POLICY & PRACTICE

The Magazine of the American Public Human Services Association

February 2017

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Setting the Stage for Health and Human Services in 2017

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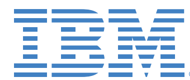

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president's memo

By Tracy Wareing Evans

Creating Modern, Responsive Health and Human Services in 2017

The theme of this issue—leading change—is the perfect place to set the stage for health and human services in 2017. It illustrates the importance that leaders at all levels of government and across the public and private sectors have in advancing system modernization and helping achieve the outcomes we want for all children and families. As appointees of the new federal administration take office and the 115th Congress begins its work, we are pleased to share our members' report, "Creating a Modern and Responsive Health and Human Services System,"[1] which sets forth how we can work together and partner with federal policymakers to modernize and strengthen the nation's health and human services system.

We've highlighted our members' core principles and some of the key accelerators of change below. We hope you will read the complete report and stand with us in our commitment to develop new and innovative service models that are evidence informed and accountable to families, to our communities, and to the nation.

We Believe

All of us should have the opportunity to live healthy lives and be well regardless of where we live, what our histories are, or what our life experiences have been.

The Opportunity

We believe that the time is ripe for significant leaps forward to create a modern, nimble health and human services system that leads to stronger, healthier families and communities.

Our Approach

We must evolve our health and human services system from the traditional "regulative model" rooted in compliance and programmatic outputs, to a "generative approach" that works seamlessly across sectors and engages whole communities in addressing the multidimensional socioeconomic issues that individuals and families face.

We have developed guiding principles for this system change that are captured in our members' *Pathways*[2] initiative and are utilizing a tool for charting progress—the Human Services Value Curve (see *The Value Curve Gone Viral*, page 8).

We believe that in order to drive this change, there must be four major outcome areas that require leveraging integrated policy and fiscal levers:

- Child and family well-being
- Employment and economic well-being
- Improved population health
- Tools we need to be successful

Our Federal Partners

Modernization of the health and human services system requires that, together, we identify the enablers and barriers to drive better outcomes and generate an adaptable, nimble ecosystem that can catalyze our collective efforts.

In order to accelerate change, we need our federal partners to provide leadership to:

Modernize and Reauthorize:

- Employment, child well-being, and nutrition programs, such as TANF and SNAP, to meet the real world

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Photo illustration by Chris Campbell

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April	March 3	What It Takes: Creating a Modern and Responsive H/HS System
June	April 28	Generating Solutions Thorough Innovation and Investing in Outcomes
August	June 30	The Destination Matters: Achieving Better Health and Well-Being
October	August 28	Maximizing Modern Tools and Platforms
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locally speaking

By Emily Kenney

Why Housing First?

I always thought I wanted to start a shelter. I knew from a very young age—14—what I wanted to do with my life: work with people experiencing homelessness. "I know how to end homelessness," I thought. "If people can just come into my shelter, I'll provide everything they need to not be homeless."

I have since abandoned that dream of owning a shelter. Not because it was too hard or because I didn't have the skill to make it happen, but because homeless shelters are not the way to end homelessness.

Really, if you think about it, that way of thinking is so backwards. Instead of focusing on the real issue, or the person's needs, I was focusing on my abilities. I thought that if I could establish a shelter and the structure that was needed to live independently—like completing chores by a certain time, going to bed by 10 p.m., waking up by 6 a.m., and never losing one's temper—and the residents could prove themselves to me, I would be teaching people to be "housing ready." Then, if they succeeded in the shelter, I could refer them to transitional housing. Transitional housing was sometimes an apartment but sometimes the same living environment with a two-year time limit and strict rules to follow and checklists to accomplish. Then, if they proved that they were "housing ready" there, they could be referred to permanent housing. And meanwhile, that whole time, the person is still living in homelessness.

And, what does that mean—to be "housing ready"? In all honesty, as one of my colleagues told me, we were trying to make people show that they lived like us. "But," she said, "it turns out people are pretty good at defining and meeting their own brand of success if you let them."

Photo courtesy of Housing First Milwaukee

So I no longer want to own a shelter. But I do want to support people by helping them define their own brand of success.

It starts with two big concepts: Housing First and Coordinated Entry. Housing First flips the paradigm from "housing ready" to one that endorses first giving people their own apartment and then providing supports for their success. Research shows communities that embrace Housing First have found that clients do better and it's cheaper. (Check out the *Mother Jones* article[1] or Gladwell's article[2] for more information.) Our Milwaukee County Housing First pilot project revealed that, after one year, it cost an average of $30/day to house people and 99 percent of people housed kept a lease for the full year.

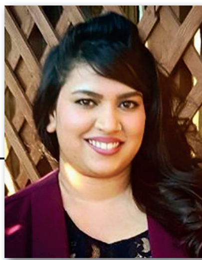
Coordinated Entry supports people by bringing together multiple agencies to work in a coordinated system of services rather than expecting clients to gain access to multiple agencies on their own. It enables agencies to better meet the needs of all clients and to prioritize critical needs.

The basic tenets of Coordinated Entry are these: a single prioritized list of clients based on a standardized assessment and coordinated staffing, case planning, and a program placement component to meet individual needs. Coordinated Entry utilizes the resources the homeless service system has in place to the fullest benefit of each client.

We have made many strides toward positive system change in Milwaukee County. We can already see the difference it is making for some of the people whom we used to assume would never be housed. However, we can't just stop here. Recently, we had a client, let's call him Jim, who received permanent housing right away. He had been homeless for years, and we were hoping that permanent supportive housing would work for him. However, he was still actively hearing voices that caused him to tear up his apartment, very literally, including tearing down the walls and tearing up floor boards.

See Housing First on page 28

from the field



By Nissa Shaffi

Addressing Housing as a Social Determinant of Health

Homelessness is a multifactorial and complex condition that has a significant impact on nearly every social determinant of health. Social determinants of health, as defined by the World Health Organization, are conditions in which individuals live, work, age, and grow.[1] Such variables include housing, socioeconomic status, employment, physical environment, and access to social supports. Collectively, these factors have the potential to influence an individual's ability to obtain health and well-being.

Chronic homelessness has been a national policy priority of increasing importance and will continue to be in the years to come.[2] As a result, health and human services (H/HS) officials will benefit greatly from adopting a proactive approach to housing placement. By tailoring housing interventions according to the unique needs of their communities, H/HS organizations will be able to generate enhanced health outcomes, while simultaneously preserving the utilization of finite community and health resources.

A report released by the National Alliance to End Homelessness revealed that as of 2015, 564,708 individuals experience homelessness nationwide.[3] Chronically homeless individuals comprise approximately 15 percent of this demographic. These individuals are federally classified as having experienced at least four episodes of homelessness over the course of three years, along with having comorbidities of a disabling condition. Disabling conditions include chronically managed conditions related to mental illness, substance abuse, developmental disabilities, or chronic illnesses such as diabetes or arthritis.

Photo via Shutterstock

Chronically homeless individuals experience an egregious lack of care continuity which may lead to lapses in treatment adherence. Ultimately, this compromises the efficacy of multidisciplinary care coordination efforts, including collaboration among primary care, mental health, and long-term care services. Addressing chronic homelessness through these types of comprehensive approaches could help identify gaps present in human-serving networks, optimize social support infrastructures, and most important, improve health and well-being outcomes among at-risk populations.

Numerous housing interventions have been implemented nationwide in an effort to address high incidents of homelessness. Utah has conducted a successful demonstration to combat homelessness through "The Road Home" initiative, which implements the Housing First model. Prior to Housing First, anti-homelessness interventions required proof of sobriety before housing assistance could be arranged. Housing First, on the other hand, provides individuals with a supportive environment where housing placement takes primary precedence. This shift in approach to providing aid for individuals experiencing homelessness has allowed chronically homeless individuals to attain immediate shelter, and with the added *option* of health intervention. Since its initial inception in Salt Lake City, The Road Home has helped Utah to successfully implement the program statewide, with a 91 percent observed reduction in chronic homelessness, from 2,000 individuals in 2005 to 200 in 2015.[4]

Rapid Rehousing is a similar housing program aimed to transition individuals and families from shelters to permanent housing through the

See Homelessness on page 28

from the field

By Jennifer Heimericks, Jeriane Jaegers-Brenneke, and JaCinda Rainey

Missouri's Story

Practical Steps Toward WIOA/TANF Alignment

Photo Illustration by Chris Campbell

The enactment of the Workforce Innovation and Opportunity Act (WIOA) of 2014 by bipartisan majorities in Congress revitalized and transformed the public workforce system to reflect the realities of the 21st century economy and meet the needs of jobseekers, workers, and employers. A key part of the WIOA vision is making government more efficient to serve the public more effectively through a comprehensive, integrated, and streamlined system.

Missouri's Temporary Assistance for Needy Families (TANF) program, which is named Temporary Assistance (TA) in Missouri, encourages partnerships to streamline services and align resources, and WIOA has solidified this concept. TA plays a vital role in WIOA by offering cash benefits to eligible participants while they are receiving assistance. Missouri chose to submit a WIOA combined state plan with Family Support Division programs as partners, including the Missouri Work Assistance (MWA) program, which is contracted to provide eligible TA participants with employment and training and other wrap-around services. The MWA offers educational assistance, training, supportive services, and job skills to help TA recipients become productive members of the workforce. While participating in these activities, MWA participants are also eligible for child-care assistance through the Family Support Division. Under WIOA, American Job Centers offer labor market analysis that helps ensure MWA participants not only get a job, but gain employment that meets the needs of employers and the participant.

However, WIOA's vision of this comprehensive, integrated, and streamlined system can only be achieved through the implementation of new policies and practices, and this is easier said than done. Since the passage of WIOA, Missouri has taken several concrete steps to better align the MWA program with its workforce development programs. These steps include:

- Changed the MWA regions to mimic WIOA regions
- Included MWA staff on Workforce Development Boards
- Hosted a WIOA Convening that partners from all regions attended to understand WIOA, the roles of various agencies, and local planning requirements
- Engaged in a WIOA Design and Delivery Team with partner agencies
- Made adjustments to requests for proposal/contracts by:
  - Requiring MWA contractors to start using the same Career Ready 101 assessment used by workforce development programs in

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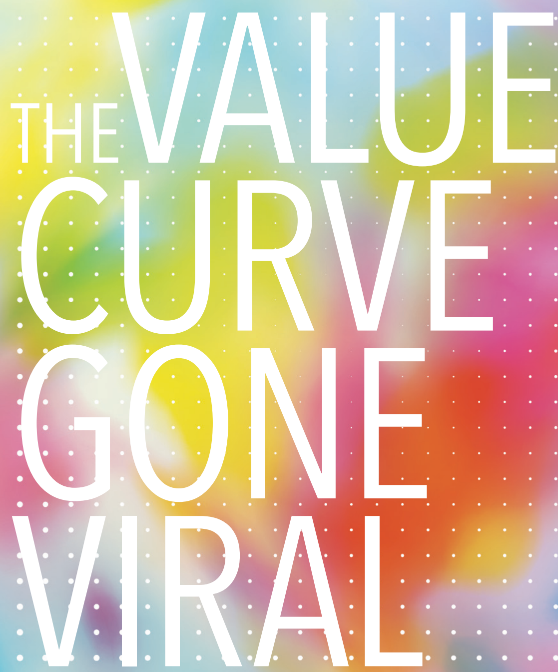
The Value Curve Gone Viral



by Phil Basso

Yes, the Value Curve has officially gone viral.

Since 2010 when this model was introduced by Harvard, at least two dozen cities and counties and six states are explicitly using the Health and Human Services (HHS) Value Curve to guide their strategic planning, practice model development, system-wide assessment and improvement plans, partnership development, strategic communications, staff development, or performance management activities.

These ongoing efforts are serving to convert tensions between programs, entities, and systems into a shared framework and language for field-wide innovation and transformation. In the United States, it's rare to see a nationally adopted framework, let alone one with sustained interest being generated at all system levels (local-state-federal), organizational tiers (executives-managers-supervisors-front-line workers), and with a broad set of active partners, including public safety, higher education, business, private and nonprofit providers, other national associations, health care, and public health.

The American Public Human Services Association (APHSA) has been at the forefront of translating the Value Curve into a set of descriptions, examples, progress drivers, observable markers, related guidance and tools, and hands-on technical support. This is my third annual feature on the Value Curve—from decoding it, to traveling with it, to witnessing its viral spread and scale.

Illustration by Chris Campbell

Why Do We Care About the HHS Value Curve?

Here's a narrative that we've developed with significant input from many agency clients and also from APHSA staff:

"We live in homes, organizations, and communities with many moving parts, like a map with many roads and signs. It's not so easy to keep track of where we want to go and how we want to get there. The Value Curve gives us a 'true north compass' for using our various maps, ensuring we don't lose sight of the ultimate destination: sustained well-being of children and youth, healthier families and communities, opportunities for employment and economic independence, and fairness between all the places we live.

The Value Curve is also like a lens—a way of looking at what we do from the point of view of our consumers. By using it, we're more likely to realize the potential of the people we serve and the systems we use to do so. It's not 'one more thing' for us to deal with on top of our pile of to-dos, but a way of looking at our efforts so that we reinforce our strengths and attend to things that we didn't see before we looked through this lens."

How Do We Evolve Our Systems Through the Value Curve Stages?

I'm routinely asked to boil down the Value Curve stages into one-word explanations! While I haven't gotten the message quite that simple, the following description is met with more smiles and head nodding than in the past:

Think of the model as a graduated lens that describes how health and human services are provided to consumers at four progressive levels of value, each building from the previous levels.

> The Value Curve gives us a 'true north compass' for using our various maps, ensuring we don't lose sight of the ultimate destination: sustained well-being of children and youth, healthier families and communities, opportunities for employment and economic independence, and fairness between all the places we live.

At the Regulative level, the key word is **integrity**. Consumers receive a product or service that is timely, accurate, cost effective, and easy to understand. And what we deliver is also within the rules.

At the Collaborative level, the key word is **service**. Consumers have an easier time when they "walk through any door" and have access to a more complete array of products and services that are available "on the shelf." We collaborate across programs, and even jurisdictions, to make this happen for them— putting them at the center of programs and services rather than asking them to navigate a complex web across different offices and often different service entities.

At the Integrative level, the key term is **root causes**. At this level, products and services are designed and customized with our consumers' input so that we address their true needs and enable them to make positive changes to their lives. This is all geared toward meaningful connections with people "upstream" to prevent problems from occurring "downstream" rather than trying to fix them after the fact, or by "treating the symptoms" while people stay in place and keep receiving the same benefits without actually enabling them to move ahead.

At the Generative level, the key term is **bigger than the family**. At this level, root cause analysis is done at a population-wide level, resulting in prevention strategies and other forms of support that are broader than what an individual or family would receive directly, and that advance the well-being of the entire community.

Does the Value Curve Apply to Roles that Are Not in Direct Service?

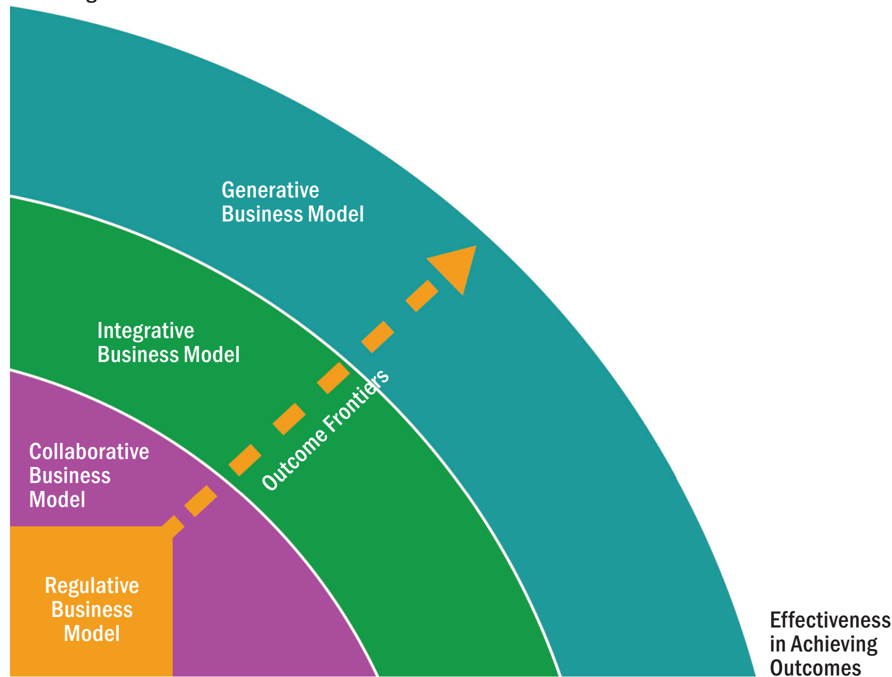
Yes, and here's an example from APHSA's own backyard. Carolyn is APHSA's office manager, responsible for security, supplies, technology, phones, conferencing, office space, welcoming new hires, etc. A few years ago, as an administrative assistant, she realized that each of these areas was being operated without clear rules, processes, and tools so she created them for each area. For her role, Carolyn was adding value at the **Regulative** stage.

She further realized that APHSA staff didn't know "who to go to" if they had a need or question in each area, as they were spread out amongst many internal and contractor roles. So she consolidated them into a single role that she then assumed. Here Carolyn was adding value at the **Collaborative** stage. She further realized that many APHSA staff waited until "post-trauma" circumstances to seek her out for rescue, and learned each staff member's tendencies so she could work with them in a more proactive, "upstream" manner. For example, Phil is technophobic and needs hand-holding when new software or hardware is introduced. Here Carolyn was adding **Integrative** value.

Carolyn noticed that APHSA's entire office, originally designed for Verizon's lawyers, is great for privacy but doesn't enable "chance encounters" essential for building relationships, creating teams, and the innovation that stems from both of these things. She's now converting a large file room into a shared relaxation and communication space… for her role, a **Generative** innovation.

Phil Basso is the Deputy Executive Director of the American Public Human Services Association.

The Human Services Value Curve



Regulative Business Model: The focus is on serving constituents who are eligible for particular services while complying with categorical policy and program regulations.

Collaborative Business Model: The focus is on supporting constituents in receiving all services for which they're eligible by working across agency and programmatic borders.

Integrative Business Model: The focus is on addressing the root causes of client needs and problems by coordinating and integrating services at an optimum level.

Generative Business Model: The focus is on generating healthy communities by co-creating solutions for multi-dimensional family and socioeconomic challenges and opportunities.

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What's an Example for People Not in Our Field that Illustrates How the Value Curve Works?

"A person walks into a drug store...," asks for cough medicine, and gets it. The product works as expected and is the same regardless of which drug store it's purchased from—that's **Regulative value**.

The same person also needs an ankle wrap, and gets that also, even though cough medicine and ankle wraps are produced in very different ways from very different places—that's **Collaborative value**.

The same person walks in and is now asked by the pharmacist, "Why do you have a cold and a bad ankle?" The discussion unearths a cold house and too much drinking brought on by a recent job loss. This deeper understanding eventually leads to a treatment program, interim housing support, and workforce reentry support so this person can get back to their strengths and thrive again—that's **Integrative value**.

The pharmacist and others look at data for all of their consumers and see alcohol abuse and unemployment spiking in a specific neighborhood, one with many strengths clouded by some current struggles. They arrange to bring prevention-oriented health counseling as well as proactive employment counseling services to that place. Longer term, the community attracts a new employer with skill requirements fitting their high-potential labor pool, and this, in turn, brings in a farmer's market right next to the drug store—that's **Generative value**.

What are Some Patterns, Themes, and Lessons Learned that are Emerging from the Value Curve Virus?

The Kresge Foundation continues to support our efforts to help our members with system integration and Value Curve progression, and here are the eight patterns we recently noted for them:

1. Agencies are finding that the HHS Value Curve and related toolkit link up nicely with their existing tools and models, rather than replacing them. What happens is that each of these devices evolves in its effectiveness when approached through the value curve lens and toolkit. This enhances the buy-in and energy around system transformation, as opposed to it being viewed as "alien" and therefore too daunting. Examples here include agencies' current use of strategic planning frameworks, SWOTs, balanced scorecards, LEAN, Baldridge, equity models, practice models, and system integration models and tools.

2. The value curve lens is, over time, organically and intuitively applied to most things the system does or wants to improve. Leadership, supervision, family engagement, and communication are common examples. Assessment of the entire system, a program or functional area, a given team, and even individual performance are being viewed and improved upon through the value curve lens, ensuring better strategic alignment and sustainability.

3. Most leadership teams struggle with "adaptive leadership" as they navigate the value curve's stages, where the solutions are not known and leaders facilitate and empower others to generate solutions rather than providing the answers and

See Value Curve on page 29

THE
FUTURE
5

Best Bets in Health and Human Services for Leaders to Create a Generative Future

How can we collaborate more effectively to transform the future?

Where do we prioritize our investments in generative change?

The answers are not so easy in an environment where exciting new opportunities often clash with entrenched ways of working.

By Debora Morris and Ryan Oakes

Illustration by Chris Campbell

Discussion at the 2016 Health and Human Services Summit—Catalysts for a Generative Future revealed five big bets for developing and scaling holistic, outcome-focused, and generative programs to meet the complex health and social challenges that too many people face today.

1. DATA: Fuel Better Interventions Faster

There is a push to move beyond using data insight solely for reporting or operational purposes and use it in a more proactive way to shape programs. Contrary to common belief, agencies do not need data warehouses, a full-time staff of data scientists, or years and years to get results.

Predictive analytics allows agencies to pinpoint high-need service areas or populations and quickly use data to develop insight-driven practice models to solve problems. This is how the Allegheny County (Pennsylvania) Department of Human Services is improving child welfare decision-making. Caseworkers have limited information when they receive a call about child abuse or neglect. And child welfare agencies cannot respond to every case. A risk-based scoring system developed through predictive risk modeling is helping caseworkers decide whether to screen calls in or out at that vital first decision point.

Rapid-cycle evaluation is a technique that agencies are exploring to act on data insight. With rapid-cycle techniques, agencies can assess the effectiveness of specific interventions faster. They can do pulse checks on what is working, make the business case to funders, and drive continuous improvements.

Working with Virginia Tech, the commonwealth of Virginia is in the early stages of an initiative to determine the effectiveness of programs for disadvantaged children in Roanoke. Rather than use a randomized controlled trial—which still has its place—the program will use rapid-cycle analytics techniques. Accenture's Gary Glickman explains, "What we're trying to do is build an analytics model that helps bridge that research and practice area to allow our research to be much more relevant on a much more timely basis."

2. ECOSYSTEMS: Multiply Impact Together

Ecosystems are the future of health and human services. Leadership for a Networked World's Executive Director Antonio Oftelie explains an ecosystem as "a set of interconnected organizations, machines, and services that can collaborate across boundaries, across silos, and design new solutions that address and solve root causes of individual, family, and community health and human services challenges."

Data insight binds ecosystems, making for even deeper connections that exist in cross-agency or cross-sector partnerships. Ecosystems create a "multiplier effect" of scale and impact. Each member has something unique and complementary to contribute to the others—and to the people they serve.

This multiplier effect is alive in Los Angeles, thanks to the Los Angeles Police Department's (LAPD) Project HOPE. As homelessness grew beyond Skid Row, the LAPD realized that it could not solve the problem alone. Police officers had their role. Social services providers had their role. They had to come together.

LAPD's ecosystem partners include the Los Angeles Housing Services Authority and other homeless services providers, the Department of Sanitation, the Office of the City Attorney, the Office of the Mayor, and the Department of Mental Health. Members participate in a quarterly "Compstat" where they are held accountable for their commitments.

More homeless individuals are getting appropriate services now. "It happened because we were able to break through a lot of barriers to get a lot of other people who usually aren't at the table with us to have the trust and the faith that we're going to try to do our best to solve the problem that is really and truly impacting individuals, neighborhoods, and the entire city," explains Todd Chamberlain, Commander and Assistant Commanding Officer of the LAPD, Operations-Central Bureau.

3. SERVICE: Place People at the Center

As organizations share data insights and develop ecosystems to provide more evidence-based services, they are making it a priority to place people at the center of it all—the hub on the hub and spoke model.

This is happening in practice at the JeffCo Prosperity Project (JPP) in Jefferson County, Colorado. The program is focused on innovative service delivery models to break the cycle of generational poverty. JPP is the convener of school, county government, and business partners.

As Director Joyce Johnson explains, this work is not done in a vacuum. JPP asks families what they need, and how. "It really was coming to them and saying, what is it that you want? And how can we serve you? Not here's the box that we've decided you need to fit into. And that seems like a small shift maybe in some ways, but it's massive if you're really going to make that change." One beneficiary explained the value of this pivot to the person. She had always been a number to the system but JPP gave her a voice.

Organizations like JPP are threading empathy into program development

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Ryan Oakes is the Managing Director, Accenture Health and Human Services Lead, North America.

> *Moving to a more generative state requires organizations to look inward as well to change the hearts, minds, and habits of the people doing the work.*

more intentionally than in the past. Service design principles provide a concrete way to do this from the idea of generation stage. This iterative, collaborative approach to program design is gaining momentum in the social services sector. For example, when the Michigan Department of Health and Human Services reinvented its child support calculator, parents and caseworkers were involved in the process.

4. ORGANIZATION: Reimagine the Culture

Learning from the "outside in" to align with people's unique experiences is essential. However, moving to a more generative state requires organizations to look inward as well to change the hearts, minds, and habits of the people doing the work. Organizational norms and cultures must change.

The federal government is challenging existing organizational practice in the health and human services space. Rafael López, Commissioner of the Administration on Children, Youth, and Families at the U.S. Department of Health and Human Services, explained his vision to "drive innovation in a very different way at the federal level using the federal levers to both, first, fund interesting and innovative ideas on the ground in collaboration with partners. And, second, try to take those lessons learned and scale them."

The first-ever White House Foster Care and Technology Hackathon is an example of an organizational and cultural shift to different ways of working. The 48-hour event invited a diverse group that included technologists, hackers, app developers, and child welfare leaders to develop apps that could respond to foster care issues. This agile way of working developed seven prototypes with limited time and resources.

Two-generation services represent another "counter-culture" way of working in this sector. They are an answer to stovepiped service delivery that is a significant barrier to whole person care. Lessons from the two-generation initiative in the state of Colorado, and Jefferson County in particular, show what can happen when agencies stop looking at people through a one-dimensional program focus.

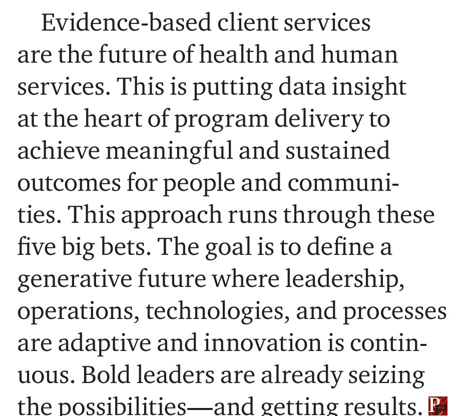
5. INNOVATION: Shift Ingrained Mindsets

While technology innovation will continue to shape the future of health and human services, innovation is not solely about technology. It is a mindset shift. Led by adaptive leaders, innovative organizations pursue fresh thinking that disrupts how things have always been done. This can be breaking new ground with systemic change or making changes to "the big little things" that can have a surprisingly positive impact on an organization's effectiveness.

Innovation is a strong theme in the state of Ohio's transformation story. Five years ago, Ohio created the Office of Health Transformation (OHT) to reinvent health and human services operations statewide. OHT's push for "practical innovation" has delivered impressive outcomes. The creation of this office in itself is a great example of structural innovation. The implementation of an integrated eligibility system for Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF)—which now includes a self-service portal for citizens—exemplifies technology innovation. The OHT is pursuing payments innovation too, using enterprise data to shift from a fee-for-service to a pay for value model.

The OHT learned early on that innovation for innovation's sake just wastes time. Innovation must be practical and grounded in smart problem solving. For example, realizing that legal boundaries to data sharing could affect its success, OHT created innovative "operating protocols" that allow OHT-sponsored initiatives to supersede state laws so that funding and data can move seamlessly among participating agencies without contracts between them.

Although it is miles away from Ohio in distance, Finland's Apotti program shares a focus on integrating health and human services to improve quality, coordinate approaches, and enable more preventive services. Modernizing IT systems will allow for innovations in the customer and service provider experiences, supporting a significant shift toward data-driven and evidence-based care models.



The Future Is About a Ladder, Not a Net

Evidence-based client services are the future of health and human services. This is putting data insight at the heart of program delivery to achieve meaningful and sustained outcomes for people and communities. This approach runs through these five big bets. The goal is to define a generative future where leadership, operations, technologies, and processes are adaptive and innovation is continuous. Bold leaders are already seizing the possibilities—and getting results.

TANF AT 20

Time for Rational Changes

By Russell Sykes and Kerry Desjardins

AFTER 20 YEARS SINCE THE ENACTMENT

of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), it is time for Temporary Assistance for Needy Families (TANF) to be modernized to better support 21st century children and families in achieving self-sufficiency. In 2015, APHSA's Center for Employment and Economic Well-Being (CEEWB) and the National Association of State TANF Administrators (NASTA) initiated a special work group on TANF reauthorization and modernization. Since then, this diverse group of TANF experts has worked together with APHSA CEEWB staff, Russell Sykes and Kerry Desjardins, to identify TANF's strengths and areas for improvement, and to develop a set of legislative, regulatory, and administrative recommendations to make the program more client- and family-centric; and modernize it to align more productively with elements of other workforce programs. After months of intense discussion and consensus building, the work group released its recommendations in November 2016, in time to share with the incoming Administration and Congress.

What follows is an overview of those recommendations.

Photo illustration by Chris Campbell

THE TIME IS RIPE FOR TANF MODERNIZATION

There has been no full reauthorization of TANF since 2005 under the Deficit Reduction Act. Today, reimagining TANF is timely for several reasons—a growing recognition that there must be a path from an initial job to higher quality employment in order to achieve economic well-being; broad acknowledgment that skill deficits and other barriers to employment exist and must be addressed to improve client employment prospects over time; and the opportunity for significant program improvement and better services for clients with the enactment of the Workforce Innovation and Opportunity Act (WIOA) in 2014. It is time to reconsider the TANF program's purposes, what activities actually produce positive outcomes, and how the overall workforce system envisioned under the WIOA can be further improved through thoughtful TANF reauthorization and modernization in 2017.

TANF must be modernized to better prepare parents to obtain the necessary entry and middle skills for meaningful employment that increase family economic security and well-being as well as provide employers with staff ready for the modern workplace. Over the years, TANF has evolved into an increasingly rigid and complex set of interconnected funding streams, rules, and mandates. It has also become too complicated in regard to countable activities and stringent work verification procedures that divert state and local staff time away from helping work-eligible adults become employed. However, the program can be updated to reflect the realities of our rapidly changing economy, particularly the nature of jobs and the preparation required for a positive career path, and to support innovative approaches while holding states accountable for meaningful outcomes for families. A major factor for future success in TANF is renewed trust between federal and state partners, which should be the hallmark of TANF as it was at its initial passage in 1996. Finally, as we move toward a new set of TANF policies and outcomes based on actual job placement and retention rather than current process measures, we must remember that states will need reasonable transition time to update their own laws, business processes, and data systems to support a more modern and effective program.

[TANF] HAS ALSO BECOME TOO COMPLICATED IN REGARD TO COUNTABLE ACTIVITIES AND STRINGENT WORK VERIFICATION PROCEDURES THAT DIVERT STATE AND LOCAL STAFF TIME AWAY FROM HELPING WORK-ELIGIBLE ADULTS BECOME EMPLOYED.

RECOMMENDATION 1: MAKE CHANGES IN 2017 TO IMMEDIATELY IMPROVE THE CURRENT TANF PROGRAM

1. To recognize the greater preparation prospective employees must have for success in the modern workplace, expand the number of countable activities under the TANF Work Participation Rate (WPR) to include broader approaches. Permit longer countable periods for currently allowable activities such as vocational education and job search/job readiness beyond current limits.

2. Remove the current distinction between core and noncore hours of participation, which is both complicated and unnecessary, and allow proportional partial credit toward the WPR for any work-eligible adult engaged in activities for at least 10 hours per week and calculated as a percentage of the 30-hour participation rule.

3. Eliminate the virtually unattainable two-parent 90 percent WPR, which has forced most states to move this TANF population to solely state-funded programs.

4. Allow a 45-day grace period before a new recipient is placed in the denominator for the WPR. It takes at least this amount of time to perform a thorough assessment and enroll a work-eligible TANF recipient in an appropriate activity (the law actually allows 90 days). After the 45 days, the client should be in both the denominator and the numerator, if fully or partially meeting the hours required for TANF WPR purposes.

5. To encourage and incentivize broader engagement and positive employment outcomes, lessen the severity of the work verification requirement over the transition period so caseworker time is not diverted away from the core goals of TANF.

6. Change the current penalty structure in TANF for failing to meet the WPR to one that solely requires states to increase their own maintenance-of-effort (MOE) investments, but does not reduce the state share of federal funds under the block grant. Shifting the penalty structure toward increased state MOE expenditures will allow more state resources to strengthen programs rather than jeopardize states' ability to help TANF clients obtain employment.

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IF NOT NOW, WHEN?

BUILDING ALLIANCES BETWEEN PUBLIC HEALTH AND HUMAN SERVICES PROFESSIONALS

By Mary Ann Cooney

Recently I was asked,

"What is the difference between population health and public health?"

After working for 30 years in public health, I should have been able to respond quickly with an elevator speech that rolled off my tongue. Instead, I paused for a long moment and thought carefully about my answer. I'd just given a presentation highlighting the ways in which state public health and human services agencies are beginning to work together to improve population health. I challenged the audience—mostly leaders in human services agencies and organizations—to think more proactively and commit to reaching out to their public health partners to plan, develop, and implement policies and practices to improve population health.

Then came that question from a member of the audience.

Photo illustration by Chris Campbell

I don't know why the answer didn't come quickly. When I finally did reply, I saw that most people recognized that population health and public health are very different. While sometimes used interchangeably, population health describes the health outcomes or health status of a group of individuals, communities, or states. Public health, on the other hand, is the science by which population health is protected, assessed, assured, and measured.

As health-focused communities of professionals, over the past month or two we've waited with anticipation to learn about the newly elected Administration's potential changes to health care policies that could eventually affect us and the clients we serve. We're hearing that the Obama Administration's health reform efforts could be halted, improved, altered, and reformed—again. Despite the uncertainty, one thing is clear: there could not be a better time to make the economic, business, and humanitarian case for how advancements in health policy have influenced the health of Americans.

Today, we know that population health is not improved solely by having access to health care, but rather through a kaleidoscope of interventions and activities that improves people's lives and, as a result, their health and well-being. Research and practice conducted over the last few decades show that ensuring the highest levels of population health in any group or community comes by aligning health care, human services, and public health efforts to improve the conditions where people work, play, pray, and live.

So why haven't these entities worked together more closely to develop policies and programs to improve and safeguard population health? Why haven't public health, health care, and human services professionals worked shoulder-to-shoulder to maintain the essential connections necessary for thriving individuals and communities? All too often, we hear that the number one barrier to developing partnerships among public health, health care, and human services professionals is a lack of understanding about what each sector "does" that aligns with and contributes to the mission of all three. To the reader, it might appear easier to articulate the similarities and differences than to suggest concrete scenarios where partnerships are natural.

While public health and health care differ in many ways, professionals in these fields have worked deliberately to design and implement joint strategies to reduce the incidence and severity of disease in populations. Public health agencies, for example, are building strong technological linkages with health care systems to analyze aggregated client data collected at the community and state levels to prioritize health improvement strategies.

Though guided by the best intentions, public health and health care have disregarded human services as the critical "third partner" in successfully improving population health. Only recently have health care and public health systems taken steps to reinvigorate population health improvement strategies by exploring new ways to work together with human services, especially governmental human services partners, toward greater efficiency and effectiveness.

Research and practice conducted over the last few decades show that ensuring the highest levels of population health in any group or community comes by aligning health care, human services, and public health efforts to improve the conditions where people work, play, pray, and live.

Leading Integration

The Association of State and Territorial Health Officials (ASTHO) is the national nonprofit organization representing public health agencies in the United States, the U.S. territories, and the District of Columbia, and more than 100,000 public health professionals employed by these agencies. ASTHO's members, the chief health officials of these jurisdictions, are the leaders who influence sound public health policy and ensure excellence in state-based public health practice. ASTHO supports its members by helping state and territorial health agencies develop and implement programs and policies in public health priority areas. ASTHO facilitates information sharing, creates dialogue with outside organizations, and identifies best practices in public health.

Over the last few years, ASTHO has worked on a number of initiatives to support public health departments in better integrating public health policies and practices within health care systems. The organization has become a leader in guiding discussions and providing examples of best practices from states that have successfully linked public health with health care. One example is ASTHO's Integration Forum, formerly known as the ASTHO-supported Primary Care and Public Health Collaborative, a partnership of more than 60 organizations and 200 individual partners seeking to inform, align, and support integrated efforts that improve population health and lower health care costs. The Integration Forum sponsored the development of an online tool to capture success stories about primary care and public health integration activities. ASTHO has captured, analyzed, and published more than 50 state and local success stories since the launch of this tool. However, a missing and much-needed perspective is how public health and human services agencies can work together

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and learn from each other's successes and setbacks in engaging communities and improving health outcomes.

ASTHO, with funding from the de Beaumont Foundation, is promoting collaboration between Medicaid and public health agencies to achieve the Triple Aim of better care, reduced costs, and improved population health outcomes. This project contributes to the goals of the Triple Aim by identifying specific opportunities, challenges, and solutions for promoting increased collaboration between Medicaid and public health leaders. ASTHO published several case studies about innovative, interagency partnerships in Colorado, Minnesota, New Hampshire, North Carolina, Texas, and Vermont to illustrate how states can facilitate collaboration across agencies by fostering a basic understanding of Medicaid and public health principles. Human services agencies are responsible for determining Medicaid eligibility and, in some states, work directly with the Medicaid office to determine services covered under contracts with health care providers.

Public health can also engage human services professionals to address health disparities. Abundant evidence points to the social determinants of health as foundational elements that influence a person's ability to achieve optimal health. ASTHO has leveraged national initiatives and the concept of Health in All Policies to promote a culture of health and safety by urging policymakers to consider and integrate social determinants into the policy process. The 2016 ASTHO President's Challenge,[1] "Advancing Health Equity and Optimal Health for All," encouraged states to adopt a Triple Aim for health equity through a variety of actions, including policy development, cross-sector collaboration, and program implementation. Many states are convening leaders from public health and human services agencies to set policy standards requiring health care systems to be active partners in developing care management programs to improve health outcomes for people experiencing housing instability, unemployment, domestic violence, and other hardships. As states seek to transform their health systems using models established by the Affordable Care Act, such as the state innovation models initiative,[2] human services agencies responsible for housing assistance programs must become integral partners with health care and public health agencies.

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GOVERNING

By Daniel Pollack

Should Being Registered as a Youth Sex Offender Be Grounds for Termination of Parental Rights?

As a general proposition, federal and state laws seek to keep families intact and keep children with their parents. Terminating a parent's rights is a decision with unequivocal consequences: The parent whose rights have been terminated has absolutely no obligations or rights whatsoever in regard to their child. Because of the finality of this decision, each state demands that certain specific procedures must be complied with in order to successfully terminate parental rights. The U.S. Supreme Court in *Santosky v. Kramer*[1] held that a moving party must meet an elevated standard—"clear and convincing"—to terminate parental rights.

Every state has some form of legislation that allows the government to notify the public about sex offenders whom it believes may pose a risk to the public. These laws are often named after seven-year-old Megan Kanka who was raped and killed by a known child molester who moved across the street from the Kanka family home in New Jersey.

What is the connection between terminating parental rights and sex offender registries? In California,[2] Hawaii,[3] Minnesota,[4] South Dakota,[5] and West Virginia[6] the requirement to register as a sexual or predatory offender may constitute grounds for termination of parental rights. For these five states, the total number of sex offender registrants in 2015 was 111,485. For the years 2013–2015, the numbers for these five states look like this:

State	2013	2014	2015
California	80,848	82,646	82,646
Hawaii	2,940**	2,974	3,035*
Minnesota	17,541	17,376	17,777
South Dakota	3,132	3,323	3,436
West Virginia	3,534*	3,798	4,591
Total Number of Registered Sex Offenders	**107,995**	**110,117**	**111,485**

Source: Parents for Megan's Law and The Crime Victim's Center. Available at: https://www.parentsformeganslaw.org/public/meganReportCard.html
Notes: Sex offender counts are as reported by state agencies.
*Sex offender count as reported on state Internet Registry.
**Source: National Center for Missing & Exploited Children

If all other states followed the lead of these five states, more than 800,000 people in 2015 would have been affected.

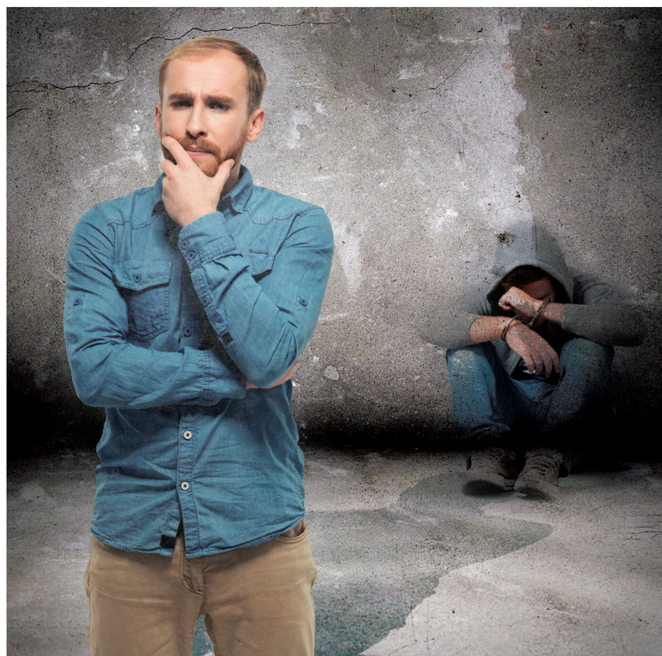

Photo illustration by Chris Campbell

To be listed on a sex offender registry, a perpetrator may have committed a range of crimes—some undeniably despicable, but some less so. At the federal level, Congress enacted the *Adam Walsh Child Protection and Safety Act.* Title I of the act, the *Sex Offender Registration and Notification Act* (SORNA), subjects many children adjudicated delinquent to the same registration requirements as convicted adult sex offenders.

Do we know how many youth are on sexual offender registries? According to Nicole Pittman, Attorney, Vice President, and Director of the Center on Youth Registration Reform, IMPACT JUSTICE, "The short answer to that question is 'no.' There is no central place to obtain this information. You would think after placing children on registries for over 20 years that there would be a system to identify how many kids are being affected. One of the main challenges in obtaining these numbers is that many states do not have a mechanism to distinguish between adults and juveniles placed on the registry. For instance, children handled in juvenile court are not 'convicted,' they are adjudicated delinquent. Yet, in most states, a 14 year-old adjudicated

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By Daniel Pollack

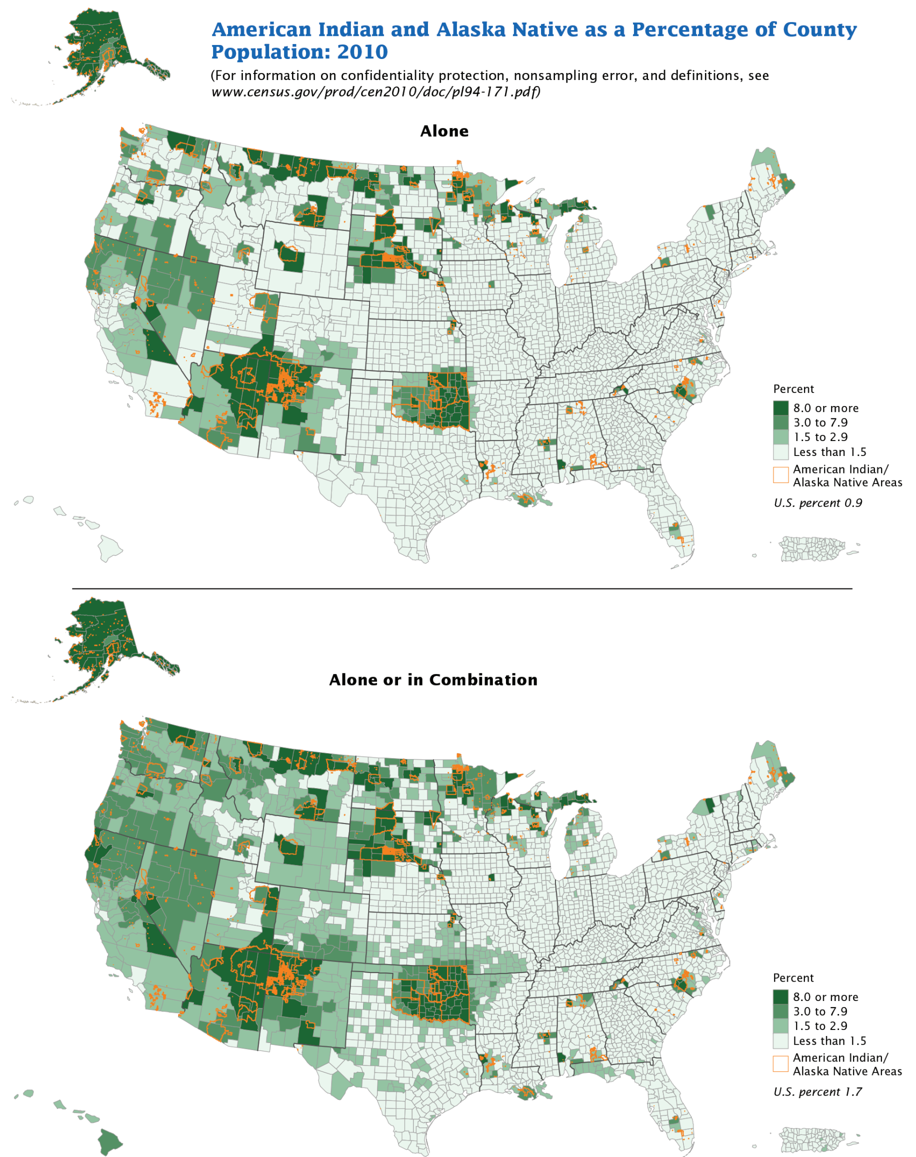
Legal Resources for Human Services Agencies Serving Native American Clients

Human services attorneys and other staff who serve Native American and American Indian individuals and communities may encounter a need for access to targeted legal resources. A 2012 report by the U.S. Census Bureau showed that the "U.S. population on April 1, 2010, was 308.7 million. Out of the total U.S. population, 2.9 million people, or 0.9 percent, were American Indian and Alaska Native alone. In addition, 2.3 million people, or another 0.7 percent, reported they were American Indian and Alaska Native in combination with one or more other races. Together, these two groups totaled 5.2 million people. Thus, 1.7 percent of all people in the United States identified as American Indian and Alaska Native, either alone or in combination with one or more other races."[1]

This article presents an abridged listing of helpful national and regional legal resources. It is not exhaustive and no endorsement is implied.

1. U.S.Department of the Interior, Bureau of Indian Affairs.[2] The website states: "The United States has a unique legal and political relationship with Indian tribes and Alaska Native entities as provided by the Constitution of the United States, treaties, court decisions, and Federal statutes. Within the government-to-government relationship, Indian Affairs provides services directly or through contracts, grants, or compacts to 567 federally recognized tribes with a service population of about 1.9 million." The wesbite also features an excellent document library.[3]

See Native Americans on page 34



Source: U.S. Census Bureau, *2010 Census Redistricting Data (Public Law 94-171) Summary File*, Table P1.

Charts courtesy of Census Bureau

By Paul Hencoski

The Importance of Governance with Incremental Modernization

Agile, modular, iterative, scrum, incremental—these are the development methodologies currently being used throughout our industry as they relate to health and human services system modernization. There is much debate about this "new" way of thinking about modernization (including ***whether or not*** it is actually new at all), particularly whether it is here to stay or is just the latest fad.

If planned for and executed properly, incremental approaches to modernization can reduce project risk and provide a more adaptable approach to modernization that can respond to new regulatory mandates or advancements in technology. In August, KPMG LLP issued a white paper, *Life After the Big Bang: Exploring Modular, Agile Paths Toward Health and Human Services Modernization,*[1] which discussed this trend and demonstrated how it was being adopted by a variety of jurisdictions. And then, in the August issue of *Policy & Practice,* I authored an article, "Planning for an Incremental Approach to Modernization," which articulated a four-step process for establishing a proper foundation for an incremental approach.

That article refers to "executive sponsor(s)" in several places. It is worthwhile to dig a little deeper into the importance that executive sponsorship plays within the governance of incremental approaches. In fact, executive sponsors play a critical role and are vital to the success of the program; this is true, in particular, for integrated programs. Without good governance, many well-intended initiatives have failed as a result of unclear mandates, a lack of decision-making, and disagreements among stakeholders.

Therefore, the question is: What does good governance look like?

Photo illustration by Chris Campbell

Based on my experience, there are five critical elements to good governance. Each is summarized below:

1. Establishment of a clear project charter—Often, project charters are glossed over as consultant speak and not important to the core of a program. It is true that a weak project charter is probably not worth the paper it is printed on. A strong project charter, however, establishes a clear vision and a set of guiding principles. These elements are important foundation blocks for making sure all participants have a shared understanding of the program goals. An effective project charter also clearly identifies the project participants, including the establishment of executive sponsorship and a clear description of the role that executive sponsor(s) will play on an ongoing basis. Once a project charter is finalized, it is often a good practice to have each executive sponsor (not a delegate!) within the broader program physically sign the document as an indication to the team of buy-in, support, and personal commitment to the initiative.

2. Active participation by senior executives—The role of the executive sponsor cannot be merely that of a figure head. We recommend that agency commissioners, secretaries, or equivalents all actively participate in the governance process. For a program within a singular agency, the commissioner or secretary may be the chair of the executive steering committee (ESC), which may comprise division directors or heads. In multiagency initiatives, the commissioners or secretaries of the participating agencies

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Inspire. Innovate. Impact. 2017 APHSA National Health and Human Services Summit

Creating a Modern and Responsive Health and Human Services System

A first-ever, joint summit between the American Public Human Services Association (APHSA) and the Alliance for Strong Families and Communities (Alliance) will bring the two organizations' networks together in an educational setting to advance solutions for improving outcomes for individuals, families, and communities across the country.

Slated for April 30–May 3 at the Hyatt Regency Inner Harbor, Baltimore (MD), the 2017 APHSA National Health and Human Services Summit reflects the shared belief of the two organizations that the time is ripe for significant leaps forward in creating a modern, responsive health and human services system.

This year's Summit will showcase inspiring, innovative, and impactful efforts to improve human services delivery from public and private partners from the health and human services and nonprofit sectors, industry experts, and thought leaders.

"Partnering with the Alliance is a natural fit for APHSA and our members," said Tracy Wareing Evans, President and CEO of APHSA. "Both of our organizations share the belief that the nation's health and human services system is a cornerstone to building a strong, dynamic, and healthy nation. By working together, we can positively impact state, local, and federal policy and ensure that all Americans are provided with the opportunities to live well and reach their fullest potential," she added.

The Summit provides attendees with the opportunity to participate in a series of workshops and sessions that will encompass a diverse set of topics ranging from policy to research to state and local initiatives; engage in valuable discussions around innovation and transformation; network with thought leaders and peers; and enhance skills and knowledge. Participants should be prepared to drive the conversation about shaping a modern human-serving system, promote these new approaches at all levels of government, and champion technological innovations that lead to improved outcomes.

The Summit will focus on broad themes: child and family well-being, employment and economic well-being and improved overall population health, well-being through the integration of health and human services systems, and innovations from the field. In addition, the programming will include updates from the new Administration and Congress on their priorities, plans, and potential policy

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HOMELESSNESS continued from page 6

use of coordinated H/HS delivery. Through the Rapid Rehousing model, individuals and families are equipped with services customized to their needs *in conjunction* with housing. Rapid Rehousing differs from Housing First in that these provisions are delivered on a temporary basis and aim to help participants (who are not chronically displaced) attain economic stability. The U.S. Department of Housing and Urban Development (HUD) stated in its 2011 report that 83 percent of people who participated in Rapid Rehousing programs were able to maintain stable housing even two years after their subsidies had expired.[5]

At a 2015 APHSA National Collaborative for Integration of Health and Human Services meeting in Arlington, VA, the Utah Department of Workforce Services gave a presentation on the outcomes of their homelessness relief efforts. Their study revealed that providing supportive housing for at-risk populations improved quality of life, greatly reduced the use of emergency services, and reduced interaction with law enforcement.[6] Evidence has shown that it is fiscally beneficial to house homeless individuals, as these interventions help provide safe shelter and facilitate cost savings for H/HS provisions. HUD estimates that the cost to finance homelessness can cost up to $30,000-$50,000 per person.[7] As demonstrated by Utah's implementation of the Housing First model, costs related to housing a chronically homeless individual ranged from $10,000–$12,000 per person.[8] From an economic standpoint, it is more cost effective to provide housing for the homeless, rather than remain idle. Supportive housing initiatives could facilitate timely access to appropriate medical and behavioral health interventions, in turn improving health outcomes, and could significantly reduce burden placed on H/HS resources.

Additional efforts of the federal government enable states and human services officials with opportunities to strategize housing placement options for Medicaid. A June 2015 informational bulletin released by the Centers for Medicare and Medicaid Services detailed guidelines for states that would help construct benefit designs that adopt a more holistic approach to addressing social determinants of health.[9] The bulletin illustrated that Medicaid could reimburse states for housing-related activities, including services like Individual Housing Transition Services. These are housing-related activities and services that help states identify and secure housing options for individuals with disabilities, those who require long-term social supports, and with added consideration for individuals who are chronically homeless.

In order to secure valuable and cost-effective services that address homelessness, it is imperative for H/HS organizations to strategically address chronic homelessness in their communities. Facilitating greater care coordination for chronically homeless individuals could equip H/HS programs to meet the significant level of need in their communities, as well as have a positive impact on addressing other social determinants of health.

To read more about social determinants of health, check out APHSA's blog at *http://www.aphsa.org/content/APHSA/en/blog/2016/06/SocialDeterminants.html*

Reference Notes

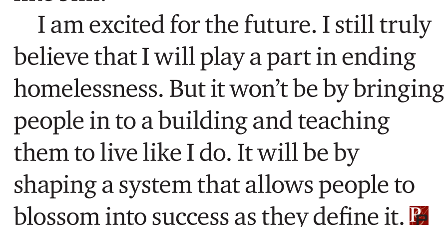
1. See *http://www.who.int/social_determinants/en/*
2. See *http://www.endhomelessness.org/library/entry/chronic-homelessness-policy-solutions*
3. See *http://www.endhomelessness.org/page/-/files/2016%20State%20Of%20Homelessness.pdf*
4. See *http://www.npr.org/2015/12/10/459100751/utah-reduced-chronic-homelessness-by-91-percent-heres-how*
5. See *https://www.hudexchange.info/resources/documents/HPRP_Year2Summary.pdf*
6. See *http://www.aphsa.org/content/dam/aphsa/pdfs/NWI/Utah%20Chronic%20Homeless%20Approach_Apr15.pdf*
7. See *http://www.npr.org/2015/12/10/459100751/utah-reduced-chronic-homelessness-by-91-percent-heres-how*
8. See *http://www.motherjones.com/politics/2015/02/housing-first-solution-to-homelessness-utah*
9. See *https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf*

***Nissa Shaffi** was a Policy Intern with the National Collaborative for Integration of Health and Human Services at APHSA.*

HOUSING FIRST continued from page 5

Including a mental health assessment and accompanying that with the resources that could help him stabilize his symptoms right away could have brought him more success. The Milwaukee County Behavioral Health Division recently secured a grant through the Kresge Foundation to get assistance from the American Public Human Services Association to figure out how best to integrate the mental health and housing systems for clients like Jim.

I am excited for the future. I still truly believe that I will play a part in ending homelessness. But it won't be by bringing people in to a building and teaching them to live like I do. It will be by shaping a system that allows people to blossom into success as they define it.



Reference Notes

1. See *http://www.motherjones.com/politics/2015/02/housing-first-solution-to-homelessness-utah*
2. See *http://gladwell.com/million-dollar-murray/*

***Emily Kenney** coordinates the Coordinated Entry Program at IMPACT, Inc. in Milwaukee, Wisconsin.*

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then expecting compliance. As always, the intuitive tendency for leadership is to "know the answers." We've been supporting leaders' use of effective governance structures and facilitated critical thinking teams as they work to internalize adaptive leadership practices.

4. Systems as a whole often confuse Stage Two and Stage Three practice, mistaking comprehensive needs assessment and service plans for co-created, customized planning based on root cause analysis. As in the pharmacy example just mentioned, providing both the medicine and the wrap is not the same as unearthing and addressing deeper challenges and then shifting to realizing people's goals and potential. We've been supporting theories of change that link cross-entity programs and services to risk factors or social determinants, and then link these factors to desired outcomes.

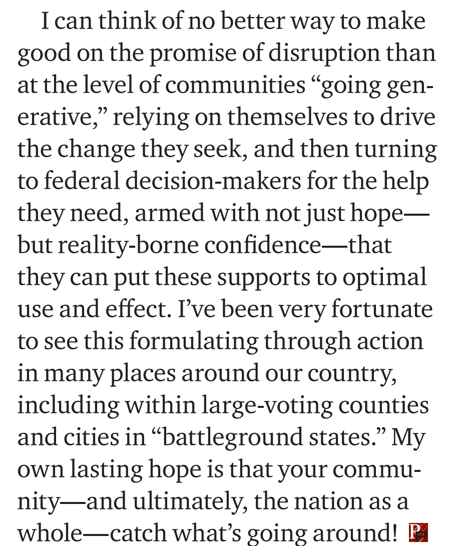
5. While difficult for them to optimize, cities and counties are more likely than states to advance their partnerships toward collective goals, values and principles, tools, data, and the like. There's a root cause for this related to scale and proximity with the same customers. There are also some common contextual barriers to optimizing partnerships based on a particular community's roles and norms, such as with K-12 school leaders, health care, public safety, housing, and the business community.

6. Most agencies initially view Regulative stage focus as inferior, even "bad," but come to understand program and service integrity as being critical to freeing up energy for further stage progression. They learn that it's more important to discern effective from ineffective regulative approaches, such as when attorneys, human resources, or financial support functions say "no" rather than working on innovations within existing regulations and policies.

7. As systems raise their sights toward the Generative work possible within their communities, they almost always land on inequities by race and poverty/income level as drivers of problems and barriers that are bigger than the family. The value curve model is useful here because it takes much of the "charge" out of what are often difficult, much-avoided conversations between community partners with different assumptions about the related root causes, guiding those conversations toward a thoughtful combination of family-based, environmental, and structural root causes and required remedies.

8. As systems "go generative" we also see a convergence of practice innovation and policy reform efforts beginning to take shape. Recent examples of this include population-level analysis of the impact of greater housing supports for the chronically homeless, and the wrap-around support that becomes possible, resulting in far more supportive policies and funding. Policy support for two-generation practices is another emerging example, as are enhanced mental health capacity-building policies and resources.

Following from these last two themes, I'll end with a note on the power of "the Value Curve gone viral" from the national political context. We've all recently seen playing out a strong motivation for institutional disruption, with a strong desire for that disruption to improve lives and communities. This is not new to national politics—in fact, it's common to see election results driven by the desire for change, undergirded by hope.



What may be different in our time is the degree of risk the public is willing to take to see better jobs, healthier people, stronger communities, and a better childhood for children.

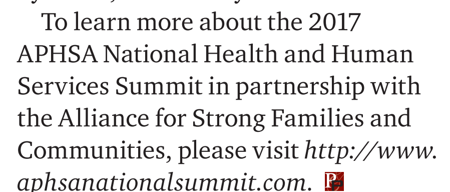
I can think of no better way to make good on the promise of disruption than at the level of communities "going generative," relying on themselves to drive the change they seek, and then turning to federal decision-makers for the help they need, armed with not just hope—but reality-borne confidence—that they can put these supports to optimal use and effect. I've been very fortunate to see this formulating through action in many places around our country, including within large-voting counties and cities in "battleground states." My own lasting hope is that your community—and ultimately, the nation as a whole—catch what's going around!

ASSOCIATION NEWS continued from page 27

changes; share best practices and real-world examples of health and human services solutions from the public and private sectors; highlight concrete examples of Value Curve progression and how it benefits human services delivery; and how to leverage converging opportunities for systemic change (e.g., advances in neuroscience, data interoperability and analytics, alternative approaches to financing, and new approaches to research).

"While there are important distinctions between the public and social sectors that must be honored, we need to be working together to share and accelerate knowledge that will help us better address the systemic issues facing the neighbors and communities we are privileged to serve," said Susan Dreyfus, President and CEO of the Alliance.

The educational content at the Summit is designed to act as a catalyst for change throughout the health and human services community and help to inform the new Congress and Administration about the innovative approaches to human services delivery and how these approaches will help to build a strong, dynamic, and healthy nation.



To learn more about the 2017 APHSA National Health and Human Services Summit in partnership with the Alliance for Strong Families and Communities, please visit *http://www.aphsanationalsummit.com.*

PRESIDENT'S MEMO continued from page 3

dynamics of today, and ensure parents are gainfully employed, and their children are healthy and well.

Promote:

- Efforts to embed and integrate two-generation approaches, especially those that braid and blend funding from evidence-informed programs and across related sectors, especially education, employment, housing, and health.
- Broader use of demonstrations and waivers to spark innovation.
- Data sharing and system interoperability across programs and sectors at all levels of government.

Align:

- Federal funding to what we know works for children and families, with a particular focus on creating a more seamless system of services that meets families where they are and empowers them to continuously improve their lives.

Remove:

- Structural barriers, including statutory and regulatory, to innovative funding approaches that test and refine what is having the greatest impact.

Recognize:

- The role of work is central to overall individual, family, and community well-being and therefore supports sustainable and career-based employment outcomes for those not connected to the world of work, consistent with the needs of employers of all sizes.

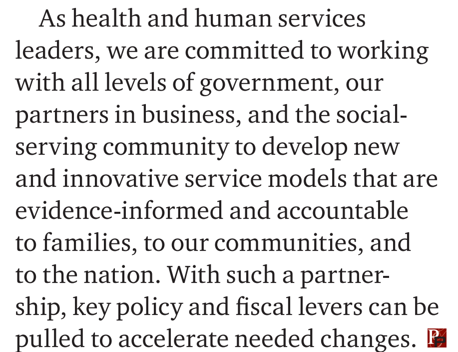
Allow:

- States, and by extension, local jurisdictions and the social-serving networks that deliver services on the ground to use outcome measures rather than measures that are centered around process.

Foster:

- Partnerships with private, academic, business, and philanthropic sectors that generate solutions for improved population-based health and well-being and ways to break the cycle of generational poverty.

Our Commitment



As health and human services leaders, we are committed to working with all levels of government, our partners in business, and the social-serving community to develop new and innovative service models that are evidence-informed and accountable to families, to our communities, and to the nation. With such a partnership, key policy and fiscal levers can be pulled to accelerate needed changes.

Reference Notes

1. See *http://aphsa.org/content/dam/aphsa/pdfs/What%27s%20New/APHSA_CreatingModernResponsiveHHSsystem_TransitionDocument_FINAL.pdf*
2. See *http://aphsa.org/content/APHSA/en/pathways.html*

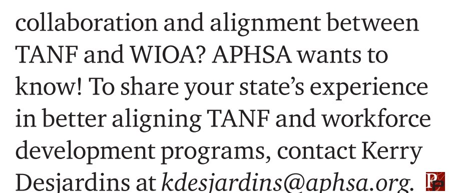
MISSOURI continued from page 7

determining participants' aptitude in math, literacy, and skill levels;
- Changing the focus to participants' outcomes, not just meeting the work participation rate;
- Focusing on career pathways, sector strategies, and stackable credentials;
- Allowing performance bonuses based on employment and training outcomes;
- Encouraging physical co-location;
- Increasing supportive services amounts to continually assist participants as they move through career pathways/stackable credentials; and
- Encouraging supportive services for participants receiving Transitional Employment Benefits and requiring that contractors continue to serve those participants as they work.

Missouri has plans to take additional steps toward alignment in 2017 including to:

- Work with the Design and Delivery team to create a standardized referral form and universal intake form;
- Engage in discussions on apprenticeships;
- Facilitate discussions on technology that would allow participants to virtually check in with case managers and take online workshops with the ultimate goal of including an online referral system; and
- Implementing a two-generational/holistic approach to case management to include both the adult(s) and youth in the household.

What practical steps is your state taking to move toward better collaboration and alignment between TANF and WIOA? APHSA wants to know! To share your state's experience in better aligning TANF and workforce development programs, contact Kerry Desjardins at *kdesjardins@aphsa.org.*



***Jennifer Heimericks** is the TANF, SkillUP, and SNAP-Ed Program Manager for the Family Support Division at Missouri's Department of Social Services.*

***Jeriane Jaegers-Brenneke** is the Assistant Deputy Director for the Family Support Division at Missouri's Department of Social Services.*

***JaCinda Rainey** is the Social Services Manager at Jackson County (Missouri) Family Support.*

staff spotlight

Name: Guy DeSilva

Title: Membership and Marketing Manager

Time at APHSA: Six months

Life Before APHSA: For the majority of my career I worked in the media industry in sales, marketing, and public relations and communications roles. I always had the desire to move into the nonprofit world and help others in some way, and when the opportunity arose to work at APHSA, I jumped at it. The work we do with our members is so important; we are positively affecting the lives of so many people across the country and it is a great feeling to know that I am a small part of that effort.

Priorities at APHSA: Increase and improve member engagement and communications. The work that our members are doing all over the country is so impressive and important. It seems like every day we hear about our members improving outcomes for individuals, families, and communities, and the more we share these stories, the stronger the entire health and human services system becomes.

What I Can Do for Our Members: Provide as much information and support as possible. If we, as an organization, can provide information, ideas, and solutions to improve the lives of the people our members help every day, then we are achieving our goal of being a true member-driven organization.

Best Way to Reach Me: I can best be reached by via email at *gdesilva@aphsa.org*.

When Not Working: My second full-time job is driving my kids to soccer and basketball practices and games, which I do with great pleasure. Spending time with my family and helping my children grow up to be good people is so enjoyable and rewarding. I also love to cook for family and friends—there is nothing better than getting a group of good friends together for a meal and great conversation filled with a lot of laughs.

Motto to Live By: Be honest, have integrity, and treat others with kindness and respect.”

ALLIANCES continued from page 23

Currently, ASTHO is working with the Centers for Disease Control and Prevention (CDC) on initiatives that are well-aligned with the human services sector's longstanding commitment to creating safe, stable families through programs authorized under Title IX of the Social Security Act. CDC's Health Impact in Five Years (HI-5) initiative,[3] for example, comprises a variety of interventions that human services and public health professionals may implement jointly, such as school-based physical activity programs, water fluoridation, tobacco control strategies, and income supports, specifically earned income tax credits. ASTHO supports HI-5 by highlighting nonclinical, community-wide approaches that lead to positive health impacts, results within five years, and cost savings. ASTHO will be developing resources for state and territorial health officials related to HI-5 that will describe strategies for enhancing cross-sector partnerships and promoting community-wide interventions.

ASTHO's community health and prevention programs address child safety, family stability, and adverse childhood experiences. The Health Resources and Services Administration, in collaboration with the Administration for Children and Families, funds states, territories, and tribal entities to strengthen home visiting programs and improve service coordination for at-risk communities. Some state health departments have focused on better integrating federal home visiting programs with health care case management by partnering with social services agencies, using best practices from traditional maternal child health and child welfare models.

In 1958, respected scientist, Sir Geoffrey Vickers, characterized the history of public health as a “record of successive re-definings of the unacceptable,” and his observation still holds true, even today. Public health and human services professionals can embrace this challenge by pushing beyond conventional boundaries and questioning the social and political conditions that influence our health. Similarly, ASTHO and the American Public Human Services Association can set an example and emerge as leaders by pursuing additional opportunities to work together and taking steps to preserve and expand these partnerships to cultivate innovation, quality, cost savings, and healthy and prosperous communities.

Reference Notes

1. See *www.astho.org/Health-Equity/2016-Challenge*
2. See *https://innovation.cms.gov/initiatives/state-innovations*
3. See *www.cdc.gov/policy/hst/hi5/index.html*

TANF AT 20 continued from page 18

7. Encourage broader use of sector-based, career pathway strategies that lead to job attainment, retention, and advancement.

8. Increase coordination and alignment across TANF, WIOA, and the Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T) program for clients to avoid duplication, promote efficiency, provide better individualized client assistance, and use more meaningful outcome measures.

RECOMMENDATION 2: CHANGE THE TANF PERFORMANCE MEASURES OVER TIME TO MUTUALLY AGREED-UPON OUTCOME MEASURES

1. Over a period of five years, transition the WPR under TANF to a new national outcome-based success measure focused on skill and credential attainment and job placement and retention with a goal of building stronger families both economically and socially. During this transition period, the WPR and the employment-related outcome measure will operate side by side with suggested key modifications to the WPR. The WPR will decline and the employment-related rate will increase at the same rate each transition year. Federal and state partners should jointly negotiate the percentage of each applicable rate annually. At the end of five years, a realistic percentage-based employment-related outcome measure would replace the WPR as the measure of TANF program success. Engagement in activities as measured under the WPR, however, would continue and be reported publicly for those not yet employed, utilizing the standards adopted in the 2011 Claims Resolution Act.

RECOMMENDATION 3: EXPAND FUNDING UNDER THE TANF PROGRAM

1. To compensate for at least part of the 32.5 percent erosion from inflation in federal TANF block grant funds since 1996, additional funding should be added.[1] Congress could dedicate any new funding solely for employment-related activities; basic cash assistance; one-time payments that might avoid the need for ongoing assistance; child care; and other specific purposes.

2. Maintain a strong TANF contingency fund and make such funding more accessible to states by reducing the level of state matching funds needed to access them.

3. Expand funding for research and evaluation efforts to determine what activities actually work and integrate data-sharing efforts between partnering agencies to remove duplication of effort, increase program efficiency, and improve the delivery of client services.

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

5. Issue a competitive request for proposal to states allowing for and separately funding 10 new pilot programs designed and focused on employment to be reviewed and launched in lieu of existing program components and measures, similar to what was done in SNAP E&T in 2014. Include a rigorous, separate competitive evaluation proposal that will measure pilot program success over time for possible replication on a broader scale, while also providing for short-term "rapid cycle evaluation" results that quickly identify obvious problems or successes.

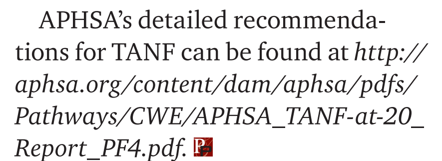
RECOMMENDATION 4: STRENGTHEN RELATED WORK INCENTIVE AND SUPPORT PROGRAMS, PARTICULARLY THROUGH A TWO-GENERATION LENS

1. Increase available funding for the Child Care and Development Fund to expand the availability of subsidized child-care slots, assure the health and safety of care, and promote the use of quality care.

2. Expand the current federal Earned Income Tax Credit (EITC) in two ways. First, increase the size of the maximum EITC for single individuals and childless couples, both as a work incentive and a critical wage supplement. Second, encourage eligible households to voluntarily save a portion of their annual EITC as a "rainy day fund" by establishing a new matching program that would fully or partially match the household contribution up to 20 percent of the value of their EITC.

3. With discussion already beginning about the reauthorization of SNAP by 2018, it is important to maintain the integrity of SNAP as a work support, a nutrition program, and a ripe area to expand and link E&T efforts to WIOA and TANF. Details on APHSA positions regarding SNAP reauthorization can be found in several policy documents on the APHSA website.[2]

APHSA's detailed recommendations for TANF can be found at *http://aphsa.org/content/dam/aphsa/pdfs/Pathways/CWE/APHSA_TANF-at-20_Report_PF4.pdf.*



Also contributing to this article was APHSA's TANF Reauthorization Work Group, a collaborative effort of the CEEWB and the National Association of State TANF Administrators (NASTA).

Reference Notes

1. See page 3 of *The Temporary Assistance for Needy Families (TANF) Block Grant: Responses to Frequently Asked Questions*, available at *https://www.fas.org/sgp/crs/misc/RL32760.pdf.*
2. See APHSA's *Pathways* Policy Brief, *Supplemental Nutrition Assistance Program: SNAP's Role and Potential in an Integrated Health and Human Services System,* at *http://www.aphsa.org/content/dam/aphsa/pdfs/Pathways/Briefs/Pathways%202.0%20Policy%20Brief%20-%20SNAP%20-%207-22-15.pdf.*

GOVERNANCE continued from page 26

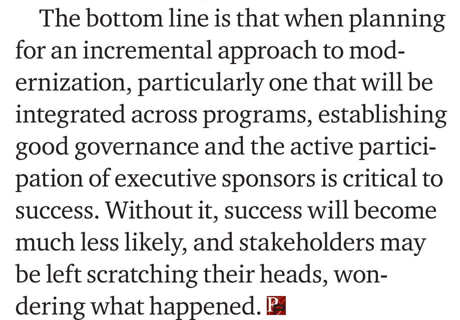
should sit on the ESC with a more senior government official (typically representing the governor or mayor) chairing the committee. Regardless of the composition, active participation is critical. We have observed clients adopting effective protocols that do not permit proxies; the senior executives must participate in person, or their agencies or divisions lose their voice in the governance process. Executive committees that adopt this governance policy have been some of the most effective that I have seen.

3. Clear decision-making protocols—As part of active participation, it is important to clearly identify what decisions executive sponsor(s) will participate in. It will not be efficient or effective to have senior executives participating in day-to-day decision-making. However, they must participate in strategic decision-making to ensure continuous buy-in and guidance for the initiative. Decisions that may alter the project charter or resolve disagreements among stakeholders are examples of strategic decisions. The charter should clearly identify decisions that will be escalated for executive review and decision.

4. Effective reporting—It is vital that, within the governance process, senior executives be provided the right amount of information in an easily consumable format. Detailed reports and reams of paper are generally not effective, as senior executives do not have time to read and digest voluminous information. At the same time, they must be given sufficient detail so that they can adequately assess project progress against timeline, quality, and budget targets. Dashboards that summarize information about these three project dimensions, along with key risks and issues, can be particularly effective and support robust decision-making.

5. Proactive risk management and issue resolution—Finally, too often, project delivery teams do not adequately escalate risks and issues within the governance process to the view of executive sponsors. It is not necessary or effective for executive sponsors to review every risk and issue; however, those with a high potential or actual criticality must be communicated early. Often, the executive sponsors are the ones in the best position to assess the potential impact, make decisions on trade-offs, or commit the necessary resources to mitigate a risk or issue.

The bottom line is that when planning for an incremental approach to modernization, particularly one that will be integrated across programs, establishing good governance and the active participation of executive sponsors is critical to success. Without it, success will become much less likely, and stakeholders may be left scratching their heads, wondering what happened.



Reference Note

1. See *http://www.kpmg-institutes.com/content/dam/kpmg/governmentinstitute/pdf/2016/hhs-agile-modernization.pdf*

Paul Hencoski *is the U.S. Lead Partner for Health and Human Services at KPMG LLP.*

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NATIVE AMERICANS continued from page 25

2. U.S. Department of Justice, Office of Tribal Justice.[4] Its purpose is "to provide a principal point of contact within the Department of Justice to listen to the concerns of Indian Tribes and to communicate the Department's policies to the Tribes and the public; to promote internal uniformity of Department of Justice policies and litigation positions relating to Indian county; and to coordinate with other Federal agencies and with State and Local governments on their initiatives in Indian country." A list of frequently asked questions pertaining to legal issues can be found on the website as well.[5]

3. The **U.S. Department of Health and Human Services, Administration for Children and Families, Administration for Native Americans (ANA)** was established in 1974. It "serves all Native Americans, including federally recognized tribes, American Indian and Alaska Native organizations, Native Hawaiian organizations and Native populations throughout the Pacific Basin (including American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands). ANA promotes self-sufficiency for Native Americans by providing discretionary grant funding for community based projects, and training and technical assistance to eligible tribes and native organizations." The website has an extensive listing of programs and resources.[6]

4. The **Library of Congress** contains an Indigenous Law Portal.[7]

5. Other resources within **U.S. federal agencies and independent regulatory agencies.**[8]

6. NativeOneStop.gov,[9] a one-stop shop for American Indians and Alaska Natives to access resources available from the U.S. Government.

7. National Indian Law Library.[10] "The National Indian Law Library (NILL) of the Native American Rights Fund is a law library devoted to federal Indian and tribal law. NILL maintains a unique and valuable collection of Indian law resources and assists people with their Indian law-related research needs." The website also has a wealth of information on federal Indian law, tribal law, and much more. An excellent resource, *A Practical Guide to the Indian Child Welfare Act* (ICWA), is available on the website.[11]

8. The **Tribal Court Clearinghouse** website[12] "provides links to all Federal Courts and case summaries of Indian law cases decided by the United States Supreme Court from 1991 through 2008 with links to the court syllabus, the full opinions for each case, and all dissents. It also contains information concerning Indian law cases pending before the U.S. Supreme Court during the current term."

9. Among much other useful information, an alphabetized tribal list is maintained by the **National Congress of American Indians.**[13] Also available is a current listing of conferences and events[14] and Native youth program information and events.[15]

10. The **National Native American Bar Association**[16] "represents the interests of all populations indigenous to the lands which are now collectively the United States: American Indians, Alaska Natives, and Native Hawaiians."

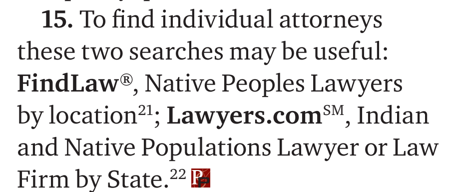
11. The **Northwest Indian Bar Association**,[17] "a non-profit organization of attorneys, judges, and Indian law practitioners in Alaska, Idaho, Oregon, and Washington, aspires to improve the legal and political landscape for Pacific Northwest Indian communities."

12. The **Alaska Native Justice Center**,[18] among other things, "… assists in the resolution of legal circumstances such as divorce, child custody, domestic violence/sexual assault, minor in consuming violations, and adult prisoner reentry."

13. The **Indian Law Resource Center**[19] "provides legal assistance to Indian nations and other indigenous peoples in the United States and throughout the Americas." All of their work is done at no cost to their clients.

14. The **Indigenous Law & Policy Center**[20] "is the heart of the Michigan State University Indigenous Law Program. The Center has two goals: to train law students to work with Indian Country, and to provide services to institutional clients such as Indian tribes, tribal courts, and other tribal organizations on a wide variety of legal and policy questions."

15. To find individual attorneys these two searches may be useful: **FindLaw®**, Native Peoples Lawyers by location[21]; **Lawyers.com**℠, Indian and Native Populations Lawyer or Law Firm by State.[22]



Reference Notes

1. The American Indian and Native Alaska Population: 2010. Available at *www.census.gov/prod/cen2010/briefs/c2010br-10.pdf.*
2. See *www.bia.gov*
3. See *www.bia.gov/DocumentLibrary/index.htm.*
4. See *www.justice.gov/otj*
5. See *www.justice.gov/otj/frequently-asked-questions*
6. See *www.acf.hhs.gov/ana/about/what-we-do*
7. See *www.loc.gov/law/help/indigenous-law-guide/americas/north-america/united-states*
8. See *www.whitehouse.gov/nativeamericans/resources*
9. See *www.nativeonestop.gov*
10. See *www.narf.org/nill/index.html*
11. See *www.narf.org/nill/documents/icwa/index.html*
12. See *http://tribal-institute.org/lists/supreme.htm*
13. See *www.ncai.org/tribal-directory*
14. See *www.ncai.org/conferences-events*
15. See *www.ncai.org/native-youth*
16. See *www.nativeamericanbar.org*
17. See *www.nwiba.org*
18. See *www.anjc.org*
19. See *http://indianlaw.org/content/programs*
20. See *www.law.msu.edu/indigenous/center-clinic.html*
21. See *http://lawyers.findlaw.com/lawyer/practice/native-peoples-law*
22. See *www.lawyers.com/indians-and-native-populations/find-law-firms-by-location*

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delinquent in juvenile court is listed on the registry, just like adults, as 'convicted.' This means that manual searches must be done to flesh out which people went on as juveniles."

According to the Juvenile Law Center in Philadelphia, "At least twenty-eight states include juvenile offenders on a public registry with little or no restrictions."[7] At the state level, in California for instance, minors cannot legally consent to sexual activity. Therefore, some acts of impermissible sexual activity between minors can be considered criminal even if both individuals are under the age of 18.[8]

Because minors in California, Hawaii, Minnesota, South Dakota, and West Virginia can wind up on a sex offender registry for a period of years, decades, or even indefinitely, in theory, once they become parents, they could immediately have their parental rights terminated. Is this really what the respective state legislatures intended? Probably not. It's time to allow for sensible enforcement of these laws, going beyond a simplistic, unilateral approach.

Reference Notes

1. 455 U.S. 745 (1982).
2. Welf. & Inst. Code § 361.5(b)(16).
3. Haw Rev. Stat. Ann § 587A-4.
4. Ann. Stat. §§ 260.012; 260C.301.
5. Ann. Laws §§ 22-24B.
6. Ann. Code § 49-6-5.
7. *http://www.jlc.org/current-initiatives/promoting-second-chances/juvenile-sex-offender-registration*. See Ala. Code § 15-20A-08; Ariz. Rev. Stat. § 13-3827; Cal. Pen. Code §§ 290-045 to 046 (placing out of state working and student registrants on the website); Colo. Rev. Stat. § 16-22-112 (once over the age of 18); Del. Code. 11 § 4121(e); Fl. Stat. § 943.043; (2013); Ga. Code § 42-1-12(i) (2012); Haw. Rev. Stat. § 846E-3; 730 Ill. Comp. Stat. 152/115 and 152/21 (2013); Ind. Code § 11-8-8-7(j) (2013); Iowa Code § 692A.121 (2013); Kan. Stat. § 22-4909; Ky. Rev. Stat. § 17.580(3); La. R.S. 15:542.1.5; Miss. Code § 45-33-36; (b); Mo. Rev. Stat. §§ 211.425(1)–(3) (because PA juvenile offenders will likely be deemed to qualify as adult/serious offenders); Mont. Code § 46-23-508; Neb. Rev. Stat. § 29-4009 (2013); Nev. Rev. Stat. § 179D.475 (2012); N.M. Stat. § 29-11A-3 (2013); N.Y. Correct. Law §168-p (special telephone database); N.D. Cent. Code, § 12.1-32-15(15) (2012); Or. Rev. Stat. § 181.592 (2012); S.C. Code § 23-3-490 (2012); S.D. Codified Laws §§ 22-24B-15, -21 (2012); Tex. Code Crim. Proc. art. § 62.005 (2013); Vt. Stat. tit. 13 § 5411(a) (2013); Va. Code § 9.1-913; Wash. Rev. Code § 4.24.550 (2012); W. Va. Code § 15-12-5 (2013). Utah and Ohio disclosure is not clear based upon current legal status. See Human Rights Watch. (2013) *Raised on the registry: The irreparable harm of placing children on sex offender registries in the U.S.* Available at *https://www.hrw.org/sites/default/files/reports/us0513_ForUpload_1.pdf*
8. Calif. Penal Code, Part. Title 9. Chapter 1 (261.5).

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our do'ers profile

In Our Do'ers Profile, we highlight some of the hardworking and talented individuals in public human services. This issue features Robert Fersh, President and Founder of the Convergence Center for Policy Resolution.

Name: Robert J. Fersh

Title: President and Founder, Convergence Center for Policy Resolution

Years of Service: I've worked on human services issues at the national level for 40 years. My first job out of law school, and a favorite one, was actually with APHSA (then the American Public Welfare Association). I staffed committees and task forces of state and local administrators in areas like Aid to Families with Dependent Children (TANF's predecessor), food stamps, and welfare reform generally. This experience grounded me with appreciation for those who actually run public human services programs.

My career path for many years related mainly to poverty and hunger in the United States. I served on the staffs of three congressional committees, held a political appointment at the Food and Nutrition Service of the U.S. Department of Agriculture, and later led a national anti-hunger organization (Food Research and Action Center) for a dozen years.

I started Convergence in 2009 to build a new approach to challenges of national consequence. We call our approach "dialogue-leading-to-action." We convene diverse and often conflicting groups, help them build relationships of trust over time, and then help them find common ground and form unlikely alliances for action. APHSA is at the table for two of our current projects on Economic Mobility and on the Federal Budget Process. We have had success on other issues such as K-12 education, long-term supports and services for elderly and disabled Americans, and nutrition and wellness.

Rewards of the Job: I find it immensely satisfying to get people who never thought they could talk to each other to collaborate to make a difference in people's lives. The ultimate pay-off for me is that these transformed relationships often lead to groundbreaking solutions on important national issues. I hope this will prove true in our current project on Economic Mobility, which has a mission central to the concerns of the public human services community. Our diverse stakeholder group—business, labor, advocacy, workforce experts, human services leaders, and more—seeks ways to improve economic opportunity, especially for low-income Americans, by creating new approaches to workforce development, quality job creation, and increased financial security.

Accomplishments Most Proud Of: Early in my career, I was proud to work closely with state food stamp directors to eliminate the rule that required most participants to pay for their food stamp allotments. Eliminating the purchase requirement made the program more accessible for millions of Americans in need. In my work on Capitol Hill, I had multiple opportunities to help forge bipartisan legislation, primarily on nutrition programs like WIC, School Breakfast and SNAP/Food Stamps. Then as an outside advocate, I helped form broad coalitions to protect and expand feeding programs for the underprivileged. And now, I am gratified to lead an organization that helps people find genuine common ground, without sweeping differences under the rug, on issue after major issue. I would cite our work on K-12 education, where a remarkable group of strange bedfellows—from charter school networks to teachers' unions—is working under our auspices to accelerate the reach of "learner-centered" education, as the most far reaching of all our accomplishments.

Future Challenges for the Delivery of Public Human Services: As an outside observer, I see the need for a new level of dialogue on balancing state and local flexibility with meeting the underlying purposes of various federal human services programs. This flexibility could potentially lead to administrative efficiency and better tailored supports and services for low-income individuals and families. However, for many advocates of flexibility, block grants are the preferred means of implementation. For others, block grants epitomize the potential to unravel the safety net. Both sides have legitimate points and I would hope we can find a way to satisfy the valid underlying interests of those engaged in this debate whose primary concern is improving the lives of those living at the edges of society.

Outside Interests: I have been active in community building and service through my synagogue and have enjoyed and participated in athletics all my life. At this point, I have been relegated mainly to golf as a competitive sport, a great test of self-acceptance and equanimity. I play that high score wins.

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