a level of HDL cholesterol of 42 mg/dL, which is just above the lower recommended limit of 40 mg/dL (*29*), whereas the level for the treated males is 11 mg/dL higher. The treatment effect is marginally significant ($P = 0.066$). This is reflected in the prevalence of dyslipidemia (elevated lipid levels). The difference in the prevalence of this condition between treatment and control groups is 0.311 for males (HDL-C < 40 mg/dL; $P = 0.179$) and 0.177 for females (HDL-C < 50 mg/dL; $P = 0.099$). The healthier metabolic status experienced by the male treatment group is confirmed by the lower prevalence of prediabetes indicators [glycosylated hemoglobin ≥ 5.7% (*30*), 0.473 versus 0.583], although the difference does not attain statistical significance ($P = 0.426$). Control males are also twice as likely to be affected by vitamin D deficiency (total vitamin D < 20 ng/mL (*31*); 0.368 versus 0.750; $P = 0.021$).

The prevalence of both severe and abdominal obesity is lower among treatment group males but the differences are not statistically significant at the 10% level. Treated females are less likely than controls to be affected by abdominal obesity, both when considering the waist-hip ratio (WHR) and when analyzing a dichotomous measure of WHR > 0.85 (*32*) (0.563 versus 0.762); both treatment effects are marginally significant ($P = 0.063$ and $P = 0.080$, respectively).

The health effects of the ABC intervention translate into lower prevalence of multiple risk factors that are particularly striking for males. Those in the treatment group are less likely to experience both obesity and hypertension [difference in mean (diff.) = 0.389; $P = 0.016$], severe obesity and hypertension (diff. = 0.375; $P = 0.005$), and dyslipidemia and hypertension (diff. = 0.333; $P = 0.006$). None of the treated males have the cluster of conditions known as metabolic syndrome [defined as waist circumference > 102 cm or 40 inches (*33*); HDL-C < 40 mg/dL; bp ≥ 130/85 mm Hg (*29*)], associated with greater risk of heart disease, stroke, and diabetes, whereas one in four in the control group is affected by it ($P = 0.007$). The prevalence of the metabolic syndrome for females [defined as waist circumference > 88 cm or 35 inches (*33*); HDL-C < 50 mg/dL; bp ≥ 130/85 mm Hg (*29*)] is lower in the treatment group, but the differences are not statistically significant at the 10% level. Finally, results for the Framingham

**Table 2. ABC intervention, females: main health results, biomedical sweep.** This table presents the inference and descriptive statistics of selected outcomes of the ABC intervention. The first column describes the outcome analyzed. The remaining six columns present the statistical analysis. The columns present the following information: (i) Control mean. (ii) Treatment mean. (iii) Unconditional difference in means across treatment and control groups. We multiply the difference in means by (−1) when a higher value of the variable in the raw data represents a worse outcome so that all outcomes are normalized in a favorable direction (but are not restricted to be positive). (iv) Conditional treatment effect controlling for cohort, number of siblings, mother's IQ, and high-risk index at birth, and accounting for attrition using IPW. Probabilities of IPW are estimated using the following variables for the biomedical sweep outcomes: prematurity (gestational age <37 weeks), mother Wechsler Adult Intelligence Scale (WAIS) digit symbol score at recruitment, Achenbach rule-breaking problem scale at age 30, and Achenbach substance abuse scale at age 30. The selection of covariates for IPW is based on the lowest AIC among models examining all combinations of covariates that present statistically significant imbalance between attriters and non-attriters. See supplementary materials section C and table S2 for details. (v) One-sided single-hypothesis block permutation *P* value associated with the IPW treatment effect estimate. By block permutation, we mean that permutations are done within strata defined by the preprogram variables used in the randomization protocol: cohort, gender, number of siblings, mother's IQ, and high-risk index. (vi) Multiple hypothesis stepdown *P* values associated with (v). The multiple hypothesis testing is applied to blocks of outcomes. Blocks of variables that are tested jointly using the stepdown algorithm are delineated by horizontal lines. *P* values ≤ 0.10 are in bold type. See table S12 for complete estimation results.

| Variable | Control mean | Treatment mean | Difference in means | Conditional treatment effect | Block *P* value | Stepdown *P* value |
|---|---|---|---|---|---|---|
| | | | *Blood pressure* | | | |
| Diastolic blood pressure (mm Hg) | 89.227 | 85.333 | 3.894 | 1.204 | 0.446 | 0.446 |
| Systolic blood pressure (mm Hg) | 135.636 | 129.666 | 5.970 | 2.185 | 0.300 | 0.380 |
| Prehypertension (systolic bp ≥ 120 and diastolic bp ≥80) | 0.727 | 0.500 | 0.227 | 0.101 | 0.222 | 0.222 |
| Prehypertension (systolic bp ≥ 120 or diastolic bp ≥80) | 0.909 | 0.667 | 0.242 | 0.244 | **0.042** | **0.069** |
| Hypertension (systolic bp ≥ 140 and diastolic bp ≥ 90) | 0.318 | 0.222 | 0.096 | −0.003 | 0.375 | 0.499 |
| Hypertension (systolic bp ≥ 140 or diastolic bp ≥ 90) | 0.409 | 0.500 | −0.091 | −0.181 | 0.721 | 0.721 |
| | | | *Laboratory tests* | | | |
| High-density lipoprotein (HDL) cholesterol (mg/dL) | 55.318 | 60.444 | 5.126 | 6.002 | 0.143 | 0.143 |
| Dyslipidemia (HDL < 50 mg/dL) | 0.455 | 0.278 | 0.177 | 0.201 | **0.099** | 0.147 |
| Prediabetes (HbA1C ≥ 5.7%) | 0.364 | 0.353 | 0.011 | 0.070 | 0.580 | 0.580 |
| Vitamin D deficiency (<20 ng/mL) | 0.727 | 0.722 | 0.005 | 0.048 | 0.303 | 0.303 |
| | | | *Obesity* | | | |
| Overweight (BMI ≥ 25) | 0.955 | 0.889 | 0.066 | 0.054 | 0.482 | 0.690 |
| Obese (BMI ≥ 30) | 0.727 | 0.666 | 0.061 | −0.112 | 0.790 | 0.790 |
| Severely obese (BMI ≥ 35) | 0.364 | 0.223 | 0.141 | 0.143 | 0.354 | 0.653 |
| Waist-hip ratio (WHR) | 0.933 | 0.876 | 0.057 | 0.053 | **0.063** | 0.101 |
| Abdominal obesity (WHR > 0.85) | 0.762 | 0.563 | 0.199 | 0.198 | **0.080** | **0.080** |
| | | | *Multiple risk factors* | | | |
| Obesity and hypertension | 0.364 | 0.278 | 0.086 | −0.028 | 0.501 | 0.641 |
| Severe obesity and hypertension | 0.136 | 0.167 | −0.031 | −0.066 | 0.696 | 0.696 |
| Hypertension and dyslipidemia | 0.182 | 0.167 | 0.015 | −0.043 | 0.486 | 0.725 |
| Metabolic syndrome (NCEP definition) | 0.190 | 0.062 | 0.128 | 0.057 | 0.184 | 0.393 |
| Framingham risk score (*34*) | 1.482 | 1.143 | 0.339 | 0.331 | **0.070** | **0.070** |

risk score (*34*) reveal that both treated males and females have a significantly lower risk of experiencing "total" coronary heart disease (CHD), defined as both stable and unstable angina, myocardial infarction, or CHD death, within the next 10 years (diff. = 2.154, $P = 0.038$ for males; diff. = 0.339, $P = 0.070$ for females).

In sum, the available evidence from the biomedical survey of ABC shows that the children who attended the child care center in the first 5 years of their lives enjoy better physical health in their mid-30s, with significant markers indicating better future health. The benefits of these health improvements are substantial and wide-ranging. Reference (*35*) provides a detailed review of the labor market costs of obesity, which range from increased absenteeism to lower productivity and wages. There are considerable losses in life expectancy due to obesity. Reference (*36*) reports estimates that 35-year-old males with hypertension would gain 1.1 to 5.3 years of expected life (0.9 to 5.7 years for females) from reducing their diastolic bp to 88 mm Hg using the Coronary Heart Disease Policy Model based on data from the Framingham Heart Study. Reference (*37*), using data from the Framingham Heart Study, finds that 40-year-old male nonsmokers suffer a loss of life expectancy of 3.1 years (3.3 years for females) because of being overweight, and of 5.8 years (7.1 years for females) because of obesity. Reference (*38*), using data from the National Longitudinal Study of Adolescent Health, shows that diabetics are less likely to be employed (by 8 to 11 percentage points), are more likely to participate in social programs (by 8 to 13 percentage points), and earn on average lower wages (by $1500 to $6000). Reference (*39*) provides further evidence from the National Longitudinal Survey of Youth 1979 that the duration of diabetes is negatively associated with employment and wages. Reference (*40*) reports a hazard ratio of 1.47 (95% confidence interval of 1.13 to 1.92) for all-cause mortality and of 2.53 (95% CI of 1.74 to 3.67) for cardiovascular mortality caused by metabolic syndrome (NCEP definition) in the San Antonio Heart Study.

### *Health Care*

Availability of health care is a necessary condition for enjoying better health, although not a sufficient one (*41*). The upper panel of Table 3 reveals that treated males were more likely to be covered by health insurance at age 30 (0.704 versus 0.476; $P = 0.039$) and to be cared for in a hospital or by a doctor when sick (0.815 versus 0.524; $P = 0.037$). There are no significant differences in the effect of the treatment for females (upper panel of Table 4).

### *Physical Development*

We analyze the effects of the intervention on early physical development, assessed using anthropometric measurements (height and weight) taken when the children had their routine assessments at multiple times in childhood. We transform the body mass index (BMI) measures into standard normal variates ($z$ scores) using the lambda-mu-sigma (LMS) method developed in (*42*–*44*). The results are reported in the bottom panel of Table 3. Treated males were less likely than controls to be overweight throughout their preschool years, with almost no treated child having a weight-for-length above the 85th percentile [the age-specific measure for being "at-risk overweight" (*45*)] in the first 2 years of life. Control males had a greater weight-for-length $z$-score change between birth and 24 months of age. More rapid increases in weight-for-length in the first 6 months of life have been associated with increased risk of obesity at age 3 (*46*). Looking at the full BMI distribution by treatment status for males shown in Fig. 1, it is evident that the distribution is both less spread out and shifted to the left for treated males relative to controls. These results are consistent with the obesity-reducing effects found in Head Start (*47*, *48*) and are consistent with evidence in the literature of the important role played by early-life nutrition (*49*). Further evidence on the

**Table 3. ABC intervention, males: health care at age 30; physical development in childhood.** This table presents the inference and descriptive statistics of selected outcomes of the ABC intervention. The first column describes the outcome analyzed. The remaining six columns present the statistical analysis. The columns present the following information: (i) Control mean. (ii) Treatment mean. (iii) Unconditional difference in means across treatment and control groups. We multiply the difference in means by (−1) when a higher value of the variable in the raw data represents a worse outcome so that all outcomes are normalized in a favorable direction (but are not restricted to be positive). (iv) Conditional treatment effect controlling for cohort, number of siblings, mother's IQ, and high-risk index at birth, and accounting for attrition using IPW. The selection of covariates for IPW is based on the lowest AIC among models examining all combinations of covariates that present statistically significant imbalance between attriters and non-attriters. See supplementary materials section C and table S1 for details. (v) One-sided single-hypothesis block permutation $P$ value associated with the IPW treatment effect estimate. By block permutation, we mean that permutations are done within strata defined by the preprogram variables used in the randomization protocol: cohort, gender, number of siblings, mother's IQ, and high-risk index. (vi) Multiple hypothesis stepdown $P$ values associated with (v). The multiple hypothesis testing is applied to blocks of outcomes. Blocks of variables that are tested jointly using the stepdown algorithm are delineated by horizontal lines. $P$ values ≤ 0.10 are in bold type. CDC, Centers for Disease Control and Prevention. WHO, World Health Organization. We use weight-for-length ≥ 85th percentile for being "at-risk overweight" under 24 months and BMI-for-age ≥ 85th percentile for being overweight for 24 months and older (*45*). See table S13 for complete estimation results.

| Variable | Control mean | Treatment mean | Difference in means | Conditional treatment effect | Block $P$ value | Stepdown $P$ value |
|---|---|---|---|---|---|---|
| | | | *Health care at age 30* | | | |
| Health insurance coverage at age 30 | 0.476 | 0.704 | 0.228 | 0.226 | **0.039** | **0.039** |
| Buys health insurance at age 30 | 0.333 | 0.630 | 0.296 | 0.248 | **0.035** | **0.080** |
| Hospital or doctor office care when sick at age 30 | 0.524 | 0.815 | 0.291 | 0.265 | **0.037** | **0.068** |
| | | | *Physical development in childhood* | | | |
| At risk overweight (CDC) at 3 months | 0.227 | 0.037 | 0.190 | 0.206 | **0.026** | 0.121 |
| At risk overweight (CDC) at 6 months | 0.250 | 0.080 | 0.170 | 0.205 | **0.074** | 0.182 |
| At risk overweight (CDC) at 9 months | 0.412 | 0.000 | 0.412 | 0.446 | **0.004** | **0.023** |
| At risk overweight (CDC) at 12 months | 0.429 | 0.000 | 0.429 | 0.408 | **0.001** | **0.009** |
| At risk overweight (CDC) at 18 months | 0.389 | 0.000 | 0.389 | 0.385 | **0.000** | **0.004** |
| Overweight (CDC) at 24 months | 0.333 | 0.000 | 0.333 | 0.343 | **0.001** | **0.011** |
| Overweight (CDC) at 36 months | 0.158 | 0.080 | 0.078 | 0.094 | 0.194 | 0.194 |
| Overweight (CDC) at 48 months | 0.300 | 0.167 | 0.133 | 0.133 | 0.150 | 0.235 |
| Overweight (CDC) at 60 months | 0.300 | 0.125 | 0.175 | 0.187 | **0.058** | 0.179 |
| Overweight (CDC) at 96 months | 0.421 | 0.120 | 0.301 | 0.286 | **0.030** | 0.117 |
| Weight-for-length change 0–24 months (CDC) | 0.858 | −0.105 | 0.963 | 1.176 | **0.058** | **0.058** |
| Weight-for-length change 0–24 months (WHO) | 1.265 | 0.166 | 1.100 | 1.397 | **0.049** | **0.057** |

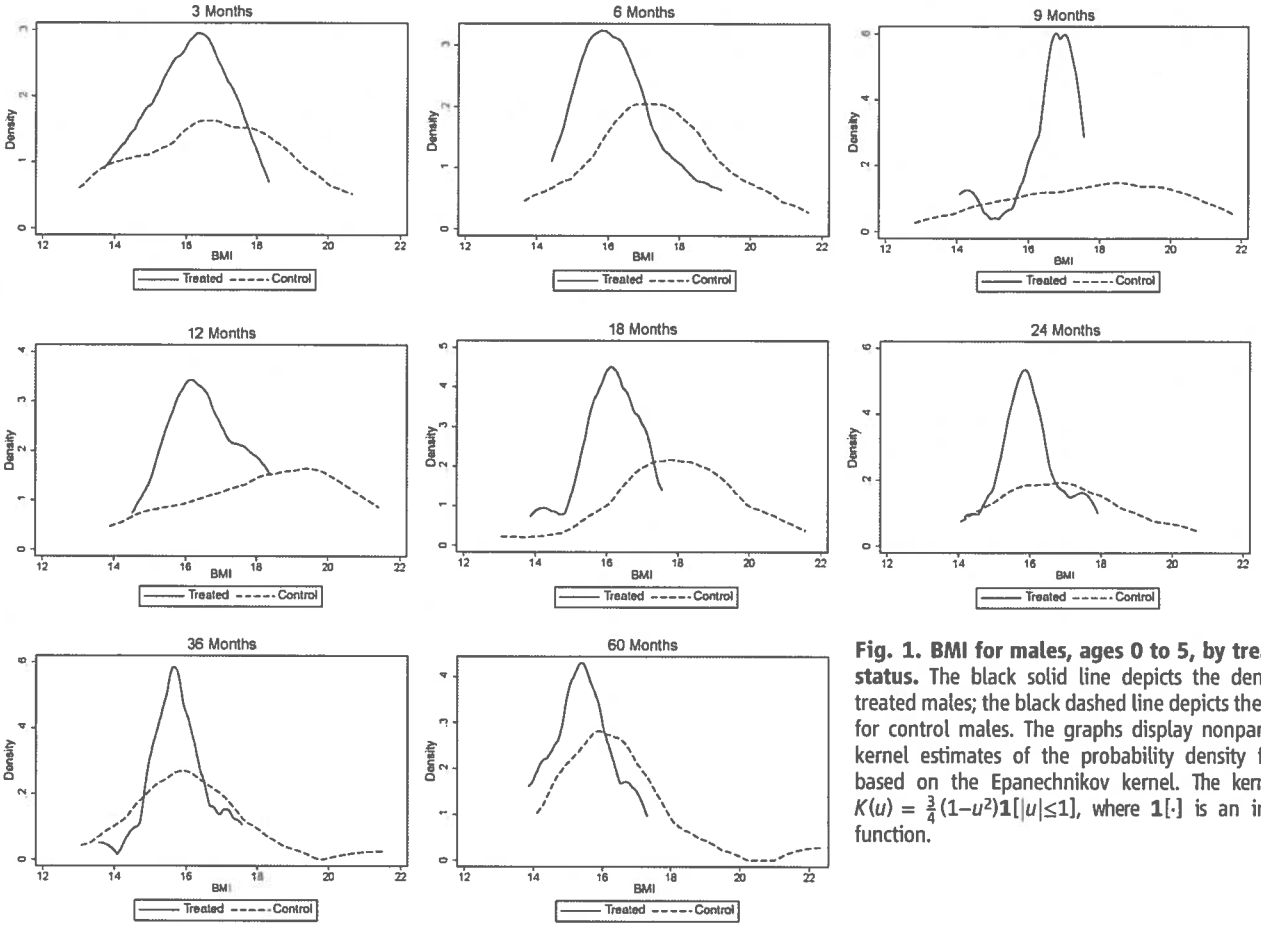


**Fig. 1. BMI for males, ages 0 to 5, by treatment status.** The black solid line depicts the density for treated males; the black dashed line depicts the density for control males. The graphs display nonparametric kernel estimates of the probability density function based on the Epanechnikov kernel. The kernel $K$ is $K(u) = \frac{3}{4}(1-u^2)\mathbf{1}[|u|\leq 1]$, where $\mathbf{1}[\cdot]$ is an indicator function.

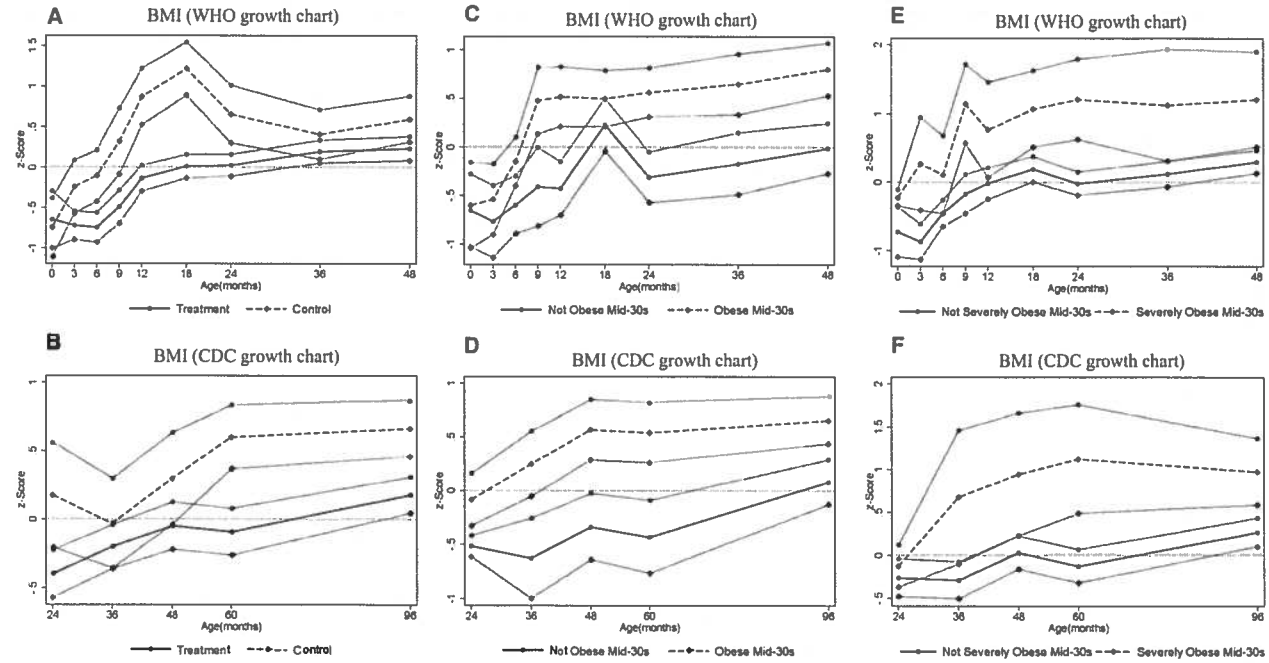


**Fig. 2. BMI for males ages 0 to 4 years (A, C, and E) and 2 to 8 years (B, D, and F), by treatment and obesity status at mid-30s.** The graphs show BMI $z$ scores at different points in childhood (0, 3, 6, 9, 12, 18, 24, 36, 48, 60, and 96 months) by treatment and control status [(A) and (B)], by obesity status (BMI $\geq$ 30) in adulthood [(C) and (D)], and by severe obesity status (BMI $\geq$ 35) in adulthood [(E) and (F)]. Solid and dashed lines represent mean BMI by age for different groups, and the bands around each line represent standard errors for the corresponding means (one standard error above and below). (A), (C), and (E) use the WHO growth charts to construct the $z$ scores; (B), (D), and (F) use the CDC growth charts. The CDC recommends the use of the WHO growth charts for less than 2 years of age (see www.cdc.gov/growthcharts/who_charts.htm).

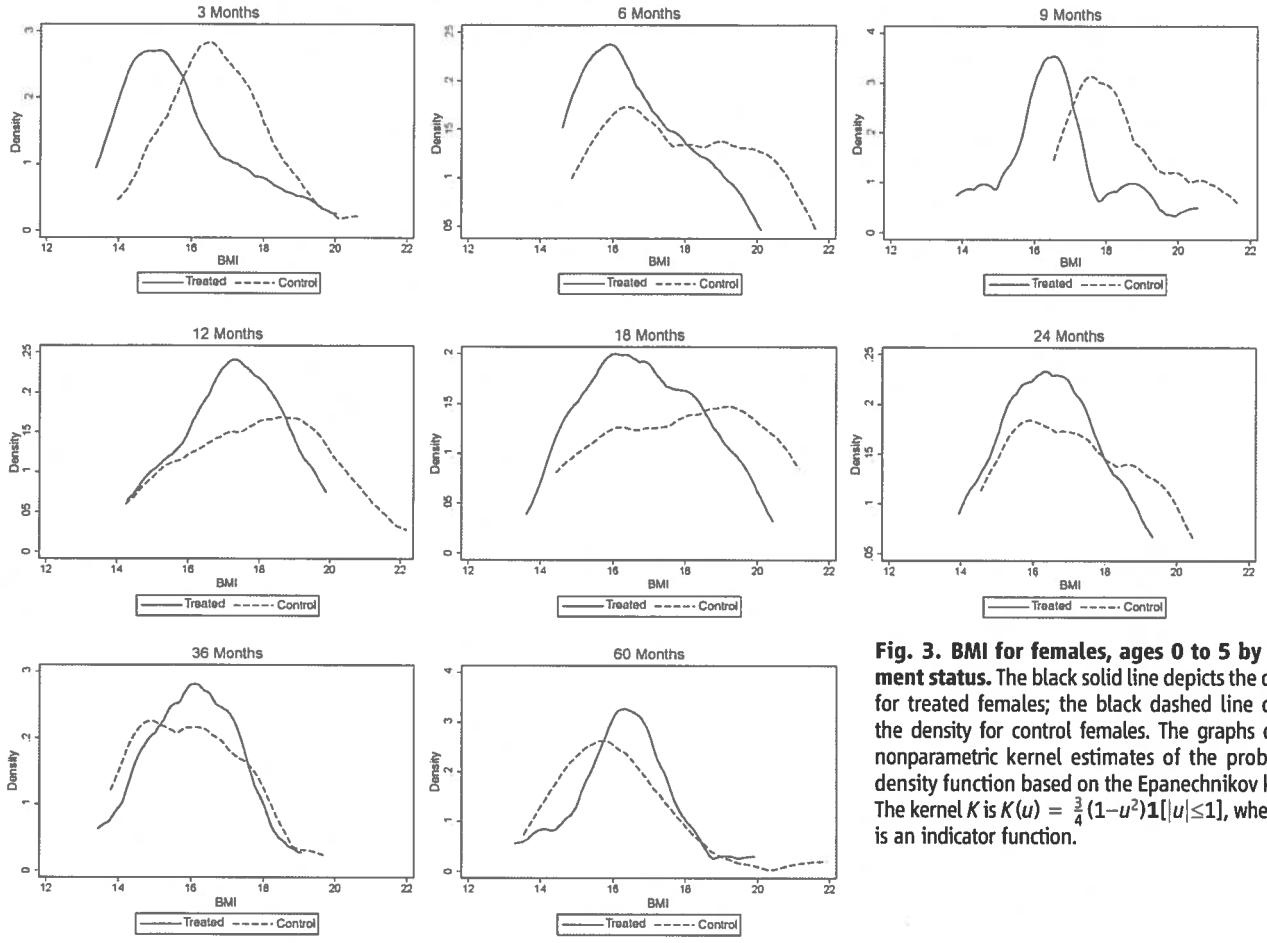


**Fig. 3. BMI for females, ages 0 to 5 by treatment status.** The black solid line depicts the density for treated females; the black dashed line depicts the density for control females. The graphs display nonparametric kernel estimates of the probability density function based on the Epanechnikov kernel. The kernel $K$ is $K(u) = \frac{3}{4}(1-u^2)\mathbf{1}[|u|\leq 1]$, where $\mathbf{1}[\cdot]$ is an indicator function.

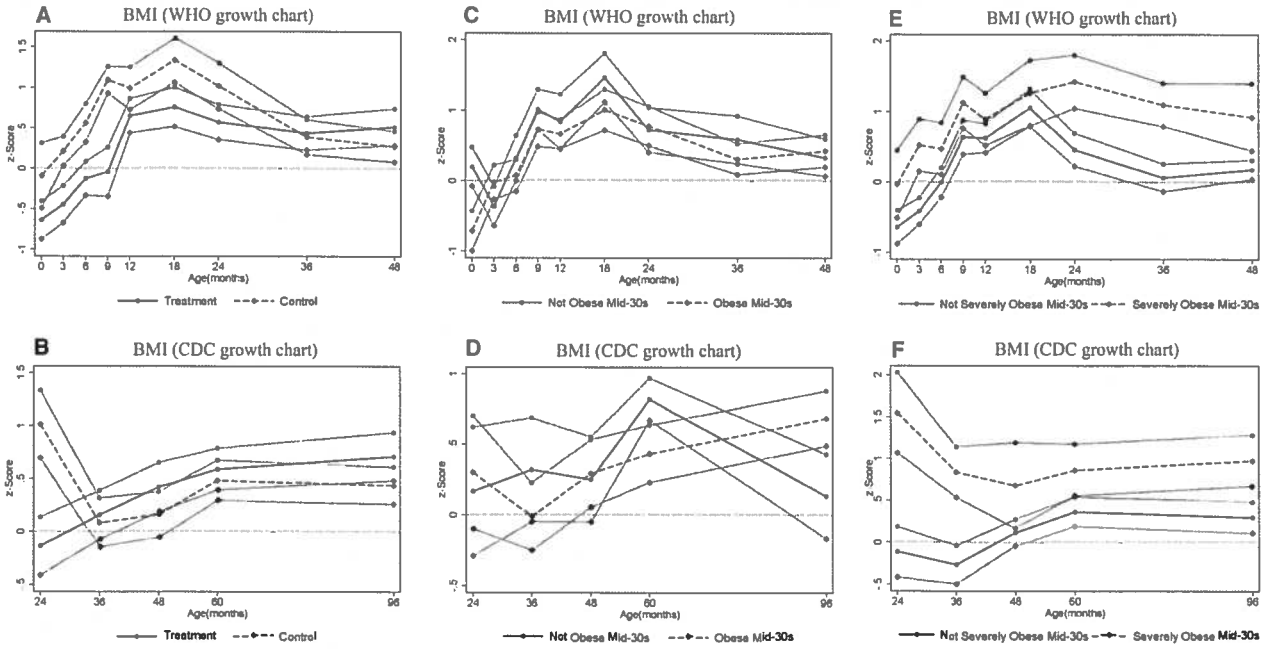


**Fig. 4. BMI for females ages 0 to 4 years (A, C, and E) and 2 to 8 years (B, D, and F), by treatment and obesity status at mid-30s.** The graphs show BMI $z$ scores at different points in childhood (0, 3, 6, 9, 12, 18, 24, 36, 48, 60, and 96 months) by treatment and control status [(A) and (B)], by obesity status (BMI $\geq$ 30) in adulthood [(C) and (D)], and by severe obesity status (BMI $\geq$ 35) in adulthood [(E) and (F)]. Solid and dashed lines represent mean BMI by age for different groups, and the bands around each line represent standard errors for the corresponding means (one standard error above and below). (A), (C), and (E) use the WHO growth charts to construct the $z$ scores; (B), (D), and (F) use the CDC growth charts. The CDC recommends the use of the WHO growth charts for less than 2 years of age (see www.cdc.gov/growthcharts/who_charts.htm).

**Table 4. ABC intervention, females: health care at age 30; physical development in childhood.** This table presents the inference and descriptive statistics of selected outcomes of the ABC intervention. The first column describes the outcome analyzed. The remaining six columns present the statistical analysis. The columns present the following information: (i) Control mean. (ii) Treatment mean. (iii) Unconditional difference in means across treatment and control groups. We multiply the difference in means by (−1) when a higher value of the variable in the raw data represents a worse outcome so that all outcomes are normalized in a favorable direction (but are not restricted to be positive). (iv) Conditional treatment effect controlling for cohort, number of siblings, mother's IQ, and high-risk index at birth, and accounting for attrition using IPW. The selection of covariates for IPW is based on the lowest AIC among models examining all combinations of covariates that present statistically significant imbalance between attriters and nonattriters. See supplementary materials section C and table S2. (v) One-sided single-hypothesis block permutation *P* value associated with the IPW treatment effect estimate. By block permutation, we mean that permutations are done within strata defined by the preprogram variables used in the randomization protocol: cohort, gender, number of siblings, mother's IQ, and high-risk index. (vi) Multiple hypothesis stepdown *P* values associated with (v). The multiple hypothesis testing is applied to blocks of outcomes. Blocks of variables that are tested jointly using the stepdown algorithm are delineated by horizontal lines. *P* values ≤ 0.10 are in bold type. We use weight-for-length ≤ 85th percentile for being "at-risk overweight" under 24 months, and BMI-for-age ≥ 85th percentile for being overweight for 24 months and older (*45*). See table S14 for complete estimation results.

| Variable | Control mean | Treatment mean | Difference in means | Conditional treatment effect | Block *P* value | Stepdown *P* value |
|---|---|---|---|---|---|---|
| | | | *Health care at age 30* | | | |
| Health insurance coverage at age 30 | 0.857 | 0.760 | −0.097 | −0.159 | 0.943 | 0.943 |
| Buys health insurance at age 30 | 0.357 | 0.400 | 0.043 | −0.027 | 0.511 | 0.810 |
| Hospital or doctor office care when sick at age 30 | 0.929 | 0.800 | −0.129 | −0.131 | 0.875 | 0.964 |
| | | | *Physical development in childhood* | | | |
| At risk overweight (CDC) at 3 months | 0.192 | 0.190 | 0.002 | −0.036 | 0.418 | 0.757 |
| At risk overweight (CDC) at 6 months | 0.423 | 0.167 | 0.256 | 0.212 | **0.040** | 0.237 |
| At risk overweight (CDC) at 9 months | 0.360 | 0.143 | 0.217 | 0.181 | 0.169 | 0.548 |
| At risk overweight (CDC) at 12 months | 0.478 | 0.208 | 0.270 | 0.141 | **0.055** | 0.276 |
| At risk overweight (CDC) at 18 months | 0.440 | 0.318 | 0.122 | 0.118 | 0.311 | 0.669 |
| Overweight (CDC) at 24 months | 0.412 | 0.174 | 0.238 | 0.195 | 0.143 | 0.517 |
| Overweight (CDC) at 36 months | 0.261 | 0.143 | 0.118 | −0.020 | 0.202 | 0.556 |
| Overweight (CDC) at 48 months | 0.192 | 0.409 | −0.217 | −0.247 | 0.944 | 0.944 |
| Overweight (CDC) at 60 months | 0.261 | 0.273 | −0.012 | −0.050 | 0.554 | 0.781 |
| Overweight (CDC) at 96 months | 0.174 | 0.350 | −0.176 | −0.230 | 0.943 | 0.985 |
| Weight-for-length change 0–24 months (CDC) | 0.857 | 0.918 | −0.062 | −0.052 | 0.658 | 0.688 |
| Weight-for-length change 0–24 months (WHO) | 1.129 | 1.215 | −0.085 | −0.006 | 0.660 | 0.660 |

importance of these early growth patterns is shown in Fig. 2. Fig. 2, A and B, shows the evolution of BMI-for-age during childhood for males by treatment status. It is noticeable that, while the BMI-for-age of the treatment group is always centered around the median for the reference population, the control group experiences a surge in the first year, which peaks at 18 months, becomes partially attenuated, and then exhibits diverging growth patterns after 5 years of age. It is striking that, when we consider the early growth trajectory by obesity status in adulthood (Fig. 2, C to F), those who are obese or severely obese in their mid-30s are already on a trajectory of above-normal BMI in the first 5 years of their lives. The effects of the intervention on early physical development are less pronounced for females (lower panel of Table 4 and Figs. 3 and 4). Fig. 4A and Table 4 show that there are significant differences in mean BMI-for-age and in the prevalence of being overweight, respectively, in the first 2 years of the intervention. These differences, however, fade out by the end of the daycare treatment. As observed for males, the females who are severely obese in their mid-30s are already on a trajectory of higher BMI-for-age in the first years of their lives (Fig. 4, E and F).

## Conclusions

This paper analyzes recently collected biomedical data for the ABC intervention. Children randomly assigned to the treatment group for ages 0 to 5 have a significantly lower prevalence of risk factors for cardiovascular and metabolic diseases in their mid-30s. Treated males have a healthier body mass in their childhood years. These early benefits persist into adulthood.

The precise mechanisms through which these effects are obtained remain to be determined. It may be improved health due to access to pediatric care and proper nutrition in the early years, improved noncognitive skills as in the Perry study (*50*), improved cognitive skills, or some combination of all three factors. The bundled nature of the treatment does not provide the necessary independent variation in the components of the intervention that would allow us to examine the sources of treatment effects. A simple mediation analysis (presented in tables S19 and S20) suggests that half of the effect of the treatment on hypertension and obesity in the mid-30s may be mediated by the BMI of the child around 1 year of age, while no statistically significant role seems to be played by the availability of health insurance or improved socioeconomic status at age 30. However, the estimated mediation effects are not precisely determined, so these findings are necessarily speculative. Whatever the channel, our evidence supports the importance of intervening in the first years of life and suggests that early childhood programs can make a substantial contribution to improving the health of adult Americans and reducing the burden of health care costs. An intervention that lasted 5 years and cost $67,000 [in 2002 dollars (*51*)] produced sustained and substantial health benefits. Early childhood interventions are an unexplored and promising new avenue of health policy.

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### Supplementary Materials

www.sciencemag.org/content/343/6178/1478/suppl/DC1
Materials and Methods
Supplementary Text
Tables S1 to S26
References (*52–112*)


12 November 2013; accepted 4 March 2014
10.1126/science.1248429


# Structure of the Yeast Mitochondrial Large Ribosomal Subunit


**Alexey Amunts,* Alan Brown,* Xiao-chen Bai,* Jose L. Llácer,* Tanweer Hussain, Paul Emsley, Fei Long, Garib Murshudov, Sjors H. W. Scheres,† V. Ramakrishnan†**



Mitochondria have specialized ribosomes that have diverged from their bacterial and cytoplasmic counterparts. We have solved the structure of the yeast mitoribosomal large subunit using single-particle cryo–electron microscopy. The resolution of 3.2 angstroms enabled a nearly complete atomic model to be built de novo and refined, including 39 proteins, 13 of which are unique to mitochondria, as well as expansion segments of mitoribosomal RNA. The structure reveals a new exit tunnel path and architecture, unique elements of the E site, and a putative membrane docking site.


Mitochondria are organelles in eukaryotic cells that play a major role in metabolism, especially the synthesis of adenosine triphosphate (ATP). During evolution, mitochondria have lost or transferred most of their genes to the nuclei, substantially reducing the size of their genome (*1*). In yeast, all but one of the few remaining protein-coding genes encode subunits of respiratory chain complexes, whose synthesis involves insertion into the inner mitochondrial membrane along with incorporation of prosthetic groups (*2*). For the translation of these genes, mitochondria maintain their own ribosomes (mitoribosomes) and translation system. The mitochondrial ribosomal RNA (rRNA) and several transfer RNAs (tRNAs) are encoded by the mitochondrial genome, whereas all but one of its ribosomal proteins are nuclear-encoded and imported from the cytoplasm. Mitoribosomes have diverged greatly from their counterparts in the cytosol of bacterial and eukaryotic cells and also exhibit high variability depending on species (table S1) (*3*). Several genetic diseases map to mitoribosomes (*4*). In addition, the toxicity of many ribosomal antibiotics, in particular aminoglycosides, is thought to be due to their interaction with the mitoribosome (*5*).

Mitochondrial translation in the yeast *Saccharomyces cerevisiae* (*6*) has been used as a model to study human mitochondrial diseases (*7*). The 74*S* yeast mitoribosome has an overall molecular weight of 3 MD, some 30% greater than that of its bacterial counterpart. It consists of a 54*S* large subunit (1.9 MD) and a 37*S* small subunit (1.1 MD).


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# Department of Housing & Human Services

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, July 28, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Agenda

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

2) **Review and approval of minutes from June 30, 2015 DHHS Advisory Committee meeting (3:33 p.m. – 3:35 p.m.)**

3) **HHS Advisory Committee Proposed Support Activities—Frank Alexander (3:35 p.m. – 4:35 p.m.)**
   a) **Update from members:** All members take time with your priority, then come back and talk about scope of what's needed to be successful; any questions, concerns, resource needs, actionable recommendations that we can incorporate into our current work plan activities or approaches to begin to evaluate for our 2016 budget options.

   b) **July 28 meeting presenters:**

| **July 28, 2015 Meeting** | | |
|---|---|---|
| | | |
| **1. Robin Bohannan** | **Ten-Year Board to End Homelessness Priorities** | **3:35 – 4:05 p.m.** |
| | | |
| **2. Dan Thomas** | **Financial and Budget Transparency and Communication to Community on Return on Investment** | **4:05 – 4:35 p.m.** |
| | | |

4) **Brainstorming session on support activities and how to operationalize our work in these areas over the next 12-24 months—Frank Alexander (4:35 p.m. – 5:00 p.m.)**
   a) In order to operationalize the various discussion items, action items, and common threads in our conversations, we would like to help the Committee map out a work plan to cover the next 12-24.
      i. Summarization of the key points that arose from our activities discussion, discussion of some key leverage points and common threads that emerged, and brainstorming of some next steps for consideration by the Committee.

5) **Matters from the committee members for consideration**

6) **August agenda items**
   a) Continued discussion of and commitment to 2015-2016 Committee work plan

7) **Next Meeting is Tuesday, August 25, 2015**, **3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

8) **Adjourn**

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, June 30, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## MINUTES

**Present:** Dan Thomas, Bobbie Watson, Penny Hannegan, Betsy Martens, Whitney Wilcox, Jeff Zayach, Frank Alexander, Susan Grutzmacher, Suzanne Crawford, Robin Bohannan, Elvira Ramos, Chris Campbell, Jim Williams

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

2) **Review and approval of minutes from May 26, 2015 DHHS Advisory Committee meeting (3:33-3:35 p.m.)**
**Minutes approved**

3) **HHS Advisory Committee Proposed Support Activities—Frank Alexander (3:35 – 4:55 p.m.)**
   a) **Update from members:** All members take time with your priority, then come back and talk about scope of what's needed to be successful; any questions, concerns, resource needs, actionable recommendations that we can incorporate into our current work plan activities or approaches to begin to evaluate for our 2016 budget options

   Today is Penny Hannegan's last meeting. Betsy Martens will be representing BHP going forward.

   b) **June 30 meeting presenters:**

| **June 30, 2015 Meeting** | | |
|---|---|---|
| | | |
| **1. Bobbie Watson** | **Early Childhood Council of Boulder County: Quality Improvement and Increased Access** | **3:35 – 4:15 p.m.** |
| | | |
| **2. Simon Smith** | **Medicaid Service Expansion Efforts** | **4:15 – 4:55 p.m.** |
| | | |

Bobbie Watson's presentation: (please see PowerPoint)
EQIT- Expanding Quality for Infants and Toddlers – training cohorts in working with infants and toddlers. We've expanded to four cohorts in Boulder County.
At risk for expulsion – training teachers to deal with these children
Touchpoints – parent is an expert in this child and this child's world. Now rolled over into licensed childcare. Boulder is 10th Touchpoints training team in CO.
Collective Impact – 1/3 of children entering kindergarten are not ready to learn. Teachers spending a lot of time with 1/3 of the class.
Dan – are orgs statutorily mandated? Bobbie - HB says members of council will be from four domains of early childhood.
ECCBC framework is set up as a logic model
Indicators above dotted line are developed indicators; below are indicators collective would like to be able to report out on (pre-school expulsion rate, for example).
Boulder and Broomfield remained co-mingled in CDPHE data, unfortunately.
Federal Kindergarten Readiness Grant – produced outcomes? No – they pulled the money after one year. We don't have a standard test in Colorado to measure Kindergarten readiness. Law passed in CO recently to ensure one central readiness test. TSGold – BVSD and St Vrain – in place by fall 2016. Visual assessment.
ECCBC board is independent 501c3, self-appointed. People are now calling Bobbie asking to be on the board, a good sign.
Unlicensed, unregulated care (Family/friends) takes up some of 24 hour "where are the 0-5 kids"? to understand kindergarten readiness.
Housing is not a specific indicator for ECCBC early child readiness.
ECCBC ITQA Grant – improving the quality of early childcare providers– partnership with DHHS and ECCBC
Indicators report – out to community every two years

BHAG
Includes pilot CCAP program – to help reduce staff turnover in licensed childcare providers. People get experience in providers, then jumping to districts. Is there a career ladder for me to make more money in childcare providers? Pilot – recruit and retain qualified staff – teacher follows child through 2 or 3 years. Susan and Whitney on the workgroup for this.
Pilot contracting for CCAP slots – Bobbie to discuss with Frank
Quality Improvement Initiatives – about $400k Race to the Top money coming in December 2016, how do we continue the work past this time?

Community Foundation? Bobbie – maxed out at 40 members of advisory council. Community Foundation is invited as a guest (Chris). We have a large guest list.
Lafayette Community School is a critical project – expanding numbers of kids in quality centers in east county. Supply/demand model important, where are 20k children in 24 hour period. Need to know how many family providers we have to target quality care in their direction. Keep including quality of services for birth to 5 population. Dan – gov't level support for these activities? Bobbie- Obama has brought additional federal dollars into early childhood – home visitation, headstart/early headstart slots.

**Committee will now switch to discussion of how each of our agencies can take a moment to knit together the initiatives and how we can proceed as a committee. How can we better align systems and functions to better meet individual and family's needs?

Elvira—I would suggest that moving forward, if it would be possible to cover inclusivity and representing under-represented populations. How is service delivery inclusive, how is this being addressed by agencies?

Jeff—how do we tie the threads in the early childhood space. Home visitation collaboration. This kind of effort is a good model. Right service, in the right amount, in the right time. How can we tie some of our efforts together.

Robin—social determinants/pillars are where we are knitted and focused. Prevention and early intervention is another glue piece. We are starting to recognize how to thread this work. Another connecting and critical piece is data. Need to dive deep into understanding the needs. Started this work but need to improve more in this area.

Elvira—new Trends report is coming out soon. Could have a report in September at the Committee meeting.

Bobbie—around this table is that we have a common outcome is thriving families and individuals. What are the mutually reinforcing activities?

Jeff—when we designed the new building, we intentionally considered how we can better integrate and work together. How can programs better work together to make service deliver more seamless. How do we transfer this to our work as a committee?

Penny—How do we have more of a City of Boulder presence with the committee, particularly in the homeless arena?

Jeff—if we can find places where we can better tie program and service delivery together. How can we better link together? Need to keep this in mind when we plan and budget.

Frank—one of the big shifts that has happened over time is that a system is designed to address a symptom/issue. Not combined to look at root cause below that and risk factors that multiply in many systems. Now, the conversation is starting to lead us toward the impact across multiple systems and how the system can evolve to one, overarching system. Holistic system. We have to start thinking about larger impacts, how do we scale up?

Jeff—thinking back to root cause is key. What policy supports can be in place to address issues up stream?

Frank—some of the things we want to think about, how to we operationalize next steps. Bring back issues in our own agency for this group to weigh in on—RE if we increase CCAP provider rates for DHHS and what should our child care budget be in 2016. After the next couple of presentations, move into the operationalization piece. Think about this for next month and the month after.

Penny—at some point, will we discuss funding decisions? Frank—more of an organic process. For DHHS, there are a lot of things that impact the work besides just funding decisions—more

Bobbie—multiplier effect. Need to keep this in mind when we look at our work.

Robin—living wage issues.

**Bring conversation starters, issues around how we operationalize. Email these suggestions to Chris and Frank.

**Get set of one page infographics to the committee. Jim W. is the lead.

**4) Matters from the committee members for consideration**

**5) July agenda items:**

a) Continued updates on Committee member activities

| **July 28, 2015 Meeting** | |
|---|---|
| | |
| **1. Robin Bohannan** | **Ten-Year Board to End Homelessness Priorities** |
| | |
| **2. Dan Thomas** | **Financial and Budget Transparency and Communication to Community on Return on Investment** |
| | |

b) Question and answer session on support activities
   i. Discussion of budgeting, planning, and strategic resources for the next 18 to 24 months.

**6) Next Meeting is Tuesday, July 28, 2015, 3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

**7) Adjourn**

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, August 25, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Agenda

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

2) **Review and approval of minutes from June 30, 2015 DHHS Advisory Committee meeting (3:33 p.m. – 3:35 p.m.)**

3) **HHS Advisory Committee Proposed Support Activities—Frank Alexander (3:35 p.m. – 4:15 p.m.)**

**Update from members:** All members take time with your priority, then come back and talk about scope of what's needed to be successful; any questions, concerns, resource needs, actionable recommendations that we can incorporate into our current work plan activities or approaches to begin to evaluate for our 2016 budget options.

a) **Final Activity Presentation:**
   i. Simon Smith and Jeff Zayach: Medicaid Service Expansion Efforts Activities (45 minutes)

4) **Facilitated planning session—Committee's work plan for the next 12-24 months—Frank Alexander (4:15 p.m. – 5:00 p.m.)**
   i. **Review and discussion of the work plan document**: Summarization of the key points that arose from our activities discussion, discussion of some key leverage points and common threads that emerged, and brainstorming of some next steps for consideration by the Committee.
   ii. **Determination of Committee Next Steps**

5) **Matters from the committee members for consideration**

6) **August agenda items**
   a) Continued discussion of and commitment to 2015-2016 Committee work plan

7) **Next Meeting is Tuesday, September 29, 2015, 3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

8) **Adjourn**

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, July 28, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Minutes

In attendance: Jeff Zayach, Robin Bohannan, Bobbie Watson, Dan Thomas, Suzanne Crawford, Laura Kinder, Elvira Ramos, Frank Alexander, Angela Lanci-Macris, Daphne McCabe, Jim Williams, Chris Campbell

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

Approved as written

**2) Review and approval of minutes from June 30, 2015 DHHS Advisory Committee meeting (3:33 p.m. – 3:35 p.m.)**

Approved as written

**3) HHS Advisory Committee Proposed Support Activities—Frank Alexander (3:35 p.m. – 4:35 p.m.)**

a) **Update from members:** All members take time with your priority, then come back and talk about scope of what's needed to be successful; any questions, concerns, resource needs, actionable recommendations that we can incorporate into our current work plan activities or approaches to begin to evaluate for our 2016 budget options.

b) **July 28 meeting presenters:**

| **July 28, 2015 Meeting** | | |
|---|---|---|
| | | |
| **1. Robin Bohannan** | **Ten-Year Board to Address Homelessness Priorities** | **3:35 – 4:05 p.m.** |
| | | |
| **2. Dan Thomas** | **Financial and Budget Transparency and Communication to Community on Return on Investment** | **4:05 – 4:35 p.m.** |
| | | |

**Ten-Year Board to Address Homelessness Priorities—Presentation by Robin Bohannan**

See the posted PowerPoint and materials for background information.

## Goals at a Glance:

- Prevent individuals and families from becoming homeless
- Provide temporary shelter, alternative housing and supportive services for those who are temporarily homeless
- Provide permanent housing with supportive services to meet the long-term needs of chronic homeless individuals
- Develop and/or improve systems to support efficient and effective plan implementation
- Promote public awareness and advocacy
- Implement an effective governance and staffing structure

### Remaining Challenges

- Data
- Service delivery philosophy
- Need for housing stock to support Housing First model; as well as permanently affordable housing vouchers
- Immediate, short-term need vs. long-term investment strategies
- Managing homelessness vs. preventing and intervening
- Mental Health, Substance Abuse – lack of ongoing resources

### Community Successes

- Housing Stabilization
- SOAR = Social Security Disability Benefits
- Permanently Supportive Housing Toolkit Collaborative
- Boulder Homeless Services Collaborative
- Lee Hill Project – Housing First
- Designated Worthy Cause Funding for PSH
- Boulder/Longmont Community Solutions re: behavioral impacts/community impacts
- 25 Cities Initiative – Housing the most vulnerable using coordinated assessment tool and related opportunities for coordinated access
- Regional Planners Initiative to identify land use barriers and suggest model code for permanently supportive housing

### Vulnerabilities

- Agency “hat” vs. Board “hat”
- Ownership of Leadership/Designated Authority
- No dedicated funding (incentives/motivators to push progress)

- No staff support other than BOCC liaison role
- Clear relationship between multiple community efforts and the plan's implementation

**Project Overview:**

**The Ten Year Plan to End/Address Homelessness** is a countywide plan governed by a BOCC-appointed advisory board. The Ten Year Plan provides a broad blueprint to support resources and action on ensuring permanent housing solutions while maintaining crisis and emergency services. The board's role is to: establish priorities for the plan's implementation, create an annual workplan to support those priorities and establish metrics and measurement processes.

**Current State:**

The plan's implementation began in late 2011 and the board established priorities and an annual workplan in 2014. An attempt to establish a measurement system was minimally successful in 2013 and continues to be a major challenge for the board.

**Desired State:**

Dynamic and successful plan implementation with a recognition of the plan's role in leading, advocating and organizing homeless systems and services.

**Generative State:**

[Describe desired long-term generative state of project/process/activity. Note if the desired state and the generative state are the same, this section does not need to be completed.]

## Section 2: Implementation Details

**Outcome of Achieving Desired State:**

- The ability to provide a comprehensive measurement of investments and community impacts
- Reduced duplication of efforts
- Application of evidence-based approaches regionally with shared promising practices – opportunities to pilot, scale, replicate
- Countywide public awareness and engagement focused on supporting solutions and community values

**Risk Factors in Achieving Desired State :**

- Resources

- Politics
- Geographic turf issues

**Interim Solutions/Resources :**

- Continued focus on board role and action
- Continued seating of skills-based board members
- Ongoing communication with BOCC for their direction/advocacy of goal implementation
- Staffing a Boulder County 10YP Coordinator

**Recommendations for HHS:**

- Seat an HHS representative on the 10YP Board
- Consider providing funding to Community Services Department for a 10YP Coordinator
- Identify/communicate strategic plan re: continued addition of PSH units to portfolio
- Continue to provide leadership in community around service coordination and technical assistance with community-based providers

**Estimated Timeline for Project :**

TBD

**Committee Action Items:**

TBD

**Estimated Cost of Project :**

[Estimation of the costs required to bring this project from development to implementation.]

1.0FTE Intergovernmental Programs Coordinator salary range: $48,816 – $70,308 + benefits

**Comments from Members of the Board:**

Angela—Would this position (10YP Coordinator) be a member of the IOC committee?—this is an internal governance committee. Robin—no decision has been made as of yet. Do have a strong opinion that it should reside in the Community Services Department.

Elvira—What is the timeframe to hire position. Would hire as soon as possible if funding became available.

Laura—where are the responsibilities being addressed without having this position. Robin—mostly through Robin or from other CS staff. Also, some community partners take on some of the duties.

Frank—when you look at the information around family homelessness versus individual focus, how do you look at this now. Robin—it is contained in the plan now. When you look at current services now, there is a lot happening. It seemed like a gap area to address individual homelessness first and then focus on family homelessnes.

Frank—could you highlight the connection to the homelessness collaborative? Robin—when you agree that you are a system and that we need to think differently about collaboration, more ideas and solutions are brought forth. Currently, the collaborative presents regularly to the 10 year plan board. Tend to consider all of the impacts of initiatives and approaches. Frank—coordinating intake processes and resources they need to implement. Robin—this is a regional goal (25 cities, MDHI smart cities), we want coordinated case management happen.

Laura—what is the most likely resource for funding for the program manager? Robin—HSSN or likely a shared resource model funded by the local governments.

Robin—Analysis leading to a Permanently Supportive Housing Plan is now being funded. RPF is being released to see what options are out there in Boulder County and to analyze the approach. This will be funded by the Consortium of Cities.

Frank—the face of the street homeless population has begun to personify poverty across the lifespan to where conversations get stuck, how do we message the general need? **Robin—Denver Foundation gathered some data—most people knew someone who was struggling with housing (real story)—Robin will send out this report to the group.** Folks are least interested in Return on Investment stories. Frank—very little in the projects pipeline, so there is a lot of scrutiny by the community when developments are being planned.

Robin—The committee can help by focusing on alignment and communication when we are planning as a board

**Financial and Budget Transparency and Communication to Community on Return on Investment Presentation—Dan Thomas**

## Section 1: Overview of Project

**Project Overview:**

**BCDHHS Transparency Project**

**Current State:**

The BCDHHS Transparency web page is currently a fundamental and basic list of reports, audits, budget presentations, and Housing Authority and Human Services Board meeting documents. Because of the difficulty this creates in terms of locating desired information (especially for our more skeptical audience members), the current presentation forms an additional obstacle that can further frustrate their ability to understand our mission and focus and effectiveness. The current Transparency page also does not get much visitor traffic, which may be due in part to the relatively ineffective display of our information. There is also currently very little available guidance in terms of how to find, use, and understand the information. And currently no outreach/marketing is being conducted to drive traffic/interest to the Transparency page.

There are additional potential modes of communication that are not being utilized in terms of relating our commitment to transparency. These would include social media, email lists, and publications.

The current approach to communicating transparency also does not include a robust approach to disseminating return-on-investment information that data might demonstrate. While these advances are being represented in other formats, including printed media, electronic media may be underutilized for this purpose.

**Desired State:**

Removal of obstacles for the public through an accessible, simple, high-level web-based representation of sources and uses of funds for BCDHHS, and better dissemination of more detailed financial information and relevant programmatic results.

Use of additional communications channels such as social media, email lists, and publications for disseminating information about budget and transparency.

Use of outcomes data on the web and in social media to help demonstrate return-on-investment as it is tied to the financial investments being made.

**Generative State:**

In this case, the Desired State and Generative State are very similar. However, in a Generative frame, community members would interact with transparency information in a way that prompts them to help define how the financial and outcomes data are presented as well as

which data are most useful. A compelling, interactive public feedback mechanism that is also quite transparent would help move us more toward a Generative state in this effort. BCDHHS expects to soon be utilizing a web-based public engagement platform that may serve as one opportunity to create a mechanism for this.

In addition, ultimately our community partners should be involved in our transparency communication in ways that help them better understand the desires of the clients we collectively serve. Demands for transparency apply not only to BCDHHS, but also to the partners we fund and with which we work. A community-level approach to transparency that involves reporting on the full range of services the community provides will also help us become much more Generative in this effort.

## Section 2: Implementation Details

**Outcome of Achieving Desired State:**

The primary outcome of achieving the desired state will be a more robust communications channel for distribution of our transparency information. This should ultimately create more goodwill with our constituents: our clients, the public, and our community partners. It should also create a much better base from which we can produce annual report materials, reports on the safety net and Community of Hope, and other similar efforts.

**Risk Factors in Achieving Desired State :**

There seems to be little risk other than the potential for increased scrutiny of funding decisions, which may lead to increased public criticism in some areas.

**Interim Solutions/Resources :**

Please see below.

**Recommendations for HHS:**

[Describe the recommended actions for HHS. These may include policy positions, funding priorities, or allocation of departmental staffing or other resources that are needed to ensure the primary tasks continue to be completed in a timely fashion. ]

1. Create an accessible, simple, infographic-based high-level transparency web site with icon-based references to “Budget”, “Financial Reports” (to include audits), “Contracts and Partners”, “Meeting Packets” (or something similar), and “Tell Us What You Think”; see the Transparent Denver web site for an example: https://www.denvergov.org/transparency/
2. Create a “Budget Quick Glance” document that will be front and center on this web page: see this document from Denver County as an example (2014 Best of the Web finalist from GovTech.com): https://www.denvergov.org/Portals/344/documents/Budget/Budget_in_Brief.pdf. This is a simple six-page document on which we can model a BCDHHS “Budget Quick Glance” four-pager. Recommendations for content include…

Pages 1-2:

- A message from the BCDHHS director including emphasis on philosophy around transparency
- A brief on the oversight by the HHSAC

- "Where the money comes from" and "…goes" pie charts, and perhaps (similar to Denver's) a "gross expenditures" chart
- Budget Highlights in terms of top expenditures
- A brief on the HSSN (high level overview of total revenues and expenditures – primary areas of focus)

Pages 3-4:

- Budget expenditures by top priorities, with short synopses of why these are priorities/potential for return on investment
- Track most appropriate indicators by community over time
- Funding blending/braiding process and how it works, why it's used
- What's next in terms of budget priorities, what we anticipate in terms of major allocations

3. Distribute "Budget Quick Glance" document in printed form (saddle-stitch booklet) to all BCDHHS locations and community partners for dissemination to clients and the general public
4. Utilize social media (Facebook, Twitter) to promote the "Budget Quick Glance"
5. Create a sign-up email list for anyone interested in knowing when the Transparency site has been updated or for major updates (i.e. publications, updated budgets/audits, etc.)
6. Include links to new transparency page (where "Budget Quick Glance" would be front and center) on all relevant BCDHHS web pages
7. Conduct HHSAC-led focus group on web site, materials
8. Survey the public (before and after the following actions) on their perceptions of BCDHHS levels of transparency, including ease of use of the transparency page and access to other financial and outcomes information. Utilize Facebook advertising to generate response; Put these surveys on the "Transparent BCDHHS" site
9. Create and highlight a "Tell Us What You Think" feedback mechanism that continually captures input from site users and other interested members of the public; commit to utilizing this information to inform content and presentation of materials

**Estimated Timeline for Project :**

Collecting data for web pages/reports: August/September 2015
Developing format of information: August/September 2015
Developing web pages/reports: September/October 2015
HHSAC-led focus group: November 2015
Social Media Marketing: December 2015/January 2016
Disseminating Budget documents to partners: December 2015/January 2016

**Committee Action Items:**

Review of report format: September 2015
Review of web site content: October 2015
HHSAC-led focus group: November 2015
Distribution of material(s) through respective channels: November 2015

**Estimated Cost of Project :**

May include need for external web hosting (using WordPress?): $40/month ($500/year)
Additional time/resources for content development (internal): $4,000
Graphic design support (photos, other elements): $500
Materials printing: $1,000

Gift cards for focus group participation ($100 each): $1,000
Additional unanticipated: $500

**Total estimated for year one: $7,500**
**Total estimated for year two (including internal time/resources for updates): $2,500**

**Comments from the Committee Members:**

Suzanne: why did you put this forth as an activity/project—Frank, we have really learned a lot when we launched the first TSN report and Dan played a critical part/role in formulating messaging and how we visually presented the report. It is crucial to have folks understand the work that we are doing—generative approach. Turn the agency over to the community. Transparency is key to a sustainable system.

Bobbie—in supporting TSN, a number of people said, aha! The reports and communications were very valuable. It gives you credibility as an agency.

Suzanne, not crazy about the "transparency page" name. Could we look at another title? Frank—may need to rethink this now. Community feeling has turned. Bobbie—something like "Your Dollars at a Glance".

Robin: GovDelivey tool could be used. People could sign up and receive information on various topics.

Group really likes the Budget in Brief document from the City/County of Denver. Good model.

Online checkbook was also a strong draw for the group—real time look at expenses.

Jim—we are looking at a county-wide engagement platform—Urban Interactive.

Frank—really likes the 2014 Budget Highlights in the Denver Budget brief documents. Do more visual and infographics.

Jeff—what are we trying to address if we went to the type of website is like the City/County of Denver? How will we maintain it and what is the return on investment?

Frank—the first budget book for DHHS, addressed what DHHS is doing. Where are you spending money, what does prevention mean. It ultimately engendered good will. DHHS is thinking this through. People bought into the agency's mission. We went from a defensive strategy to a more proactive, positive strategy. This might be less work, more strategic work. We are constantly having to produce reports and if we have a concise report that is easily accessible, we save time and money.

Robin—there is a potential other strategy to tap into advocates out there to get out our message.

Jim—the more generative frame around this would be a more interactive site, where folks help us formulate the messaging.

4) **Brainstorming session on support activities and how to operationalize our work in these areas over the next 12-24 months—Frank Alexander (4:35 p.m. – 5:00 p.m.)**
   a) In order to operationalize the various discussion items, action items, and common threads in our conversations, we would like to help the Committee map out a work plan to cover the next 12-24.
      i. Summarization of the key points that arose from our activities discussion, discussion of some key leverage points and common threads that emerged, and brainstorming of some next steps for consideration by the Committee.

Frank—see the memo created to help guide the work plan conversation. We are trying to narrow and coalesce all of the activity discussions and idea put forth.

Every day that goes by, we make decisions. Staff produce work, clients get served. Right now, we are completing a number of strategic projects, staring new projects, aligning work across departments and across sectors. We will have to make decisions around where resources are allocated and reallocated.

Elvira—Trends Report presentation will occur on September

Robin—lens here, how do we bring other venues together that are not represented by this Committee? Frank—it depends on the service area, broad community needs versus more targeted needs. Robin—Mental Health issues for example. Frank—we have a huge amount of staff and resources invested in the mental health system. One example, we took all pitches in the Medicaid field and brought them together.

**One prudent approach would be to invite all of the activity staff liaisons to the August work session.

Elvira—could we come together as a committee and see some of the other proposals and budget requests that are out there?

Frank—another example, how do we think about the entire early childhood space and investments. Tracks are already moving forward, FRC with Sister Carmen, CCAP, in home visits, etc. Many different pieces.

Jeff—it would be helpful to look at targeted conversations early on, bring those to the committee early on. Frank—the original topics were picked with this in mind. Real power comes from aligning the funding with the partnerships to the internal resources.

5) **Matters from the committee members for consideration**

None

6) **August agenda items**
   a) Continued discussion of and commitment to 2015-2016 Committee work plan

7) **Next Meeting is Tuesday, August 25, 2015**, **3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

8) **Adjourn**

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

**Discussion framework for building the DHHS Advisory Committee work plan and summary of activity conversations to date**

**Introduction:** During 2015, the HHSAC has engaged in robust discussions on activities Committee members could support that would allow us to further leverage the collective strength of our strategic partnerships. As our locally-developed community-based safety net becomes increasingly driven by individuals and families, focuses more effectively on upstream prevention oriented programming, and develops data-driven cross sector solutions, **we would like to further leverage the collective strength of our partnerships by focusing on specific high-value propositions.** In order to operationalize the various discussion items, action items, and common threads in our conversations, we would like to help the Committee map out a work plan to cover the next 12-24 months that considers overall HHS strategic plans and budget priorities, so that the activities/propositions can align.

This document is intended to summarize key points that arose from our activities discussion, spell out some key leverage points and common threads that emerged, and propose some next steps for consideration by the Committee.

**Key considerations for the Committee:** We are always trying to coordinate community priorities, priorities laid out in the HSSN funding, overall HHS strategic priorities and the agency's "Big Hairy Audacious Goal" (BHAG):

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

**In addition, our thinking has focused on:**

- What kind of actionable strategies are possible both at the DHHS budgetary level and operational level?
- What are the key top priorities and what are the leverage opportunities of those priorities?
- Do you agree with the common threads identified from the presentations and listed below? If not, what other common threads do you see? What service and policy priorities do you see within each discipline?
- How do we best strengthen families and build healthy communities across different systems using tools and approaches such as: a common framework that considers; common assessments and case management tools, appropriate policy, and coordinated strategies across systems as keys to success.
- How do we streamline and scale solutions?

## High-level list of common threads throughout our discussions:

| | |
|---|---|
| Early Childhood space | Holistic approach to service delivery |
| Data integration | Family Driven |
| Common case management and common assessment framework | Collective Impact/common agenda |
| Housing supports | Specialty care and health care utilization/Medical home and home care |
| Cultural competency/cultural awareness | Right service, in the right amount, in the right time. |
| Prevention Oriented | Social Determinants of Health |
| Pillars of Self Sufficiency | Mutually reinforcing activities |
| Targeting root cause | Family preservation |

## Possible High Value Propositions from a DHHS perspective:

1. **Medicaid Service Expansion Efforts:**
    a. How HHS can support capacity development within the Medicaid service provider population that will support the now expanded enrollees with better access to primary and specialty care services?
        i. Funding priorities for service or capital dollars that can be provided?
    b. Provide continued guidance on funding requests in targeted health/mental health areas that support further integration and sustainable business models, including the dental health arena.

2. **Early Childhood Council of Boulder County: Quality Improvement and Increased Access**:
    a. Recommendation on staffing and funding priorities that would align with the work of the ECCBC and that are accomplishable in next 12-24 months.
    b. Align proactive activity with potential state and federal future funding.

3. **Ten-Year Board to End Homelessness Priorities:**
    a. Recommendation on HHS staffing and funding priorities that would align with the work of the 10YB in the supportive housing arena and that are accomplishable in next 12-24 months

4. **Financial and Budget Transparency and Communication to Community on Return on Investment:**
    a. Recommendations to HHS on what you see as the level of transparency within various documents, how well we are meeting the needs of the taxpaying public. In particular, we are very focused on communicating around upstream investments in prevention, ROTI, and integrated/blended payments for services in a manner that supports community alignment and progress.

5. **Enhanced service delivery for the Latino community and strengthening recruitment and retention of bilingual and bicultural staff:**
    a. Support the development of an HHS plan that will enhance both service delivery and staff retention, recruitment, and promotion.

6. **Evaluate BCPH strategic priorities and HHS priorities for enhanced alignment:**
    a. Recommendations for enhanced alignment and focused community work within those contexts—Health Improvement Plan process and the HHS Social Determinants framework.
    b. Where is the greatest nexus with PHIP? How do we best support PHIP goals with HHS activities and join efforts?
        i. ECE
        ii. HEAL
        iii. FRS/FRC
        iv. Mental Health also falls here as does early childhood efforts such as toxic stress that we know will impact mental health in the longer term. Timing for a comprehensive approach may be an issue and we can discuss more at the next meeting.

7. **Community work with the Hospitals:**
    a. Updated information on the opportunities for better system collaboration with the hospitals on enrolling the remaining uninsured populations and -most importantly- effectively serving the at-risk populations that are significant consumers of hospital resources with the Social Determinants of Health context.
        i. Provide updates on the data, fiscal and service trends occurring in a post-ACA world.
8. **Family Resource Centers**:
    a. Where are the opportunities and risks within the next 1-2 years, and the potential to scale the model into the Longmont community?
    b. Provide a more detailed understanding of the financial benefits and challenges of the FRC model and the projections for growth and services in the coming years compared to the last five years

9. **Dream Big Project**:
    a. Provide a summary of the current status of the Dream Big Project and how it connects with and will influence our efforts within early childhood investments, community-based case management, and supportive housing models.
    b. Define what progress has been made, where are the opportunities and risks within the next 1-2 years, and the potential to scale the model throughout different housing sites.
    c. Provide a more detailed understanding of the financial benefits and challenges of the Dream Big Project and the projections for growth and services in the coming years. What are the policy questions and implications of the expansion?

## Discussed High Value Propositions, Support Strategies, and Leverage Points for Committee Partnerships

| Activity | High value propositions | Staff or Technical Assistance/Resources needed | Leveraging opportunities | Priority (low, medium, high) |
|---|---|---|---|---|
| | | | | |
| **BCPH Strategic Plan Activities** | 1. Primary prevention GENESIS/GENESISTER program funding ending in January of 2016 | This will be funded up to ~$200k, working with GENESIS/GENESISTER staff to increase coordination between other HHS and community programs. | | |
| | | | | |
| | 2. LARC expansion and potential funding cuts | LARC expansion was part of Public Health funding request, BVWH is being funded to provide LARC | | |
| | | | | |
| | 3. Potential GENESIS pilot with Clinica – space integration | | | |
| | | | | |
| | 4. Conversation with Salud about GENESIS type approach | | We have General Operating contract with Salud…any opportunities to include this in a 2016 contract? | |
| | | | | |
| **ECCBC** | 1. Pilot CCAP program which ties enhanced reimbursement to staff career ladder to improve staff recruitment/retention | Future consideration | | |
| | | | | |
| | 2. Pilot for contracting for CCAP slots | In process | | |
| | | | | |
| | 3. Pay for Success Model: Expansion of Community Infant Program | In process | | |
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|---|---|---|---|---|
| | 4. Supporting the Lafayette Community School | In process | | |
| | | | | |
| | 5. Funding for ECE needs assessment + supply/demand model | One time request | | |
| | | | | |
| | 6. Long term support for ECE Quality Improvement Initiatives | To be coordinated with Race to the Top (RTTT) funding | | |
| | | | | |
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| | | | | |
| **Medicaid Service Expansion Efforts** | 1. Investments in physical expansion projects underway by Salud and Clinica | | | |
| | | | | |
| | 2. Clinica working to expand Lafayette clinic for medical and dental access | | | |
| | | | | |
| | 3. BCHIC (Boulder County Health Improvement Collaborative) recently focused on a strategic planning process, and identified access to specialty care as a priority- will work to bring specialty providers across the county to the table to identify current barriers to providing care to Medicaid/uninsured, and develop programs to improve access | | | |
| | | | | |
| | 4. Integration of behavioral health and primary care models throughout community (SIM model) and enhancing access to mental health services | | | |
| | | | | |
| | 5. Municipal conversations about supporting healthy and | | | |

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|---|---|---|---|---|
| | intended pregnancy | | | |
| | | | | |
| **Dream Big Initiative** | 1. Continued funding and technical support for Dream Big as a collective impact model | | | |
| | • Identify a backbone structure for Dream Big;<br>• Finalize benchmarks and theory of action;<br>• Define the continuum of integrated services that will serve families;<br>• Develop partnership agreements to outline each partner's roles and responsibilities;<br>• Start to develop funding resources for sustainability;<br>• Create data-sharing agreements. | | | |
| | 2. Define service population and scaling capacity and system impact | | | |
| | | | | |
| **Enhanced service delivery for the Latino community** | 1. Promotoras program continuation—Supported by BOCO Community Services Program through the Area Agency on Aging | | | |
| | | | | |
| | 2. Incorporate cultural competency and inclusivity practices and activities throughout all service areas | | | |
| | | | | |
| | 3. Identify specific strategies that will enhance service delivery | | | |
| | | | | |
| **Family Resource Centers/Schools** | 1. Identify implementation plan and best practices for FRCs and formalize FRC/FRS partnership model | | | |
| | | | | |
| | 2. Define Longmont FRC/FRS process and timing | | | |
| | | | | |
| **Community work with the Hospitals** | 1. Support integrated activity with the hospitals to shift the system to more preventative services—medical home and in home care | | | |

| | | | | |
|---|---|---|---|---|
| **10 Year Plan to Address Homelessness** | 1. Seat an HHS representative on the 10YP Board | | | |
| | | | | |
| | 2. Consider providing funding to Community Services Department for a 10YP Coordinator | 1.0 FTE Intergovernmental Programs Coordinator salary range: $48,816 – $70,308 + benefits | | |
| | | | | |
| | 3. Identify/communicate strategic plan re: continued addition of PSH units to portfolio | | | |
| | | | | |
| | 4. Continue to provide leadership in community around service coordination and technical assistance with community-based providers | | | |
| | | | | |
| **Transparency Project** | 1. Link to project plan | Total estimated for year one: $7,500<br>Total estimated for year two (including internal time/resources for updates): $2,500 | | |
| | | | | |

**Suggestions for next steps:**

1. Brainstorming session where we get more specific requests for technical support, operational alignment or funding requests. How do we best evaluate more specific asks across multiple disciplines and prioritize activities and time line activities
    a. Each member should start to narrow and prioritize their requests for funding and technical assistance in preparation for an ****August work session.**

**Attachment A: Initial Activity Memo to the Advisory Committee**


**Memo**

**To:** Department of Housing and Human Services Advisory Committee

**From:** Frank Alexander, Director, BCDHHS

**Date:** March 31, 2015

**Re:** Proposed Activities from HHSAC members to support DHHS Strategic Priorities in next 12 months

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Dear HHSAC members,

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

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

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

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

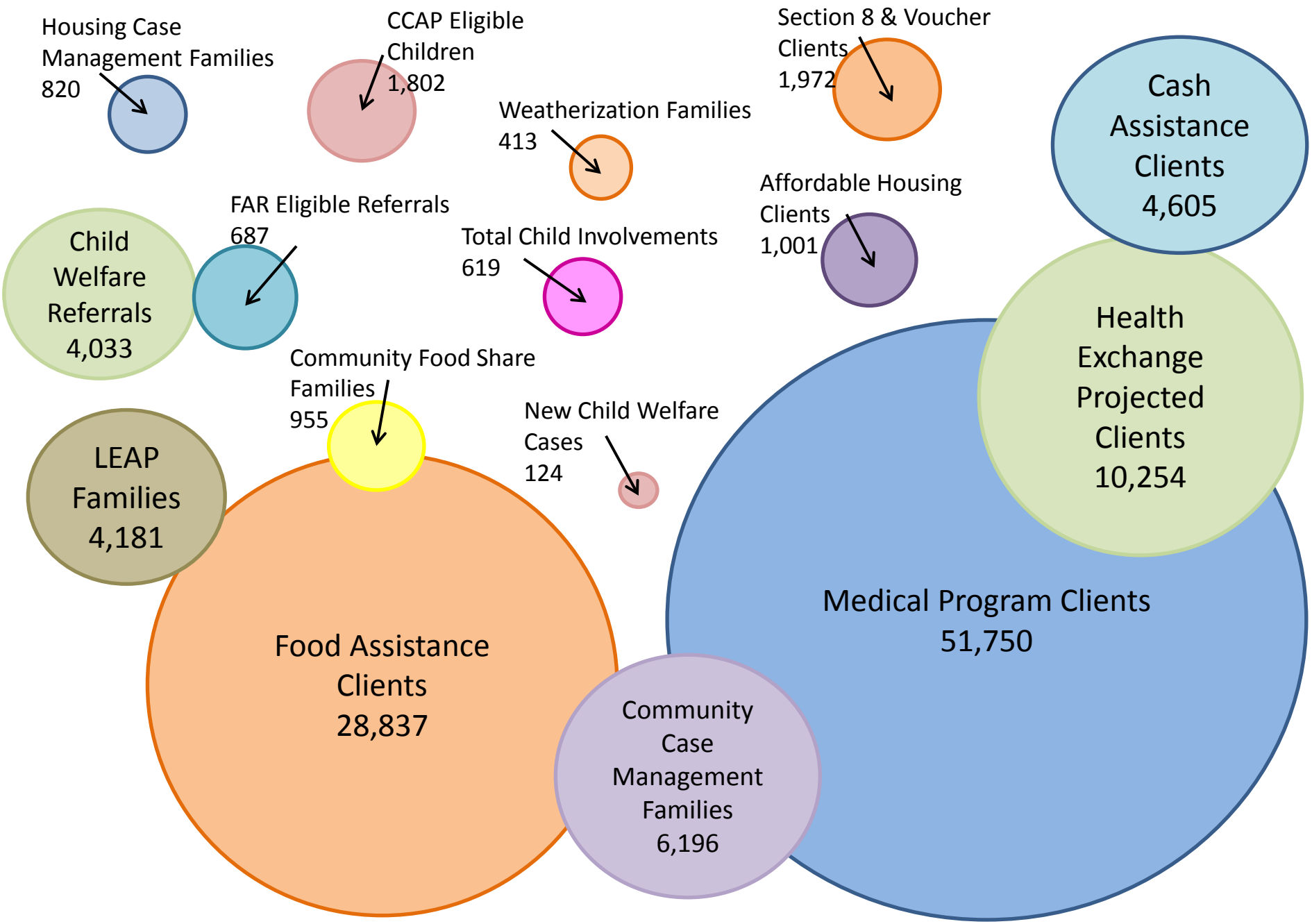
1. **Medicaid Service Expansion Efforts:** Request for input and suggestions for specific ways that HHS can support capacity development within the Medicaid service provider population that will support the now expanded enrollees with better access to primary and specialty care services. In particular, are there funding priorities for service or capital dollars that can be provided? One specific request is guidance to review the Dental Aid summary for operating subsidy and give guidance to HHS on how to respond to this type of request, solicit other like requests, and suggest what the implications of these supports are. Recommended Primary HHSAC member: Simon Smith with Jeff Zayach Secondary. Staff Liaison: Frank Alexander.
2. **Early Childhood Council of Boulder County: Quality Improvement and Increased Access**: Summary of the evaluative work of the ECCBC priorities at both the Advisory Council and Executive Board and a summary of HHS staffing and funding priorities that would align with the work of the ECCBC and that are accomplishable in next 12-24 months. Recommended Primary HHSAC member: Bobbie Watson with Secondary Suzanne Crawford. Staff Liaison: Terri Albion/Susan Grutzmacher.
3. **Ten-Year Board to End Homelessness Priorities:** Review of the Ten Year Board current priorities and process and a recommendation on HHS staffing and funding priorities that would align with the work of the 10YB and that are accomplishable in next 12-24 months. Recommended Primary HHSAC member: Robin Bohannan with Secondary Penny Hannegan. Staff Liaison: Daphne McCabe.
4. **Financial and Budget Transparency and Communication to Community on Return on Investment:** Review HHS "Transparency" website, Safety Net Mill Levy documents from TSN and HSSN, budget presentations and financial communications, and Board information from fiscal perspective and make recommendations to HHS on what you see as the level of transparency within the documents, how well we are meeting the needs of the taxpaying public. In particular, we are very focused on communicating around upstream investments in prevention, ROTI, and integrated/blended payments for services. Recommended Primary HHSAC member: Dan Thomas with Secondary Simon Smith. Staff Liaison: Jim Williams.
5. **Enhanced service delivery for the Latino community and strengthening recruitment and retention of bilingual and bicultural staff:** Review current service and staff demographics in relation to population base and poverty rates, recommendations of the Latino Task Force, community-wide needs assessments, the work of the Cultural Competency Committee, and conduct applicable focus groups with residents and partners to support the development of an HHS plan that will enhance both service delivery and staff retention and recruitment. Recommended Primary HHSAC member: Dahlia Dorta with Secondary Elvira Ramos. Staff Liaison: Myriam McDowell and Chris Campbell.
6. **Evaluate PHIP priorities and HHS priorities for enhanced alignment:** Review the alignment of the Public Health Improvement Plan process and the HHS Social Determinants framework and make recommendations for enhanced alignment and focused community work within those contexts. Recommended Primary HHSAC member: Jeff Zayach. Staff Liaison: Summer Laws and Angela Lanci-Macris.
7. **Community work with the Hospitals:** Evaluate the current hospital financial and service landscape and provide updated information to HHS on the opportunities for better system collaboration with the

hospitals on enrolling the remaining uninsured populations and -most importantly- effectively serving the at-risk populations that are significant consumers of hospital resources with the Social Determinants of Health context. Provide updates on the data, fiscal and service trends occurring in a post-ACA world. Recommended Primary HHSAC member: Laura Kinder with Secondary Simon Smith. Staff Liaison: Stephanie Arenales.

8. **Family Resource Centers**: Provide a summary of the current status of the Family Resource Center service and case management model. Define what progress has been made, where are the opportunities and risks within the next 1-2 years, and the potential to scale the model into the Longmont community. Provide a more detailed understanding of the financial benefits and challenges of the FRC model and the projections for growth and services in the coming years compared to the last five years. Recommended Primary HHSAC member: Suzanne Crawford with Secondary Bobbie Watson. Staff Liaison: Melissa Frank-Williams.
9. **Dream Big Project**: Provide a summary of the current status of the Dream Big Project and how it connects with and will influence our efforts within early childhood investments, community-based case management, and supportive housing models. Define what progress has been made, where are the opportunities and risks within the next 1-2 years, and the potential to scale the model throughout different housing sites. Provide a more detailed understanding of the financial benefits and challenges of the Dream Big Project and the projections for growth and services in the coming years. What are the policy questions and implications of the expansion? Recommended Primary HHSAC member: Penny May with Secondary Robin Bohannan. Staff Liaison: Whitney Wilcox.

Once these suggestions or others are adopted, I would recommend that the committee members come back to the April meeting with some basic sense of their targeted analysis, questions to help clarify the focus areas, and what will be required to provide some actionable recommendations that we can incorporate into our current work plan activities or begin to evaluate for our 2016 budget options. We can utilize the April meeting to have a wide-ranging discussion on the questions members have on their focus areas and we can collectively brainstorm next steps. We can also begin to set forth a calendar for May/June/July that will continue to support the presentation of these recommendations and help us think about our budgeting, planning, and strategic resources for the next 18 to 24 months.

# HHS Service Populations: 9/2013 through 8/2014



# Transformation across systems

Mental Health

Public Health

Education

Human Services


BOULDER COUNTY HOUSING & HUMAN SERVICES

Boulder County

Hope for the future, help when you need it.

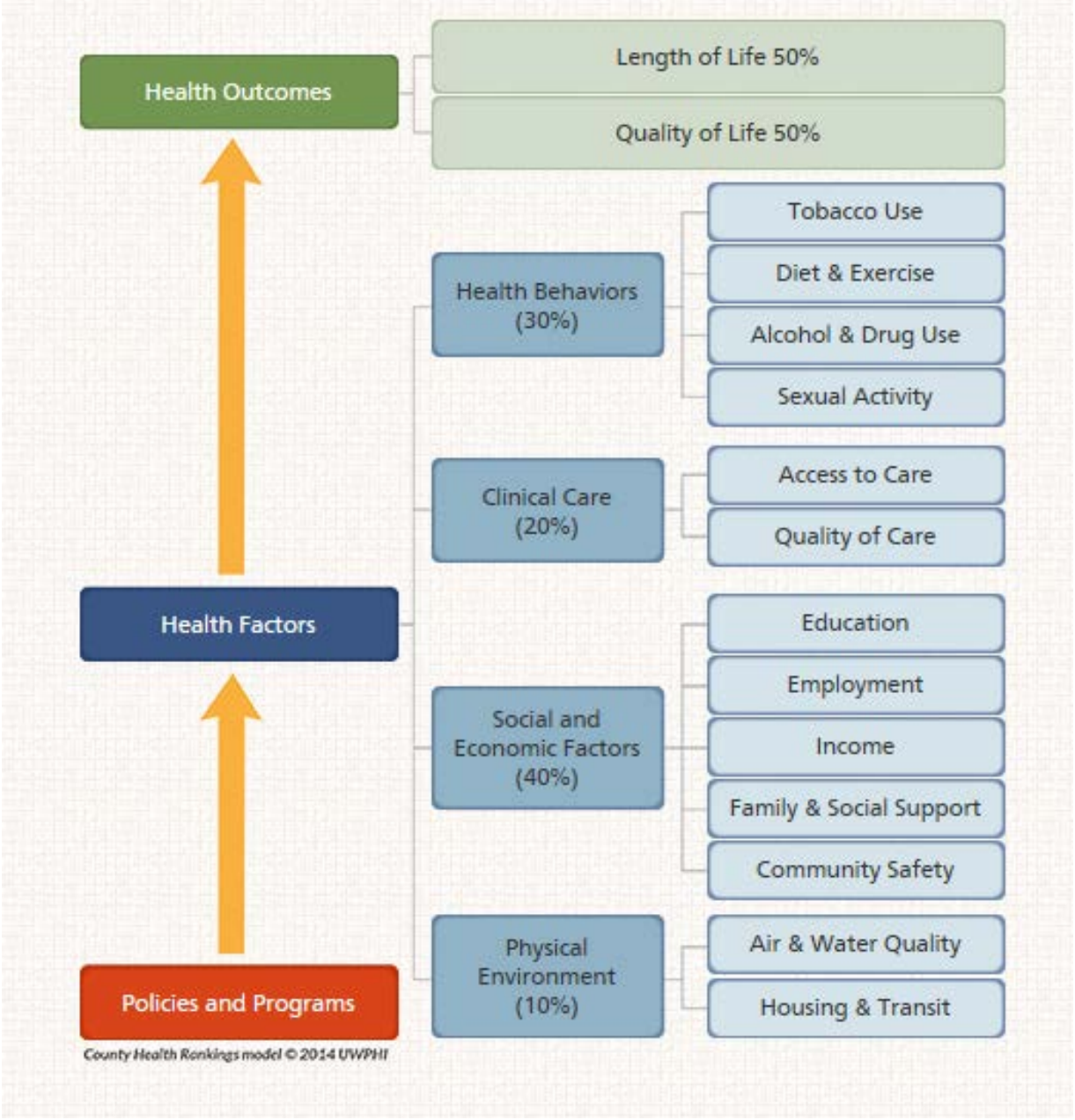
# Social Determinants of Health & Pillars of Family Stability


BOULDER COUNTY HOUSING & HUMAN SERVICES

Boulder County

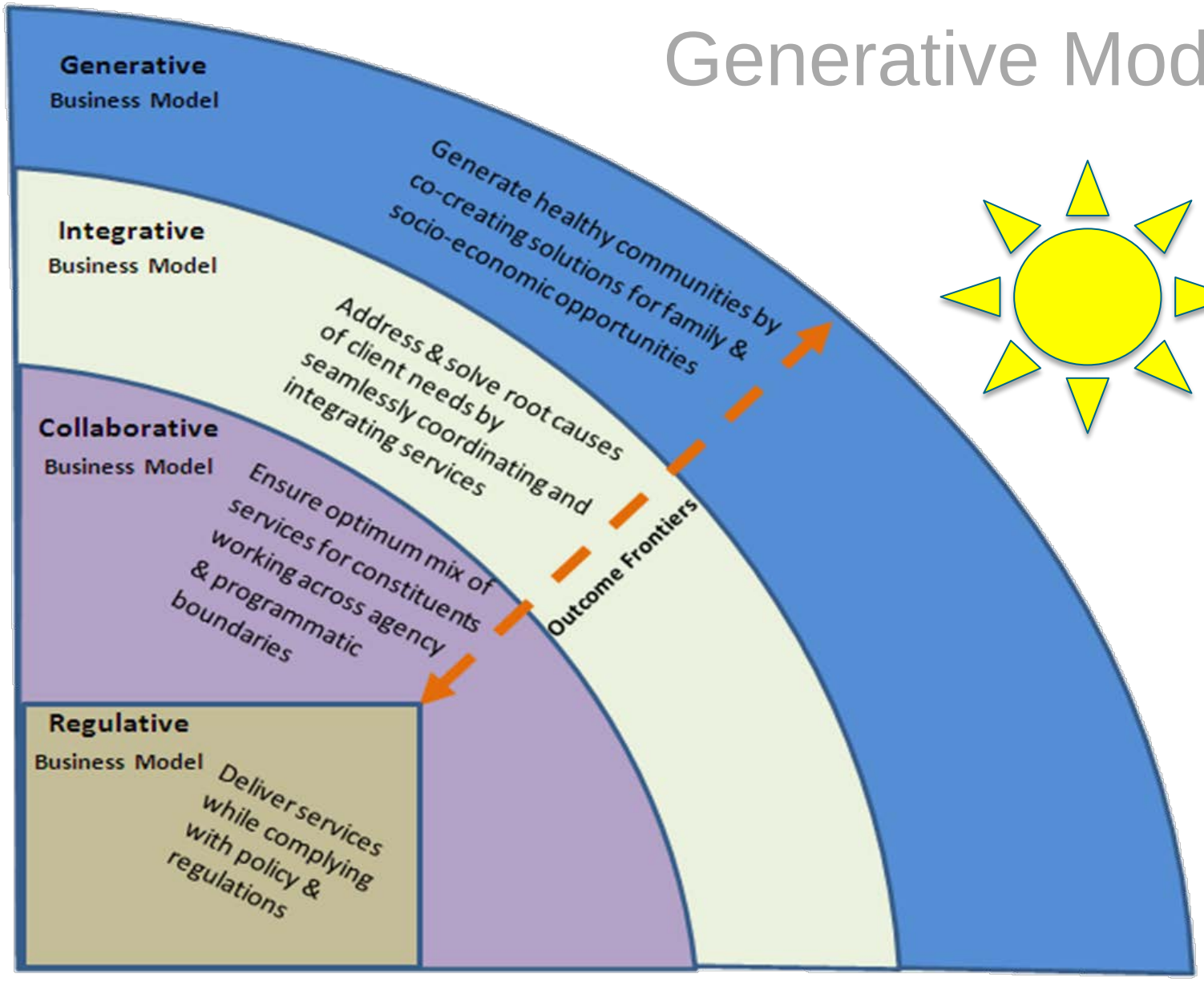
Hope for the future, help when you need it.

# Social Determinants Model and Community Health Outcomes




*Model for community health, University of Wisconsin Population Health Institute*

# Generative Model




BOULDER COUNTY
HOUSING & HUMAN SERVICES

Boulder County

Hope for the future, help when you need it.

# Safety Net Collaborative Approach (HSSN)

Invest in families early, before they hit crisis

Strengthen early intervention and prevention

Invest in community-based safety net services

Promote individual and family stabilization

- Expand on our ability to provide **food and financial assistance**
- Extend our ability to help with **housing and rent**
- Increase access to **health care**
- Provide more help for families to access **quality child care**
- Boost **job training** and **employment supports**
- Create and support community-based **Family Resource Centers**
- Increase access to **mental health** and **substance abuse services**

BOULDER COUNTY HOUSING & HUMAN SERVICES

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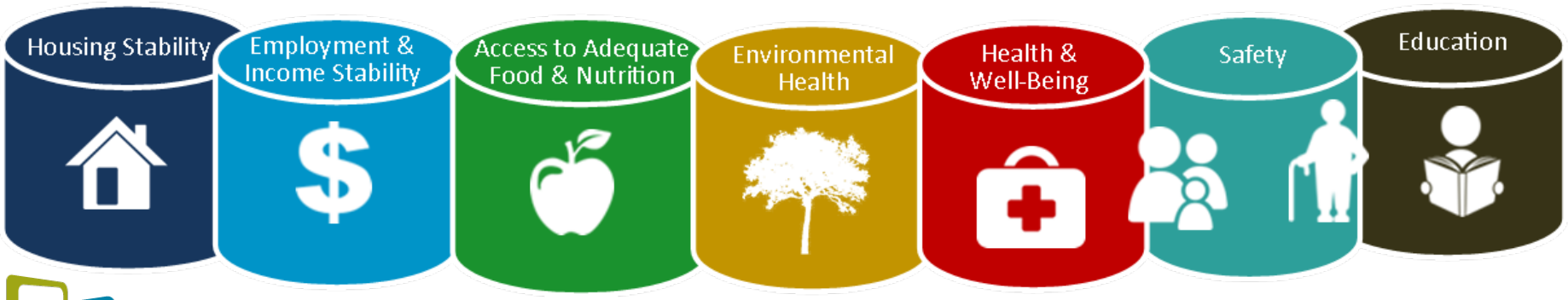
Frank

# Building Healthy Thriving Communities

- Constant Feedback Loop
- Continuous Learning Environment
- Common Community Indicators
- Integration of Community Strategic Plans

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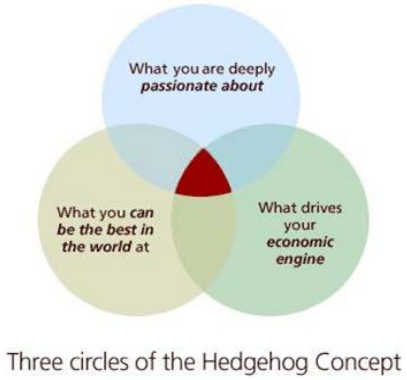
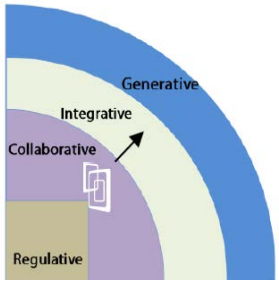


Three circles of the Hedgehog Concept

# HHS BHAG

(Big Hairy Audacious Goal)




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

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# DHHS Strategic Priorities

## Nurturing Community Integration

- Strengthening the Community Safety Net
- Integrating Case Management
- Early Childhood Plan for Boulder County

## Building the Pillars to Self-Sufficiency

- Access to Health Coverage/ Prevention
- Expanded Housing Continuum
- Educational and Employment Development/ Empowerment

## Revolutionizing the DHHS Workforce/ Infrastructure

- Data Infrastructure/ Data-Informed Practice
- Comprehensive & Sustainable Economic Engine
- Comprehensive, Agile DHHS Staffing & a Modern DHHS Workforce

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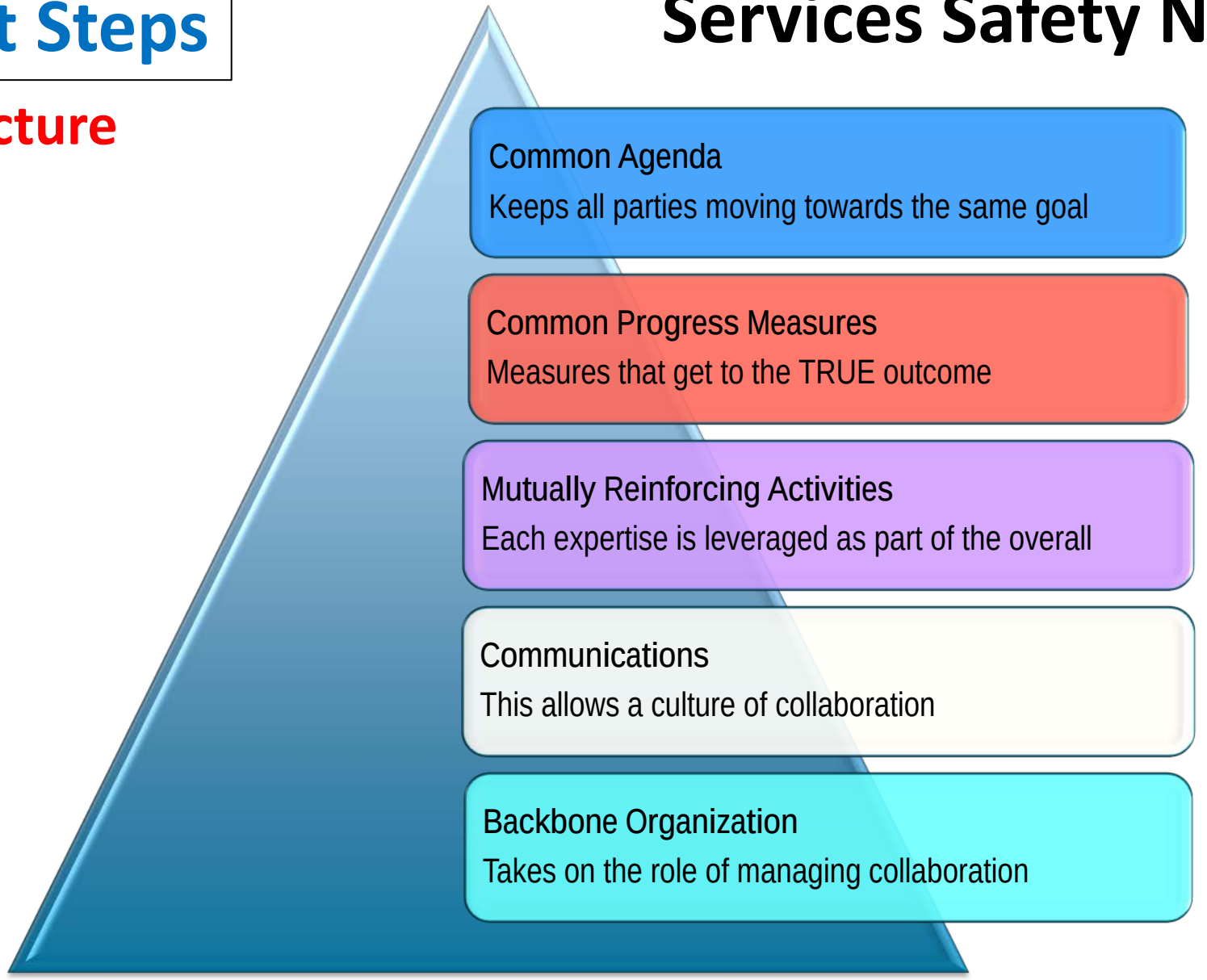
# Community of Hope: Generative Human Services Safety Net

## Next Steps

### Structure



# Boulder County Outcomes Model

# Generative Human Services Safety Net

## Pillars & Guiding Principles

Housing

Employment and Income Stability

Food and Nutrition

Health and Well-being

Safety

Education

### Human Services Vision

"To create a seamless, community-wide safety net that supports individuals and families to stabilize and thrive."

- Community-wide Planning and Outcomes
- Evidenced Based Practices
- Leveraging Resources
- Transparency
- Shared Data
- Integrated Services
- "Any Door " Service Linkage
- Data Driven Decision Making
- Front End Prevention/Intervention
- De-institutionalization

# Department of Housing & Human Services

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, September 29, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Agenda

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

2) **Review and approval of minutes from June 30, 2015 DHHS Advisory Committee meeting (3:33 p.m. – 3:35 p.m.)**

3) **2015 TRENDS Report presentation—Erika Stutzman, Trends Director, the Community Foundation of Boulder County (3:35 p.m. – 4:15 p.m.)**
   i. Presentation and discussion of top trends
   ii. Questions from the Committee and Staff

The 2015 Trends Report is available at http://www.commfound.org/trendsmagazine
Today's presentation available
at https://prezi.com/lcesiri7h0fu/dhhs/?utm_campaign=share&utm_medium=copy

4) **Continued discussion—Committee's work plan for the next 12-24 months—Frank Alexander, Angela Lanci-Macris (4:15 p.m. – 5:00 p.m.)**
   i. **Update from DHHS staff and Advisory Committee Members on project meetings and action steps:**
      a. Review of Family Resource Model process from staff and Suzanne Crawford
         1. Process review
         2. Sample plan
         3. Next steps
      b. Other Committee Updates
      c. Committee Break-Out Session (if time allows)

ii. **Committee Next Steps**
    a. Compile detailed work plan draft using sample tool
    b. Timeline: high level benchmarks for next 3-6 months

HHS Advisory Committee Liaison Work Group

i. Phone check in monthly: week after the advisory committee meeting
ii. Done mostly via email: email follow up
    a. Commitment to clear action steps
iii. Follow up status report
iv. Agenda creation

5) **October agenda items**
    i. Continued discussion of and commitment to 2015-2016 Committee work plan

6) **Next Meeting is Tuesday, October 27, 2015**, **3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

7) **Adjourn**

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, August 25, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Minutes

**In attendance:** Bobbie Watson, Dan Thomas, Suzanne Crawford, Simon Smith, Betsey Martens, Laura Kinder, Jeff Zayach, Robin Bohannan, Dalia Dorta, Elvira Ramos, Frank Alexander, Chris Campbell, Summer Laws, Angela Lanci-Macris, Stephanie Arenales, Whitney Wilcox, Daphne McCabe, Melissa Frank Williams, Susan Grutzmacher, Jim Williams, Maggie Crosswy

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

Approved as written

**2) Review and approval of minutes from June 30, 2015 DHHS Advisory Committee meeting (3:33 p.m. – 3:35 p.m.)**

Approved as written

**3) HHS Advisory Committee Proposed Support Activities—Frank Alexander (3:35 p.m. – 4:15 p.m.)**

**Update from members:** All members take time with your priority, then come back and talk about scope of what's needed to be successful; any questions, concerns, resource needs, actionable recommendations that we can incorporate into our current work plan activities or approaches to begin to evaluate for our 2016 budget options.

a) **Final Activity Presentation:**
   i. Simon Smith and Jeff Zayach: Medicaid Service Expansion Efforts Activities (45 minutes)

## Medicaid Service Expansion Discussion

**Medical Expansion**

As part of the Affordable Care Act (ObamaCare), the state of Colorado expanded Medicaid by increasing the criteria under which Colorado residents are eligible for Medicaid coverage- primarily increased the income level requirement, and has allowed more adults to access Medicaid insurance.

Above the Medicaid income threshold, the Connect for Health Colorado subsidized insurance market makes private insurance plans available up to 400% of the Federal Poverty Level.

This expansion is a big deal for the state- it has allowed hundreds of thousands of Coloradans to gain eligibility for healthcare. Many more people with health insurance coverage (Medicaid or exchange insurance products) but this by itself does not equal access.

Medicaid coverage has resulted in increased demand for access to care, beginning in primary care (medical home) and then accessing specialty outpatient and hospital based services.

**The Medicaid expansion has also revealed significant pent-up demand for services- newly insured have long delayed medical services due to prohibitive costs, have lots of primary and specialty care needs.**

Medicaid reimbursement for services (as a payer) is relatively low compared to private insurance payments= as a result (and this is not new to Medicaid) when medical providers (both primary care and specialty care) have more demand for their services than access, they typically focus on higher payer sources, and limit (either completely or partially) services to Medicaid patients. Hospital ERs cannot turn away Medicaid and therefore this becomes an access point for care, even if it is not an emergent health condition.

*Expanded insurance coverage does not automatically equal expanded access to healthcare services*

**Opportunities of Medicaid expansion in Boulder County:**

- Thousands of newly insured patients who never had insurance now have coverage- particularly for specialty and hospital access, this means receiving services does not result in bills that the patient could not otherwise afford. This equals more revenue from the Health Centers and we can invest these resources (expansion, etc.)

- For some medical providers, particularly Federally Qualified Health Centers- Clinica and Salud, shift from uninsured to Medicaid means that many patients who have always been served now result in additional revenue to the clinics, allowing for expansion and reinvestment opportunities

- More Medicaid patients are enrolled into the Medicaid Accountable Care Collaborative program (RCCO), which over time will be a vehicle for payment reform, improved care coordination, and quantification/reallocation of cost savings in the system.

**Challenges of Medicaid expansion in Boulder County:**

- Limited access to primary care services and specialty services for Medicaid insured
- Relatively poor reimbursement limits willingness to expand services to this insured population
- Significant expansion of the insured market (subsidized insurance exchange) has put pressure on recruitment and retention of competitive health positions- particularly doctors, but also nurses, licensed behaviorists, certified coders, medical assistants…this has led to significant

inflation of the marketplace and has forced all employers to ratchet up salary costs, etc. For providers serving the Medicaid and uninsured populations, this has created challenges to growth- revenue gains from Medicaid expansion has mostly been poured back into inflationary salary than investments in expanded access and services

**Current efforts to expand access in Boulder County:**

- Investments in expansion projects underway by Salud and Clinica.
- Clinica working to expand Lafayette clinic for medical and dental access
- BCHIC (Boulder County Health Improvement Collaborative) recently focused on a strategic planning process, and identified access to specialty care as a priority- will work to bring specialty providers across the county to the table to identify current barriers to providing care to Medicaid/uninsured, and develop programs to improve access.

**Dental Expansion**

Alongside the Medicaid expansion as part of the Affordable Care Act, the Colorado state legislature also passed a bill in 2013 that expanded coverage of the Medicaid dental benefit, bringing many more adults in line with Medicaid dental insurance coverage. This is a huge benefit and opportunity.

Very similar to the medical side, this has resulted in many uninsured now gaining Medicaid dental coverage, and a lot of pent-up demand for deferred dental services is emerging.

Also similar to the medical side, there is a limited amount of dental access available to Medicaid patients in Boulder County- Medicaid reimbursement is poor compared to many private dental insurers, and therefore many private practices limit/cap/avoid Medicaid patients.

According to a recent Colorado Health Institute report, Gilpin county is classified as a dental desert. The FQHC serving that community closed its Black Hawk clinic in November, and Clinica has absorbed some of their patients at our Boulder facility. 17.8% of Boulder county dentists accept Medicaid, though on the private practice side many of these dentists significantly limit their Medicaid panel sizes. Dental Aid and Clinica's models are population focused and culturally oriented to serve the Medicaid population (language, wrap around services, sliding scales, care coordination) and in my opinion are the best vehicles through which to solve the coverage issue across the county. Similarly Salud provides dental services in their Longmont facility.

**Challenges of Medicaid Dental expansion in Boulder County:**

- With limitations of private practice business models interested in expanding quality dental services to Medicaid, the safety net is the predominant player for current and future access to dental services: Dental Aid, Salud, and Clinica all provider dental services. Cost of dental expansion, particularly capital investments in dental equipment is a challenge for expansion
- For Dental Aid, Medicaid payment reimbursement is a challenge to sustaining and growing access

**Opportunities for Medicaid Dental expansion in Boulder County:**

- Clinica and Dental Aid are looking at a Caring for Colorado grant program to pilot and expand dental access through remote/virtual dental services, which has the opportunity to use expanded duty dental hygienists to provider dental services with remote/virtual support from a dentist.
- Clinica is actively working to expand access to dental care in eastern Boulder County through the construction of a new facility that would include a dental clinic integrated within an expanded medical clinic.

## Comments from the Committee on Medicaid Expansion discussion:

Jeff: where are the increases in cost of care coming from generally? Simon, primarily from staffing costs—we are facing a significant MD shortage for example. Competition for services is highly competitive and this is driving up costs. 76% of Clinica's budget last year was for staffing. Facilities costs are high as well.

Betsey: who are the members of BCHIC? Summer—Public Health/DHHS/CS, Medical providers (Clinics and Hospital providers), other community nonprofits (about 30-40 members).

Jeff—what is happening with folks that do not receive specialty care? Simon—deferred care for some and some go to the emergency rooms with emergent needs. Bobbie—greatest cited reason that children are absent from Elementary school is dental issues.

Frank—From a consolidation/scaling perspective, the natural issue that will face the system over the next few years is how to scale up to meet the needs. Practice consolidations, billing consolidations, technologies consolidations? Simon—we always explore alternate delivery mechanisms and service delivery models—need to be innovative here. Challenge is that private practices are shifting clients to Clinica because they do not want to accept Medicaid. In terms of dental, still need to work on this from a scaling perspective.

Jeff—philosophical question: trend of private providers stepping out of Medicaid. Do we develop clinics or press the private sector to get involved in Medicaid? Simon—Community Health centers have a higher reimbursement rate—more sustainable model. System is more tailored to the clients as well in the clinic model.

Jeff—dental expansion: if we need to push the policy/legislation change for the more innovative model, we should work together.

Robin—how do we push the hospitals to invest more in the communities and prevention activities? Summer Laws/Namino Glanz could educate us more.

Angela—we currently have 58,000 enrolled on Medicaid and we are working to get more folks into medical homes for example. Is there wisdom that you can impart for our practices? Simon—from a prevention standpoint, the earlier folks can establish care, the better. Help folks make the linkage to a medical home.

4) **Facilitated planning session—Committee's work plan for the next 12-24 months—Frank Alexander (4:15 p.m. – 5:00 p.m.)**
    i. **Review and discussion of the work plan document**: Summarization of the key points that arose from our activities discussion, discussion of some key leverage points and common threads that emerged, and brainstorming of some next steps for consideration by the Committee.

What we want to do is to use the expertise of this group to move forward. Internalize the priorities into the strategic work of the department. We want to take some tangible actions within the department and turn things into action items—keep the momentum moving forward.

DHHS will be entering into our next **Strategic Planning Session** this fall.

- All of the work that we have been doing this past year was built upon the foundation of last year's strategic planning session, combined with the Community of Hope Summit feedback from Sept.

- We feel that we are still on target with the **strategic priorities**, set out from last year - as they are still very relevant to our **BHAG**.

- You have all seen our **SLT work plan**. At our strategic planning meeting last fall, we defined these work projects, and have been aggressively working towards the achievement of these.

- Each one has a very detailed work plan associated with it, and as we move through the months and our tasks, each project becomes closer to completion.

| |
|---|
| **St Vrain Building** |
| **Housing Development Projects** |
| **Community Investment Contract Process** |
| **Flood Recovery** |
| **HHS Competency Based Performance Framework** |
| **Development of overall HHS Organizational Development Plan** |
| **Integrated Case Management Projects** |
| **Strengthen Financial Analysis and Reporting tools and Systems (Human Services)** |
| **2014/2015 State Fiscal Year Close** |
| **Housing Fiscal Team Meeting & Housing Financial Tools Enhancement** |
| **2016 Budget Process & Multi-Year Forecasts** |

- **Examples:** St Vrain Building, Competency Based Performance Framework.

- Community Investment Contract Process: ongoing year to year, certainly our primary area of focus in **Safety Net Collaboration and Coordination** of service delivery. For example: include fall RFP, HSP performance based, plans for FRC in Longmont July, and mid-year RFP for emergent needs)

So as part of our **constant feedback loop**, and our goal of **integrating community strategic plans**, we want to hear from you all your deeper thoughts on the **High Value Propositions** that we've proposed to this group, prior to our strategic planning session.

We may want to fine tune and better define our focus in the coming weeks, so that our SLT can hone in on our planning and focus for 2016.

Frank—what inside of the department can we do over the next 12 months that will help move the Medicaid expansion work together that is in lock step with the department's work and the community partners work. Dan—Smoother path to find a provider for example.

Dental access for example—this came to the agency from many different areas, we considered, and then gave them bridge funding for a 12 month period. In the meantime, Dental Aid could work with Clinica and work to create a more sustainable model.

Angela—Family Resource Center model in the Longmont area—connect with Suzanne, discuss best practice and models. This will help us ramp us to help fund a FRC model in Longmont.

Bobbie: mutually reinforcing activities—dental issues in children are 100% preventable. Worked with the City of Boulder to start to address this. One early childhood activity—10 minute lap review for example. Frank—what happens on the back end is these programs can be calibrated to be more effective and be deployed in a more effective order. Prioritization of services and resources.

Review **High Value Propositions** and **Next Steps**.

**Action item: DHHS staff will meet with each Committee member and discuss how we can better work together, discuss where we are currently at in the community work and in the department work. Start to make connections between various priorities and create actionable steps. **Additional staff members that are encouraged to attend the upcoming meetings. This work will happen and come back to the committee at the September meeting.**

5) **Matters from the committee members for consideration:**

None

6) **September agenda items**
   a) Continued discussion of and commitment to 2015-2016 Committee work plan
   b) Presentation of the Trends Report

7) **Next Meeting is Tuesday, September 29, 2015**, **3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

8) **Adjourn**

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## HHSAC: Boulder County Family Resource Model Work Plan

**Goal:** The goal of the Boulder County Family Resource Model project is to create a tightly-coordinated network of neighborhood hubs, consisting of school districts, county and city programs, and community-based organizations aimed at improving academic and behavioral outcomes of students and strengthening the family ecosystem.

| Objective | Activities | People Responsible | Target Completion Date | Deliverables | Notes: |
|---|---|---|---|---|---|
| **1-Formalize a standard governing structure, guiding principles, and best practices for the Boulder County Family Resource Model and implement across our three critical service sectors- schools, county/city government, and community based organizations.** | Activities and Timeline:<br>a) Draft Guiding Principles, Guidelines and Structure for Family Resource Model in Boulder County and propose to key stakeholders including HHSAC. | Melissa Frank Williams, Whitney Wilcox | 10/23/15 | Initial implementation plan | Include: FRCA Membership Guidelines, Boulder County Family Resource Model framework identifying relationships and governing structure, Family Development Credential, Commitment to adherence to Family Strengthening Support Standards, and data sharing agreements |
| **2-Formalize data sharing agreements and processes between BVSD, SVVSD, DHHS and Community Partners.** | a. School districts and BOSS staff compile report on requirements and possible scenarios around data sharing agreement between HHS, schools and community partners.<br>b. Implement first phase of plan | Jason McRoy, Whitney, SCCC staff, BVSD staff | 11/15/15<br>1/30/15 | Report of options and plan | |

| | | | | | |
|---|---|---|---|---|---|
| **3- Implement pilots using guiding principles, guidelines and structure in three key regions of Boulder County (East County- Lafayette/Louisville/Superior, Longmont, Boulder/Mountain Communities)** | a) **East County**: Pilot integrated case management between SCCC/Sanchez/HHS that's to be scaled up in other East County schools<br>i. SCCC and HHS staff meet with Sanchez staff and identify core services, shared goals, opportunities for tighter coordination<br>ii. Roles and responsibilities for each partner are outlined and agreed to in MOU<br>iii. Integrated case management between SCCC, Sanchez, and HHS launches<br>iv. Data sharing protocols and agreements created between 3 entities | Suzanne and Marc (SCCC), Whitney, Sanchez staff TBD | i-10/15/15<br>ii-11/15/15<br>iii-1/15/15<br>iv-3/15/16 | Document outlining the model<br>MOU<br>Data sharing agreement | |
| | b) **Boulder:** Customize and implement pilot using above steps in Boulder<br>-Compile initial plan with key partners | Melissa, Whitney, BVSD, COB, EFAA | 1/15/16 | Initial implementation plan | |
| | c) **Longmont:** Customize and implement a pilot in Longmont<br>-Compile initial plan with key partners | Melissa, Whitney, Sarah B. COL, SVVSD, OUR Center | 3/15/15 | Initial implementation plan | |

# Department of Housing & Human Services

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BOULDER COUNTY HOUSING & HUMAN SERVICES

**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, October 27, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Agenda

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

2) **Review and approval of minutes from September 29, 2015 DHHS Advisory Committee meeting (3:33 p.m. – 3:35 p.m.)**

3) **2016 DHHS Budget Overview Presentation—Will Kugel, DHHS Finance Director (3:35 p.m. – 4:05 p.m.)**
   i. Human Services and Housing Authority budget reviews
   ii. Committee questions

4) **2015 DHHS Annual Report Draft review—Frank Alexander, Jim Williams, Maggie Crosswy (4:05 p.m. – 4:45 p.m.)**
   i. Committee feedback on overall layout, messaging, and resonance with the community
      a. What overall message does the report deliver?
      b. How is the flow of the report (does the order make sense, does it move well from one section to the next)?
      c. What's missing from the report? What could be removed?
      d. When thinking about members of the community with whom you regularly interact, how well do you think this report will resonate with them?

5) **Continued discussion—Committee's work plan for the next 12-24 months—Frank Alexander (4:45 p.m. – 5:00 p.m.)**
   - **i. Update from DHHS staff and Advisory Committee Members and staff liaisons:**
     a. Project Updates
     b. Project pacing discussion

6) **December Agenda Items:**
   - i. Continued discussion of and commitment to 2015-2016 Committee work plan
   - ii. Discussion of joint meeting with the Board of County Commissioners (Human Services Board and Housing Authority Board)—**January 26, 2016 meeting.**

7) ****No November meeting. Next Meeting is Tuesday, December 8, 2015, 3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

8) **Adjourn**

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, September 29, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Minutes

**In attendance:** **Committee Members:** Laura Kinder, Simon Smith, Suzanne Crawford, Bobbie Watson, Jeff Zayach, Betsey Martens, **Staff:** Frank Alexander, Melissa Frank Williams, Summer Laws, Whitney Wilcox, Stephanie Arenales, Daphne McCabe, Jim Williams, Will Kugel, Jason McRoy, Kit Thompson, Susan Caskey

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

Approved as written

2) **Review and approval of minutes from June 30, 2015 DHHS Advisory Committee meeting (3:33 p.m. – 3:35 p.m.)**

Approved as written

3) **2015 TRENDS Report presentation—Erika Stutzman, Trends Director, the Community Foundation of Boulder County (3:35 p.m. – 4:15 p.m.)**
   i. Presentation and discussion of top trends
   ii. Questions from the Committee and Staff

The 2015 Trends Report is available at http://www.commfound.org/trendsmagazine

Today's presentation available at
https://prezi.com/lcesiri7h0fu/dhhs/?utm_campaign=share&utm_medium=copy

Comments and questions from the Committee Members and staff:

Frank—what do you think we should be doing? Erika—affordable housing is an issue, pricing out the middle class, too much income on housing (not saving, not giving, etc.). Regional approach to affordable housing is a need. Also, need to address the Colorado paradox—very educated population, very healthy population, not raising our kids this way—big concern. Childhood obesity is a good example of this paradox—very healthy adult population, not so healthy kid population.

Simon—first piece of data was the age wave, all the subsequent data said that the issue isn't there (more in early childhood for example). This is an interesting question. Erika, more of a safety net for the aging population (Social Security, Medicare, etc.)

**4) Continued discussion—Committee's work plan for the next 12-24 months—Frank Alexander, Angela Lanci-Macris (4:15 p.m. – 5:00 p.m.)**

Frank—As we continue our conversations around Committee activities, it should be noted that this work has already provided a lot of valuable input into DHHS budgeting processes and strategic work. We are doing a ton of work based on the feedback that has been provided by committee members to date. This isn't always seen by the committee and Frank wanted to thank the group for their insight thus far.

i. **Update from DHHS staff and Advisory Committee Members on project meetings and action steps:**
    a. Review of Family Resource Model process from staff and Suzanne Crawford
        1. Process review
        2. Sample plan
        3. Next steps:

Goal could be that this format could evolve into one master plan that we can all use. Summer—what is the focus of the work plan. Melissa—some of the work is cross-departmental and some is just focused on DHHS. Angela—this work plan is informing some practice that DHHS can employ—High-impact actions that can impact health outcomes for example. Frank, we are expecting that each committee/group working on a task/project will have a DHHS focus and others; it is a much broader body of work.

Jeff—if this work plan moves forward and it requires more resources, how does that work. Frank, priorities that were put out reflect talents of the group, and identified community priorities. We are trying to align with groups from across the county. In some cases, we focus on community partnerships (FRS/FRC model). There are complex issues however—r.e. school based services discussions. We are trying to think through all of the pieces in a methodical way

and try to be aligned in the end—considering both funding and systems implications to reach sustainability for our safety net.

Frank—Homeless services collaborative example—BOHO, Shelter, Bridge House, went through an assessment (Burns Report), we (DHHS) are a key funder as well as technical assistance. Because of the way that this committee has approached their needs, we were able to support their recommendations—data needs, health care needs, etc. This could be how this group approaches some issues. Simon—this is significant, this coordination. Betsey—our group can provide some facsimile of this coordination.

Frank—these kinds of models is how we are going to approach this big body of work moving forward with a similar construct—Evidence-based, prevention-based work, data-driven work. More sophisticated approach with our partners. We need to start to make some progress on these issues. Align business operations, and deal with general social problems.

Angela a good example of how we are going to approach the work moving forward—PHIP and DHHS Alignment—were able to draw on current examples where there has already been better coordination—Nurse Family Partnership and DHHS Child Welfare coordination. Then we asked the question, how can we do some more enhancement and alignment? Mental Health spectrum was one area—DASH grant (sharing of data to improve health outcomes).

Frank—from a sheer infrastructure perspective—we are looking to lock down the many initiatives into a consistent frame so we are moving in the same direction—no more shiny pennies. It is our responsibility to make sure we are understanding the core economics at play and are creating a sustainable system.

Simon—must capture the collective impact of these initiatives.

Betsey—would be good to review the Community of Hope event findings—seems like a lot of this work is grounded in the outcomes of this event.

Frank: do know that, the end game for us, is that some of the work will prioritized over other work. This process will get incorporated into the master DHHS work plan.

b. Other Committee Updates
c. Committee Break-Out Session (if time allows)

**ii. Committee Next Steps—Action Items**

**a. Meet once again with your groups and looks to compile detailed work plan draft using sample tool**
**b. Timeline: high level benchmarks for next 3-6 months**
**c. Keep in mind the high-level, collective impacts. Help tie out these connections in work plans.**

iii. **HHS Advisory Committee Liaison Work Group next steps**

i. Phone check in monthly: week after the advisory committee meeting

ii. Done mostly via email: email follow up

   a. Commitment to clear action steps

iii. Follow up status report

iv. Agenda creation

**5) October agenda items**

i. Continued discussion of and commitment to 2015-2016 Committee work plan

**6) Next Meeting is Tuesday, October 27, 2015**, **3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

**7) Adjourn**

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

BOULDER COUNTY
HOUSING
& HUMAN
SERVICES

Hope for the future, help when you need it.

# Boulder County Housing & Human Services
# 2016 Budget Hearing
# October 27, 2015

# Our Mission:

## Promoting safe, healthy and thriving communities

BCDHHS is dedicated to supporting and sustaining healthy communities that strengthen individuals and families while promoting human dignity and hope for the future.

# Our Goals for Today:

- Present the 2016 Boulder County Housing & Human Services requested budgets to the board in a public format.
- Address any questions from the materials presented today.

# Key Considerations in Reviewing these Budgets

1. Long-term goals of stable and sustainable Housing and Human Services
2. Managing our personnel to withstand potential future downturns
3. Ensure our investments in the community align with our strategic goals

# Key Considerations in Reviewing these Budgets

1. Kestrel is a major project for HHS in 2016. The Kestrel project will drive a significant amount of work and fiscal discipline in in 2016.

2. The Human Services budget is largely continuation funding with the most significant increase associated with merit.

3. BCHA operations are in a stable phase and the budget reflects a largely continuation funding.

# Agenda

- Housing Authority Budget Overview
- Human Services Budget Overview

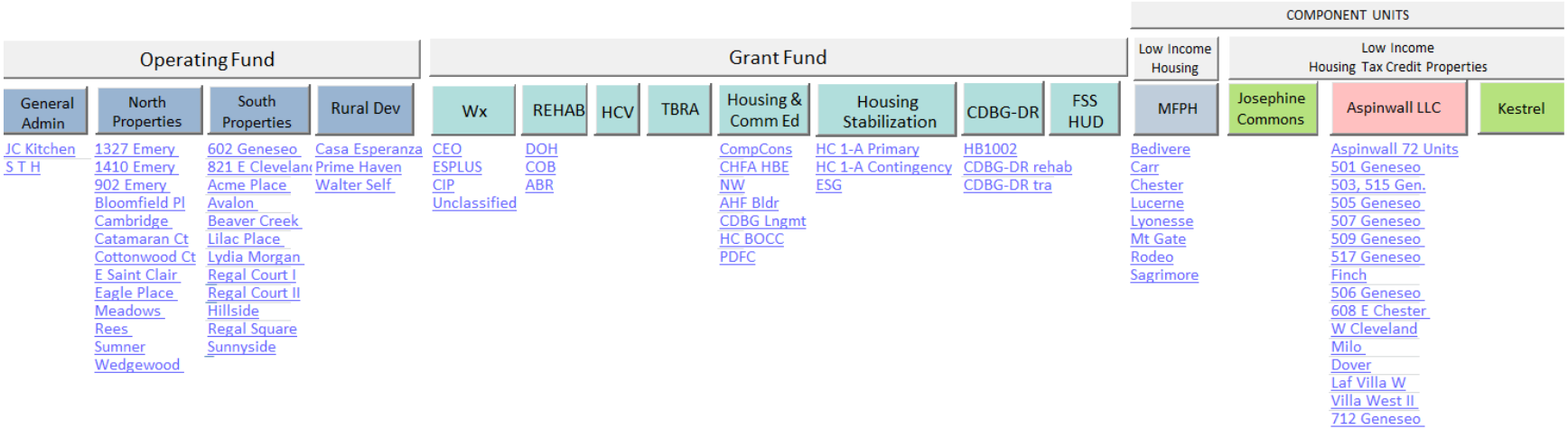
# Boulder County Housing Authority



611 units of affordable housing throughout Boulder County

BOULDER COUNTY HOUSING AUTHORITY

# BCHA Structure - 2016




BOULDER COUNTY HOUSING & HUMAN SERVICES

Boulder County

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# 2015 Successes

Housing portfolio is strong with low vacancy

Increased affordable housing stock with completion of Aspinwall in Lafayette

$2.3 million in developer fees – reinvested in increasing affordable housing stock and maintaining current housing stock

# 2016 Opportunities

Kestrel development project adding another 195 affordable housing units upon completion

BCHA's partnering with DHHS to integrate programming, including short-term emergency housing

$2,582,123 CDBG-DR round 2 funding

Higher rent allowances – 79% of maximum (excluding component units)

Land Donation in Lafayette

# 2016 Risks

Real estate risk in financing and constructing Kestrel

Changes in Federal funding

- HUD support for the planned growth of the Housing Choice Voucher Program
- HOME program funding for TBRA

Remediation: $1,500 per unit for tests & $10,000 per unit for insurance deductible

- 2016 budget has $309,145 set aside for non-routine maintenance costs

2013 flood support structures scaling back and ending (2016 / 2017)

# 2016 Assumptions

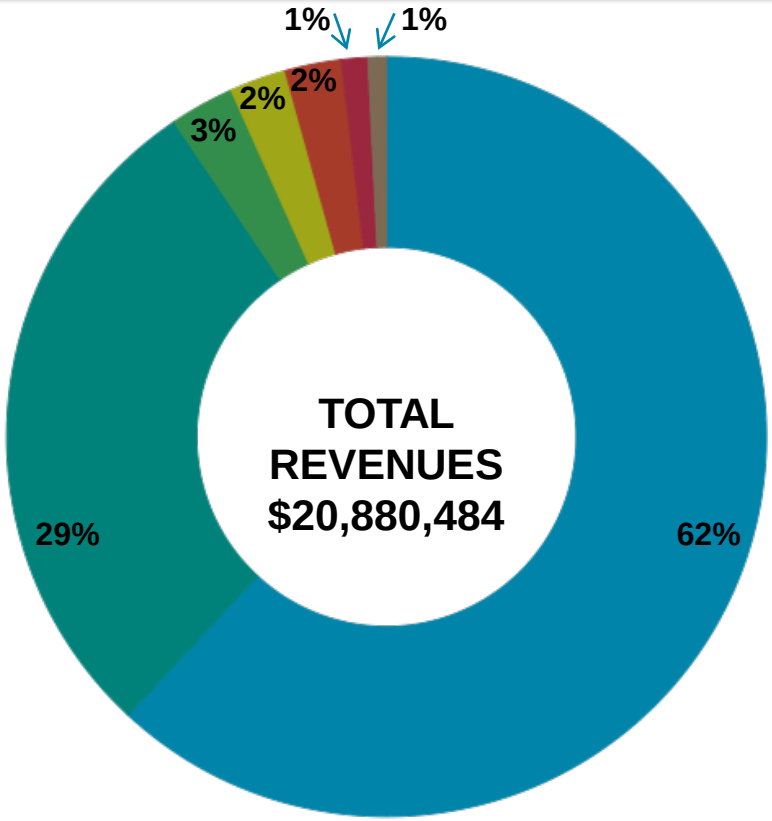
Kestrel development project approved and funded

- Low income housing tax credit formed in early 2016
- LIHTC completion by the end of Q1 2017

97% Occupancy Rate of rental properties

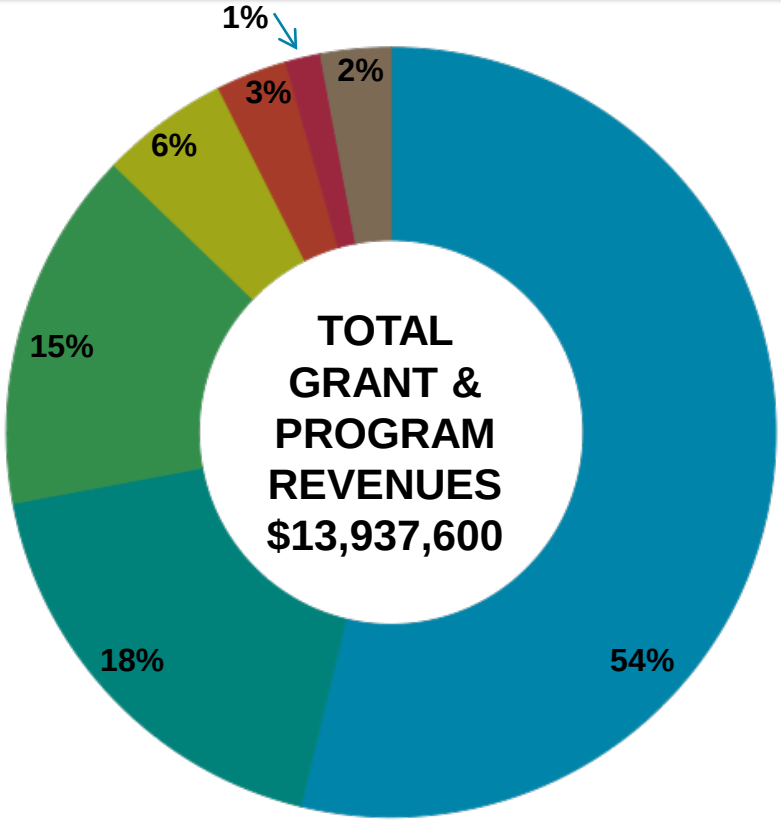
2% inflation rate

# BCHA Revenues $20,880,484 w/ component units



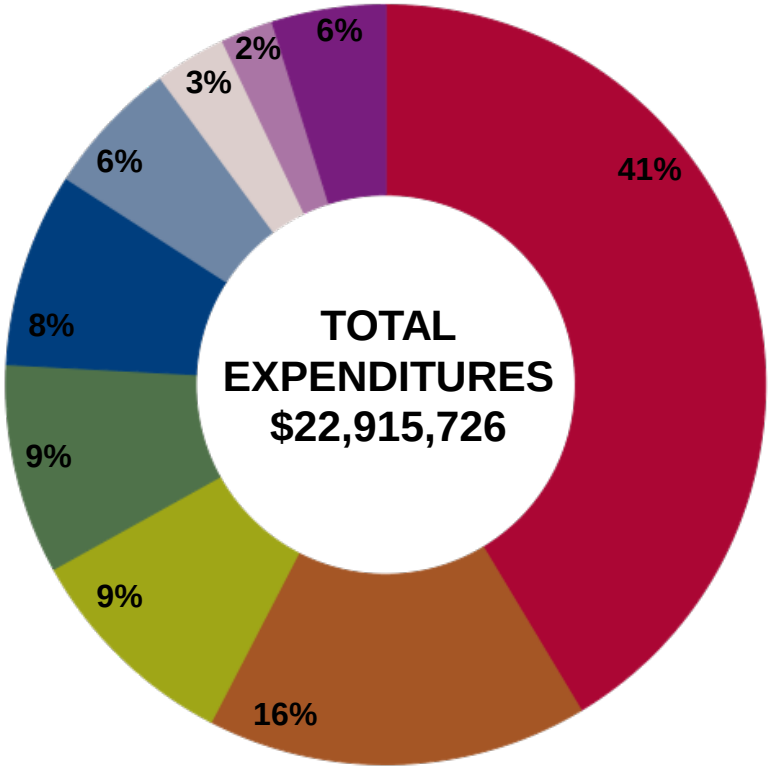

- Grant Revenues ($12,928,328)
- Tenant Rental Income ($5,980,611)
- Housing Choice Voucher Administrative Fees ($571,200)
- Program Revenue & Fees ($503,023)
- Interest Income ($499,839)
- Transfers In ($234,596)
- Management Fee Income ($162,887)

# BCHA Grant and Program Revenues
# $13,937,600



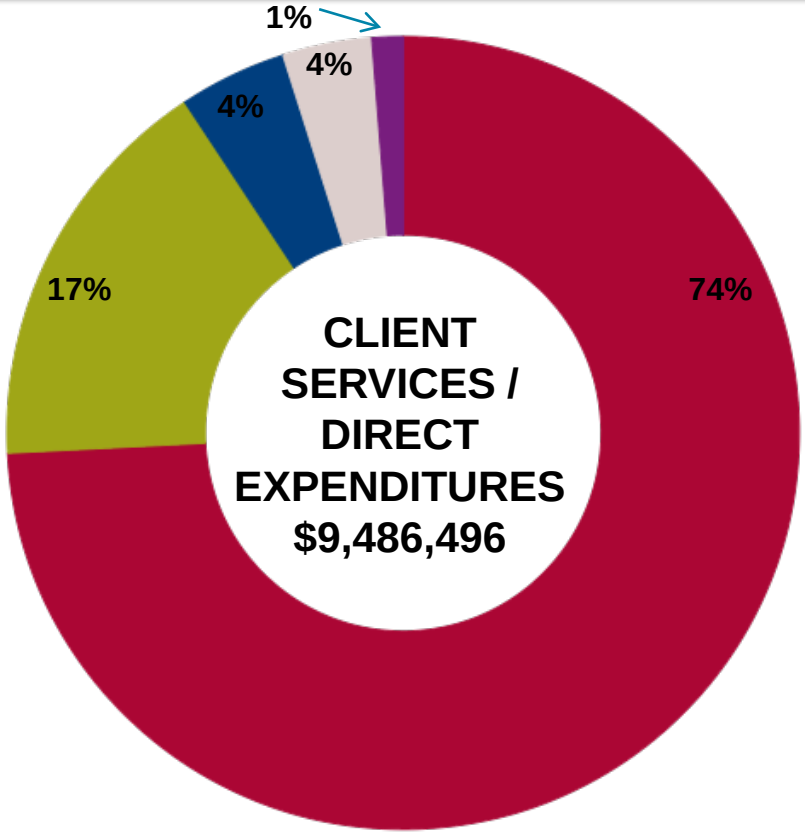

- Housing Choice Vouchers ($7,496,200)
- Weatherization ($2,545,816)
- CDBG-DR & HB1002 ($2,112,749)
- Housing Stabilization Program ($752,000)
- Tenant Based Rental Assistance ($415,743)
- Housing & Community Education ($205,195)
- Other: Rehab ($197,773), FSS Program Coordinator Grant ($192,124), Josephine Commons Kitchen ($20,000)

# BCHA Expenses $22,915,726 w/ component units




- Client Services/Expense ($9,486,496)
- Direct Salary & Benefits ($3,712,668)
- Depreciation ($2,137,856)
- Contractual Services ($2,044,748)
- Direct Non-payroll Expenses ($1,896,044)
- Interest Expense ($1,326,730)
- Indirect Salary & Benefits ($694,800)
- Weatherization Operational ($510,635)
- Other: Indirect Non-payroll Expenses ($409,121), Non-Routine ($320,569), Legal & Other Fees ($178,576), Management Fees ($162, 887), Transfer Out ($34,596)

# Client Services/ Direct Expenditures $9,486,496




- HAP Rent and Utility Expense ($7,038,000)
- HSP Rent and Utility Expense ($1,566,993)
- TBRA Rent Expense ($415,743)
- CDBG-DR Temporary Rent Assistance ($345,760)
- Short Term Housing Rent Expense ($120,000)

# BCHA 2016 Operating Budget

| | Excluding Component Units | MFPH | Tax Credit Property Josephine Commons | Tax Credit Property Aspinwall | Total |
|---|---|---|---|---|---|
| Total Revenues | 18,250,257 | 263,064 | 694,738 | 1,672,425 | 20,880,484 |
| Total Expenditures (operating) | 18,173,316 | 147,846 | 381,759 | 713,622 | 19,416,543 |
| **Net Operating Income** | **76,941*** | **115,218** | **312,979** | **958,802** | **1,463,941** |
| Less Non-Op Cash Expenditures | 535,504 | 79,704 | 206,119 | 540,000 | 1,361,327 |
| Less Depreciation | 741,577 | 35,514 | 489,753 | 871,011 | 2,137,856 |
| **Net Income** | **-1,200,140** | **0** | **-382,893** | **-452,209** | **-2,035,242** |

Component units operating budgets are cash flow favorable.

* In addition $1,425,502 to be drawn from pre-planned reserves, bringing BCHA net cash flow favorable.

# BCHA Capital Spending Plan

# 2016 Capital Plan Summarized

- $602,074 Controlled maintenance Costs
- $ 31,000 Replacement vehicle
- $ 10,000 Development Land Bank
  $643,074

**BCHA 2016 CAPITAL PLAN - $643,074**

**$485,000 from unrestricted (Master) & $158,074 from restricted funds**

**Controlled Maintenance when completed will touch half of the BCHA units excluding JC & AW.**

| Controlled Maintenance (17 properties) | |
|---|---|
| Grounds | $29,300 |
| Parking Lot | $134,746 |
| Kitchen | $35,000 |
| HVAC/Water Heater | $66,000 |
| Siding | $120,000 |
| Flooring | $22,028 |
| Bathroom | $18,000 |
| Exterior Painting | $137,000 |
| Driveway & Sidewalk | $15,000 |
| Roof | $25,000 |

# Kestrel

LOUISVILLE, COLORADO

## Capital Development – Kestrel

- Estimated project capital budget for 2016 is $35,038,313
- January 15th construction close date

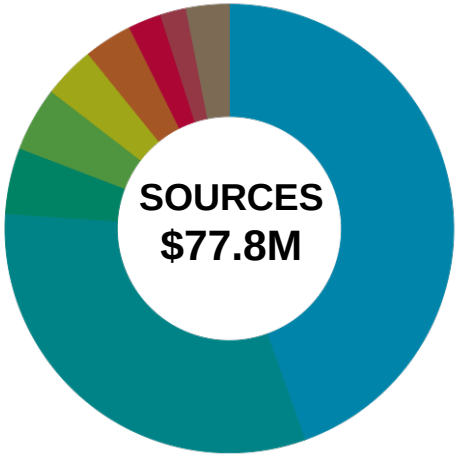
## Accomplishments for 2016

- All infrastructure complete
- Construction on both senior and multi-family will be well under way

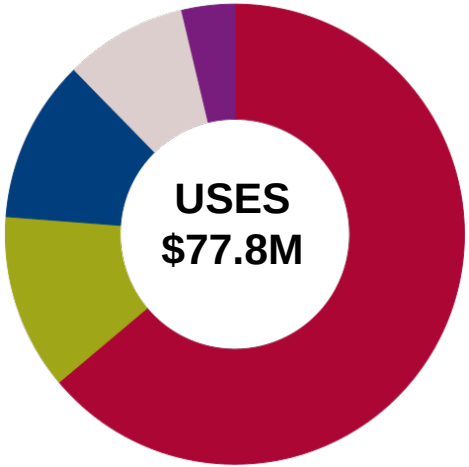
## Big bang for the county's buck!

- The project creates 195 new affordable units plus it allows the housing authority the ability to reinvest in affordable housing with developer fee
- BCHA/BCHHS/Worthy Cause contribution = 7% of total budget

*Annual Estimated Revenues = $2.7M*
*Annual Estimated Expenses = $1.1M*
*Net Operating Income = $1.6M*
*Annual Estimated Debt Payment = $1.3M*




- LIHTC Equity (Redstone) ($34.6M)
- Private Activity Bonds ($24.5M)
- CDBG-DR Funds ($3.7M)
- BCHA/BCDHHS ($3.6M)
- Land Carryback ($2.9M)
- Deferred Developer Fee ($2.7M)
- Worthy Cause Funds ($1.85M)
- CO Division of Housing ($1.45M)
- Other: Louisville Permit Fees and Rebates ($1M), HOME Funds ($900K),
  Energy Credits Equity ($500K)




- New Construction ($49.7M)
- Infrastructure ($9.6M)
- Construction & Financing ($8.9M)
- Developer Fee ($6.7M)
- Land ($2.9M)

# Fund 098 Funded 2016 Decision Package Requests

**Replace One 2006 Ford Van with comparable new vehicle**

**$31,000**

**One Housing FTE (annualized increase from base + 20% PERA/FICA)**

**$54,000**

Section 8: New position to start early 2016

- One occupancy assistant
  - Funded by surplus HUD admin fund disbursements and HUD unrestricted net asset reserves
    - BCHA anticipates issuing an additional 50 vouchers over the next 1-2 years
    - Current caseload is prohibiting a supervisor from fully assuming supervisor duties.
    - A pro-active enhanced service delivery model resulting in increased front end work

**Anticipated budget supplemental request (estimated October 2016)**

New positions to manage and maintain Kestrel:

- Two property managers (PM4) six months prior to occupancy
- One maintenance tech plus vehicle (MT2 or MT3) six months prior to occupancy

# Boulder County Human Services

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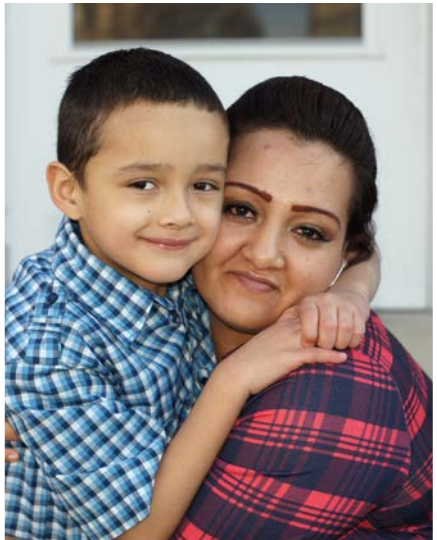


# 2015 Successes

Passage of Boulder County Human Services Safety Net 2014 Ballot Initiative (November 2014) at approximately $6M/year

Award of a third IV-E Waiver: Trauma-informed programming $107,218

Favorable State 2014-15 year-end closeouts that covered over-expended Child Welfare, Core Services and CCCAP programs

Contributions to new St. Vrain Building ($2.915M), including administrative partnerships with Public Health and Community Services. New North Broadway lobby ($166k) (expected 4Q15)

Benefits of integration of safety net services, infrastructure systems, and funding streams

Strengthened community partnerships

# Risks 2016 and Beyond

Effect of TABOR limitations – more pressure on programs with no additional funds

Block grant funding level changes made through allocation committees (Child Welfare, Colorado Works, Child Care, County Administration)

Increased Child Care spending at the State level may reduce or eliminate surplus distributions at closeout

Managing increased referrals for APS and Child Welfare Hotline

Child Care requirements, including impact of HB 1317, exceed expanded funding opportunities

Unforeseen natural, economic or other disasters

The level of term staffing and turnover within our term staffing.

# Opportunities 2016 and Beyond

Year 1 of extended 15 year Boulder County Human Services Safety Net funds will continue to provide resources for a larger community impact of services (approximately $6M/year)

Year 3 of consolidation of Human Services contracts under the BCDHHS umbrella for more strategic and effective partnering and service delivery (approximately $8.2M)

Potential further funding from the State for additional Child Welfare FTE

IMPACT transition to HHS (new appropriation HU2) will afford new efficiencies and more collaborative programming (approximately $2.3M)

Continuation of Child Abuse hotline funding to supplement State-wide rollout of focused programming into 2016

Community of Hope - new opportunities to strengthen our generative safety net

# 2016 Assumptions

DHHS unbudgeted reserves for disaster emergency operations

Social Services Fund property tax revenue has a 5.5% increase over 2015

Human Services Temporary Safety Net increase by $977,693 over 2015

Non-Profit Community Contracts funding consistent with 2015 funding

No or minimal available HSSN Fund 032 balance

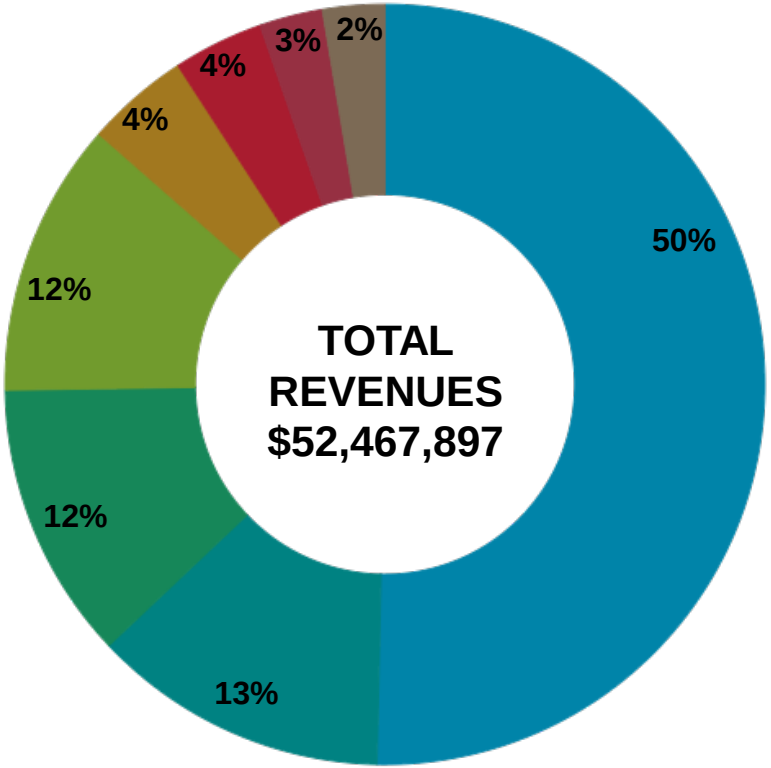
First six months SFY16-17 major program allocations same as final six months SFY15-16

# Fund 012 Funded 2016 Decision Package Requests

| | | |
|---|---|---|
| 3400 Broadway Family Visitation Room Reconfiguration | CEF 46411 | $ 29,198 |
| 3400 Broadway Family Visitation Room Video Equipment | COM 46410 | $ 25,825 |
| Total Requested One-time Funding | | $ 55,023 |

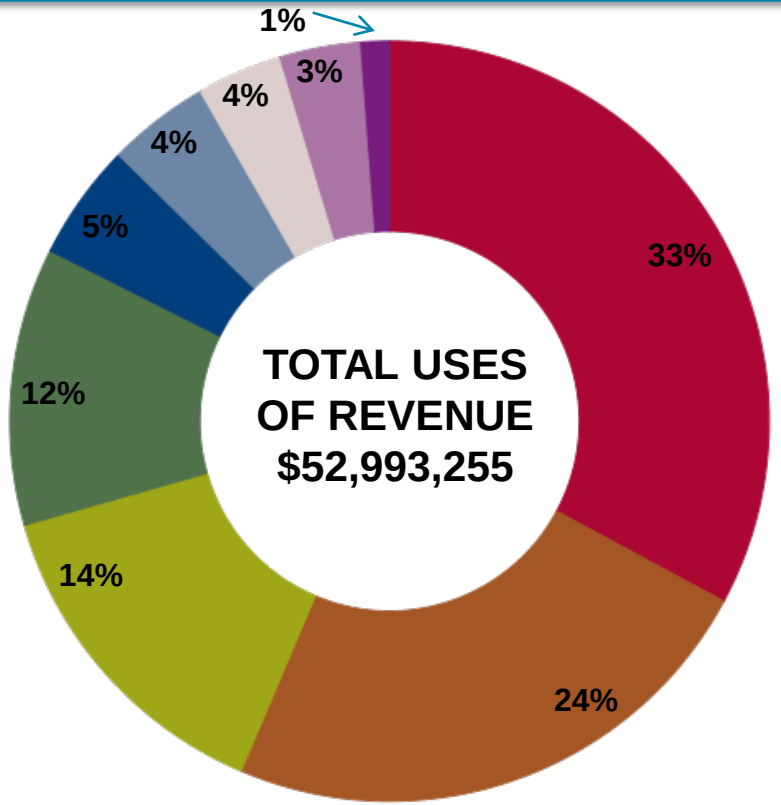
General Fund 01 has a $208,473 request (BAR 46717) that would partially offset increases to our St. Vrain Community Hub Coffman Street rental expense. It will be considered in conjunction with similar requests from Community Services and Public Health in the Fund 01 budget review.

# 2016 Budgeted Sources of Revenues
# $52,467,897 (Preliminary)



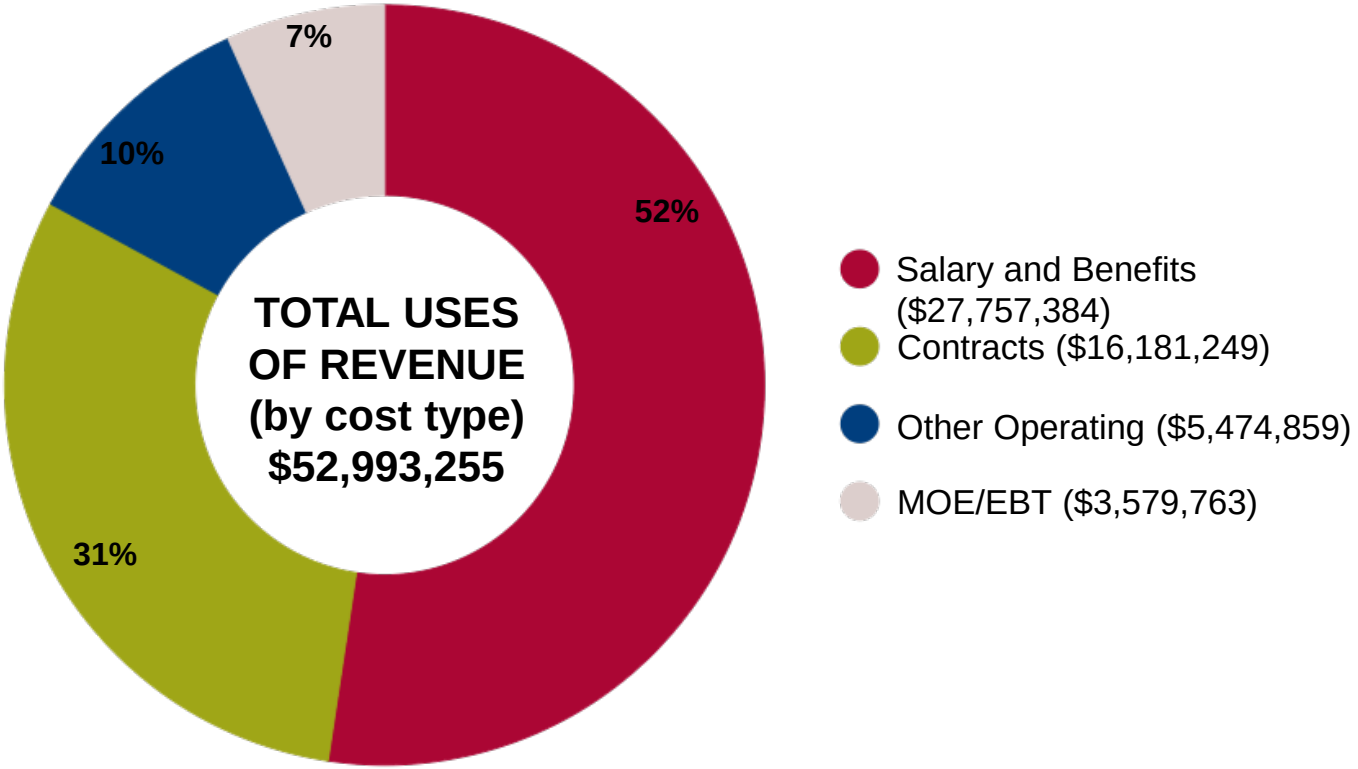

- Intergovernmental - Fed/State ($26,409,572)
- Property Taxes ($6,619,954)
- HHS Contracts Fund 01 ($6,195,179)
- Human Services Safety Net Fund ($6,129,344)
- IMPACT ($2,304,545)
- HHS Contracts Fund 020 ($2,012,289)
- HHS Fund 020 ($1,412,286)
- Other: Earned Incentives - Fed/State ($693,417), Private Grant Funds ($641,311), Investment Interest Income ($50,000)

# 2016 Budgeted Uses of Revenues
# $52,993,255 (Preliminary)




- Community Contracts and County Funded ($17,412,540)
- Child Welfare ($12,475,308)
- County Administration ($7,520,080)
- TANF / Colorado Works ($6,261,355)
- Child Care ($2,622,297)
- Other Grant Funds ($2,304,545)
- Child Support Administration ($1,929,484)
- Other Federal/State Programs ($1,824,956)
- Core Services ($642,690)

# 2016 Budgeted Uses of Revenues Cost Type View $52,993,255 (Preliminary)



# Projected 2016
# Fund Balance - Fund 012

| | | |
|---|---|---|
| IMPACT Fund Balance at Jan. 1, 2016 | $ | 1,690,977 |
| **Human Services Fund Balance at Jan. 1, 2016** | **$** | **7,550,613** |
| Beginning Fund Balance at Jan. 1, 2016 | $ | 9,241,590 |
| | | |
| 2016 revenue budget base | $ | 52,467,897 |
| 2016 expense budget base | $ | (52,993,255) |
| 2016 Budgeted Use of Fund Balance | $ | (525,358) |

# Community Investments


# Community Investments

## General Fund 001 and Health & Human Services 020

| Investment by Pillar | 2016 Budget |
|---|---|
| Housing Stability | 375,470 |
| Food & Basic Needs | 789,833 |
| Health & Well-Being | 1,302,859 |
| Community Mental Health | 4,685,366 |
| Safety | 391,324 |
| Education | 277,616 |
| IMPACT Transition from MHP to HHS | 400,000 |

**2016 Highlights**

- Continuation of 2015 investments  across 34 agencies
- Begin transition of general operating contracts to performance-based contracts starting 2017

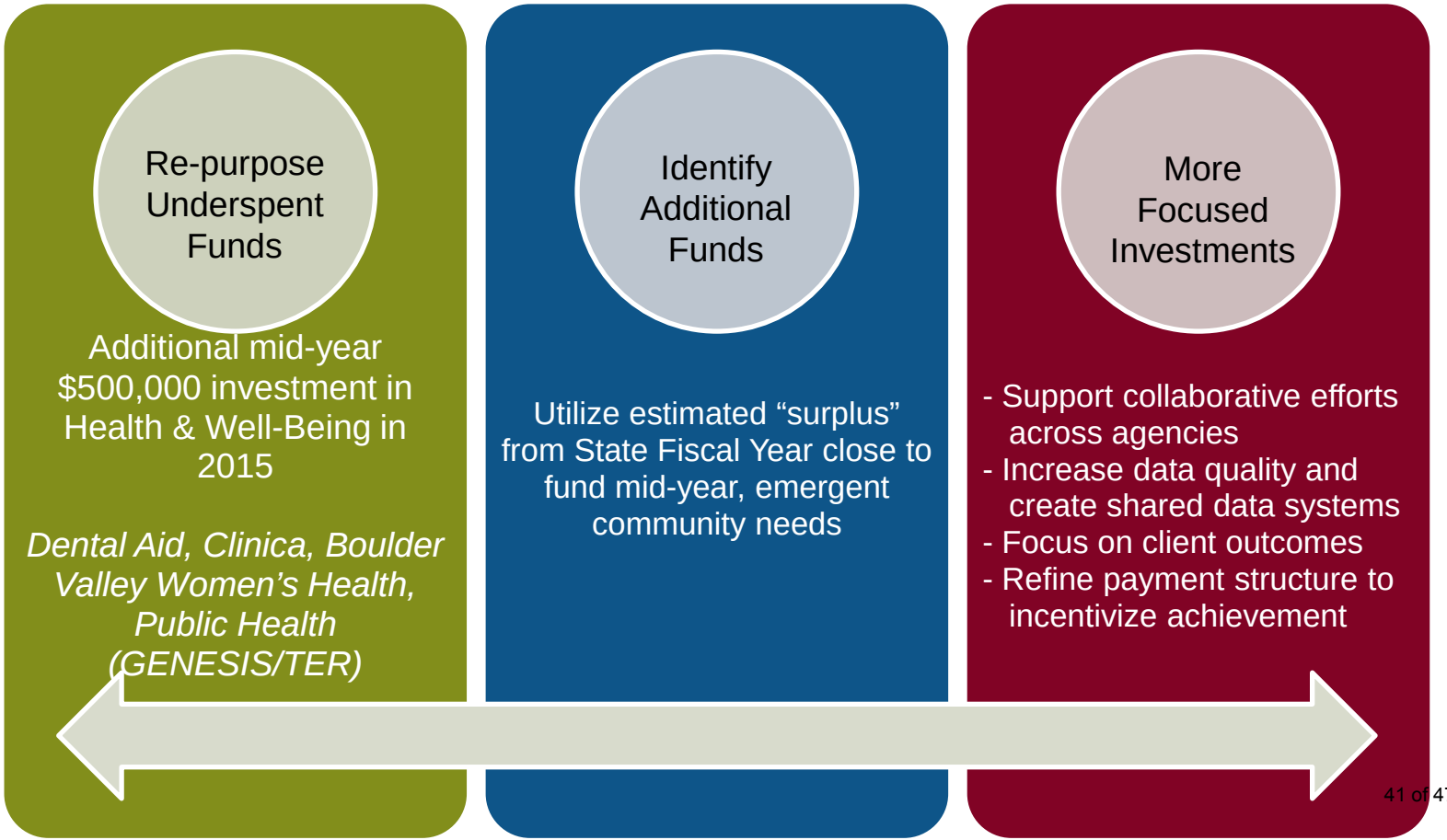
# Human Services Safety Net Investments

| Investment by Pillar | 2015 Budget | 2016 Budget | Variance |
|---|---|---|---|
| Housing Stability | 1,006,422 | 1,859,788 | 853,366 |
| Health & Well-Being | 934,050 | 1,044,606 | 110,556 |
| Safety | - | 15,000 | 15,000 |
| Education & Skill Building | 843,499 | 923,000 | 79,501 |
| Access to Benefits (Eligibility Staff) | 2,211,192 | 2,173,416 | (37,776) |
| Mid-Year Emergent Needs | 156,488 | 113,524 | (42,964) |
| Grand Total | $ 5,151,651 | $ 6,129,334 | $ 977,683 |

**2016 Highlights**

- Additional revenue of $977,683
- Transition Housing Stabilization Program contracts to performance-based contracts
- Additional investments in homelessness services and early childhood education
- Investment in a family resource center in Longmont
- Budget for mid-year disbursement for emergent needs

# Leveraging of Community Investments



# BCHA requested budget $22,915,726
# Human Services requested budget $52,993,255

## FTE & Term Positions (as of October 13, 2015)

| | Fund 001 | Fund 010 | Fund 012 | Fund 098 | Grand Total |
|---|---|---|---|---|---|
| FTE | 10.00 | - | 307.35 | 62.25 | 379.60 |
| Term | - | 8.00 | 90.35 | 11.00 | 109.35 |
| Total | 10.00 | 8.00 | 397.70 | 73.25 | 488.95 |

BOULDER COUNTY HOUSING & HUMAN SERVICES

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Boulder County

# Thank you

**Boulder County Commissioners**

**Residents**

**Partners**

**County staff**

for your on-going support and leadership!

The workplan that I am working on is **PHIP and DHHS Strategic Priorities alignment**, and my partners in this work will be Summer, Susan Caskey, Melissa, Heather Matthews, Andrea Poniers and Lori McLean.

I haven't connected with Heather or Lori on this as yet, but plan to send them a meeting invite before Wed.

You will see that Summer and I decided that there are many areas of alignment between our 2 departments related to Mental Health. I have detailed them out in to 4 areas:

1. **Determine where the greatest nexus between HHS and PHIP is at this time**
    a. Mental Health related to:
        i. Early Childhood: Raising of America Campaign
        ii. Early Childhood: Project LAUNCH Grant
        iii. Early Childhood: Assuring Better Childhood Development Work Group
        iv. Youth Mental Health: collaborative with IMPACT and school districts

Susan, Andrea, Melissa and I have started work with SVVSD, you can see detail there in the attached meeting minutes. We plan to have a follow-up meeting with them in December.

**PHIP and DHHS Strategic Priorities WORK PLAN –** Evaluate PHIP and HHS priorities for enhanced alignment between the PHIP process and HHS social determinates framework to service delivery.

**Goal:** To ensure the macro work being completed by Public Health is integrated into HHS programming by ensuring evidence based practice service implementation in areas of our mutual community work.

**Staff Liaisons:** Angela Lanci-Macris, Summer Laws, Susan Caskey, Andrea Poniers, Lori McLean

| Objective | Activities & Timeline | People Responsible | Target Completion Date | Deliverables | Notes: |
|---|---|---|---|---|---|
| **1. Recommendations for enhanced alignment** | **1. Determine where the greatest nexus between HHS and PHIP is at this time**<br>a. Mental Health related to:<br>i. Early Childhood: Raising of America Campaign<br>ii. Early Childhood: Project LAUNCH Grant<br>iii. Early Childhood: Assuring Better Childhood Development Work Group<br>iv. Youth Mental Health: collaborative with IMPACT and school districts | Jeff, Angela, Summer, Stephanie, Heather, Andrea, Susan | 9/29/2015 | Team meeting | COMPLETED |
| **2. Early Childhood practice and service alignment: Raising of America Campaign** | **1. How does HHS best support PH goals in this area?**<br>a. Determine if there are ways to build upon campaign momentum by coordinating viewings with DHHS CM teams<br>b. Determine if CORE training would be a viable venue<br>c. Other ideas? | Heather and Angela | 11/30/2015 | Meeting | |

| | | | | | |
|---|---|---|---|---|---|
| | **2. Ideas for collaboration in this area** | | | | |
| **3. Early Childhood practice and service alignment: <u>Project LAUNCH</u>** | **1. How does HHS best support PH goals in this area?**<br><br>**2. Ideas for collaboration in this area** | Heather and Angela | 11/30/2015 | Meeting | |
| **4. Early Childhood practice and service alignment: <u>Assuring Better Childhood Development Workgroup</u>** | **1. How does HHS best support PH goals in this area?**<br><br>**2. Ideas for collaboration in this area** | Lori McLean and Angela | 11/30/2015 | Meeting | |
| **5. Youth Mental Health: collaborative with IMPACT and School Districts** | **1. How does HHS best support PH goals in this area?**<br><br>**2. Ideas for collaboration in this area**<br>a. Situational Analysis of the School District services<br>a. IMPACT Board Meeting | Andrea Poniers, Susan Caskey, Melissa Frank-Williams<br><br>Angela, Andrea, Susan, Sarah Buss | 9/30/2015<br><br>10/9/2015 | Meeting | **completed** |

| | | | | | |
|---|---|---|---|---|---|
| | b. BC and SVVSD Brainstorm meeting on service delivery collaboration (see notes from meeting 10/14) | Angela, Andrea, Susan, Sarah Buss, MFW, Ty, Jackie, Matt (SVVSD) | 10/14/2016 | | |
| | c. BC and SVVSD re: next steps on "How" to enhance service collaboration | Angela, Andrea, Susan, Sarah Buss, MFW, Ty, Jackie, Matt (SVVSD) | Early Dec 2016 | | |
| | | | | | |
| | | | | | |

# Department of Housing & Human Services

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

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BOULDER COUNTY HOUSING & HUMAN SERVICES

**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, December 08, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

## Agenda

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

2) **Review and approval of minutes from October 27, 2015 DHHS Advisory Committee meeting (3:33 p.m. – 3:35 p.m.)**

3) **Discussion Item— HHSAC's work plan and meeting priorities for the next 12-24 months—Frank Alexander (3:35 p.m. – 3:40 p.m.)**
   i. **Overview Presentation: Angela Lanci-Macris and Melissa Frank-Williams (3:40 p.m. – 4:00 p.m.)**
   ii. **Discussion of DHHS staff and Advisory Committee Members and staff liaisons (4:00 – 4:30 p.m.)**
      a. Project Updates from Committee members
      b. Project pacing discussion and continued role of staff liaisons
      c. Plan 2016 calendar and priorities

4) **Plan for January 26, 2016 meeting with the Board of County Commissioners (Human Services Board and Housing Authority Board)—Frank Alexander (4:30 p.m. – 5:00 p.m.)**
   a) Committee Work plan and project updates
   b) Focus areas for discussion with the Commissioners

5) **Upcoming Meetings—**
   a) **January Agenda Items:**
      i. Joint meeting with the Board of Count y Commissioners

****Note time and location change** Next Meeting is Tuesday, January 26, 2015, 3:00 p.m., 2525 13th Street, Large Conference Room, Boulder.**

## 6) Adjourn

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# Department of Housing & Human Services

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**DHHS Advisory Committee**
**MONTHLY MEETING**
**Tuesday, October 27, 2015, 3:30-5:00 p.m.**
DHHS Kaiser Building,
Large Conference Room, 2525 13th Street, Boulder

**In Attendance:** Laura Kinder, Bobbie Watson, Jeff Zayach, Simon Smith, Dan Thomas, Dalia Dorta, Robin Bohannan, Betsey Martens, Elvira Ramos,

**Staff:** Frank Alexander, Jim Williams, Chris Campbell, Will Kugel, Melissa Frank-Williams, Maggie Crosswy

## Committee Action Items:

**Action Item: DHHS Annual/Community Report**—send any additional comments or edits for the 2015 DHHS Community Report to Jim Williams. **November 13 deadline.**

**Action Item: DHHS Annual/Community Report**—continue to brainstorm a name for the DHHS Annual Report. Examples include: "DHHS Community Report", "DHHS Call to Action Report". **November 13 deadline.**

**Action Item: January 26, 2016 Joint Meeting with the Advisory Committee and Board of County Commissioners—**Members need to contemplate what issues they would like to discuss with the Commissioners in this joint meeting. We will discuss an agenda/focus for the meeting, in detail, at the **December 8, 2015** Advisory Committee meeting.

## Meeting Minutes

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

**Approved as written**

2) **Review and approval of minutes from September 29, 2015 DHHS Advisory Committee meeting (3:33 p.m. – 3:35 p.m.)**

**Approved as written**

3) **2016 DHHS Budget Overview Presentation—Will Kugel, DHHS Finance Director (3:35 p.m. – 4:05 p.m.)**
   i. Human Services and Housing Authority budget reviews
   ii. Committee questions

See the 2015.10.27 HHSAC Packet for the majority of the notes on the 2016 DHHS Budget.

Frank, we've had a busy couple of weeks from a strategic planning and budget perspective. We had the preliminary budget hearing with the Board two weeks ago, and a formal budget hearing today. Everything is in formation for this Committee based on this schedule and we want to hear from you about our priorities in relation to the 2016 budget and our strategic priorities/annual report. This is my 17th year of budget hearings and I am excited that every year we have moved closer to a more transparent, community lead budget process which has allowed us to be more agile and responsive to the needs of the community.

Frank—also of note, the Board of Commissioners agreed to and are excited about a **joint meeting** with this Advisory Committee on **January 26, 2016.** Please keep this on your calendars.

Presentation from Will Kugel:

**Key Considerations in Reviewing these Budgets**

1. Long-term goals of stable and sustainable Housing and Human Services
2. Managing our personnel to withstand potential future downturns
3. Ensure our investments in the community align with our strategic goals

**Other Key Considerations in Reviewing these Budgets**

1. Kestrel is a major project for HHS in 2016. The Kestrel project will drive a significant amount of work and fiscal discipline in in 2016.
2. The Human Services budget is largely continuation funding with the most significant increase associated with merit.
3. BCHA operations are in a stable phase and the budget reflects a largely continuation funding.

Frank—keep in mind that, underlying these high-level considerations is our continued focus on blending, braiding and integrating funding sources to reach a more sustainable funding picture (sustainable economic engine). This is really the meat of this 2016 budget.

Frank—one of the important messages to the Advisory Board is that the state administration has been very supportive of the safety net and therefore, many programs and services have seen significant enrollment increases. What we will experience in the coming years is the impact of these higher-enrollments, things like the child welfare hotline, mandatory reporting for older adults, etc., and therefore we know that will not be able to fund these programs through the state blocks at these high levels. Additionally, the budgets will be strained by the TABOR caps. What that means is that we need to be more integrated and more generative as a community to more efficiently support families and individuals. Need to look for sustainable solutions as a community.

**Comments and Questions from the Committee:**

Bobbie—Could you clarify the intent for the 3 commercial pads/parcels at the new Kestrel Development? Frank—we do have commercial parcels at Kestrel that we would love to partner with a key community provider to provide services (3 parcels). We'd love to hear the Committee's thoughts on how we could creatively take advantage of these parcels.

Betsey—keep in mind that construction pricing is a huge risk point. Keep this in mind with Kestrel.

4) **2015 DHHS Annual Report Draft review—Frank Alexander, Jim Williams, Maggie Crosswy (4:05 p.m. – 4:45 p.m.)**
    i. Committee feedback on overall layout, messaging, and resonance with the community
        a. What overall message does the report deliver?
        b. How is the flow of the report (does the order make sense, does it move well from one section to the next)?
        c. What's missing from the report? What could be removed?
        d. When thinking about members of the community with whom you regularly interact, how well do you think this report will resonate with them?

Jim, the intent with the report is to create something that expresses everything that we do in relation to our community partnerships. Frank—this group did incredible work on the 2013 Budget Book and we are building on past iteration—we still have requests for this report, so we are excited for this next version of the budget book/community report.

Jim/Frank: Of note, this report is designed with separable sections that can be pulled/printed individually and taken to meetings where those topics are being discussed or shared with stakeholders who focus on those topic areas (based on the pillars of self-sufficiency). Robin and Willa recently presented to the Planning Board with the housing supports section and we presented the budget sections to the Board of Commissioners today.

Frank—timing on this report. You are the first group to see this. Goal is to sync up with the December budget approval process. Gives us a month and a half to tweak this data and messaging wise.

Infographic sheets are so important to crystalizing the hard conversations around addressing community needs. We are trying to set the context/table for all of the hard conversations—here is the next challenge that we need everyone to rally around (access, supports, prevention). Next phases of the work.

**Comments from the Committee Members:**

Elvira—photos are amazing. Visually pleasing and tells the story of our clients very well.

Bobbie—like the stand alone sections for presentation. Frank—We'll have PowerPoint slides available for staff and community partners to provide.

Betsey—who is the audience for this report? Does it have a design—Policy makers, public? Jim—it is all of the above if we do it the right way. Really digestible for policy folks and also designed for a community partner to keep in their lobby. In terms of the public side of this, it functions as a humanizing annual report. Focuses on people. Frank—there are 1 page info graphics behind these that we will continue to distribute to tell the community story. 2013 budget almost became a policy framework. It's had a lot of different team. Suite of things that are designed to connect and be usable.

Page 10—incredible infographics.

Dalia—Cost burdened housing infographic is difficult to understand. Might need to be simpler. Also, consider a shorter version of the report in Spanish.

Robin—beautiful, huge resource for the community. Folks have been asking for this. Maybe not call it an annual report. Just call it a Community Report. Call to action report? Need to think about a name for it. Love the idea of the executive summary. 4 page thing or so.

Bobbie—quality of services is critical. It blends over everything, so how do we capture this? Latino fingerprint here? How do you do this and capture this? Critical in housing and all of the other pillars. How do you do this? Would like to see the calling out of the Latino community more explicitly…Dalia—maybe have some testimonials or snapshots of families. Would be nice to hear their voices…Jim—this does happen in the TRENDS report. Dalia—points out the differences in access. Bobbie—set the community context—here is what the community looks like, this is nested as a backdrop. Simon—this is a county report and this is the way to go. Stay away from the demographic look. We have really great services and need to focus on these.

Dalia—Frank's message at the beginning is too long.

Bobbie—what I come back to is to relate to folks that poverty is a significant issue on Boulder County. Community of Hope frame.

Dalia—maybe for the next report, have some comments from folks about the quality of service you are receiving. Important to start getting the data at some point, regardless of putting it in the report. Client experience should be a focus. Frank—we are about continuous quality improvement—feedback loop for staff, immediate adjustments. The quality of their service is a complex question. Jeff—put a statement in the report about this—we use your feedback for quality improvement. Put in what we value in terms of client experience, up front, would be helpful.

5) **Continued discussion—Committee's work plan for the next 12-24 months—Frank Alexander (4:45 p.m. – 5:00 p.m.)**
   - **i. Update from DHHS staff and Advisory Committee Members and staff liaisons:**
     - a. Project Updates
     - b. Project pacing discussion

**Tabled until next meeting

6) **December Agenda Items:**
   - i. Continued discussion of and commitment to 2015-2016 Committee work plan
   - ii. Discussion of joint meeting with the Board of County Commissioners (Human Services Board and Housing Authority Board)—**January 26, 2016 meeting.**

7) ****No November meeting. Next Meeting is Tuesday, December 8, 2015**, **3:30 p.m.** Kaiser Large Conference Room, 2525 13th Street, Boulder

8) **Adjourn**

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