POLICY & PRACTICE

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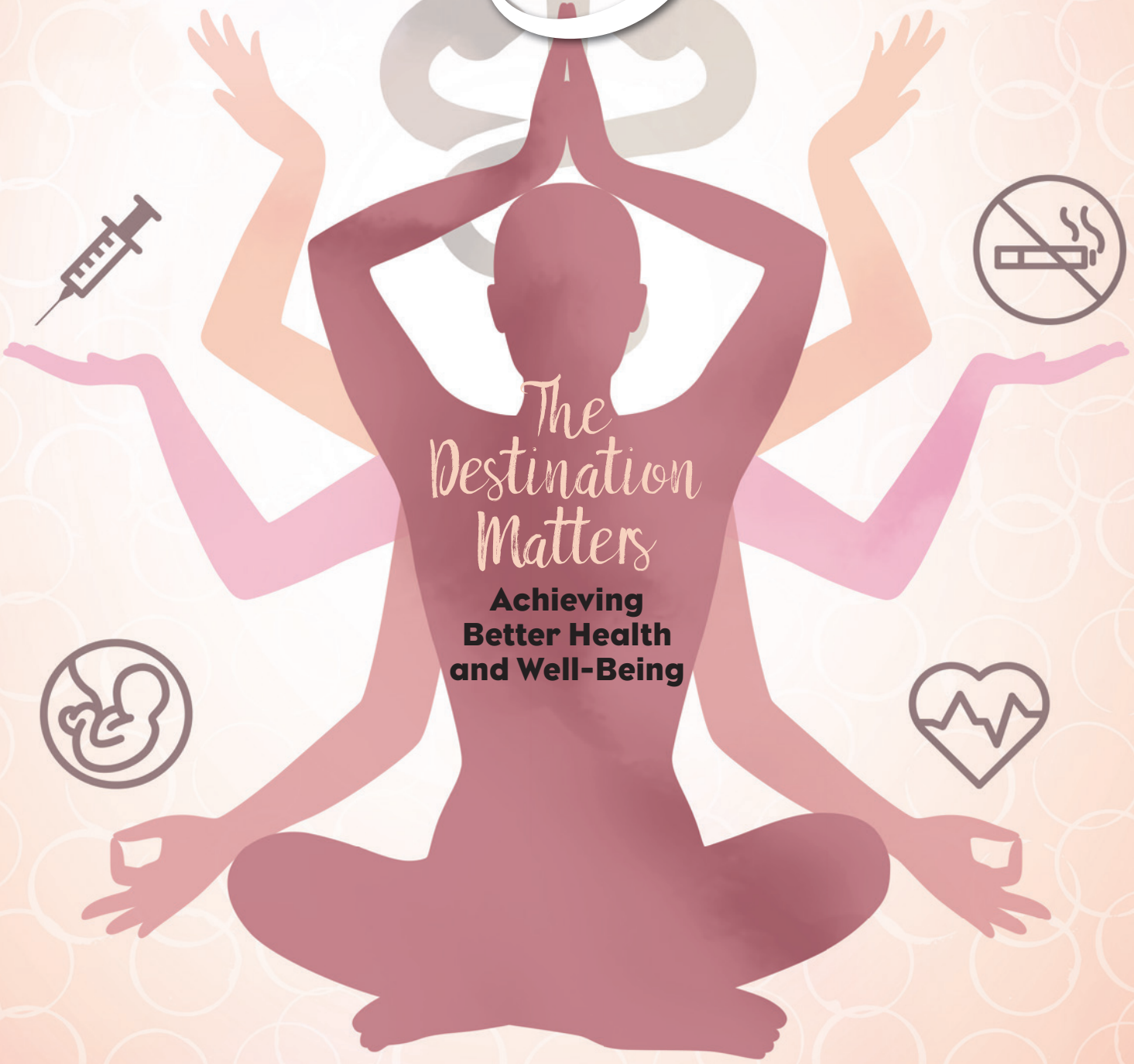
August 2017



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contents

Vol. 75, No. 4
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features

departments

Cover Illustration by Chris Campbell

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***Vision:* Better, Healthier Lives for Children, Adults, Families, and Communities**

***Mission:* APHSA pursues excellence in health and human services by supporting state and local agencies, informing policymakers, and working with our partners to drive innovative, integrated, and efficient solutions in policy and practice.**

By Tracy Wareing Evans

Leading with Purpose:
Pioneers for Thriving Communities

As I sit down to write this column, I find myself re-energized by a remarkable couple of days spent with health and human services leaders from across the nation who are sparking innovation and driving systems change in their communities. In late June, we held our third annual retreat of the Local Council members of APHSA in San Diego with more than 60 local county and city directors, senior executives, and partners deeply committed to improving population health and well-being, and exemplifying what it means to consistently lead with that purpose in mind.

I only wish my column could come even close to adequately conveying the power of the stories we heard. In a time when it can feel as a nation that we're not making the strides we need to for families and communities, we heard compelling case studies involving collective impact approaches deliberately focused on progression along the Human Services Value Curve, and how those efforts are beginning to realize measurable outcomes and return on investment for local communities. I've briefly summarized the content below and encourage you to take a deeper look at each of these examples of how cities and counties, and the local communities within them, are helping lead the way.

Illustration via Sutterstock

Local Jurisdictions as Key Drivers of Innovation and Systems Change

Before turning to the content, I'd like to share my own reflections on why local jurisdictions are a key accelerant for systems change. Beyond the obvious fact that these agencies are closest to the ground, there is a movement afoot that positions leaders in counties, cities, and rural regions to come together across the nation in ways that transcend political divides and keep family and community at the forefront of our nation's collective thinking. By starting with the end in mind—families that are healthy and well in thriving communities—localities can bring leaders across sectors and systems together within the context of the place in which each of them lives and contributes.

The power of this context should not be underestimated—it's rooted in where we all live, learn, love, work, play, and age. When we can better understand the daily experiences of communities through the people that live there and community-level data (e.g., by zip code or even within zip codes), we are much better equipped to reveal root causes as well as structural biases embedded in our service delivery systems. And, when we openly and intentionally share these issues with a peer community of local leaders, as our members do, the impact is felt beyond that of a single community. This connection to people and place provides the foundation for designing an ecosystem that is robust and symbiotic—one that is values based (helping realize the human potential in all of us), spans traditional sector boundaries, is adaptable to local needs, and supports human progress.

This is not to diminish the role of states or the federal government in carrying out effective delivery of health and human services. Indeed, it is meant to amplify the role of policymakers and leaders at state and federal levels by lifting up what is possible,

See President's Memo on page 38

POLICY & PRACTICE

Vol. 75, No. 4 www.aphsa.org

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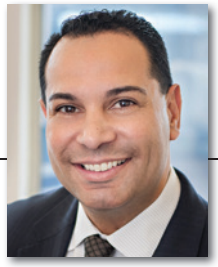

By Héctor Colón and Chris Abele

The Road to Zero:

How Chronic Homelessness Is Ending in a Major Rust Belt Community

"I was just so…overwhelmed," said Michael "Squirrel" Macias. "I actually think I cried myself to sleep that first night … joyful tears."

Squirrel spent the previous two years living in a makeshift shelter along the banks of the Milwaukee River. A former member of what he referred to as the "wife and kids and cubicle life," Squirrel slowly fell victim to a combination of drugs and undiagnosed mental illness.

When we met him, Squirrel was one of the hundreds of people in Milwaukee County who, as of September 2015, was considered "chronically homeless." Chronic homelessness is defined by the U.S. Department of Housing and Urban Development (HUD) as those who are without a home for a collective 12 months over a 36-month time span.

"My first winter out there [in 2013], I had been out there for maybe eight months," Squirrel said. "I had built an awesome structure. It was winterized. It had a little kitchen area, a little sleeping area, and you could almost stand in it! Three days before Christmas, I stayed at a friend's house for a night, and I came back, and I guess the Sheriff's Department found it. They took every single thing I owned."

Squirrel took months to recover from that setback. Around a year and a half later, in June 2015, we declared we were going to do something big. We were going to take all of these hundreds of individuals and house them within three years. We knew this would be a major undertaking. In making this declaration, we also knew we would be the largest metropolitan area in the nation to end chronic homelessness, and the timeline we set for ourselves would make us the fastest in history to accomplish such a feat.

Michael "Squirrel" Macias paints in Milwaukee apartment. He's a participant in the county's Housing First program to combat chronic homelessness.

Only *two years* later, the end is already in sight.

In our January 2017 "Point in Time" count [a HUD-mandated count of all the homeless individuals in our jurisdiction], that number of individuals considered chronically homeless was shaved down to just 56. In May 2017, we announced 75 more housing units scheduled to come on line before the end of the summer. We're almost there. And we did this by employing the "Housing First" philosophy.

Housing First was first deployed in 1988 in Los Angeles by Tanya Tull's "Beyond Shelter" program, and first fully fleshed out by Dr. Sam Tsemberis of New York University, when he founded Pathways to Housing in New York City. The basic premise is simple: provide housing to those with chronic needs without precondition. Housing First does not demand that participants be sober before entering housing, or participate in treatment for substance abuse, mental illness, or anything else.

"The voluntary nature of treatment programs is what makes them successful," said Milwaukee County Housing Division Administrator Jim Mathy. "Treatment for these types of issues is far more successful, we've

See Homelessness on page 35

By Michael Petersen and Joseph Fiorentino

When Data Insight Is a Matter of Life and Death:
The Role of Data and Analytics in Addressing the U.S. Opioid Crisis

A pediatric emergency physician in a suburb of St. Louis gives parents the devastating news that their 18-year-old son has died of a heroin overdose. A life extinguished far too soon. This horrifying scenario plays out every day across the United States from the big cities to the heartland. This is the front line of the opioid epidemic—a battle the country is losing.

Public Health Emergency

The acting Centers for Disease Control and Prevention Director, Dr. Anne Schuchat, has called the opioid epidemic a public health emergency from which 33,000 Americans die a year. That's a staggering 91 people every day—our children, brothers and sisters, and mothers and fathers. Deaths related to opioid overdose have now surpassed the rate for those caused by automobile accidents and firearms.[1]

In addition to the loss of life, the opioid epidemic has a massive impact on society at large. Its tentacles touch the foster care, Medicaid, social care, criminal justice systems and more, putting new demands on already strained resources. This is because opiod addiction is a multidimensional and complex phenomenon. There is no silver bullet fix. Addressing the nation's opioid crisis demands addressing multifactorial causes and impacts, which is not easy.

Data: The First Line of Defense

The best way to do this is with comprehensive data insight into risk factors, behaviors, patterns, and profiles that inform effective intervention, education, and prevention strategies. The good news is that local governments and organizations

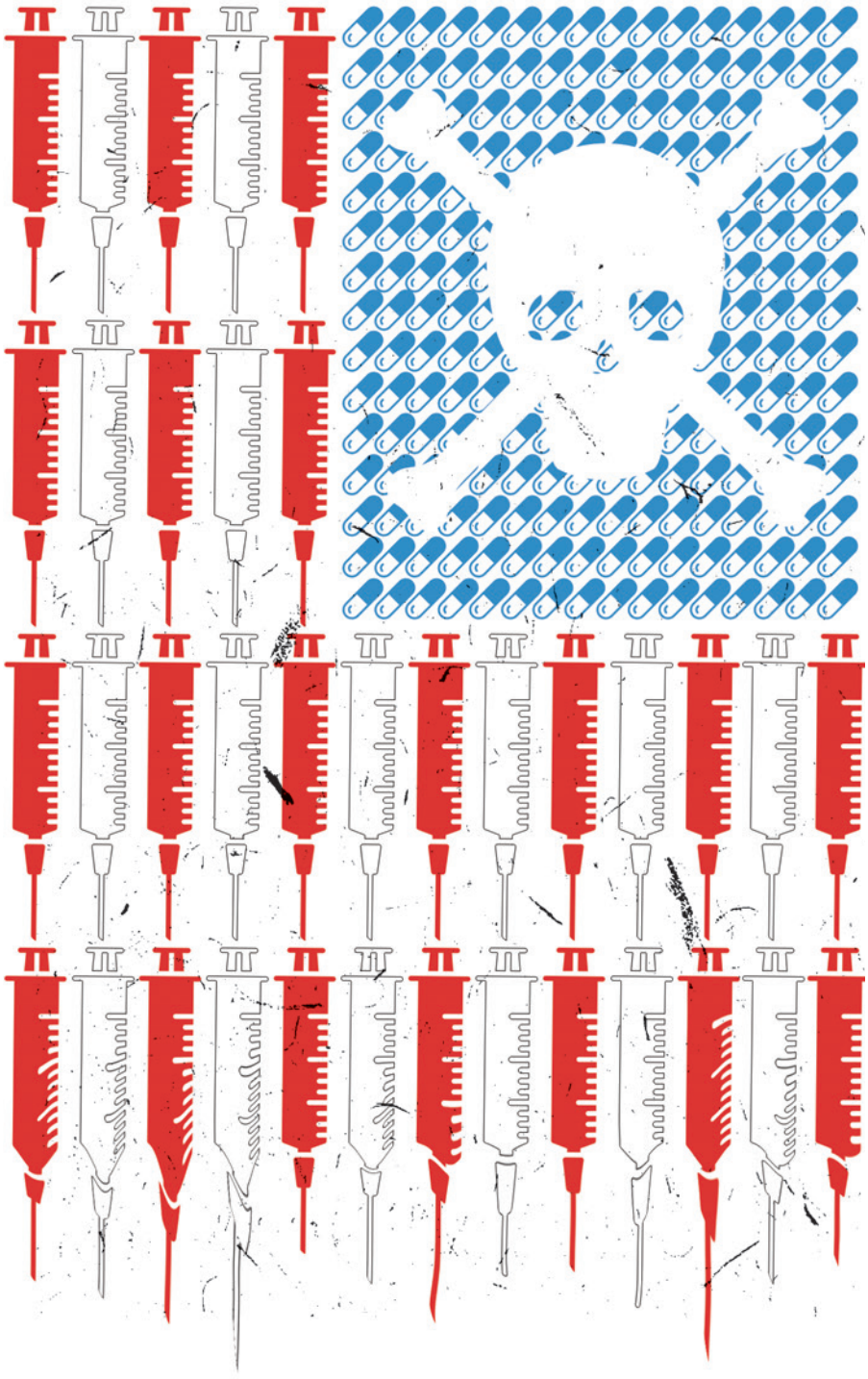

Illustration by Chris Campbell

across the health and human services spectrum—from public health institutions and behavior health entities to pharmacies and providers—possess relevant data.

The bad news is that the data are isolated as individual datasets across multiple organizations. Complicating things even further, policies often prohibit agencies from sharing data with each other and people are often ambivalent about sharing their personal data. Despite these barriers, accessing and assembling disparate data is critical to paint the full picture of all the factors driving the opioid problem. It will take courageous leadership to bridge historically siloed systems or datasets. Progress does not come from having data. Progress comes from *how* organizations use it.

Break Through to the Big Picture

Advances in data tools and analytics platforms make it possible for health and human services organizations battling opioid addiction to gather and analyze disparate datasets for that elusive holistic picture. This does not require huge financial investments and infrastructure build-outs. And it does not take years to start seeing outcomes.

But it does demand a new data mindset. First, policies and regulations must allow the secure sharing of key datasets for the purpose of combatting this issue. What's more, organizations must abandon the fruitless search for "perfect data" and focus on targeted, rapid methods to extract insights faster from both clinical data and big data that are available right now. Finally, organizations need digital platforms as the technical backbone to connect stakeholders in new ways. This allows ecosystems of groups looking at the issue through different lenses to collaborate, sharing data and coordinating whole-person intervention and prevention approaches.

The Art of the Possible

What would this look like in practice? Take the example of babies born with neonatal abstinence syndrome (NAS). These babies become addicted to opioids while in the womb. NAS is a lead indicator of women who may be addicted to opioids. NAS data can be correlated with other risk factor data including social, criminal justice and health data, along with clinician prescribing behavior.

Pulling all these together and using advanced analytics tools such as machine learning and predictive modeling, organizations can identify the nature of problems at a more granular level than ever before. Using data and analytics, it is possible to understand the story of specific clusters—or even a single individual—and predict the best possible measures to support them and target resources.

Combining and analyzing data in new ways not only traces the factors leading to addiction, it can also identify the costs of all the services an individual may require as a result. Take another look at the NAS example. Using analytics, organizations can identify areas by zip code with the largest frequency of NAS. They can build a profile of those patients that

See Opioids on page 34

Promising Practices for Incident Management

How We Can Keep Vulnerable Citizens Safer

By Sarah Salisbury and Ashley Fawcett

Protecting those who are most vulnerable, particularly our elders and people with intellectual or physical disabilities, is an essential function of state governments. As the backbone of systems of care that provide the programmatic and financial supports for these populations, state and local human services agencies have a core responsibility to ensure that people are safe and that abuse and neglect of program participants is prevented.

In trying to identify and prevent such abuse and neglect, many state human services agencies are hindered by fragmented processes and insufficient information technology (IT) systems for incident reporting and management. States, providers, and officials directing these programs can improve services and decrease risks by improving their incident management business processes, upgrading their IT systems to improve information sharing, and developing standardized, automated protocols for reporting and tracking incidents within their existing IT systems. Doing so will help those being served to realize their human potential and more fully contribute to their communities.

Photo Illustration by Chris Campbell

The Challenge

Human services programs operated by state and local government agencies, often through a network of third-party contracted provider entities, promote well-being and a higher quality of life for our nation's citizens that have physical and intellectual disabilities with long-term special needs. States retain responsibility for service oversight and the protection of these individuals from abuse and neglect. They are ultimately responsible for tracking, investigating, and managing incidents and complaints reported by individuals (recipients, family, community members) and providers.

In most states, incident reporting has evolved in a piecemeal manner, agency by agency and provider by provider. It is not uncommon for states to maintain different processes and systems to manage incidents for vulnerable individuals receiving support or services at state operated, licensed, and certified programs and facilities. This often leads to business problems such as:

- Multiple systems and databases for incident reporting and management translate into additional costs for user training and system maintenance;
- Legacy incident management systems (or lack thereof) customized to meet evolving business needs;
- Inconsistent data elements across multiple agency systems;
- Lack of standardized reporting, provider information across programs/agencies, and cross-program coordination.

As a result, state human services agencies often lack access to quality incident data across all of a state's human services programs (even within the same agency). This can inhibit an agency's view of critical information inclusive of the full incident management lifecycle. To complicate matters, individuals may be served by multiple programs and providers may contract with more than one state human services agency. Problems can occur when agency populations overlap and incident management systems do not communicate with one another. A disparate system of incident reporting can result in:

- Inhibited progress toward client-centric, integrated human services delivery, including data integration efforts across agencies and programs;
- Inability to identify trends that drive preventive measures, strengthen responses, and improve existing approaches to incident management and continuous quality improvement of services;
- Risk that agencies charged with oversight of vulnerable individuals can be held responsible for recipient injury or death; and
- Risk to individuals when no single agency obtains a full picture of incidents occurring at the individual or provider levels.

Real-Life Implications

The lack of incident management, coordination, and oversight results in public agencies increasing their dependence—and spending of public funds—on both public and for-profit providers that serve individuals with disabilities.

The statistics are sobering for the 53 million adults (one out of every five adults) in the United States that live with a disability:[1]

- In one recent study, more than 70 percent of individuals with disabilities report they have been victims of abuse (this included verbal, emotional, physical, sexual, neglect, and financial abuse), and more than 90 percent of individuals with disabilities who were victims of abuse said they had experienced such abuse on multiple occasions.[2]
- Among individuals with disabilities who reported being victims of abuse, nearly two-thirds (63 percent) did not report it to the authorities.[2]
- In most cases, when victims with disabilities reported incidents of abuse to authorities, nothing happened.[2]

U.S. crime statistical systems do not identify children with disabilities, making it difficult to determine their risk of abuse. However, a number of small-scale studies found that children with all types of disabilities are abused more often than children without disabilities:[3]

- Studies show child disability rates of abuse are variable, ranging from a low of 22 percent to a high of 70 percent.
- One in three children with an identified disability for which they receive special education services is a victim of some type of maltreatment (e.g., neglect, physical, sexual).
- Children with any type of disability are 3.44 times more likely to be victims of some type of abuse.

The above statistics exemplify the risk that states and providers face every day when not thinking critically about incident management.

Promising Practices

Some states have made strides toward improving their incident management processes, procedures, and systems. Unfortunately, there are still too few examples of these real-life promising practices described below.

Consolidating Human Services Agencies' Incident Management Systems

Pennsylvania consolidated three incident management systems into one enterprise incident management system covering intellectual

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disabilities, long-term living, aging, early intervention, child welfare, mental health, and substance abuse populations. This transition created a centralized incident management repository and allowed providers to report incidents in accordance with the Adult Protective Services Act.

Exploring Universal Incident Management

In 2013, New York State created a separate agency to transform how the state protects individuals in state-operated, certified, or licensed facilities and programs.

The state recently developed business requirements, conducted a fit-gap analysis of existing systems, and evaluated commercial off-the-shelf products to help inform the feasibility of a Universal Incident Management System (UIMS) that meets cross-agency needs and maximizes efficiency by smart re-use of existing technology assets. A UIMS would help ensure the safety and well-being of vulnerable individuals, including people with disabilities, a history of substance abuse, and other medical, mental health, and behavioral health needs, in addition to children in foster care and special education.

Creating a Statewide Child Advocacy Office

In 2008, legislation designed to overhaul the Massachusetts child welfare system included creating a new child advocacy office. This child advocacy office investigates incidents involving children in state care, including reviewing complaints from the public and reporting any findings directly to the governor. In response to a recent series of high-profile incidents at residential schools for children with disabilities, the child advocacy office initiated an inter-agency review of the public and private residential and day programs that provided educational services to children and young adults with complex needs, and the oversight systems for these programs. Specific objectives include identifying and improving assessment and monitoring of risk factors to improve the safety of children at residential schools, and identifying process improvements to enhance the efficiency of monitoring and oversight.

Improving Incident Management and Quality of Services

States and providers can proactively improve their incident management systems before circumstances beyond their control force a reactive response to an adverse event. However, it is important to recognize that the success of any endeavor, incident management included, is not solely dependent upon a technology solution.

Modernizing technology without redesigning business practices and policies will not solve the problems discussed above. It is critical that states address business processes before moving forward with any technology solution.

There should be a shared focus on implementing incident management data standardization and process consistency wherever it is possible, without compromising the missions and requirements of involved agencies. States can achieve this goal by:

See Incident Management on page 39

Tapping into the Potential of Public Health and Social Services Partnerships

A Framework to Improve Outcomes for Disadvantaged Workers

By Shawn Kneipp and Kerry Desjardins

Millions of Americans suffer from one or more chronic diseases. Individuals with lower income, lower levels of education, or who are racial or ethnic minorities bear the brunt of chronic disease, posing a great challenge to their workforce engagement and economic well-being. Despite being a very common and difficult barrier to sustainable employment and self-sufficiency, the human services system generally does not sufficiently address clients' chronic health conditions. But evidence shows that partnerships between public health programs and human services programs can lead to better health and employment outcomes.

Chronic Disease in the United States

Annually, $1.3 trillion is spent on chronic disease treatment in the United States.[1] Much of this cost relates to insufficient management of chronic disease conditions and the onset or exacerbation of symptoms that inevitably follow.[2,3,4] Over time, poor disease management and symptom control impairs functioning in key life domains—such as employment.[5] These health-related limitations manifest as employee presenteeism (the practice of coming to work despite illness or injury, often resulting in reduced productivity) and absenteeism—where reduced productivity in the workplace costs U.S. employers $1,685 per employee per year, or $225.8 billion annually.[6] Nearly 48 million Americans report some degree of chronic disease-related functional limitation or disability.[7,8] However, socioeconomically disadvantaged populations account for the greatest productivity and health care system costs, given they have a higher disease prevalence, worse symptom control, and more significant health-related work limitations.[9,10,11,12]

Dr. Shawn Kneipp is an Associate Professor at the University of North Carolina at Chapel Hill's School of Nursing.

Kerry Desjardins is a Policy Analyst at the Center for Employment and Economic Well-Being (CEEWB) at the American Public Human Services Association.

There is a tendency to think of a select few conditions when we hear the term *chronic disease*. Most often, these are the conditions that are the major causes of U.S. deaths (e.g., heart disease and diabetes), and thus are widely believed to account for most of the individual and societal burdens outlined here. In reality, however, a wide range of health problems meets the criteria of being "chronic health conditions," which are defined as "conditions that are generally not cured, once acquired."[13]

These statistics, and the ways in which chronic health conditions impede securing or maintaining employment, are familiar to this audience and others working in the social services sector. For example, in the Temporary Assistance for Needy Families (TANF) program, health problems have long been recognized as significant barriers to employment. Incentives for screening for mental health, substance abuse, and domestic violence as health-related barriers to employment, for example, were written into the legislation that established TANF in 1996.[14] However, this set of health problems is narrowly defined relative to the wide array of chronic health conditions that can act as barriers to employment.

Health and Employment Outcomes for TANF Clients

A focus on screening for mental health and substance abuse among TANF clients may have encouraged some degree of coordination or integration across the social and health services sectors. What we have learned since 1996 from one of our studies, however, and what is being echoed in the broader health literature, is that a 20-year, policy-driven history of focusing on these chronic health conditions in isolation has blunted the progress that could be made in achieving better outcomes for TANF clients. In a randomized controlled trial sponsored by the National Institute of Nursing Research* that used a community-based approach,[15] the first author (Kneipp) tested the efficacy of a public health nursing screening, referral, and case-management program on improving health and employment outcomes with 432 women receiving TANF. (See details of the intervention at *https://innovations.ahrq.gov/profiles/public-health-nurses-provide-case-management-low-income-women-chronic-conditions-leading.)* In that study, chronic health conditions were defined broadly (as described above). Even though participants in the sample were, on average, just under 30 years old, they also had an average of 3.8 chronic health conditions. By working together to address clients' health conditions collectively, as interrelated and having a compounded effect on an individual's ability to function, this public health nursing–social services intervention improved the health of TANF clients. The intervention increased health care visits for depressive symptom evaluation, reduced depressive symptoms, and increased functional status. Employment outcomes improved as well with a 9 percent increase of moving into employment among the intervention group, and moving into employment, on average, 35 days earlier than clients who did not receive the intervention.[16] Moreover, improved health and employment outcomes persisted even in the midst of the most recent economic recession.[17]

Annually, $1.3 trillion is spent on chronic disease treatment in the United States. Much of this cost relates to insufficient management of chronic disease conditions and the onset or exacerbation of symptoms that inevitably follow.

Moving to an MCC Framework

Within the health care and public health domains, there has been increased emphasis on moving from programs that focus on singular chronic health conditions to programs developed from a Multiple Chronic Condition[14] (MCC) framework. A core principle of the MCC framework is that the symptoms (i.e., the physical-mental sensations that people feel or experience—such as fatigue or pain) and morbidity (i.e., the limitations that often follow and impair employment functioning) from chronic conditions rarely manifest in isolation or as disease-specific problems. Rather, symptoms and the resulting functional limitations overlap, intersect, and act *synergistically* across chronic health conditions. In response to this new way of thinking, public health recommendations and national initiatives from the Institute of Medicine, the Centers for Disease Control and Prevention, and the National Institute of Occupational Safety and Health are increasingly advocating that programs address a broader set of chronic health conditions.[18] For the TANF program, this means that by screening and referring for a mental health condition such as depression (even when considered in the context of concurrent substance abuse), we are missing the opportunity to address what are increasingly recognized as shared biological processes that underlie a number of chronic health conditions and contribute to the severity of symptoms and functional limitations experienced by individuals. Moreover, the activation of these processes with the onset of a first or primary chronic disease often leads to the development of comorbid conditions—that is, the development of additional chronic health conditions.

Some of the study findings in the sample of women receiving TANF can help illustrate MCC overlap and processes. First, depression and low back pain were fully expected to emerge as the most prevalent conditions in the sample. This was not the case—rather, headaches were most prevalent (53 percent), followed by back pain (50 percent), depression (50 percent), and seasonal allergies (38 percent). Second, the data were further examined to understand the extent to which job loss in the prior year was associated with the most prevalent conditions in the sample; only headache and allergies were significantly associated with job loss in the prior year.[19] Combined, women with both headache and allergies were nearly three times as likely to report a job loss in the prior year compared to those who reported neither headache nor allergies as chronic conditions.[19]

On the surface, both headaches and allergies are widely considered "common," "every day," "simple," or "ordinary" health problems that are routinely experienced, and probably adequately managed by many women. However, individual and environmental factors—such as the chronic and cumulative stress of economic insecurity; family instability; lack of social support; volatile schedules and caregiving responsibilities; inconsistent access to adequate, quality health care; and lack of health education—commonly experienced by human services customers—often overload their psychological coping bandwidth, limiting the cognitive resources they can dedicate to managing their health. Furthermore, insufficient financial resources can limit their access to even over-the-counter treatments for temporary symptom relief.

The social services and public health sectors have much to gain from greater collaboration, especially with regard to serving public assistance recipients, a group that frequently experiences health-related barriers to economic security.

In most TANF screening that occurs, neither headaches nor allergies would likely be identified given they do not fall within the narrow scope emphasized in the TANF legislation. If mentioned by TANF clients while in the program, it is equally likely that neither would rise to the level of significant "concern," unless the client directly attributes prior job loss to one of these conditions. Despite this, women with more frequent migraines are more likely to develop subsequent depression—a health-related barrier recognized in the TANF legislation—thus, controlling migraine (and allergy symptoms) are both highly relevant to preventing depression and improving functioning.[20] Based on the first author's 20 years of experience as a nurse practitioner, most people are themselves not fully aware of how, collectively, these conditions negatively affect their functioning unless the complex, cyclical relationships between symptoms, self-management approaches taken, and outcomes from their use of self-management strategies are probed and made explicit.

On the "biological processes" front, recent evidence suggests that both the frequency and disability of migraine headaches are higher in individuals with rhinitis (i.e., a stuffy or runny nose from seasonal or environmental allergies).[21] There is also evidence that optimal treatment of allergy-related symptoms reduces the number of migraine headaches.[22] Finally, there are believed to be psychobiological processes involved in the later development (or onset) of depression among women who experience migraines.[23]

In the TANF study sample, a diagnostic interview was not completed to validate that "headaches" self-reported as chronic health conditions by study participants were indeed migraine headaches. However, given the age of the sample, and that migraine accounts for the majority of headache types in similar age groups, it is probable that most of

See Partnerships on page 37

Bring It On

A Provider, A Researcher, and A New Way of Improving Lives

We asked Heather Reynolds, President and CEO of Catholic Charities Fort Worth (CCFW) and James Sullivan, Director of the Wilson Sheehan Lab for Economic Opportunities (LEO) at the University of Notre Dame about their work together to reduce poverty and improve lives.

Here's what they had to say.

Heather Reynolds: When I became CEO of CCFW more than a decade ago, I read a newspaper article about a CEO retiring from a local homeless shelter. In the article, he shared that after more than two decades of work with the homeless, he thought they were not any better off than the day he had started. Last year, when our organization set a goal of moving 10,000 families out of poverty over the next decade, I was asked if that goal scared me. It does. What scares me even more is the idea that I would be quoted in the newspaper sharing similar sentiments.

The destination matters, and if the journey is what gets you there, then you had better believe that the journey matters, too. A huge part of the journey at CCFW is to invest in research so we can get to our end goal—our destination—of ending poverty one family at a time. We have upped the bar on what ending poverty means—it means families making a living wage, having three months of savings, and being free of debt and government assistance.

We decided to make a change: no more band aids or repeat customers, no more quantifying output goals that only counted the number of people served. We decided we were going to double down on things that we know work with families and shed ourselves of programs and services that did not.

And that requires practitioners and researchers coming together to find out what really works to end poverty.

James Sullivan: Enter the Wilson Sheehan Lab for Economic Opportunities (LEO)—a premier national poverty research lab housed in the Department of Economics at the University of Notre Dame. We match top researchers with social services providers to conduct impact evaluations that identify the innovative, effective, and scalable programs and policies that support self-sufficiency. LEO's research is conducted by Notre Dame faculty, along with an interdisciplinary network of scholars from across the country, with expertise in designing and evaluating the impact of domestic programs aimed at reducing poverty and improving lives. William Evans and I co-founded LEO in 2012 and were quickly introduced by a national partner, Catholic Charities USA, to the interesting work and leadership at CCFW.

HR: We were asked in those early days, again and again, "Are you sure you want to be told what you are doing doesn't work?" Our response—"bring it on."

For example, we know that one of the keys to ending poverty is helping people find living-wage jobs, and one of the keys to getting a living-wage job is a certificate or associate's degree in a growing industry in our local market. But we also know that less than 20 percent of students who start community college actually graduate, even though a degree is a surefire way to break the cycle of poverty.

JS: That's right. Previous research tells us there are four main reasons why community college students drop out: cost, not being prepared for the academic rigors, social and institutional obstacles like not knowing how to access financial aid or settle on a degree plan, and personal obstacles not related to school—life just getting in the way.

Research and services largely focus on the first two. But much less attention has been given to personal obstacles and social and institutional obstacles.

HR: And this would be our sweet spot. As we designed the rollout of our new Stay the Course program, LEO worked with us to embed a randomized control trial (RCT) evaluation in order to rigorously measure the impact of the program and really understand the cause-and-effect mechanisms of the program. Together, we are learning if and how case management makes a difference for low-income students to persist in school and graduate, moving them forward on their path out of poverty.

Stay the Course students are paired with a Navigator—a case manager who walks with them for up to three years of their college career, helping them traverse the school system and overcome the obstacles that normally derail their education. Support may initially be securing housing to avoid homelessness for a family unit, or help enrolling in classes for someone who has never had a family member attend college, or funding a car repair to get that twenty-something single man to class for his exam, or help getting back on track when a class is failed because a single working mom could not keep up when her child got ill. This kind of support—the financial, emotional, tangible support of having a case manager work alongside these clients—this is what creates success.

Since we started Stay the Course more than three years ago, we've served about 400 students and have expanded from one campus to two.

JS: We will release a report on the effect of Stay the Course on student academic outcomes later this summer. The results thus far are quite promising, both for persistence in school and for degree completion.

HR: And now, we plan to replicate Stay the Course in 6–10 locations around the country to demonstrate that our intervention works outside

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of Fort Worth. We are scaling up next year to add three additional community colleges with plans to add additional sites in the years ahead.

JS: The story of Stay the Course is an important one for students and for evidence-based policy and practice. CCFW saw a need in the clients they were serving that attended community college. They designed a program, drawing on their own expertise in case management, and applied specifically to the nonacademic needs of this population. LEO worked with CCFW to evaluate Stay the Course to provide both continuous feedback to the program managers and staff and to determine, independently and rigorously, the impact of the program on the students it serves. The replication of Stay the Course represents the next stage in creating, evaluating, and scaling evidence-based programs and policies. This effort will inform not only the work of the communities where Stay the Course becomes active, but more generally, national and state policy on community college persistence and completion.

HR: Right now, the social services industry concerns me. So much of what we do is based on funding and the anecdotal story of someone's success. But anecdotes are not evidence. I cringe when I'm approached with the sentiments from a colleague in the industry who says, "I don't think it is ethical for you to conduct research and have people in a control group when they desperately need the services you offer."

Not one nonprofit I know can serve everyone. So why not at least use our "no" as an opportunity to better our services?

JS: A control/comparison group does not mean denying services—often it means providing one group "the status quo" and providing another group a new/bold/enhanced service that has not yet been tested. A comparison group allows you to determine if it was the program itself that helped your clients achieve their goal—in this case to complete college.

Sometimes we get questions about the ethics of conducting research in this way. To be clear, this only works because systems and agencies are already constrained—by funding, staffing, space, and mission—by whom they can and cannot serve. Furthermore, the research we do is always reviewed by Notre Dame's Institutional Review Board (IRB) to ensure clients are properly aware of their participation in research, and that we, the researchers, and the agencies are appropriately using the information and data gained from the research to inform practice and improve understanding of a given field of research.

RCTs are more familiar in the medical field—drug companies run trials to test new products as a part of standard practice before the Federal Drug Administration (FDA) will approve a drug for a given ailment. Without FDA approval, medicines are not allowed to be used, *because they are not proven to work*. We do not currently have a similar agency or entity that requires and regulates poverty solutions.

HR: If we would never accept approval without RCT in the health care industry, why is it okay for those we serve in poverty? Why is it okay for our nation, our taxpayers, to not even know if their dollars work? Why are we on our ethical high horse all the while providing services without evidence of whether they really make a difference or worse, actually harm the underprivileged?

It is scary to test what you are doing. Every time we know we are getting a new report from LEO, I think we all hold our collective breath with concern and anticipation for what the results will say. We want to get it right and it is hard to be willing to accept the hard truth—that sometimes what you do does not work.

JS: Our goal at LEO is to use the tools of analysis we have to benefit frontline providers and agency leaders as they develop and run programs that truly impact their clients—help them secure a job, move them through school, improve housing stability, move them to self-sufficiency. We know that the best way to measure cause-and-effect of a program is to carefully create a comparison group so that the differences we might find between the people being served and those not being served by a new program are clearly attributable to the program. We can also help by measuring the cost-benefit of the program so that where money is tight and each dollar counts, providers can make informed decisions about which programs do the most for the best value.

HR: Like LEO, we are committed to cracking the code on how to end poverty. So, are we sure we want to be told what we are doing does not work? Yes, if it doesn't work, we want to know. The stakes are too high. Bring it on.

The replication of Stay the Course represents the next stage in creating, evaluating, and scaling evidence-based programs and policies. This effort will inform not only the work of the communities where Stay the Course becomes active, but more generally, national and state policy on community college persistence and completion.

Mindful MEDICAID

Using Behavioral Economics to Move the Needle on Maternal and Child Health

By Melissa Majerol and Patrick Howard

Have you ever sworn off fast food, only to sneak a fry from your kid's plate when she looks the other way? Or realized you still haven't enrolled in that 401k plan even though you promised yourself you would? Sure you have. We all have.

As common as these problems are, they're pretty odd when you think about it. We tend to see ourselves as rational human beings who make decisions consistent with our own self-interests, but these are just two examples of how we make choices each day that are at odds with what we actually want for ourselves.

It turns out that economists can't always predict how even the most rational people will respond to policies or incentives. So how can policymakers design programs to drive desired behaviors?

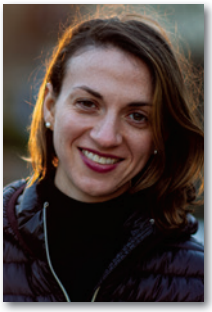
Illustration by Chris Campbell

That might be a job for *behavioral economists*. Behavioral economics goes beyond simple incentive structures and examines the complex psychological, social, and cognitive factors that affect human decision-making. Through an understanding of these factors, behavioral economists develop theories about human behavior, run real-world experiments to validate their hypotheses, and offer solutions.

Indeed, the field of behavioral economics is ripe with applications for health care, and the Medicaid program in particular. Behavioral economics can offer a low-cost way to decrease program costs while driving better health outcomes—a true "win-win" strategy.

Governments' use of behavioral economics is fairly recent. In 2010, Britain became the first country to create a government unit dedicated to the study and application of behavioral economics. The Behavioural Insights Team (BIT), also known as the "Nudge Unit," designs interventions that prompt people to pay their taxes on time, or show up for scheduled medical appointments.[1]

Indeed, the field of behavioral economics is ripe with applications for health care, and the Medicaid program in particular. Medicaid accounts for a substantial portion of state budgets and covers vulnerable populations at critical points in their lives. And though Medicaid coverage and services are available at nominal or no-cost, getting eligible people to enroll in the program and use cost-effective preventive services can be a challenge.[2] Behavioral economics can offer a low-cost way to decrease program costs while driving better health outcomes—a true "win-win" strategy.



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Patrick Howard is Principal, U.S. State Government Central Consulting Leader, at Deloitte.

Focus the Microscope: Drawing from Behavioral Science to Promote Maternal and Child Health

Collectively, Medicaid programs across the country cover roughly half of all childbirths and 40 percent of children.[3,4] This makes the program uniquely positioned to promote maternal and child health in the United States. In our recent report, *Mindful Medicaid*, we discuss how pregnant women enrolled in Medicaid are more likely than women with private insurance to delay prenatal care until late in their pregnancy or to skip prenatal care altogether, and how low-income children are less likely than higher income children to receive complete vaccinations.[5]

To address these disparities, we explore how behavioral economics could be harnessed to move the needle on maternal and child health in Medicaid by focusing on three areas:

1) **Messaging.** Communications that leverage positive peer pressure (or *social proof*, as behavioral economists like to call it) can be effective at getting pregnant women to quit smoking. The Louisiana Department of Health has already caught on to this concept. It has teamed up with the 2Morrow Inc. smoking cessation app, SmartQuit, which regularly sends soon-to-be parents success stories about people who, under similar pressures, were able to quit smoking to achieve their goals. Though it is still early, the initial results have suggested that the behavioral-based strategies of SmartQuit are more effective than alternative smoking cessation apps.[6]
2) **Choice architecture.** Behavioral science reveals that people are more likely to stick with a *default*—the result you get if you do not make a choice—than they are to actively make a new, alternative choice. So why not make the default the best option? There is evidence that automatically booking people for vaccination appointments increases vaccination rates. States could auto-book children and expectant moms for appointments in order to increase vaccination take-up rates.
3) **Program tools.** It might sound simple, but sending out text reminders and having people make formal commitments (to themselves and to others) could go a long way to improving maternal and child health. Findings from behavioral economics show that detailed, personal commitments (or *implementation intentions)* have increased the rate at which unemployment beneficiaries in the United Kingdom have returned to work.

Another study indicates that making commitments to others (or *social commitments*) were the most effective approach at getting people in Kenya—even those with the most limited financial resources—to save money.[7] Commitment devices and reminders are effective program tools and can be used to nudge expectant mothers to attend prenatal appointments and stay healthy during their pregnancy. They can also encourage parents to bring their babies in for well-baby visits.

Getting Started: Bringing These Insights Back to Your State

For program directors and managed care organizations looking to apply these insights to their Medicaid population, we suggest an experimental approach before going to scale. No two Medicaid programs are the same, so before designing an intervention, policymakers should consider taking the following steps:

- **Take the time to develop a hypothesis** about where your program may be falling short. If you believe it's the message, consider a more socially driven communication.
- **Establish evaluation measures.** Whatever initiative you settle upon, test it. Collect quality data and rigorously evaluate its effectiveness.
- **Revise accordingly.** Did the test produce positive outcomes? If not, and the problem was with the behavioral nudge itself, think about drawing on other behavioral tools to address this problem.

While behavioral economics is still an emerging field, a rich body of evidence is beginning to develop to inform how people can be nudged to make better choices for themselves. For Medicaid programs that effectively leverage these behavioral principles, the potential payoff is better health outcomes at lower cost.

Connecting Behavioral Concepts to Medicaid Opportunities

Area of Focus	Behavioral Concept	Medicaid Opportunities
Messaging	• *Social proof* to motivate behavior and inspire confidence	• Help expectant mothers quit smoking
Choice architecture	• *Smart defaults* to make the best choice the path of least resistance	• Encourage Medicaid enrollment and increase vaccination rates
Program tools	• *Commitment* devices to articulate plans and engender positive reinforcement • *Reminders* embedded in technology to minimize forgetfulness	• May increase likelihood of receiving prenatal care and staying healthy during pregnancy • May increase vaccination rates, prenatal visits, and well-baby visits

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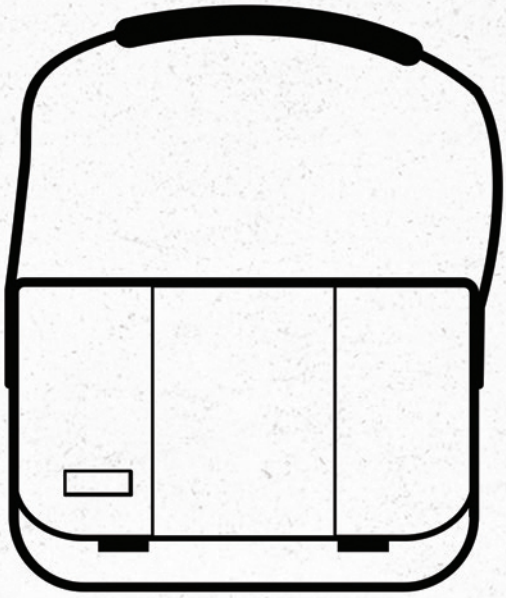

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DESTINATION *employment*

THE BENEFITS OF WORK AND THE IMPORTANCE OF SUBSIDIZED EMPLOYMENT

BY RUSSELL SYKES

We are already aware of the economic benefits of work as the best avenue out of poverty: wages at an entry-level job are higher than public assistance benefits in every state; wage supplementation programs through the tax system, such as the Earned Income Tax Credit and the Child Tax Credit increase income for working families. Supplemental Nutrition Assistance Program (SNAP) benefits not only aid with food purchases, but they free direct wage income for other purposes. Entering the workforce is the first step toward economic advancement and a career.

But we too often overlook the important social benefits of work.

Jobs provide much more than income alone—they are personal and help define us. What we do for work is an important aspect of who we are. Most of us spend about a third of our lives working. Work is also a key part of our interactions with others and a way to build a network of colleagues and friends as well as a social support system. In a broader realm, employment is critical to social cohesion and civic engagement.[1]

The human services system provides unemployment insurance, temporary cash assistance through Temporary Assistance for Needy Families (TANF), and disability benefits through Supplemental Security Income and Social Security Disability Insurance for those who truly cannot work due to physical, developmental, or mental health issues. Truth be told, these programs provide minimal income and many people who are disabled would prefer supported work settings. Similarly, many people receiving TANF and SNAP would like to acquire the necessary skills to work. Programs that are critical to work such as subsidized child-care and assistance with transportation exist, but are dramatically underfunded. Work for those who can work provides social and economic glue as well as a better life, but for hard-to-serve populations, finding employment is often not easy. The benefits of work are also important for healthy families and individuals. The workplace and employment play a major role in the social determinants of health. Working with others lessens isolation and depression. Being in the workplace creates friendships and networking opportunities that can advance careers and life satisfaction. Improving the conditions in which we live, learn, work, and play, and the quality of our relationships will create a healthier population, society, and workforce. Health starts in our homes, schools, workplaces, neighborhoods, and communities.[2]

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AVENUES TO EMPLOYMENT HOW SUBSIDIZED JOBS CAN ASSIST THE HARD TO SERVE AND HELP EMPLOYERS

The process of getting a job is sequential and involves understanding the culture and requirements of the workplace, developing the soft skills that employers demand, getting a first start in the labor market, acquiring additional necessary skills on the job or through targeted education and training prior to or wrapped around entry-level work. The process also involves being flexible, resilient, and working hard and increasing abilities over time to build a career.

Education is important; finishing high school and, for many, getting post-secondary education in a two-year or four-year program is valuable, but employers and other intermediary partners are understanding the importance of career and technical education aimed specifically at the jobs that exist in the local community as the pathway to employment, advancement, and careers. As the workforce changes and modernizes, having the requisite middle-skills that are technical in nature and portable across occupations requires an associate degree or sometimes less. But only skilled labor, with extensive training, can fill these positions.[3]

Middle-skill jobs require industry or employer-based curriculum and training that is job specific, which in turn is incentivizing community colleges and the workforce system to partner with employers to deliver training, or deferring to employers themselves to focus on apprenticeships, on-the-job training, and mentoring.

But for many jobseekers, such as youth and those leaving various types of assistance and entering the labor market for the first time, there is a risk for employers that the fit on the job may not work out due to various obstacles such as child care, transportation issues, and lack of work experience. A proven tool to address this reality and to share risk with employers is subsidized or trial employment agreements developed between employers and workforce agencies or their contractors where the goal is to underwrite all or part of the wage for an agreed-upon period and with clear expectations that the employer, based on evaluation of the worker, will convert the job to an unsubsidized position. The remainder of this article will focus on how subsidized employment works, how the subsidies can be paid, and examples of success.

WHAT IS SUBSIDIZED EMPLOYMENT?

Subsidized employment is a simple construct, using public funds for a period of trial employment where all or part of the wage is not paid for by the employer. An interested and participating employer who hires a TANF recipient, for instance, can receive a full or partial subsidy from TANF funds for an established period instead of directly paying the wage, the costs of on-the-job training, or other costs such as benefits associated with employment. Subsidized employment is also a countable work activity under TANF.

The subsidy can come from several sources of funds used singularly or in tandem: grant diversion, where all or part of what would otherwise be the recipient's cash assistance payment is given directly to the employer; a subsidy through any public funds that have been appropriated specifically to operate a wage subsidy program, or diverting the SNAP benefit to an employer.[4]

While terms differ, well-run subsidized employment programs support both the client and the employer effectively. The length of subsidy is established up front with the employer, contractor, and subsidized worker and reasonable expectations are normally

included for the employer to independently hire the worker after the expiration of the subsidy if the work performance has been strong.

In most instances, the length of the subsidy varies and there can be benchmarks for renewal. A standard length that allows the employer to evaluate the subsidized employee is six months. In some cases, a period of three months is established. Lengthier subsidies can go up to nine months, but rarely one year. Keeping the subsidy period short and including reasonable expectation of the job becoming permanent discourages employers from simply using the subsidy as a revolving door of free labor, when they may have made the hire in any event.

BENEFIT TO THE CLIENT AND EMPLOYER

There are numerous benefits to the client. They are in the workplace gaining experience and being paid through a regular payroll check. They gain specific skills related to the occupation. If the employer offers benefits to its nonsubsidized employees, the client can receive the same or similar benefits financed by the wage subsidy. Support services such as child-care and transportation assistance are often available. Having a job imparts self-worth much more than staying on cash assistance.

Hiring TANF participants and other recipients of public assistance assessed as job ready still poses certain risks for employers. TANF recipients often have less job experience and familiarity with workplace expectations than other potential employees. As single mothers in most instances, they often have child support, child-care, and transportation issues to navigate. Subsidizing their wage, therefore, becomes an equalizer in the hiring process, as risk to the employer is being underwritten as their skills and fit for the job are measured.

Employers can offset training and benefit costs as well as wages and can tailor on-the-job training, skill acquisition, and workplace expectations to their own industry. The subsidy allows the employer a trial period to evaluate the individual, whom they might not otherwise have hired, prior to deciding whether to retain them on an unsubsidized basis.

INITIAL SUBSIDIZED PLACEMENTS IN SUCH EMPLOYMENT SECTORS CAN LEAD TO SUSTAINABLE EMPLOYMENT, A BETTER CHANCE FOR ECONOMIC ADVANCEMENT, AND LESS NEED FOR FUTURE PUBLIC FINANCIAL ASSISTANCE.

RELATIONSHIPS ARE CRUCIAL

Critical to success is a strong and trusted relationship between the contractor and employers in their service area, and a clear understanding of employers' precise needs. This requires a mutual working relationship and job development component that can individually match clients to specific jobs.

Contractors can maximize other subsidies to employers when they desire to hire the subsidized worker independently after the subsidy ends by helping them gain easy access to applicable Work Opportunity Tax Credits that may be available. They can also make sure employees have access to available low-income tax credits like the Earned Income Tax Credit.

Most wage subsidy programs operated by states, local districts, or their contracted vendors are focused on the sectors that are most likely to be hiring in their labor market. These most often include health care, retail, hospitality, security, transportation, community service, data entry, banking, and other service sectors. Generating a familiarity with the local labor market and employers is critical to success.

In addition, certain sectors offer opportunities for future advancement, a perfect example being various levels of skilled nursing certifications. Such advancement has become known in workforce development as "career pathways." Initial subsidized placements in such employment sectors can lead to sustainable employment, a better chance for economic advancement, and less need for future public financial assistance.

PROVEN RESULTS: TANF EMERGENCY CONTINGENCY FUND EMPHASIZED SUBSIDIZED EMPLOYMENT

The enactment of the TANF Emergency Contingency Fund (TECF) as part of the American Recovery and Reinvestment Act of 2009 (ARRA) prompted widespread use of subsidized employment. TECF allowed three purposes: paying additional cash assistance needs, one-time nonrecurring payments, and transitional subsidized employment. In total, TECF allocated $5 billion to states, almost $1.3 billion of which was allocated to subsidized employment in the public, private, and not-for-profit sectors.

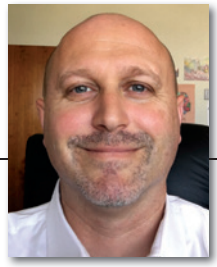
Also, by the Department of Health and Human Services' Administration for Children and Families' accounts, ARRA subsidized employment programs were highly successful because they secured jobs for traditionally harder to serve populations, such as noncustodial fathers, and many participants transitioned to unsubsidized employment.

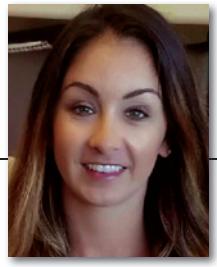
States lined up to embrace these new funds, especially for subsidized employment. In fact, 39 states initiated or expanded subsidized employment programs.

A study by the Economic Mobility Corporation (EMC) of five TECF subsidized jobs programs demonstrates clear success in helping disadvantaged individuals during hard economic times increase their incomes as well as improve their chances of finding permanent employment when the subsidy expired.[5]

See Employment on page 36

By Pete Cervinka and Christina Oliver





National Electronic Interstate Compact Enterprise: California's Experience

Everyone working in child welfare does it because they want to improve the lives of children. Social workers investigate allegations, make family maintenance or removal decisions, and develop case plans in the best interest of children. If removal from biological parents is necessary, children and youth then do better when they are placed in homes with committed, nurturing families. Placements with the child's relatives are even better. And sometimes, unfortunately, those relatives do not live in the child's home state. In a child welfare world that is already complicated enough, crossing state boundaries adds a whole other level of complexity to ensuring that children get where they need to be, in an environment that is safe and protective, with access to necessary services.

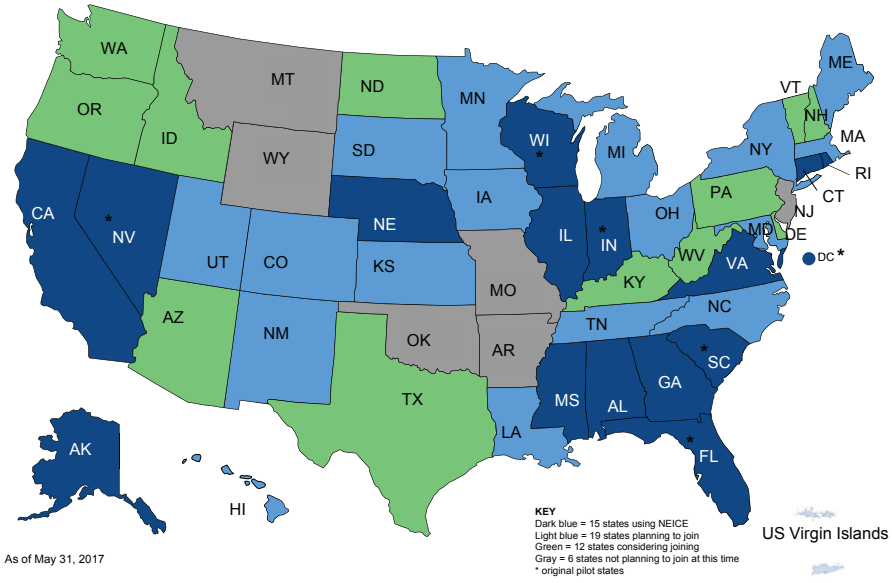
The Interstate Compact on the Placement of Children (ICPC) process is both critically important and time intensive. Lots of data and documents are required to successfully place children in another state. For years, California has struggled to work with other states in a timely and effective manner. There were too many stories about more immediate conflicting priorities for one of the parties to a placement, lost or misplaced paperwork, telephone tag, time zone differences, logistical arrangements, and assuring licensing requirements.

California is not alone in facing these challenges. In October 2013, seeking a better way of doing business, the American Public Human Services Association supported the District of Columbia and five states to begin using a cloud-based solution for securely sharing data and documents. Known as the National Electronic Interstate Compact Enterprise (NEICE), development of this solution was made possible by an initial innovation grant from the Office of Management and Budget and then an implementation grant from the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. Three and a half years later, many states are using it—a testament indeed to its value and ease of use!

The California Department of Social Services joined NEICE in July 2016, seeking to reduce the amount of time from a child's placement request to a placement decision and permanency in another state, through improved timely communication across state lines. Cost savings to our state from reduced printing and mailing, and the opportunity to move in the direction of centralizing our placements in one web-based system, also give NEICE strong appeal. (That is of added importance in a state-overseen, county-operated child welfare system like ours, by the way.) We are actively pushing our goal that all interested California counties will be using NEICE by the end of this summer. With only partial implementation, California already has seen the benefits of NEICE through faster placement approval times and increased communication between states.

A recent case example of the efficiency and speed of the NEICE database was a turn-around time of only three days from the time we received the placement packet, entered it into NEICE, and sent the information to Virginia for a

NEICE Implementation Progress



Although there are some up front set-up and training costs, and an annual maintenance fee, when we looked at those items as the equivalent of a few months' placement costs for a single child, and then at how much faster we are able to get our kids into safe and healthy committed relationships despite state boundaries, it was a slam-dunk decision to sign up.

residential Regulation 4 placement. This was a huge improvement compared to our pre-NEICE experience. Typically, residential placements have had a two-week turnaround from the time we receive a packet, send it out to the receiving state, and obtain the signed documentation. The database is easy to use, allows quicker communication among states, and saves time and money.

Although there are some up front set-up and training costs, and an annual maintenance fee, when we looked at those items as the equivalent of a few months' placement costs for a single child, and then at how much faster we are able to get our kids into safe and healthy committed relationships despite state boundaries, it was a slam-dunk decision to sign up. We had lots of implementation support from the NEICE team, including training and modest customizations based on our unique needs. We have scheduled monthly check-ins to solicit our feedback and suggestions about how NEICE can be improved. The NEICE team continues to be open to our input and we are grateful for their attention and responsiveness.

Of course, any database is only as good as the information in it, and ICPC is a two-way street between states. The more states that use NEICE, the better it becomes for everyone involved. Sixteen states are in, 19 more have active plans to join, and we encourage the rest of you green and gray states (see progress map on the previous page and at *http://www.aphsa.org/content/dam/AAICPC/PDF%20DOC/NEICE%20Progress%20Map%20External%20(13).pdf)* to become any shade of BLUE! (And no, in case you ask, California did not choose the color scheme …)

Sign a simple memorandum of understanding, make small investments in training and the annual fee—your workforce and the children it serves will reap a huge return on your investment over the long term. Joining NEICE is cheaper before May 2018; everything you need to know can be found at *http://aphsa.org/content/AAICPC/en/actions/NEICE.html.* Please consider joining those of us already on the NEICE, for the children.

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By Daniel Pollack

Foster Children, Foster Parents, and Drunk Driving

Want to be a foster parent in Nebraska? You can't have had a driving under the influence (DUI or DWI) conviction for the previous five years.[1] Similar policies exist in Montana,[2] Nevada,[3] Texas,[4] West Virginia,[5] and other states. Should foster parents with *any* history of being convicted for drunk driving be required to install a device in their car that inhibits the car from starting until sobriety is confirmed?

It is heartening to hear that drunk driving fatalities have reached record low levels. Nevertheless, according to the Centers for Disease Control and Prevention (CDC) "every day, 28 people in the United States die in motor vehicle crashes that involve an alcohol-impaired driver. This amounts to one death every 53 minutes."[6] The CDC also reports that in 2014, "9,967 people were killed in alcohol-impaired driving crashes, accounting for nearly one-third (31%) of all traffic-related deaths in the United States."[7] Regarding children, "[o]f the 209 child passengers ages 14 and younger who died in alcohol-impaired driving crashes in 2014, over half (116) were riding in the vehicle with the alcohol-impaired driver."[8] Still, studies show that 50 to 75 percent of convicted drunk drivers continue to drive without a license.

There are proven strategies to curtail impaired driving. In part, this is due to a surge of various technologies. Most of the devices are similar to a breathalyzer. The interlock device measures the blood alcohol content in a person's system. If it exceeds a prescribed level, the device temporarily locks the car's ignition and a record of the failed test is made. These technologies can ensure that foster children have a reduced chance of being in a car driven by a foster parent who may be under the influence.

In its latest report, *Campaign to Eliminate Drunk Driving,* Mothers Against Drunk Driving notes that studies show "interlocks reduce DUI recidivism by 67 percent, and laws requiring interlocks for all offenders would reduce DUI deaths by 15 percent nationwide."[9]

"These statistics are startling," says Maryland attorney Harvey Schweitzer. "While we can't prevent all drunk driving by foster parents, we should take any steps we can to reduce the chance that a foster parent, quite possibly with a foster child in the car, will drive while impaired. As a lawyer and parent who cares about the welfare of children in general and who also advises private foster care agencies regarding liability and risk management, the mandatory installation of an interlock device with a DUI history makes a lot of sense."

The Model Guideline for State Ignition Interlock Programs notes that "State ignition interlock programs include partners in law enforcement, state highway safety offices, prosecutors,

See Drunk Driving on page 34

Photo Illustration by Chris Campbell

By Daniel Pollack

Good Child Welfare Metrics May Help Avert Lawsuits

Today's child welfare administrators, supervisors, and front-line staff need real-time information for real-time concerns. So do the clients, regulators, advocates, and journalists that have an interest in the agency. Without immediate access to relevant data, tragedies—otherwise preventable—may occur. And, as we all know, lawsuits frequently follow tragedies.

Child welfare workers need to be able to perceive trends, establish goals, and measure results. A great aid is to use appropriate metrics. Trying to make informed agency decisions without metrics is like driving at night in a dense fog.

This article suggests some meaningful metrics that can be easily captured.

Photo Illustration by Chris Campbell

1. **Average First Reply Time.** Speed may not be a client's foremost concern, but it is undoubtedly very important. Valid or not, clients easily interpret a slow response from an agency as incompetence and lack of concern. An agency that responds to a call quickly dramatically increases its chances of gaining client satisfaction and addressing a potentially serious situation.
2. **Average Resolution Time.** There are countless child welfare activities. Many of them have imposed timelines, either by statute, regulation, or internal policy and procedure manual. For instance, depending on the nature of a report of suspected child abuse or neglect, a child protective service investigator must respond within 24 hours. A supervisor or administrator would benefit greatly by knowing the exact response time of each worker or unit. Yes, an average response of 23 hours is legally acceptable, but this is far from ideal.
3. **Client Satisfaction.** Every child welfare administrator wants to know that when someone calls for help that is exactly what they'll receive. This metric measures the overall satisfaction level of clients and their interactions with the agency. It also helps to pinpoint specific decision points that need improvement. Most important, it measures what matters to the clients ("clients" meaning the public, regulators, or actual clients). If we don't know what clients want, we can't measure it.
4. **Team Functioning.** Every child welfare agency openly declares its commitment to teamwork. Teams create an atmosphere of mutual support, boosting the confidence of individuals, assisting each person to do his or her best. Good teamwork can reveal talents and leadership skills. Some basic metrics to gauge team functioning might include regular attendance at team meetings and prompt return of phone calls to other team members. Quality teamwork cannot be measured by a single metric; a diverse array is needed. More sophisticated metrics can measure whether individual team members are contributing to the creativity and success of the team.
5. **Human Resources.** As an administrator or supervisor, there are a number of simple metrics to look at: absence rate, turnover rate, time it takes to fill a position, and tenure of employees.

See Metrics on page 34

What Works in Training and Technical Assistance? Introducing the NSDTA Journal

Training and Development in Human Services—Supporting Change in Child Welfare: An Evaluation of Training and Technical Assistance is the latest journal published by the National Staff Development and Training Association (NSDTA). It presents findings from a series of studies to evaluate the National Resource Centers and Implementation Centers funded by the Children's Bureau over the past 10 years.

Guest Editors—Anita P. Barbee from the University of Louisville and Brian Deakins and Jane Morgan from the U.S. Department of Health and Human Services—assembled a comprehensive look at what works for building organizational capacity and offer important lessons on how to implement and sustain change efforts. The journal concludes with an article examining how Pennsylvania's child welfare training system utilizes the APHSA Organizational Effectiveness (OE) model in their training and technical assistance partnership with local child welfare agencies to build effective child welfare organizations. Research on embedding an OE model into a training system shows evidence of producing positive outcomes on worker performance and organizational change.

Led by APHSA's OE team, the process used the DAPIM™ model to assist the agency in achieving a sequential approach of quick wins, short-term goals, and long-term outcomes. Survey respondents said the work led to positive organizational changes that have been sustained over time. Projects were most often directed toward continuous quality improvement of agency processes and operations, with smaller percentages focusing on culture and climate, practice change, staff development, workforce issues, development of internal OE capacity, and client outcomes. Research on embedding an OE model in a training operation shows evidence of its effectiveness in producing positive outcomes on worker performance and organizational change. In addition to the specific changes targeted by the OE projects, key informants described a new emphasis on accountability, greater empowerment of staff, and more inclusive and participatory decision-making within their organizations. According to Barbee, "The model of providing both training and technical assistance to courts, tribes, and states is one that local child welfare systems should consider as they approach building capacity in their own jurisdictions."

The downloadable journal can be found at: *http://aphsa.org/content/NSDTA/en/home.html*

NSDTA Annual Conference

Join the learning explosion at the National Staff Development and Training Association (NSDTA) Annual Conference in Savannah, GA, at the Hyatt Regency from September 17–20! Gather keys to unlocking performance by building on the past, growing in the present, and innovating for the future. Come explore and actively participate in cutting edge, innovative techniques and ideas. Expect to leave with enhanced learning along with an awareness of new advancements and technologies. This year's features include:

- The Honorable Mayor Eddie DeLoach presenting the Key to the City.
- Bobby Cagle, Director, Georgia's Division of Family and Children Services (GA DFCS), welcoming everyone by sharing innovations occurring in Georgia.
- Attend presentations from not one but four nationally recognized keynote speakers!
  - > Art Kohn, AKLearning, inspires with "How the Brain Learns and Retains Information"
  - > Joe Urbanski, Total Solutions Group, with an action-packed "Make Training a *Want To* Not a *Have To*"
  - > Ray Jimenez unleashes creativity with "Micro-Learning and the Shrinking World of Work"
  - > Ginger Pryor, Deputy Director, GA DFCS, motivates with "Setting the Tone: Value Propositions for Building Strong Leadership"
- Play and learn at the **Innovation Station**. Stop by, interact, and apply technology on the spot. Receive keys that will help unlock information for future application.
- **More than 50 Workshops** offered by national experts to unlock performance.
- Join **Lunch and Learn** opportunities for sharing past experiences and brainstorming innovative ideas together.
- **Dine-Around** with experts in the field. Join Joe, Ray, Art, Ginger, and others for dinner at a variety of restaurants.
- **Network, Network, Network!**

Come get your learning on! Gather the keys to unlock your future for innovative and creative new ideas! Hope to see you in Savannah!

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Carissa Phelps

OPENING KEYNOTE SPEAKER

Writing Wrongs:
Embracing the Survivor Narrative

Monday, October 9

CHILD WELFARE BREAKOUT SESSION

How to Move our Agencies Beyond Dialogue to Best Practices

OPIOIDS continued from page 7

includes their income, employment status, use of the health care system, chronic diseases, and history of substance abuse, to name a few.

With this data insight, agencies can calculate the cost of interventions across the health and human services spectrum for a 360-degree cost analysis of the patient and the impact to their families. With this insight, agencies can align resources with specificity and prioritize addressing high-cost causal factors. This model would apply to any disease associated with IV drug use such as HIV, hepatitis C, or endocarditis.

The Work Must Never Stop

Once a program is in place, it is vital to measure its results. Constantly. Diligently. Continuous reporting of progress gauges the efficacy of opioid addiction programs and indicates where and how they may need to be adjusted. By using data and analytics to create new insights, this nation can come one step closer to mitigating, even preventing, the spread of this epidemic.

Reference Note

1. Comments made at the 2017 National Drug Rx Drug Abuse and Heroin Summit, Atlanta, GA

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Joseph Fiorentino *is Managing Director of Health and Human Services at Accenture.*

DRUNK DRIVING continued from page 30

judiciary, driver licensing agencies, probation, manufacturers, and treatment (p.2)."[10] It's time to add state foster care programs to that list.

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METRICS continued from page 31

6. **Website Effectiveness.** After completing an inventory of the agency's website, it should be easy to identify the specific interests of site visitors. Is there a "comments" section prominently displayed on the website? What are the metrics of those comments?

Washington attorney Bryan G. Smith reflects that "there is a common denominator in every lawsuit I have filed against a social service agency on behalf of a foster child who was abused or neglected while in care: The agency had few or no metrics with which to measure its own success or failure and consequently had no internal accountability for those successes and failures."

It is no easy task to come up with conclusive metrics that measure a child welfare agency's performance, especially because, based on experience and data, child welfare systems and services are constantly being redesigned. Just as an agency's goals and objectives alter over time, the toolbox of performance metrics to track progress toward those goals will continuously change. In any event, our job is to make sure the way child welfare systems and services are designed in theory is the way they are working in practice. Good child welfare metrics help us monitor, audit, and make tough, informed decisions, and can help us keep the agency out of legal hot water.

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HOMELESSNESS continued from page 5

found, when the first step in that treatment is the person saying, by themselves, 'I'm ready for this.' And when they say that, we're there and ready to go."

In Milwaukee County, we utilized apartment complexes with on-site services, but most options consisted of scattered site housing units throughout the community.

"It felt really surreal, you know, to feel like a human being again," said Squirrel, sitting in his eclectically furnished, one-bedroom apartment in Milwaukee's trendy East Side neighborhood. "There's a lot of dignity involved. I hadn't seen a psychiatrist in two years. I had stopped taking my meds. But when I got my first place, it really took me two or three weeks to realize … I had a toilet … and a bathroom. I had a shower that I could go and shower in *any time!*"

Human dignity is the primary goal of Milwaukee County's Housing First program. At the same time, fiscal responsibility, as stewards of taxpayer money, is also critical. To that end, the results we have achieved are best described as "jaw-dropping."

The Milwaukee County Housing First program operates on a $2 million annual budget. With that investment, our analysis shows we have reduced BadgerCare (Medicaid) costs to the state of Wisconsin by $2.1 million. We have reduced unreimbursed costs to our Behavioral Health Division (part of our own department) by more than $714,000. We have reduced the number of municipal violations among our participant group from an annual average of 240 down to 39, and with that, another half million dollars in savings to state, county, and municipal justice expenses.

We have partnered with the Downtown Milwaukee Business Improvement District, the Milwaukee Police Department, and Milwaukee County District Attorney's Office to refer chronically homeless individuals to us instead of making arrests on nuisance violations. Our local 2-1-1 service provider, Impact, Inc., serves as a coordinated entryway for all homeless needs in the county. The local homeless shelters have partnered with us and expanded their mission to be full-fledged homeless service providers with case management services.

"It felt really surreal, you know, to feel like a human being again. There's a lot of dignity involved."

—SQUIRREL, SITTING IN HIS ECLECTICALLY FURNISHED, ONE-BEDROOM APARTMENT IN MILWAUKEE'S TRENDY EAST SIDE NEIGHBORHOOD.

As for the participants themselves, 100 percent of them are participating in services to help meet their needs, including substance abuse and mental health care. It is worth reiterating the *voluntary* nature of this participation.

Additionally, 77 percent of participants have experienced an increase in income since coming into the program. This is important since participants contribute a fixed percentage of their income toward rent. The more income a participant has, the more they can contribute, and more of our taxpayer dollars go to bringing more chronically homeless individuals into the program.

Twenty-seven percent of our participants have found employment.

Most important, in almost two years of the program's history, we have had zero evictions, and 99 percent of participants remain in the program more than a year after entering. All exits have been voluntary, and the participants remain housed. We have a Resident Advisory Council where Housing First participants gather monthly to set *real* housing policy.

As for Squirrel, a member of that Council, he's working part time, hoping his therapists green-light him to work full time soon. On top of that, he's developing a magazine concept for Housing First residents and the overall homeless community in Milwaukee County. He hopes to have it published before the end of the year.

We were able to help Squirrel, and hundreds of other people, because we prioritized our resources. We broke down silos within the Department of Health and Human Services and with our partners. We developed robust collaborative efforts with the City of Milwaukee, Milwaukee Housing Authority, shelter providers, coordinated entry, District Attorney, the judiciary, and many more. The community has come together to do the right thing with leadership, partnership, and resources.

Our work is still in progress, however, and the headwinds are picking up.

The most recent budget proposals from the current administration would zero out Community Development Block Grants and HOME funds. These funds currently provide about 50 percent of our annual operating budget for Housing First. If such a thing would come to pass, we could see at least half of our participants put back out on the streets by the end of that month.

That would be the *best* case scenario, if the federal budget were to pass as proposed.

What we know for sure, though, is that the Housing First model is not only the humane thing to do, the right thing to do, but it is also the *smart* thing to do. Housing First values the dignity of the most vulnerable in our community with better outcomes and significant savings. This is one of those programs that truly yields a great return on investment. We see this in our data, and in our people. We just hope we can complete our journey down the Road to Zero before it disappears.

***Héctor Colón** is the Director of the Milwaukee County Department of Health and Human Services.*

***Chris Abele** is the County Executive in Milwaukee County.*

EMPLOYMENT continued from page 27

The study noted that "Across the sites, employers reported retaining 37 percent of the subsidized workers after the subsidy period ended, and the most common reasons given for not retaining workers were poor attendance and other performance issues." Program designers should build more supports into these programs to help workers succeed on the job and to increase post-subsidy retention. According to employers, the most common supports needed were child care, transportation, coaching on communications, and computer skills.

The EMC findings stated:

- Participation in subsidized employment programs led to increases in employment and earnings.
- The programs were especially effective for the long-term unemployed.
- Employers reported hiring more workers than they would have otherwise, and workers with less experience than their usual hires.
- Most participating employers reported multiple benefits from the program, including expanding their workforces, serving more customers, and improving their productivity.

Unfortunately, when TECF funds expired in 2010, most states and localities had to terminate or scale back their subsidized employment efforts. Given the generally positive results of these wage-subsidy efforts, one of the more promising TANF approaches has been greatly truncated. Ongoing disputes over TANF reauthorization federally, which have led to numerous one-year extensions of the current program, have left states and localities to fend for themselves. Other than a handful of efforts using state and city funds, subsidized employment is greatly underutilized.[6]

WHY EXPAND SUBSIDIZED OR TRANSITIONAL EMPLOYMENT PROGRAMS NOW?

Perhaps the most compelling reason to re-emphasize subsidized employment is demonstrated by another finding of the EMC study—nearly 63 percent of the jobs through the TECF wage subsidy program would not have been created without the subsidy.

MDRC has recently reviewed several findings from subsidized employment efforts.[7]

- Unemployment remains high for many disadvantaged and displaced groups making subsidized jobs important.[8]
- Subsidized employment programs targeting people recently released from prison can reduce recidivism.
- Subsidized employment programs can reduce welfare dependence and increase payment of child support by noncustodial parents.
- While earlier subsidized employment programs focused on public-sector employment, recent subsidized employment programs have sought to place participants in jobs in the private sector, a much more fertile ground for future success.

PERHAPS THE MOST COMPELLING REASON TO RE-EMPHASIZE SUBSIDIZED EMPLOYMENT IS DEMONSTRATED BY ANOTHER FINDING OF THE EMC STUDY–NEARLY 63 PERCENT OF THE JOBS THROUGH THE TECF WAGE SUBSIDY PROGRAM WOULD NOT HAVE BEEN CREATED WITHOUT THE SUBSIDY.

Given the positive outcomes and the financial, health, and social benefits of work, as well as the increasingly competitive hiring process, it is time for a fresh look at subsidized employment.

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the headaches reported would meet migraine criteria.[24] Although this limits the conclusions that can be drawn directly from the data, it should not detract from our purpose here—illustrating why considering a broad array of, and multiple, chronic conditions is warranted to address chronic health conditions in the clients served by human services agencies (both the social services sector, as well as the health care and public health sectors).

Conclusion

The social services and public health sectors have much to gain from greater collaboration, especially with regard to serving public assistance recipients, a group that frequently experiences health-related barriers to economic security. Evidence-based interventions are available to reduce the extent to which a broad array of chronic health conditions (and most often, multiple chronic conditions) act as barriers to employment.[16] For example, implementing the screening, referral, and case-management intervention described here for TANF clients can be readily accomplished by coordinating efforts across the social services and public health sectors. As part of a more complex view of the factors that shape health and employment outcomes, interventions such as these that provide direct health services should be complementary to, and not a replacement for, efforts to address the many other social determinants of health—a perspective that is embraced by both the American Public Human Services Association and the American Public Health Association. Additional research to determine the efficacy of extending a similar model using an MCC framework beyond the TANF population is needed.

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staff spotlight

Name: Candy Hill

Title: Senior Director, Policy and Government Affairs

Time at APHSA: Six months

Life Before APHSA: State Human Services Executive in Michigan and Executive in national nonprofit organizations in charge of policy and government affairs, development, communications, and marketing.

What I Can Do for Our Members: Engage and support members in leading efforts to advance public policy that supports the goal that all of us should have the opportunity to live healthy lives and be well regardless of where we live, what our histories are, or what our life experiences have been.

Priorities at APHSA: Build a comprehensive influence strategy that advances our *Pathways* work, leveraging and engaging the expertise and experience of our members.

Best Way to Reach Me: By email at *chill@aphsa.org* or text message at 703-203-1371.

When Not Working: I'm an avid reader, engaged in my parish community, and a political junkie.

Motto to Live By: Smile often, think positively, give thanks, laugh loudly, love others, dream big.

PRESIDENT'S MEMO continued from page 3

even in the most troubled of communities, and enabling evidence-informed decisions that are human centered and framed around the social determinants of health and well-being. The journey is not an "either/or," it is a collective one that brings leaders at all levels of government, community-based and social-serving organizations, social enterprises, employers, philanthropy, and families together to shift mindsets and catalyze change in policy and practice.

More About What We Learned at the Local Retreat

Over the course of two days, we took a deep dive to learn about San Diego County's Live Well journey toward community-wide wellness, and the ways in which the entire county, through local partners and leaders at all levels, is improving outcomes across 10 indicators chosen by the community as key drivers of living well. Through the dimensions of the social determinants of health (or well-being, as we increasingly like to refer to them), we heard the incredible accomplishments of Milwaukee County in nearly eliminating chronic homelessness, and the power of a community coming together to build a roadmap for child well-being in Monterey County (CA).

Dakota County (MN) showcased the "art of the possible" in connecting its education and public health systems to link data and use analytics to identify children who are at risk of not achieving third grade reading levels so that more focused attention can be directed to them and their parents in their very early learning years. We also "zoomed in" on what enabled the successful development of truly integrated data systems in San Diego and Montgomery County (MD).

Joined by key national partners from the Kresge Foundation, the Abdul Latif Jameel Poverty Action Lab at the Massachusetts Institute of Technology, and Harvard Government Performance Labs, we heard how both philanthropy and academia are supporting systems change through next generation and ecosystem thinking; evidence-informed practices; a focus on root causes; and capturing return on investment. We also heard how San Diego's education, child welfare, behavioral health, law enforcement, and many other community partners have joined forces to tackle the serious issue of human trafficking through its Commercial Sexual Exploitation of Children task force.

We're committed to lifting these stories, and many others, up for policymakers and for the field in general. You can find these presentations on our website at *aphsalocal.com* and other stories from the field in our interactive map *(aphsa.org/content/APHSA/en/pathways/INNOVATION_CENTER.html)*. We'll continue to highlight stories in both feature articles and our "Locally Speaking" column in *Policy & Practice*. Also, look for opportunities to join webinars to hear directly from these and other generative leaders at *aphsa.org/content/APHSA/en/events/WEBINARS.html*.

Tracy Wareing Evans

INCIDENT MANAGEMENT continued from page 11

- Identifying and considering relevant enterprise initiatives that can resolve current business problems such as developing common data elements, master provider and client indices, business rules engines, and web services;
- Identifying a solution to support incident management and quality assurance needs for programs and agencies that do not currently have an incident management system;
- Reviewing and re-engineering business processes; and
- Analyzing and modifying regulations, policies, and procedures to improve consistency and clarity.

This will provide states with the economies of scale to support a coordinated approach to incident management and, where appropriate, establishing a foundation to further address the unique needs of agencies and programs. States with a cross-agency commitment to incident management should complete a further series of essential work activities prior to moving forward with the design, development, and implementation of any technology solution, including:

There should be a shared focus on implementing incident management data standardization and process consistency wherever it is possible, without compromising the missions and requirements of involved agencies.

- Establishing a governance structure;
- Developing detailed business requirements;
- Creating data management and governance procedures;
- Conducting outreach and communications;
- Identifying funding; and
- Completing procurement requirements (if needed).

States that choose not to implement a technology solution can still reap significant gains by taking steps to ensure incident management standardization and consistency. If a state determines that there is a cross-agency commitment that will meet the broader business needs of the agencies, a further series of essential work activities should be completed prior to moving forward with the design, development, and implementation of any technology solution. States and providers that take steps to improve their incident management processes and IT systems will reap the rewards of better outcomes for their most vulnerable populations.

Reference Notes

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PROFILE continued from page 40

effectively, which in the end, is what we all hope to achieve.

Future Challenges for the Delivery of Public Human Services: Anyone involved with human services delivery knows that what we do every day is not easy; it takes a special dedication and devotion to helping others work to reach their full potential. We face many challenges moving ahead, but within those challenges lies opportunity. In 2013, the proposal to merge Perry County Transportation into Job and Family Services arose—an opportunity I did not want to miss. Access to transportation has been proven to have a positive impact on local economies and I was sure that the Perry County community would benefit from integrating transportation with the other human services we provide. The integration effort showed immediate impact; residents now had access to transportation to meet essential needs like getting to medical appointments, local businesses now had access to new customers, and jobs were created—we needed people to transport our residents.

This is an example of the future I, and many of us, see for health and human services—integration of multiple agencies under one roof to provide a single point of service for our clients. The more we can utilize technology, the faster we can move toward a more collaborative and integrated model of service delivery.

Little Known Facts About Me: My husband, Mike, and I currently live in New Lexington, OH, with our children on our family farm. When we are not working with the horses on the farm, we are heavily engaged with volunteering in our community: the community theater, county 4-H club, and many local benefits with our musical talents. We also enjoy going camping as a family.

Outside Interests: I am involved in many community programs outside of work such as the United Way of Muskingum, Perry, and Morgan Counties, and the Perry County Community Improvement Corporation.

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 Cheryl Boley, Director of the Perry County (OH) Job and Family Services Agency

Name: Cheryl Boley

Title: Director, Perry County (OH) Job and Family Services Agency

Years of Service: 22 years—seven years in my current position

Rewards of the Job: The betterment of families and communities through public service has been the focus of my career. I have dedicated more than 22 years to identifying and removing barriers that prevent families and communities from securing the basic necessities that are required to build their futures. The experience I secured while in Franklin County (OH) cultivated the proficiencies I would later employ as Director of Perry County Job and Family Services and as the County Lead for development and implementation of Ohio's statewide County Shared Services Project (CSS).

I began as an entry-level eligibility worker at Franklin County Job and Family Services, which is now Ohio's largest metro area. It was there that I developed my passion and drive to effect change, which led me to move into management at that agency and where I eventually became an Assistant Director and remained for 16 years. It was in Franklin County that the foundation of my future was established.

In 2010, I was appointed by the Perry County (OH) Commissioners as Director of the Perry County Job and Family Services Agency. The appointment allowed me to serve the needs of my own rural community. Perry County is one of Ohio's 32 Appalachia counties where approximately two out of five residents receive food assistance or some other form of assistance. Recognizing some of the same challenges that metropolitan areas encounter and identifying unique obstacles that rural communities face, I immediately went to work seeking ways to have a positive and continuing impact on our community.

Accomplishments Most Proud Of: The accomplishments I treasure the most are those that have had an immediate impact and a sustainable legacy. I am, perhaps, most proud of the voluntary statewide coalition we built to utilize technologies and business processes to deliver a common client experience.

As any director can attest, they work hard for their communities and their staff, and their time is at a premium. The need never ceases, and while satisfying, the work is endless. They serve on numerous boards, provide community outreach, support commissioners, and always seek to improve lives. It is this mindset and sense of duty that propelled me to accept the request to work on the statewide Ohio Benefits Project as Lead for CSS.

Having worked within my own Canton District on our vision of CSS, being involved in the background planning for C8 and on numerous projects in Franklin County, I felt my experience made me uniquely qualified to lead this project. I worked with the CSS team to identify and vet advanced technologies, including audio signature, call center platform, virtual hold, and dashboard data reporting. These technologies were then incorporated with the county-driven CSS, progressive business processes, and have now been implemented across multiple counties.

I worked closely with my team to educate county Job and Family Services (JFS) Directors throughout Ohio about the CSS initiative. The CSS participation was voluntary, and CSS Directors created their own shared services groups (hubs) consisting of 8–10 counties. The initial intent was for counties to go live with all programs in the new Ohio Benefits System. Unfortunately, that stalled when the SNAP/Cash conversion was delayed. Not wanting to endure a long delay, I offered an alternative path with the Medicaid Pull Ahead (MPA) plan. The MPA allowed CSS work to move forward and gave counties the ability to reclaim their work for Medicaid renewals from Automated Health Systems and their work for Medicaid applications from the C8 group. This allowed counties to move forward and continue with their collaborations.

To date, 56 of Ohio's 88 counties are committed to CSS. This includes six county-created hubs and six stand-alone metro agencies. Two metro agencies and four hubs totaling 35 counties have gone live and are now processing their own Medicaid intakes and renewals. The CSS project team has successfully met all of its deadlines and commitments. The result will be that the majority of Ohio's JFS clients will be served by a hub, through the Enterprise Call Center, and will have a common client experience. We are delivering services more efficiently and

See Profile on page 39

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