ALLAN HANCOCK COLLEGE

PROGRAM REVIEW

2015-2016

Program Name: Human Services

Self Study Members: John Lovern, Al Avila, Tom Vandermolen, and Sofía Ramírez-Gelpi

PROGRAM REVIEW

Status Summary - Plan of Action-Post Validation

During the academic year 2013 John Lovern and the validation team completed a six-year program review. The self-study and validation team developed a final plan of action post-validation based on information in the self-study and the recommendations of the validation team. The action plan and its results are listed below:

PLAN OF ACTION	ACTION TAKEN, RESULT AND STATUS
1. Develop an assessment mechanism /system for Student Learning Outcomes	Accomplished via cooperation with SLO Coordinator.
2. Incorporate teaching strategies that appeal to younger students (e.g., greater use of Internet resources by all program faculty).....	Accomplished through encouragement and supervision of part-time faculty. Every human services course now makes greater use of Internet resources.
3. Streamline internship courses.....	Accomplished via course creation and modification with cooperation and assistance of the Academic Policies and Planning Committee and associated processes.
4. Ensure that all program courses are requirements for certificates or degrees	Accomplished via course modifications with cooperation and assistance of the Academic Policies and Planning Committee and associated processes.
5. Cooperate with neighboring colleges to assist students taking courses at more than one (e.g., Cuesta College, Santa Barbara City College).....	Accomplished through ongoing contact and cooperation with coordinators/directors of corresponding programs at Cuesta and Santa Barbara City Colleges and mutual membership and participation in Advisory Committees with Cuesta College.
6. Evaluate teaching equipment needs and work with CTEA coordinator in attempt to obtain funds for needed equipment.....	Accomplished but ongoing need exists. The Human Services program has relatively few equipment needs. However, this issue will need to be addressed every 6-year cycle.
7. Restore/increase coordinator reassigned time.....	Accomplished. Reassigned time was restored. Changes in the size and scope of the program may require an increase in reassigned time.

8. Evaluate need for second full-time human service.....Continue to advocate for full-time faculty.
faculty member

Allan Hancock College Program Review

Comprehensive Self-Study

Program review is intended to be a reflective process that builds on the extensive information gathered for the Annual Updates and lays out the program's major directions for the future.

I. Program Mission *(must align with college mission statement)*

Describe the need that is met by the program or the purpose of the program. For CTEA programs only, show that "the program does not represent an unnecessary duplication of other vocational or occupational training programs in the area."

Human Services Program Mission Statement

This program prepares students for employment in the human services fields and further education by providing experiences that emphasize intellectual and technical excellence, creativity, personal and interpersonal skills, professionalism, and cultural competence.

Human Services Program Overview

The Human Services programs provide the knowledge and skills necessary for entry level employment positions in the social service, mental health, addiction treatment, substance use prevention, and related fields, as well as opportunities for upgrading the skills and knowledge of individuals already employed in these fields. Program graduates work in a number of varied settings including drug and alcohol addiction treatment and prevention, family services, parent education, social service eligibility workers, youth shelters, community health care, juvenile corrections, and case management services.

The course of study for the degrees and certificates offered by the Human Services program includes a broad range of specialized vocationally-oriented, university-transferable academic courses. The curriculum provides academic knowledge about personal and social problems, helping skills, human service careers, agencies and organizations that provide helping services, and standards of professional conduct. In addition, students apply the knowledge they acquire in the classroom in real-life helping situations and settings during their one-semester field internships in human service agencies.

Our instructors are experienced professionals in the fields of human services, mental health, and addiction treatment and prevention, such as clinical psychologists, licensed clinical social workers, licensed marriage and family therapists, pharmacists, and others. Students are expected to grow both personally and professionally as a result of their classroom experiences.

The Human Services programs include the following certificates and associate degrees:

- Human Services: Specialized Helping Approaches - Certificate of Accomplishment
- Human Services: General - Certificate of Achievement
- Human Services: General - Associate in Science
- Human Services: Family Studies - Certificate of Achievement
- Human Services: Family Services Worker 3 - Certificate of Accomplishment
- Human Services: Family Services Worker 2 - Certificate of Accomplishment
- Human Services: Family Services Worker 1 - Certificate of Accomplishment
- Human Services: Co Occurring Disorders - Certificate of Achievement
- Human Services: Advanced Helping Skills 2 - Certificate of Accomplishment
- Human Services: Advanced Helping Skills 1 - Certificate of Accomplishment
- Human Services: Addiction Studies Foundation - Certificate of Accomplishment
- Human Services: Addiction Studies Basic - Certificate of Accomplishment
- Human Services: Addiction Studies Advanced - Certificate of Accomplishment
- Human Services: Addiction Studies - Certificate of Achievement
- Human Services: Addiction Studies - Associate in Science

Duplication

Communication with Cuesta College and Santa Barbara City College and consideration of programs offered by these colleges support the conclusion that the Human Services program does not represent an unnecessary duplication of other vocational or occupational training programs in the area.

II. Progress Made Toward Past Program/Departmental Goals

Summarize the progress the program/department has made toward achieving its goals during the past six years. Discuss briefly the quality, effectiveness, and strengths of the program as reflected in its Annual Updates. Show the relationship between the program goals, the mission of the college, the district strategic plan, and the impact on student development and success.

During the past six years, enrollment in the the Human Services program has remained steady with the exception of the last couple of years. The program has one full-time faculty member (currently vacant), one program coordinator (currently vacant) and ten active part-time instructors. Classes are offered regularly at the Santa Maria campus, occasionally at the Lompoc Valley campus, on-line to students throughout the state of California, and for inmates at the Lompoc Federal Correctional Institution. Human Services students can pursue two associate degrees, four certificates of achievement, and nine certificates of accomplishments. The catalog lists thirty-six human services courses.

As demonstrated by the results of student surveys administered during Course Review, students are highly satisfied with the courses offered by the Human Services program. All faculty members are highly qualified, with extensive professional experience providing human services, including a licensed clinical psychologist with 30 years of professional experience in diverse settings, several licensed clinical social workers, licensed marriage and family therapists, a licensed pharmacist, and others— none of whom possess less than a masters degree in their field.

Unfortunately, it has not been possible to track how many Human Services program completers have gone on to gain employment in the human services field, or how many have gone on to successfully pursue advanced degrees, but some anecdotal evidence is available. For example, one of the duties of the program coordinator is to visit the sites where students are interning, to meet with the students and their site supervisors. Very often—approximately half the time—the site supervisors are past completers of Allan Hancock College's Human Services program. In addition, many program completers have gone on to pursue bachelors and masters degrees, as communicated to the program coordinator in informal contacts with past completers. The program coordinator has written, and continues to be asked to write, numerous letters of recommendation in support of program completers' applications for admission to four-year universities and graduate programs. At least one program completer has attained both bachelors and masters degrees and returned to Allan Hancock College as a Human Services instructor. And at least two program completers have not only become employed in the human services and addiction treatment fields, but have received full pardons of convictions that they received during their active addictions.

Thus, it is clear that the Human Services program is furthering the college mission of providing "pathways that encourage our student population to achieve personal, career, and academic goals through coursework leading to skills building, certificates, associate degrees, and transfer." In addition, because human services faculty members are all dedicated to their professions, dedicated to providing the best possible educational experience for students, care deeply about and go to great lengths to assist students, and continue to stay in touch with students after they have completed their studies as informal mentors, it is abundantly clear that students in the Human Services program are directed, focused, nurtured, engaged, connected, and valued, as spelled out in the college's Strategic Plan.

III. Analysis of Resource Use and Program Implementation

Describe the program's current allocation and use of human, physical, technology, and fiscal resources. Are resources sufficient and appropriate to meet program needs? Can program resources be reallocated to better meet student needs?

Resources utilized by the Human Services Program:

- **Human**: One full-time professor (currently vacant) and coordinator (currently vacant); ten part-time instructors; one part-time department administrative assistant who is shared with other members of the Social and Behavioral Sciences Department.

- **Physical**: Classrooms for twenty-one sections scheduled for the Fall 2016 semester (including two sections at the Lompoc Federal Correctional Institution and three at the

Lompoc Valley Center); one portable media projector, and one video camera; and miscellaneous office supplies (file folders, blank CDs and DVDs, etc.).

- **Technological**: One desktop computer in the coordinator's office and access to Canvas online teaching platforms.

- **Fiscal**: The Human Services budget is quite small relative to other programs. A copy of the budget may be found in Appendix 1. It allocates sufficient money to provide for mandatory association memberships (i.e., The California Association for Alcohol and Drug Educators, the association that certifies the Addiction Studies Certificate and also certifies addiction counselors), most necessary office supplies, and a few books each year. Most years, there are no requests for teaching equipment.

Adequacy of Resources:

- **Human**:

Faculty: Given the size of the Human Services program, consideration needs to be given to adding one full-time faculty member in addition to filling the vacant full-time faculty and coordinator position. Although in the past there have been numerous individuals qualified to serve as part-time instructors of HUSV courses residing in our geographical area, and much interest on the parts of potential candidates, it has recently become more difficult to staff some course sections. In addition, the size and scope of the program has made coordination duties more taxing and time consuming. An additional full-time faculty member would increase the ability of the program to meet student needs.

Classified: The support of the Social and Behavioral Sciences administrative assistant continues to meet the needs of the program.

- **Physical**: Classroom availability has met the current program needs.

- **Technological**: The program coordinator requires a dedicated laptop. All new faculty utilizing Canvas as a teaching tool need to be trained.

- **Fiscal**: The budget continues to meet the needs of the program.

IV. Program SLOs/Assessment

What are your program student learning outcomes? Have each of these been assessed since the last comprehensive program review? How are they measured? What did the assessment data indicate about the strengths and weaknesses of your program? What changes do you plan based on these data?

SLO assessment data may be found in Appendix 2. Unfortunately, Human Services SLOs have not been assessed consistently, especially by part-time instructors. This deficiency will be remedied by directing all Human Services program faculty (including the coordinator) to assess SLOs every semester. In addition, clear instructions will be provided so that every instructor will not be overwhelmed by the task. To accomplish these two goals, the program coordinator will send the following message to every part-time Human Services program instructors every semester:

Dear Human Services program instructors:

All instructors are required to **assess** whether students have accomplished the **Student Learning Outcomes (SLOs)** for each course that they teach. During the 6-year program review, it was discovered that we have not been meeting this requirement consistently. Faculty need to begin this review immediately (starting with the Fall 2016 semester), and to do it every semester in the future. The following information will help you with this task:

Here is how to assess SLOs:

A. Find the SLOs for the course(s) that you teach.
B. Phrase the SLOs as questions (example below).
C. Include the questions on your final/last exam each semester—on a separate sheet that can be detached from the completed exam.
D. Collect all of the completed SLO answer sheets.

Example:

A. Identify the course SLOs. For example, the SLOs for HUSV 101 are:
   1. Students who complete this course will be able to explain their motives for becoming a helping professional and how these motives may affect their job performance.
   2. Students who complete this course will be able to define the steps required to pursue training to become a member of a specific helping profession.

B. Phrase the SLOs as questions. For example, the HUSV 101 SLOs phrased as questions are:
   1. Having nearly completed HUSV 101, are you able to explain your motives for becoming a helping professional and how these motives may affect your job performance?
   Check one box: ☐Yes ☐No
   2. Having nearly completed HUSV 101, are you able to define the steps required to pursue training to become a member of a specific helping profession?
   Check one box: ☐Yes ☐No

C. When you make up your last/final exam, place these questions at the end, on a separate page that can be detached from the completed exam. Make sure, when you send your print order to Campus Graphics, that the SLO questions will be on a separate sheet. When you collect the exams, detach the SLO answer sheets.

A Listing of all of the HUSV SLOs and SLOs-phrased-as-questions may be found in Appendix 3.

Finally, as Course Outlines of Record are updated, it is likely that some SLOs will also need to be updated.

V. Trend Analyses/Outlook

Using the information already gathered in the AUs (e.g., enrollment and achievement data; student learning outcomes assessment and analysis; input by advisory boards; existing articulation

agreements; labor market trends) summarize the major trends, challenges, and opportunities that have emerged in the program since the last program review

1. Results of Student Data Collection

These results were provided in the Course Review document submitted earlier. The summary presented in that document is repeated below in the Student Data Summary section.

2. Retention and Success Results

A comparison of Human Services program retention and success rates by academic year as presented in the table entitled "Retention and Success by Academic Year by Course HUSV," demonstrates that Human Services program retention and success rates fluctuate somewhat from year to year but overall compare favorably with the retention and success rates of the college.

3. Student Demographics

Student demographics are essentially unchanged from the last six year program review. The great majority of students are either Hispanic/Latino/Latina or White, with more Hispanic/Latino/Latina than White students, and more female than male students. Because some students who enroll in the Addiction Studies certificate and degree programs do so after beginning their recovery from addictions, these students may be slightly older than the average community college student.

4. Advisory Committee Input

The program coordinator asks for input every year during Advisory Committee meetings, as well as during frequent contacts with Advisory Committee members. The input received has been incorporated repeatedly into curriculum, thus ensuring that the curriculum remains relevant and current and meets the needs of employers and potential employers. In addition, the program coordinator has on several occasions provided trainings to staff members of some Advisory Committee member agencies, for example, one-day trainings on case management for Good Samaritan Services. Recent examples of responses to Advisory Committee recommendations include the development of a human services writing course and the incorporation into the HUSV 111 (Addiction Treatment and Recovery) curriculum of Medi-Cal information, which is needed because many local addiction treatment programs bill Medi-Cal for services that they provide.

4. Responsiveness to Community Needs

Throughout his tenure as coordinator, Dr. Lovern has been involved in community outreach activities and professional activities that benefit the community. For example, he served for seven years as a member of the San Luis Obispo County Drug and Alcohol Advisory Board; participated in a committee of Santa Barbara County Behavioral Wellness Services to develop a curriculum on co-occurring disorders, and did single-handedly develop that curriculum; participated in that agency's Systems Change Steering Committee; developed training materials for the peer counseling program of Santa Barbara County Behavioral Wellness Services resulting in the hiring and training of a new (to Santa Barbara County) occupational category; and numerous other, related activities. When contacted by authorities of the Lompoc Federal Correctional Facility and Lompoc-based Hancock College administrators, Dr. Lovern met with prison authorities, including the warden, and developed the means to offer the entire Addiction Studies curriculum at the prison, including the possibility of inmates to complete internships while on furlough in the community.

5. Labor Market Trends

Data were obtained from the Center of Excellence Labor and Market Research on key occupations for which the Human Services program offers training and certificates. See Appendix 4 for summaries of these data. A brief summary indicates the following:

- Community and social service occupations are growing "faster than the average for all occupations."
- Job prospects for Social and Human Service Assistants are "good overall," with the proviso that additional education and training will be beneficial for those seeking employment in this field.
- The percent change in demand for substance abuse and behavioral disorder counselors is projected to be 22 percent from 2014 to 2024.

6. Impact of Mental Health and Addiction Parity and Third Party Reimbursement Changes

The passage of the Affordable Care Act (See Appendix 5) and the Mental Health Parity and Addiction Equity Act (See Appendix 6) have begun create, and will continue to increase opportunities for greater and greater numbers of individuals to qualify for and receive affordable mental health and substance use disorder treatment services. Along with these opportunities will come increasing demands for providers of these services.

7. Enrollments

Enrollments in Human Services program courses reached a peak during the recession that began in 2008. As the economy stabilized, enrollments declined across all courses but have remained highest in HUSV 101, 102, 103, 106, 110, 132, 142 (Internet class), 143 (Internet class), and the internship courses. However, enrollments in the fall 2016 semester.

As applicable, please address the breadth, depth, currency, and cohesiveness of the curriculum in relation to evolving employer needs and/or transfer requirements, as well as other important pedagogical or technology-related developments.

As suggested in Course Review, all of the Course Outlines of Record are in need of updating, and the necessary updates have been identified and the Course Outlines are in the process of being updated. With these changes, the curriculum will have sufficient breadth, depth, currency, and cohesiveness. This conclusion is supported by the student data that have been collected.

Annual meetings with the Human Services Advisory Committee have ensured that the curriculum remains current and meets employer needs. New course proposals suggested by the Advisory Committee are in process, and suggestions for enriching particular courses have been adopted.

All Human Services program courses are transferrable to the California State University system, but as electives—with the exception of California State University, Fullerton, which accepts some coursework toward its Human Services major. The CSUF website states: "Community college transfer students may apply a maximum of 12 units of coursework in human services and related fields towards the total of 54 units. Transfer of any units must be approved by the department adviser. For transfer students with a certificate in Substance Abuse, Domestic Violence or Gerontology, up to 18 units of coursework in human services may be applied to the total of 54 units."

Nearly all human services courses provide an online Canvas site for the convenience of students, and as a way to provide additional information and resources to them. Beyond that, the Human Services program has little need for technology at the present time, since the skills taught in all courses are interpersonal rather than technical and do not require the use of specialized equipment .

VI. Long-Term Program Goals and Action Plans

Describe the long-term plans for changing or developing new courses and programs, other actions being taken to enhance student success, and the need for professional development activities and other resources to implement program goals. Be sure to show how these plans are related to assessment results. (Plan should cover five-year period and include target dates and resources needed.)

A. Curriculum Plans

New courses. Two new courses are being proposed. The first course being proposed, which was recommended by the Advisory Committee, and which the Advisory Committee approved after viewing a draft version of the Course Outline, is "Effective Writing for Human Services." The second course, which was repeatedly requested by human services students, is "Ethics for Human Services Professionals."

Course modifications. Numerous modifications were suggested by Course Review with the rationale for the changes being to update the courses and keep them current.

The new courses and the course modifications are in the process of being made, and they should be completed by the end of the spring semester 2017.

B. Professional Development Activities for All Faculty Members

As evidenced by documents in Appendix 7, the human services field, the mental health field, and the addiction treatment field are all undergoing rapid change. Evolving governmental approaches to social services, the emergence of new paradigms for treatment of mental illness and substance use disorders, the growing importance of evidence-based practices, and a plethora of new interpersonal helping methodologies all demand that faculty members in the Human Services program take pains to keep their knowledge and skill sets current, so that students receive up-to-date instruction. Therefore, it is recommended, first, that the one full-time faculty member and program coordinator be provided with training opportunities toward this ongoing need, and, second, that similar training opportunities be provided to the growing number of part-time instructors (ten at last count). Fortunately, several part-time instructors are employed by local county departments of mental health and addiction treatment and are provided ongoing training by their agencies, but several instructors are not so fortunate, and it would benefit students greatly if all faculty members were provided with continuing education in their respective fields. Funds should be made available to meet this need on an ongoing basis, beginning immediately.

C. Coordinator Reassigned Time Increase

Since the last time the program coordinator's reassigned time was adjusted, the duties have grown considerably, with the addition of numerous course sections, numerous new part-time instructors, new courses being offered at the Lompoc Valley campus, and the entire Addiction Studies certificate program being offered at the Lompoc Federal Prison. Therefore, a ten percent increase is recommended. Target date: Fall 2016.

D. Consideration of a Second Full-Time Human Services Instructor

Between this six year program review and the next one, serious consideration will be given to the question of whether or not an additional full-time HUSV faculty member should be recruited and hired.

E. Clerical Support

The Human Services program depends on the Social and Behavioral Sciences Department's administrative assistant for clerical support.

F. Budget Increase

A copy of the Human Services program's budget may be found in Appendix 1. The funds budgeted for this program have remained stable for many years. Although program needs have not been great in the recent past, and the program has been able to manage with the funds that have been provided, it is now time for an increase so that adequate supplies, educational materials, and other resources will be able to be readily available as needed.

G. Assessment of SLOs

Student Learning Outcomes have not been assessed consistently. Instructors will be directed to assess outcomes for every course offering. After Course Outlines are updated, necessary changes to SLOs will also be performed. This task should be completed by the end of the Spring 2017 semester.

H. Increase Enrollments in Selected Courses

Some HUSV courses have declined in enrollment in spite of offering useful educational opportunities for students. The courses with declining enrollments will be evaluated to determine what actions might increase enrollments. For example, by marketing the course more aggressively or offering more online courses. This evaluation should be completed by Spring 2017.

STUDENT DATA SUMMARY

The following responses are repeated from the Course Review document:

State at least three positive factors about the discipline/program identified by students. Include the number (or percentag) of students responding and any implications for planning.

Responses to every one of the questions to which students responded (n-148 - 240) fell in the "Highly Satisfied" range. There was some variation between items because responses to some items indicated higher satisfaction within the "Highly Satisfied" range while others indicated lower satisfaction within that range.

The questions with the highest "Highly Satisfied" scores were as follows (in order, beginning with the highest scores):

- Quality of instruction within the program.
- Contribution towards your intellectual growth.
- Clairty of course goals and learning objectives.

State at least three negative factors about the discipline/program identified by students. Include the number (or percentage) of students responding and any implications for planning.

The questions with the lowest "Highly Satisfied" scores were (in reverse order, beginning with the lowest scores):

- Advice about the program from counselors.
- The availability of courses offered in the Human Services program.
- The coordination of courses offered in the Human Services program and courses offered in other departments that may be required for your major.
- Availability of appropriate library resources.

Responses to the remaining questions assessing satisfaction with the program fell around the middle of the "Highly Satisfied" range.

Two additional questions inquired (a) whether students would recommend taking courses in the Human Services program and (b) whether students plan on taking additional courses in the Human Services program. Answers to both questions (n-0237) fell well within the "Strongly Agree" range.

State any other information (use responsive numbers) that you obtained from student data (e.g. focus groups, questionnaires, or SGIDs) that may be of special interest to the self study team. What planning implications will result from this information?

Conclusion: Since all of the responses indicated high satisfaction with every aspect of the Human Services program, no changes are recommended based on these results. However, the fact that two of the lowest "Highly Satisfied" scores concerned advice from college counselors and availability of materials in the library, the following two goals are suggested:

(1) Given the unique attributes of the Human Services program, it would be beneficial if there was an embedded counselor assigned to the Human Services program; and
(2) The program coordinator should recommend to the library materials that would benefit human services students.

COURSE REVIEW VERIFICATION

Discipline: Human Services Year: 2015

This section has been completed separately and was published in the Course Review Document.

STUDENT DATA COLLECTION

This section has been completed separately and was published in the Course Review Document.

ASSESSMENT PLAN

This part of the program review demonstrates alignment of courses with coverage of program student learning outcomes and lays out the program's plans for conducting assessments over the forthcoming five years.

PROGRAM LEARNING OUTCOMES

- As stated earlier, the Human Services program Mission Statement is as follows:

  This program prepares students for employment in the human services fields and further education by providing experiences that emphasize intellectual and technical excellence, creativity, personal and interpersonal skills, professionalism, and cultural competence.

- Program and Course Learning Outcomes may be found in Appendix 8.

ASSESSMENT METHODS

Student Learning Outcomes (SLOs) will be assessed using student questionnaire data. SLOs will be rephrased as questions that can be answered with a Yes or No answer, and the questions will be included in the last exam given in each HUSV course, or in separate questionnaires for students in case there is no exam (as in the Practicum and Practicum Seminar courses).

IMPLEMENTATION OF ASSESSMENT

All Human Services program instructors will be responsible for collecting SLO assessment data.

ALIGNMENT OF COURSE SLOs

Alignment of Course SLOs may be found in Appendix 2.

ASSESSMENT CALENDAR

SLO assessments will be conducted at the end of each semester.

PLAN FOR DISSEMINATION OF RESULTS

Results will be shared electronically with every Human Services program instructor and Social and Behavioral Sciences faculty member and will be presented in a Social and Behavioral Sciences department meeting once a year. This will occur either near the end of the academic year or near the beginning of the following year, as convenient for scheduling and faculty availability. In addition, written summaries will be shared with the Learning Outcomes and Assessment Committee, the dean, and the Vice President, Academic Affairs.

PLAN OF ACTION - PRE-VALIDATION
Six Year

DEPARTMENT: Social and Behavioral Science PROGRAM: Human Services

List below as specifically as possible the actions which the department plans to take as a result of this program review. Be sure to address any problem areas which you have discovered in your analysis of the program. Number each element of your plans separately and for each, please include a target date. Additionally, indicate by the number each institutional goal and objective which is addressed by each action plan. (See Institutional Goals and Objectives)

RECOMMENDATIONS TO IMPROVE **STUDENT LEARNING OUTCOMES** AND ACHIEVMENT	**Theme/Objective/ Strategy Number AHC from Strategic Plan**	**TARGET DATE**
Update CORs and corresponding SLOs	SLS1	Spring 2017
Add 2 new courses: Effective Writing for Human Services and Ethics for Human Services Professionals	SLS2	Spring 2017
Assess SLOs annually	SLS1	Spring 2017

RECOMMENDATIONS TO ACCOMMODATE CHANGES IN **STUDENT CHARACTERISTICS**	**Theme/Objective/ Strategy Number AHC from Strategic Plan**	**TARGET DATE**
Enrollment Changes Market select courses and make a determination whether some courses should be offered online to increase enrollments	SLS6	Spring 2017
Demographic Changes No appreciable demographic changes since last program review	N.A.	N.A.

RECOMMENDATIONS TO IMPROVE THE **EDUCATIONAL ENVIRONMENT**	**Theme/Objective/ Strategy Number AHC from Strategic Plan**	**TARGET DATE**
Curricular Changes No curricular changes needed.	N.A.	N.A.
Co-Curricular Changes No co-curricular changes needed.	N.A.	N.A.
Neighboring College and University Plans No new plans needed with neighboring colleges or universities		

Related Community Plans No changes needed in related community plans.	N.A.	N.A.

RECOMMENDATIONS THAT REQUIRE ADDITIONAL RESOURCES	**Theme/Objective/ Strategy Number AHC from Strategic Plan**	**TARGET DATE**
Facilities None at this time		
Equipment Laptop equipment may be needed between now and the next six year program review. Assess needs annually.	IR3 ,IR4	Fall 2017
To allow purchase of new equipment, increase HUSV budget.	IR2	Fall 2016
Staffing Revisit question of whether to recruit and hire a second full-time HUSV faculty member.	IR1	Spring 2017
Instead of generic college counselors, have at least one embedded counselor	SLS3, 4, 5, 6	Spring 2017

Human Services Validation Team Report
Executive Summary

I. MAJOR FINDINGS

A. Strengths of the Program

1. The program provides trained potential employees for a growing human services industry, especially for substance use disorder treatment industry, whose need for qualified personnel has increased dramatically.
2. The program maintained constant enrollments since the last program review.
3. Program staff includes one full-time instructor with coordination duties, and 10 qualified part-time instructors.
4. Students have the option to earn two Associate in Science degrees, 4 certificates of achievement, and 9 certificates of accomplishment.
5. The program has fostered strong connections with external agencies in the community.
6. Labor market data indicates faster than average occupation growth with a 22% increase in need for behavioral disorder counselors from 2014-2024. In short, the HUSV program meets the needs of a growing human services industry.

B. Concerns Regarding the Program/Discipline

1. Low-enrolled and seldom-offered courses should be removed from the curriculum (i.e. HUSV 144, HUSV 124).
2. Consider sunsetting courses that no longer meet student needs and/ or consider offering these as noncredit workshops.
3. Consider incorporation of new Medi-Cal reimbursement requirements, such as use of the American Society of Addiction Medicine placement criteria, into relevant courses.
4. The program's teaching equipment needs should be noted and itemized in the program review in order for budget to be increased and/or equipment purchased.
5. SLO assessment data have not been consistently assessed indicating a need to engage and encourage part-time instructors in collecting and tracking these data.
6. Training/professional development is not provided for part-time faculty. All part-time faculty should have an opportunity for Canvas training.
7. The two lowest ranked questions on the student surveys related to advice from college counselors and the availability of materials in the library. These concerns should be addressed.

II. RECOMMENDATIONS

1. Consider the faculty prioritization process to request the hiring of another full-time instructor.
2. Provide/promote training or other professional development activities to engage and encourage part-time faculty in the continuous improvement of the program. Canvas training should be offered to all part-time faculty.
3. Work with agency counselors and case workers (i.e. guest speakers, field trips) so that students are better informed about the opportunities within the Human Services occupation.
4. Continue efforts to encourage students to complete programs.
5. Increase the availability of Human Services related materials in the library.
6. Continue efforts to promote program graduates into community-based related occupations (i.e. internships, externships, CWE, etc.).
7. Continue efforts to recruit potential future students from community agencies (jail, drug treatment programs, high schools, etc.).
8. Continue efforts in Diversity Training which seems to be a current hot button for the Human Service Industry.
9. Modify courses to update required and recommended textbooks/materials within Course Outlines to assure that they are no more than 5 years old, whenever possible. This will assure that content being taught is current, relevant, and meets industry needs.

Validation Team Signature Page:

Thesa Roepke, Department Chair, Applied Behavioral Sciences

Brian Stokes, Department Chair, Social and behavioral Sciences

Thomas Van Der Molen, Professor, Psychology

John Lovern, Chair, Human Services Self Study

Sofia Ramirez Gelpi, Dean, Academic Affairs

PROGRAM REVIEW -- VALIDATION TEAM MEMBERS

TO: Academic Dean

Date: 9/4/19

From: John Lovern

(Name) Brian Stokes

(Related Discipline/Program) Anthropology

(Name) Tisa Roepke

(Unrelated Discipline/Program) Early Childhood Studies

(Name)

(Unrelated Discipline/Program)

At the option of the self-study team, the validation team may also include one or more of the following: a. someone from a four-year institution in the same discipline; someone from another community college in the same discipline; a high school instructor in the same discipline; a member of an advi r committee for the pr ram Please com lete the follow as relevant to our pr ram review

(Name) (Title)

Affiliation: Telephone Contact Number:

Address (Mailing) City/State/Zip email addres.

(Name) (Title)

Affiliation: Telephone Contact Number:

Address (Mailing) City/State/Zip email address

(Name) (Title)

Affiliation: Telephone Contact Number:

Address (Mailing) City/State/Zip email address

APPROVED: Sofia Ramirez Golpi 9/5/2019

Academic Dean Date

PLAN OF ACTION – POST-VALIDATION

(Sixth-Year Evaluation)

DEPARTMENT Social & Behavioral Sciences PROGRAM Human Services

In preparing this document, refer to the Plan of Action developed by the discipline/program during the self-study, and the recommendations of the Validation Team. Note that while the team should strongly consider the recommendations of the validation team, these are recommendations only. However, the team should provide a rationale when choosing to disregard or modify a validation team recommendation.

Identify the actions the discipline/program plans to take during the next six years. Be as specific as possible and indicate target dates. Additionally, indicate by the number each institutional goal and objective which is addressed by each action plan. (See Institutional Goals and Objectives) The completed final plan should be reviewed by the department as a whole.

Please be sure the signature page is attached.

RECOMMENDATIONS TO IMPROVE DESIRED **STUDENT OUTCOMES** AND IMPROVE STUDENT PERFORMANCE	**Theme/Objective/ Strategy Number AHC from Strategic Plan**	**TARGET DATE**
Consistently assess the SLOs/PLOs to identify outcomes that need to be modified	Goal IE2	5/2026

RECOMMENDATIONS TO ACCOMMODATE CHANGES IN **STUDENT CHARACTERISTICS**	**Theme/Objective/ Strategy Number AHC from Strategic Plan**	**TARGET DATE**
Enrollment Changes: Low-enrolled and seldom-offered courses should be removed from the curriculum (i.e., HUSV 112, HUSV 122, HUSV 124 & HUSV 144).	Goal SLS1	5/2026
Demographic Changes: Assess data to assure the program is meeting the needs of the diverse student population, relative to diversity, equity, and inclusion.	Goal SLS7	5/2026

RECOMMENDATIONS TO IMPROVE THE **EDUCATIONAL ENVIRONMENT**	**Theme/Objective/ Strategy Number AHC from Strategic Plan**	**TARGET DATE**
Curricular Changes: Review and update Human Services degrees and certificates. Consider adding course HUSV 135 (Ethics for Human Services	Goal SLS2	5/2026

Professionals) or Philosophy 105 (Ethics) to degrees and/or certificates if appropriate.		
Co-Curricular Changes: No co-curricular changes needed.	N.A.	N.A.
Neighboring College and University Plans: No new plans needed with neighboring college or universities.	N.A.	N.A.
Related Community Plans: Promote outreach and professional activities that benefit the community such as working with Santa Barbara County Behavioral Wellness Services.	Goal SLS6	5/2026

RECOMMENDATIONS THAT REQUIRE ADDITIONAL RESOURCES	**Theme/Objective/ Strategy Number AHC from Strategic Plan**	**TARGET DATE**
Facilities: None at this time.	N.A.	N.A.
Equipment: None at this time.	N.A.	N.A.
Staffing: All part-time faculty should complete Canvas training and achieve DL Certification.	Goal IR3	5/2026

VALIDATION TEAM RECOMMENDTIONS Disregarded or modified (if appropriate)	**REASON**	**ACTION/CHANGEEGE**
Recommendation Familiarize students with Medi-Cal reimbursement requirements, such as the American Society of Addiction Medicine placement criteria.	An understanding of current billing practices in the industry would benefit students.	
Recommendation Educate counselors regarding the courses, certificates and degrees for Human Services program.	Lowest ranking questions on student surveys related to counselors.	

PLAN OF ACTION – Post-Validation

Review and Approval

Plan Prepared By

Brian Stokes

Date:

Thomas Vandermolen

Date:

Rick Pauls

Date:

Date:

Date:

Reviewed:

Department Chair* Brian Stokes Date:

*Signature of Department Chair indicates approval by department of Plan of Action.

Reviewed:

Dean of Academic Affairs Rick Pauls Date:

Vice President, Academic Affairs Robert Curry (Sep 27, 2021 12:06 PDT) Date: 09/27/21

APPENDIX 1

Human Services Budget

FY 20-21 Human Services Budget

Account	Account Title	Adjusted Budget	Year to Date	Available Balance	
111000	Academic Instr Salaries Reg Load	$ 49,675.08	$ 144.93	$ 49,530.15	
121000	Academic Non Instr Reg Load	$ 21,289.32	$ -	$ 21,289.32	
131000	Part Time Faculty Instr/Subs	$ -	$ 58,159.63	$ (58,159.63)	
133000	Academic Instr Salaries Overload	$ -	$ 6,170.90	$ (6,170.90)	
				$ 70,819.47	**Salaries**
311000	Academic Instructional STRS/DB	$ 13,057.00	$ 1,604.30	$ 11,452.70	
314000	Academic Instr STRS/CB	$ -	$ 2,099.45	$ (2,099.45)	
335000	Acdmc/Clssifd Instr FICA-Medicare	$ 1,026.00	$ 934.61	$ 91.39	
341000	Academic/Classified Instr Hlth&Wlfr	$ 9,640.44	$ -	$ 9,640.44	
351000	Academic/Classified Instr SUI	$ 35.00	$ 32.29	$ 2.71	
361000	Academic/Classified Instr Wrkrs Cmp	$ 554.00	$ 504.75	$ 49.25	
				$ 19,191.41	**Benefits**
471000	Food - Business Meetings/Events	$ 150.00	$ -	$ 150.00	
				$ 150.00	**Meeting Food**
531000	Dues & Memberships	$ 300.00	$ -	$ 300.00	
				$ 300.00	**Dues and Memberships**
Expenditure Total		$ 96,176.84	$ 69,650.86	$ 90,460.88	
				$ (26,130.35)	

APPENDIX 2

Student Learning Objectives Assessment

Comprehensive Program Review (CPR) Learning Outcomes Assessment Data

This document contains the data from the last 6 years as reported to Institutional Effectiveness via eLumen. The packet contains charts and tables that indicate outcome performance by Course Learning Outcomes (CLO), Program Learning Outcomes (PLO), and Institutional Learning Outcomes (ILO).

Sample question from the CPR:
What are your program student learning outcomes? Have each of these been assessed since the last comprehensive program review?

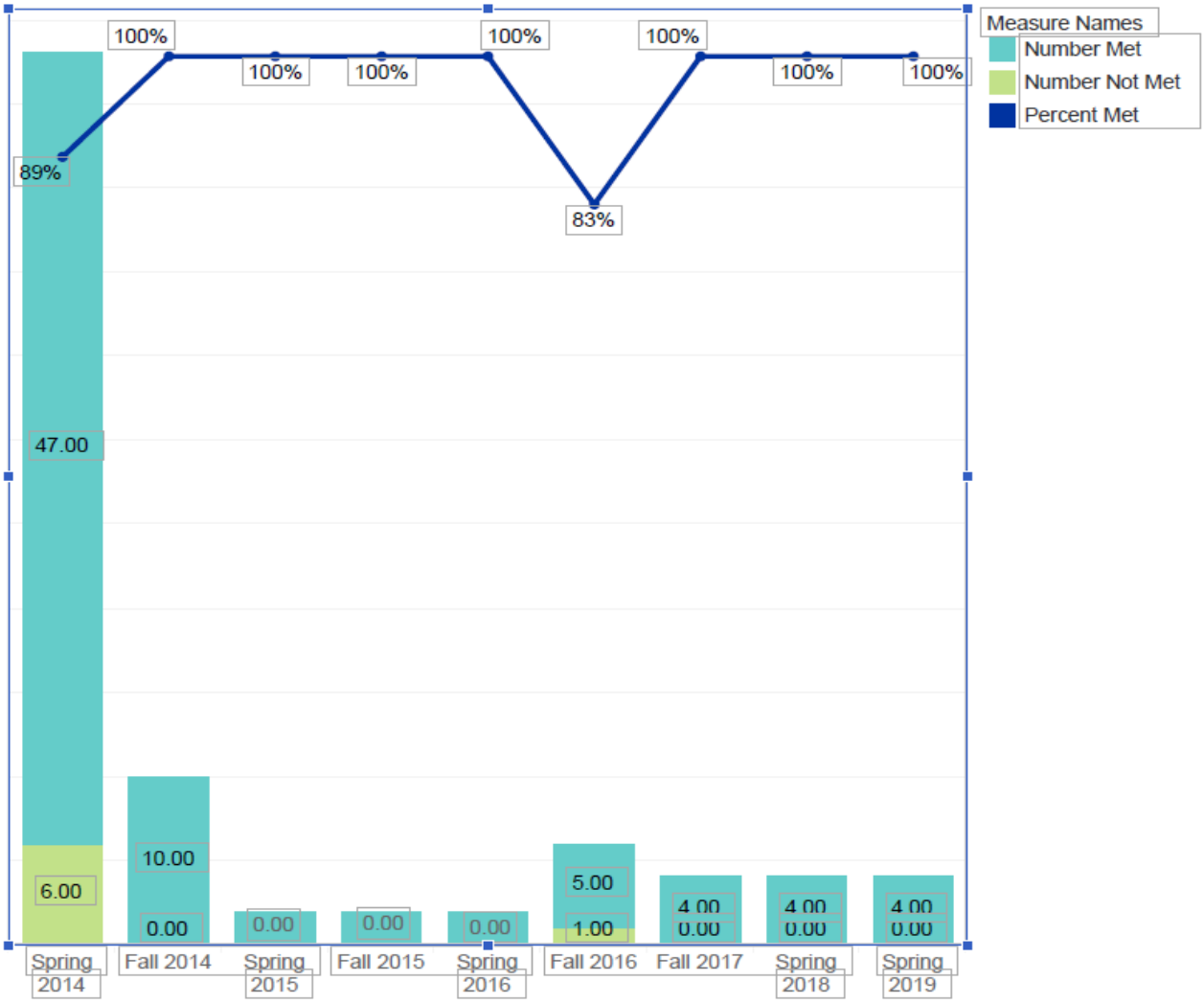
Items to look for:

1. Courses with little to no completed assessments;
2. Table Data in red that indicates performance that was below the 70% benchmark;
3. Improvement plans that have suggestions for improvements;
4. Any patterns in data or missing data that is concerning or lauding.

Charts, Tables and Graphs

1. **Historical PLO Performance Chart: Human Services**- This chart shows the PLO percent and the number of students that meet standards by term.
2. **Historical PLO Performance Table: Human Services**-This table shows the overall PLO performance during the last 6 academic years, including percent and numbers of students meeting standards.
3. **Historical CLO Performance Chart: Human Services**-This chart shows the CLO percent met and the count of students that met standards by term.
4. **Historical CLO Performance Table: Human Services**-This is a chart of the table presented above.
5. **Historical Course Performance: Human Services-**This is a SLO assessment by course, including percent and number of students that met standards.
6. **ILO Performance Table: Human Services**-This is the ILO performance of the program for the past 6 academic years.
7. **ILO Performance Chart: Human Services-**This is the ILO performance of the program for the past 6 academic years in a table that includes the number of courses that are connected to each ILO.
8. **Program Learning Outcomes: Human Services**- List of PLOs for the selected program.
9. **Course Learning Outcomes: Human Services-** List of CLOs for the selected program.

1. **Historical PLO Performance Chart: Human Services**- This chart shows the PLO percent and the number of students that meet standards by term.

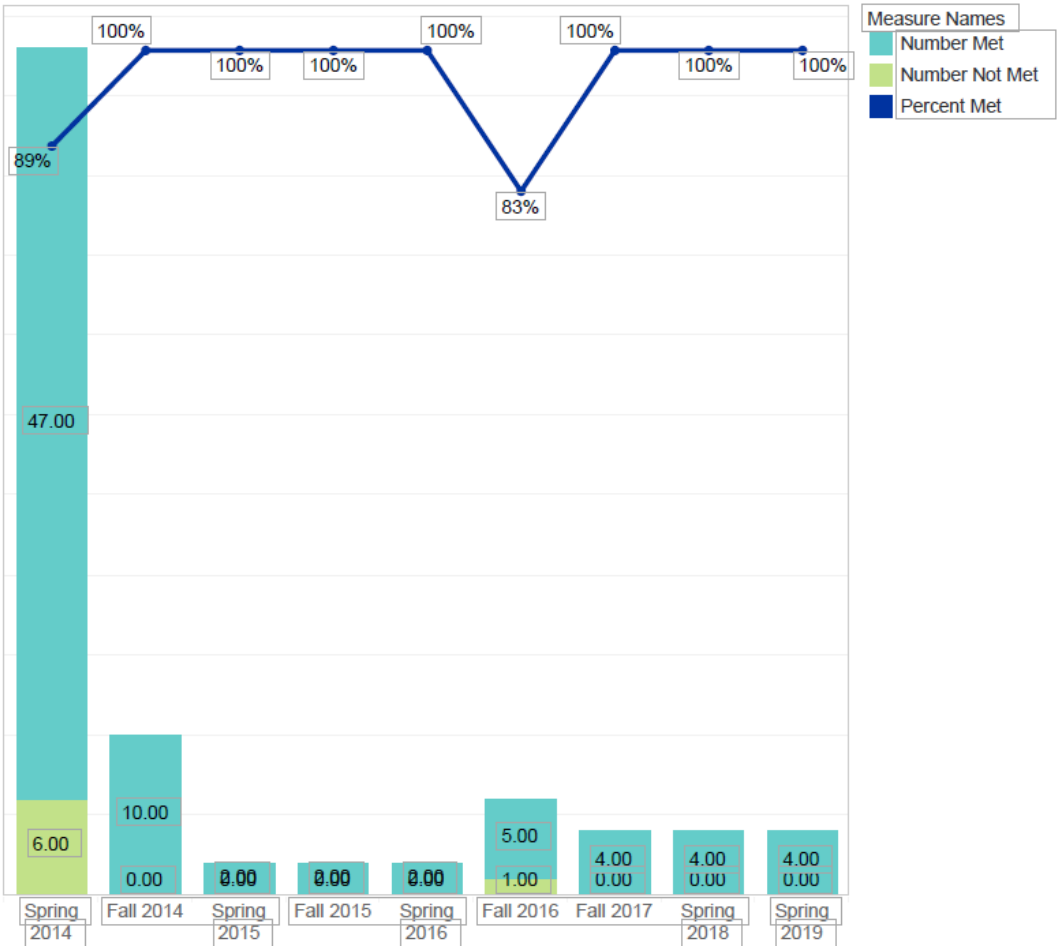


2. **Historical PLO Performance Table: Human Services**-This table shows the overall PLO performance during the last 6 academic years, including percent and numbers of students meeting standards.

2.Historical PLO Performance Table: Human Services- This is a table showing the overal PLO performance over the last 6 academic years, including percent and numbers of students meeting standards.

			Number Met	Number Not Met	Percent Met
HUSV	HUSV PSLO3 - Ethics and Boundaries: Graduates will be familiar with a professional association's code of e..	HUSV127	28.00	3.00	90%
		Total	28.00	3.00	90%
	No PLO Associated	HUSV103	17.00	2.00	89%
		HUSV127	35.00	2.00	95%
		Total	52.00	4.00	93%
	Total		80.00	7.00	92%

3. **Historical CLO Performance Chart: Human Services**-This chart shows the CLO percent met and the count of students that met standards by term.



4. **Historical CLO Performance Table: Human Services**-This is a chart of the table presented above.

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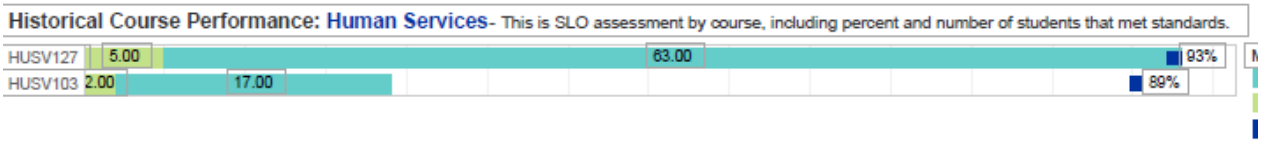
			Number Met	Number Not Met	Percent Met
HUSV103	HUSV2	Be familiar with a professional associationâ€™s code of ethics and demonstrate the ability to behave in accord with it. They will be able to define appropriate professional relationship boundaries and detect when these boundaries are crossed or violated. They ..	17.00	2.00	89%
HUSV127	HUSV1	Explain the neurobiology of emotions and â€œemotional hijacking.â€	35.00	2.00	95%
	HUSV2	Define emotional intelligence in terms of specific emotional skills and explain their benefits.	28.00	3.00	90%

5. **Historical Course Performance: Human Services-**This is a SLO assessment by course, including percent and number of students that met standards.

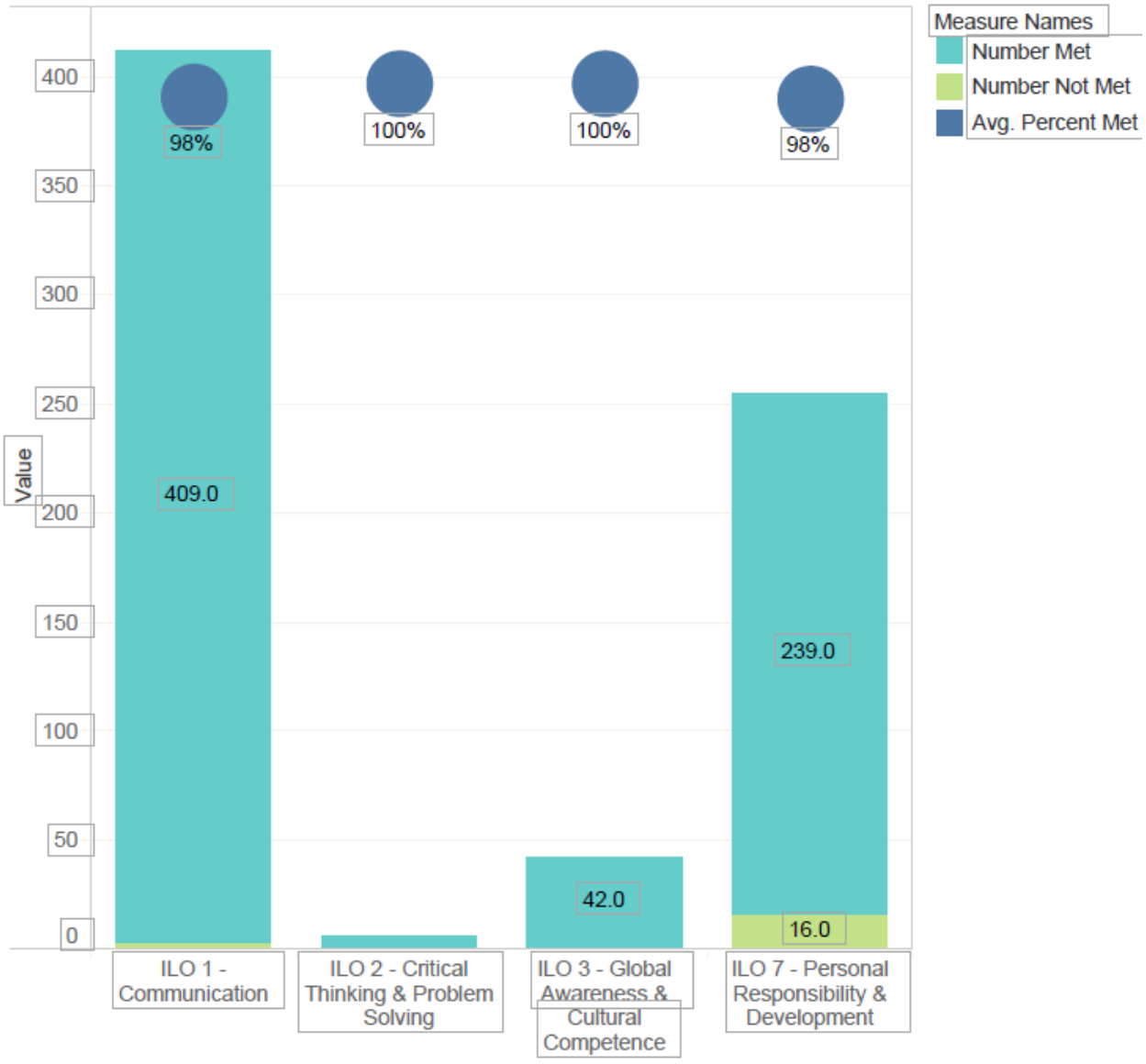


6. **ILO Performance Table: Human Services**-This is the ILO performance of the program for the past 6 academic years.

3. ILO Performance Table: Human Services- This is the ILO performance of the program for the past 6 academic years.

	# of Connected Courses	Avg. Percent Met
ILO 1 - Communication: Communicate effectively using verbal, visual and written language with clarity and purpose in workplace, community and academic contexts.	12.0	98%
ILO 2 - Critical Thinking & Problem Solving: Explore issues through various information sources; evaluate the credibility and significance of both the information and the source to arrive at a reasoned conclusion.	1.0	100%
ILO 3 - Global Awareness & Cultural Competence: Respectfully interact with individuals of diverse perspectives, beliefs and values being mindful of the limitation of your own cultural framework.	1.0	100%
ILO 7 - Personal Responsibility & Development: Take the initiative and responsibility to assess your own actions with regard to physical wellness, learning opportunities, career planning, creative contribution to the community and ethical integrity in the	11.0	98%

7. **ILO Performance Chart: Human Services-**This is the ILO performance of the program for the past 6 academic years in a table that includes the number of courses that are connected to each ILO.



8. **Program Learning Outcomes: Human Services**- List of PLOs for the selected program.

HUSV PSLO1 - Possess knowledge and skills that will enable them to competently and ethically carry out the duties and responsibilities of jobs in the general human or social service field. The knowledge and skills that they will possess fall under the foll
HUSV PSLO2 - Interpersonal Helping Skills: Graduates will possess interpersonal skills required to engage empathically with clients, develop safe and trusting relationships with them, assess their strengths and problems, and recommend appropriate intervent
HUSV PSLO3 - Ethics and Boundaries: Graduates will be familiar with a professional association's code of ethics and demonstrate the ability to behave in accord with it. They will be able to define appropriate professional relationship boundaries and detect
HUSV PSLO4 - Documentation: Graduates will demonstrate the ability to create and maintain appropriate client documentation, including intake notes, service or treatment plans, progress notes, discharge notes, and other documentation such as informed consen

The view is broken down by PLO. The data is filtered on Term1 and Program (ILO_Perf (MASTER_AA_SPOL_UPLOADS)). The Term1 filter keeps 12 of 29 members. The Program (ILO_Perf (MASTER_AA_SPOL_UPLOADS)) filter keeps Human Services. The view is filtered on PLO, which keeps 240 of 711 members.

9. **Course Learning Outcomes: Human Services-** List of CLOs for the selected program.

HUSV101	HUSV1	Explain their motives for becoming a helping professional and how these motives may affect their job performance.
	HUSV2	Define the steps required to pursue training to become a member of a specific helping profession.
HUSV102	HUSV1	Define ethical and culturally competent approaches to interviewing clients, assessing their strengths and problems, and recommending ameliorative services.
	HUSV2	Appropriately to document their provision of these services.
	HUSV3	Be familiar with a professional associationâ€™s code of ethics and demonstrate the ability to behave in accord with it. They will be able to define appropriate professional relationship boundaries and detect when these boundaries are crossed or violated. They will be able to maintain client ..
HUSV103	HUSV1	Develop safe and trusting relationships with simulated clients, assess their strengths and problems, and recommend appropriate interventions and/or referrals. They will demonstrate the ability to manifest the core conditions of helping relationships, including empathy, non possessive w..
	HUSV2	Be familiar with a professional associationâ€™s code of ethics and demonstrate the ability to behave in accord with it. They will be able to define appropriate professional relationship boundaries and detect when these boundaries are crossed or violated. They will be able to maintain client ..
HUSV104	HUSV1	Manifest the core conditions of helping relationships, including empathy, non possessive warmth, genuineness, and congruence, in a group service setting.
	HUSV2	Interact in a group setting so as to encourage the development of a positive, problem-solving, working group process.
HUSV105	HUSV1	Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients
	HUSV2	Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV106	HUSV1	Understand and explain family system dynamics from at least one theoretical perspective and list many of the effects of child abuse and neglect.
	HUSV2	Describe their own families of origin and how they were personally affected by the dynamics of these families.
HUSV107	HUSV1	Define the core components that constitute culturally competent practice.
	HUSV2	Explain how to apply the core components of cultural competence to working in the helping field with members of at least one oppressed minority culture.
HUSV108	HUSV1	Define what constitutes a crisis, both in terms of the situation giving rise to the crisis and the state of mind of the person in crisis.
	HUSV2	Explain how to intervene with a client who is in one of two different types of crisis.
HUSV110	HUSV1	Define the short-term and long-term effects of several categories of substances that are frequently abused.
	HUSV2	Explain the differences between substance use, substance abuse, and substance dependence.
HUSV111	HUSV1	Explain the core competencies of addiction counseling as listed in TAP 21 (Center for Substance Abuse Treatment. Addiction Counseling Competencies- The Knowledge, Skills, and Attitudes of Professional Practice. Technical Assistance Publication (TAP) Series 21. DHHS Public..

HUSV112	HUSV1	Possess communication skills that will enable them, in a collaborative manner and without creating resistance, to influence people with problems to begin to participate in a constructive change process.
	HUSV2	Be able to interact with angry, dissatisfied people in a manner that reduces anger and engenders cooperation.
HUSV113	HUSV1	Explain the unique addiction treatment needs of women.
	HUSV2	Define and describe perinatal addiction treatment.
HUSV120	HUSV1	Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	HUSV2	Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV122	HUSV1	Explain why it is difficult to define consciousness and compare and contrast different states of consciousness.
	HUSV2	Describe how states of consciousness change or switch, and how these transitions influence are influenced by individual functioning.
	HUSV3	Describe and discuss societal and cultural mechanisms designed to alter or control consciousness.
HUSV126	HUSV1	Practice meditation, mindfulness, and/or relaxation as a self-management and health-promotion strategy.
HUSV126	HUSV2	Teach others to practice meditation, mindfulness, and/or relaxation as a self-management and health-promotion strategy.
HUSV127	HUSV1	Explain the neurobiology of emotions and â€œemotional hijacking.â€
	HUSV2	Define emotional intelligence in terms of specific emotional skills and explain their benefits.
HUSV128	HUSV1	Describe the history of the study of well-being in the Western world.
	HUSV2	List several factors that predict or enhance personal well-being and fulfillment.
HUSV130	HUSV1	Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	HUSV2	Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV132	HUSV1	Describe and distinguish between the mental and physiological effects associated with stimulant, sedative, narcotic, hallucinogen, inhalant, and anabolic steroid use.
	HUSV2	Understand dependence, withdrawal, and the different forms of tolerance from drugs.
HUSV140	HUSV1	Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	HUSV2	Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV142	HUSV1	Describe the schism that exists between the mental health and substance dependence treatment communities.
	HUSV2	Describe how to screen for and assess co-occurring mental illness and substance use disorders.
HUSV143	HUSV1	Describe at least one model of treatment of co-occurring mental illness and substance use disorders.
	HUSV2	Describe at least one emerging approach to treatment of co-occurring mental illness and substance use Disorders (such as specialty courts, assertive community treatment, etc.)
HUSV144	HUSV1	Possess a thorough understanding of the Twelve Steps of Alcoholics Anonymous.
	HUSV2	Be able to explain the benefits of the Twelve Steps to individuals who may be able to benefit from them.
HUSV150	HUSV1	Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	HUSV2	Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV160	HUSV1	Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	HUSV2	Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV170	HUSV1	Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	HUSV2	Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.

CLO broken down by Course and Clo#. The data is filtered on Term1 and Program (ILO_Perf (MASTER_AA_SPOL_UPLOADS)). The Term1 filter keeps 12 of 29 members. The Program (ILO_Perf (MASTER_AA_SPOL_UPLOADS)) filter keeps Human Services.

APPENDIX 3

SLOs and SLOs Phrased as Questions

COURSE	Student Learning Objectives	Student Learning Objects Phrased as A Question
HUSV 101	SLO1 - Explain their motives for becoming a helping professional and how these motives may affect their job performance.	Having almost completed HUSV 101, are you able to explain your motives for becoming a helping professional and how these motives may affect your job performance?
	SLO2 - Define the steps required to pursue training to become a member of a specific helping profession.	Can you define the training needed and steps toward becoming a helping professional in your chosen field?
HUSV 102	SLO1 - Define ethical and culturally competent approaches to interviewing clients, assessing their strengths and problems, and recommending ameliorative services.	Can you define culturally and ethical approaches to providing health services?
	SLO2 - Appropriately document their provision of these services.	Have you documented the services you have provided?
	SLO3 - Be familiar with a professional association's code of ethics and demonstrate the ability to behave in accord with it. They will be able to define appropriate professional relationship boundaries and detect when these boundaries are crossed or violated. They will be able to maintain client confidentiality and know the conditions under which confidentiality must be broached.	Are you able to describe professional relationship boundaries and when those boundaries are violated? Can you describe client confidentiality?
HUSV 103	SLO1 - Develop safe and trusting relationships with simulated clients, assess their strengths and problems, and recommend appropriate interventions and/or referrals. They will demonstrate the ability to manifest the core conditions of helping relationships, including empathy, non possessive warmth, genuineness, and congruence.	Are you able to describe the core conditions of helping relationships?
	SLO2 - Be familiar with a professional association's code of ethics and demonstrate the ability to behave in accord with it. They will be able to define appropriate professional relationship boundaries and detect when these boundaries are crossed or violated. They will be able to maintain client confidentiality and know the conditions under which confidentiality must be broached.	Are you able to describe the definition and use of empathy, non-possessive warmth, genuineness and congruence in helping relationships?
HUSV 104	SLO1 - Manifest the core conditions of helping relationships, including empathy, non possessive warmth, genuineness, and congruence, in a group service setting.	Can you identify and demonstrate the core conditions of helping relationships in a group service setting?
	SLO2 - Interact in a group setting so as to encourage the development of a positive, problem-solving, working group process.	Can you describe how to promote positive, problem-solving in a group environment?
HUSV 105	LO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients	Are you able to apply the helping skills and knowledge learned in class to real clients?
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.	Can you identify interpersonal helping skills and how to document your work with real clients?
HUSV 106	SLO1 - Understand and explain family system dynamics from at least one theoretical perspective and list many of the effects of child abuse and neglect.	Are you able to explain family system dynamics and the potential effects of child abuse and neglect?
	SLO2 - Describe their own families of origin and how they were personally affected by the dynamics of these families.	Can you describe your own family history and dynamics?
HUSV 107	SLO1 - Define the core components that constitute culturally competent practice.	Are you able to describe the core components of culturally competent practice?

	SLO2 - Explain how to apply the core components of cultural competence to working in the helping field with members of at least one oppressed minority culture.	Are you able to explain core components of cultural competence in working with minorities?
HUSV 108	SLO1 - Define what constitutes a crisis, both in terms of the situation giving rise to the crisis and the state of mind of the person in crisis.	Can you describe situations and the state of minds that arise in a crisis?
	SLO2 - Explain how to intervene with a client who is in one of two different types of crisis.	Can you explain how you would intervene with a client in crisis?
HUSV 110	SLO1 - Define the short-term and long-term effects of several categories of substances that are frequently abused.	Can you identify the short- and long-term effects of substance abuse?
	SLO2 - Explain the differences between substance use, substance abuse, and substance dependence.	Are you able to distinguish between substance use, abuse and dependence?
HUSV 111	SLO1 - Explain the core competencies of addiction counseling as listed in TAP 21 (Center for Substance Abuse Treatment. Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice. Technical Assistance Publication (TAP) Series 21. DHHS Publication No. SMA 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.)	Are you able to describe the core competencies of addiction counseling as outlined in TAP 21?
HUSV 112	SLO1 - Possess communication skills that will enable them, in a collaborative manner and without creating resistance, to influence people with problems to begin to participate in a constructive change process.	Are you able to communicate in a collaborative manner with people and encourage them to participate in constructive change process without creating resistance?
	SLO2 - Be able to interact with angry, dissatisfied people in a manner that reduces anger and engenders cooperation.	Are you able to communicate while reducing anger and encouraging cooperation in people who are angry and dissatisfied?
HUSV 113	SLO1 - Explain the unique addiction treatment needs of women.	Are you able to describe the treatment needs of women?
	SLO2 - Define and describe perinatal addiction treatment.	Can you describe the treatment protocols for perinatal women?
HUSV 120	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.	Are you able to demonstrate the knowledge and skills learned during this course in practical situations with real clients?
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.	Can you demonstrate interpersonal helping skills with real clients and appropriately document the services ?
HUSV 121	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.	Are you able to demonstrate the knowledge and skills learned with real clients?
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.	Can you demonstrate interpersonal helping skills with real clients and appropriately document the services ?
HUSV 122	SLO1 - Explain why it is difficult to define consciousness and compare and contrast different states of consciousness.	Are you able to define consciousness and describe why it is difficult to define?
	SLO2 - Describe how states of consciousness change or switch, and how these transitions influence and are influenced by individual functioning.	Can you describe how states of consciousness change or switch and how these transitions are influenced by and influence individual functioning?
	SLO3 - Describe and discuss societal and cultural mechanisms designed to alter or control consciousness.	Are you able to define and discuss societal and cultural mechanisms designed to alter or control consciousness?

HUSV 124	NONE	NONE
HUSV 126	SLO1 - Practice meditation, mindfulness, and/or relaxation as a self-management and health-promotion strategy.	Are you able to practice meditation and/or relaxation as a self-management and health-promotion strategy?
	SLO2 - Teach others to practice meditation, mindfulness, and/or relaxation as a self-management and health-promotion strategy.	Can you teach others meditation and/or relaxation techniques for self-management and health promotion?
HUSV 127	SLO1 - Explain the neurobiology of emotions and “emotional hijacking.”	Can you describe the neurobiology of emotions and emotional hijacking?
	SLO2 - Define emotional intelligence in terms of specific emotional skills and explain their benefits.	Are you able to define emotional intelligence in terms of emotional skills and explain their benefits?
HUSV 128	SLO1 - Describe the history of the study of well-being in the Western world.	Are you able to describe the history of well-being in the Western world?
	SLO2 - List several factors that predict or enhance personal well-being and fulfillment.	Can you list factors that predict or enhance personal well-being and fulfillment?
HUSV 130	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.	Can you describe experiences that you've had in this course that demonstrated the knowledge and helping skills you've learned?
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.	Can you describe and demonstrate interpersonal helping skills with real clients and how to document your services?
HUSV 131	SLO1- Apply the knowledge and skills developed in the classroom in an appropriate workplace setting that relates directly to addiction studies.	Are you able to describe how you would apply the addiction studies knowledge in a workplace setting?
HUSV 132	SLO1 - Describe and distinguish between the mental and physiological effects associated with stimulant, sedative, narcotic, hallucinogen, inhalant, and anabolic steroid use.	Can you describe and distinguish between the mental and physiological effects associated with different drugs and anabolic steroids?
	SLO2 - Understand dependence, withdrawal, and the different forms of tolerance from drugs.	Are you able to describe the dependence, withdrawal and tolerance of various drugs?
HUSV 135	SLO 1 - Identify the two most common ethics violations committed by helping professionals and explain how to avoid them.	Can you describe the most common ethics violations committed by helping professionals and how to avoid them?
	SLO 2 - Apply an ethical decision-making model to various real-world scenarios and ethical dilemmas for human services professionals.	Are you able to explain how to apply an ethical decision-making model to real-life scenarios and the ethical dilemmas faced by helping professionals?
HUSV 140	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.	Can you list examples of the knowledge and skills acquired in this course and how they impact your experience with real clients?
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.	Can you describe how to provide ethical, interpersonal helping skills in the workplace with real clients. Are you able to document your services?
HUSV 141	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.	Are you able to explain how you applied the knowledge and skills learned in this course as a helping professional?
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.	Can you describe how you practiced, ethical, interpersonal helping skills with real clients in the workplace? Did you document these services?
HUSV 142	SLO1 - Describe the schism that exists between the mental health and substance dependence treatment communities.	Are you able to describe the schism between mental health and substance dependence treatment communities?

	SLO2 - Describe how to screen for and assess co-occurring mental illness and substance use disorders.	After this course are you able to screen for and assess co-occurring mental illness and substance use disorders?
HUSV 143	SLO1 - Describe at least one model of treatment of co-occurring mental illness and substance use disorders.	Are you able to describe one model treatment of co-occurring mental illness and substance use disorders?
	SLO2 - Describe at least one emerging approach to treatment of co-occurring mental illness and substance use disorders (such as specialty courts, assertive community treatment, etc.)	Can you describe one emerging treatment approach for co-occurring mental illness and substance abuse disorders?
HUSV 144	SLO1 - Possess a thorough understanding of the Twelve Steps of Alcoholics Anonymous.	After this course are you able to outline the Twelve Steps of Alcohol Anonymous?
	SLO2 - Be able to explain the benefits of the Twelve Steps to individuals who may be able to benefit from them.	Can you describe the benefits of the Twelve Steps of Alcohol Anonymous?
HUSV 145	SLO1 - Upon completion of this course, students will be able to prepare written human services documentation accurately, correctly, and in a professional manner.	Are you able to prepare documentation of helping services in an accurate, correct and professional manner?
	SLO2 - Upon completion of this course, students will be familiar with American Psychological Association style requirements.	Can you describe requirements of the American Psychological Association style?
HUSV 148	NONE--Not in Course Catalogue but in Course Outline of Record	NONE
HUSV 150	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.	Can you describe the knowledge and skills learned in this course and how they apply to your helping competence with real clients?
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.	After this course can you identify interpersonal skills and knowledge that impact how you provide helping services to real clients?
HUSV 151	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.	Can you describe how your helping experiences solidified the knowledge and skills learning in this course?
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.	After this course can you identify interpersonal skills and knowledge that impact how you provide helping services to real clients?
HUSV 160	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.	Can you describe how your helping experiences solidified the knowledge and skills learning in this course?
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.	After this course can you identify interpersonal skills and knowledge that impact how you provide helping services to real clients?
HUSV 161	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.	Can you describe how your helping experiences solidified the knowledge and skills learning in this course?
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.	After this course can you identify interpersonal skills and knowledge that impact how you provide helping services to real clients?
HUSV 170	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.	Can you describe how your helping experiences solidified the knowledge and skills learning in this course?

	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.	After this course can you identify interpersonal skills and knowledge that impact how you provide helping services to real clients?
HUSV 189	SLO1 - Development of sound research techniques	Can you describe some of the sound research techniques learned in this course?
	SLO2 - Recognize the value of independent study and enhance proficiency in a particular area of study by accumulating the knowledge and skills beyond the regular class offering.	Can you describe your study focus on how that impacts your helping services knowledge and skills in the workplace?
	SLO3 - Realize his/her individual responsibility in acquiring knowledge.	Are you able to explain how this course impacted your knowledge and skills as a helping professional?

APPENDIX 4

Center of Excellence in Labor Market Research
Reports on Human Service
Programs and Occupations

Appendix: Occupation definitions, sample job titles, five-year projections for human services occupations

Social and Human Service Assistants (21-1093)

Assist in providing client services in a wide variety of fields, such as psychology, rehabilitation, or social work, including support for families. May assist clients in identifying and obtaining available benefits and social and community services. May assist social workers with developing, organizing, and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or dependent care.

Sample job titles: Addictions Counselor Assistant, Advocate, Clinical Assistant, Outreach Specialist, Residential Care Assistant, Social Services Aide, Social Services Assistant, Social Work Assistant, Social Work Associate, Social Worker Assistant

Entry-Level Educational Requirement: High school diploma or equivalent
Training Requirement: Less than one month on-the-job training
Incumbent workers with a Community College Award or Some Postsecondary Coursework: 36%

Community Health Workers (21-1094)

Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs.

Sample job titles: Apprise Counselor, Assistant Director of Nutrition and Wellness Programs, Chief Program Officer, Community Health Outreach Worker, Community Health Program Coordinator, Community Health Program Representative (Community Health Program Rep), Community Health Promoter, Community Health Worker (CHW), Community Nutrition Educator, HIV CTS Specialist (Human Immunodeficiency Virus Counseling and Testing Services Specialist)

Entry-Level Educational Requirement: High school diploma or equivalent
Training Requirement: Less than one month on-the-job training
Incumbent workers with a Community College Award or Some Postsecondary Coursework: 29%

Program Completion and Outcome Methodology

Exhibit 10 displays the average annual California Community College (CCC) awards conferred during the three academic years between 2016 and 2019, from the California Community Colleges Chancellor's Office Management Information Systems (MIS) Data Mart. Awards are the combined total of associate degrees and certificates issued during the timeframe, divided by three in this case to calculate an annual average. This is done to minimize the effect of atypical variation that might be present in a single year.

Community college student outcome information is from LaunchBoard and based on the selected TOP code and region. These metrics are based on records submitted to the California Community Colleges Chancellor's Office Management Information Systems (MIS) by community colleges, which come from self-reported student information from CCC Apply and the National Student Clearinghouse. Employment and earnings metrics are sourced from records provided by California's Employment Development Department's Unemployment Insurance database. When available, outcomes for completers are reported to demonstrate the impact that earning a degree or certificate can have on employment and earnings. For more information on the types of students included for each metric, please see the web link for LaunchBoard's Strong Workforce Program Metrics Data Element Dictionary in the References section (LaunchBoard, 2020a). Finally, employment in a job closely related to the field of study comes from self-reported student responses on the CTE Employment Outcomes Survey (CTEOS), administered by Santa Rosa Junior College (LaunchBoard, 2020a).

Job postings data is limited to the information provided by employers and the ability of artificial intelligence search engines to identify this information. Additionally, preliminary calculations by Georgetown Center on Education and the Workforce found that "just 30 to 40 percent of openings for candidates with some college or an associate degree, and only 40 to 60 percent of openings for high school diploma holders appear online" (Carnevale et al., 2014). Online job postings often do not reveal the hiring intentions of employers; it is unknown if employers plan to hire one or multiple workers from a single online job posting, or if they are collecting resumes for future hiring needs. A closed job posting may not be the result of a hired worker.

Table 1: 2019 to 2024 job growth, wages, education, training, and work experience required, IEDR

Occupation (SOC)	2019 Jobs	5-Yr Change	5-Yr % Change	Annual Openings (New + Replacement Jobs)	Entry-Experienced Hourly Wage Range (10th to 90th percentile)	Median Hourly Wage (50th percentile)	Average Annual Earnings	Typical Entry-Level Education & On-The-Job Training Required	Work Experience Required
Social and Human Service Assistants (21-1093)	4,847	689	14%	746	$12.94 to $31.04	$18.67	$42,800	High school diploma or equivalent & 1 month	None
Community Health Workers (21-1094)	448	68	15%	67	$16.14 to $38.25	$23.09	$52,600	High school diploma or equivalent & 1 month	None
Total	**5,295**	**758**	**14%**	**813**	**-**	**-**	**-**	**-**	**-**

Source: Emsi 2020.4

Addiction Studies
Alcohol and Controlled Substances (TOP: 2104.40)

June 2019

Prepared by the South Central Coast Center of Excellence for Labor Market Research

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Program Recommendation

This report was compiled by the South Central Coast[1] Center of Excellence to provide regional labor market data for the program recommendation – Addiction Studies. This report can help determine whether there is demand in the local labor market that is not being met by the supply from programs of study (CCC and non-CCC) that align with this occupation group.

Key Findings

- In the South Central Coast region, **the number of jobs related to Addiction Studies are expected to increase** over the next five years.
- All four associated occupations are anticipated to experience **a low risk of automation**.
- In 2017 there were 194 regional completions in programs related to the occupations identified as related to Addiction Studies and 817 openings, indicating an **undersupply** in this area.
- Typical entry-level education ranges from a **high school diploma or equivalent** for Social and Human Service Assistants & Community Health Workers to a **Bachelor's degree** for Substance Abuse and Behavioral Disorder Counselors & Community and Social Service Specialists, All Other.
- Completers of regional Alcohol and Controlled Substances programs (TOP 2104.40) from the 2015-2016 academic year had a **median annual wage** upon completion of $25,648.
- 48% of students are **earning a living**.
- 66% of students are **employed within a year** after completing a program.

[1] The South Central Coast Region consists of San Luis Obispo County, Santa Barbara County, Ventura County, and the following cities from North Los Angeles County: Canyon Country, Castaic, Lake Hughes, Lancaster, Littlerock, Llano, Newhall, Palmdale, Pearblossom, Santa Clarita, Stevenson Ranch, and Valencia.

Occupation Codes and Descriptions

Currently, there are four occupations in the standard occupational classification (SOC) system that were identified as relevant for this analysis. The occupation titles and descriptions, as well as reported job titles are included in Exhibit 1.

Exhibit 1 – Occupation, description, and sample job titles

SOC Code	Title	Description	Sample of Reported Job Titles
21-1011	Substance Abuse and Behavioral Disorder Counselors	Counsel and advise individuals with alcohol, tobacco, drug, or other problems, such as gambling and eating disorders. May counsel individuals, families, or groups or engage in prevention programs.	Addictions Counselor, Case Manager, Chemical Dependency Counselor (CD Counselor), Chemical Dependency Professional, Clinical Counselor, Correctional Substance Abuse Counselor, Counselor, Drug and Alcohol Treatment Specialist (DATS), Prevention Specialist, Substance Abuse Counselor (SA Counselor)
21-1093	Social and Human Service Assistants	Assist in providing client services in a wide variety of fields, such as psychology, rehabilitation, or social work, including support for families. May assist clients in identifying and obtaining available benefits and social and community services. May assist social workers with developing, organizing, and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or dependent care.	Advocate, Caseworker, Community Coordinator, Family Support Worker, Home based Assistant, Human Services Program Specialist, Mental Health Technician, Outreach Specialist, Social Services Assistant, Social Work Associate
21-1094	Community Health Workers	Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs.	Apprise Counselor, Assistant Director of Nutrition and Wellness Programs, Chief Program Officer, Community Health Outreach Worker, Community Health Program Coordinator, Community Health Program Representative (Community Health Program Rep), Community Health Promoter, Community Health Worker (CHW), Community Nutrition Educator, HIV CTS Specialist (Human Immunodeficiency Virus Counseling and Testing Services Specialist)
21-1099	Community and Social Service Specialists, All Other	All community and social service specialists not listed separately.	--

Source: O*NET Online

Current and Future Employment

In the South Central Coast region, the number of jobs related to Addiction Studies are expected to increase over the next five years. Exhibit 2 contains detailed employment projections data for these occupations.

Exhibit 2 – Five-year projections for Addiction Studies in the South Central Coast region

SOC	Occupation	2018 Jobs	2023 Jobs	2018-2023 Change	2018-2023 % Change
21-1018 (21-1011)	**Substance Abuse, Behavioral Disorder, and Mental Health Counselors (Substance Abuse and Behavioral Disorder Counselors)**	1,568	1,871	303	19%
21-1093	**Social and Human Service Assistants**	2,564	2,917	353	14%
21-1094	**Community Health Workers**	253	287	34	13%
21-1099	**Community and Social Service Specialists, All Other**	613	663	50	8%

Source: Economic Modeling Specialists International (EMSI)

Earnings

In the South Central Coast region, the average wage for the listed occupations is $20.38 per hour.

Exhibit 3 contains hourly wages and annual average earnings for this occupation. Entry-level hourly earnings are represented by the 25th percentile of wages, median hourly earnings are represented by the 50th percentile of wages, and experienced hourly earnings are represented by the 75th percentile of wages, demonstrating various levels of employment.

Exhibit 3 – Earnings for Addiction Studies in the South Central Coast region

SOC	Occupation	Entry-Level Hourly Earnings	Median Hourly Earnings	Experienced Hourly Earnings
21-1018 (21-1011)	**Substance Abuse, Behavioral Disorder, and Mental Health Counselors (Substance Abuse and Behavioral Disorder Counselors)**	$16.55	$19.66	$23.69
21-1093	**Social and Human Service Assistants**	$16.40	$20.27	$25.11
21-1094	**Community Health Workers**	$17.36	$21.25	$26.94
21-1099	**Community and Social Service Specialists, All Other**	$17.71	$22.90	$29.87

Source: Economic Modeling Specialists International (EMSI)

Employer Job Postings

In this research brief, real-time labor market information is used to provide a more nuanced view of the current job market, as it captures job advertisements for occupations relevant to the field of study. Employer job postings are consulted to understand who is employing controlled substance counselors, and what they are looking for in potential candidates. To identify job postings related to Addiction Studies, the following standard occupational classifications were used:

21-1011	Substance Abuse and Behavioral Disorder Counselors
21-1093	Social and Human Service Assistants
21-1094	Community Health Workers
21-1099	Community and Social Service Specialists, All Other

Top Occupations

In 2018, there were 125 employer postings for occupations related to Addiction Studies.

Exhibit 4 – Top occupations in job postings and risk of automation tables

SOC Code	Occupation	Job Postings, Full Year 2018
21-1093	Social and Human Service Assistants	68
21-1011	Substance Abuse and Behavior Disorder Counselors	31
21-1099	Community and Social Service Specialists, All Other	16
21-1094	Community Health Workers	10

Source: Labor Insight/Jobs (Burning Glass)

SOC Code	Occupation	Risk of Automation
21-1093	Social and Human Service Assistants	Low
21-1011	Substance Abuse and Behavior Disorder Counselors	Low
21-1099	Community and Social Service Specialists, All Other	Low
21-1094	Community Health Workers	Low

Source: Labor Insight/Jobs (Burning Glass)

Top Titles

The top job titles for employers posting ads for jobs related to Addiction Studies are listed in Exhibit 5. Junior Outreach Specialist is mentioned as the job title in 5% of all relevant job postings (6 postings).

Exhibit 5 –Job titles

Title	Job Postings, Full Year 2018
Junior Outreach Specialist	6
Senior Service Officer	5
Substance Abuse Counselor	5
Community Support Attendant	4
Coordinator	4
Outreach Specialist	4
Student Relations Technician	4

Source: Labor Insight/Jobs (Burning Glass)

Top Employers

Exhibit 6 lists the major employers hiring professionals in the Addiction Studies field. The top employer posting job ads was Mental Health America of Los Angeles. The top worksite cities in the region for these occupations were Ventura, Santa Clarita, Lancaster, Oxnard, and Santa Barbara.

Exhibit 6 – Top employers (n=116)

Employer	Job Postings, Full Year 2018
Mental Health America of Los Angeles	12
Lmt	4
Atria Senior Living	3
Bank of the West	3
Cencal Health	3

Source: Labor Insight/Jobs (Burning Glass)

Skills

Case Management is the most sought after skill for employers hiring for jobs related to Addiction Studies.

Exhibit 7 –Job skills (n=102)

Skills	Job Postings, Full Year 2018
Case Management	33
Mental Health	31
Treatment Planning	20
Cardiopulmonary Resuscitation (CPR)	19
Customer Service	16

Source: Labor Insight/Jobs (Burning Glass)

Industry Concentration

Exhibit 9 shows the industries where most working in the field of Addiction Studies are employed in the South Central Coast region. Note: 16% of records have been excluded because they do not include an industry. As a result, the chart below may not be representative of the full sample.

Exhibit 9 – Industries employing within the field of Addiction Studies, 2018

Industry	Occupation Group Jobs in Industry	% of Occupation Group in Industry
Health Care and Social Assistance	53	51%
Public Administration	15	14%
Educational Services	13	12%
Finance and Insurance	12	11%
Manufacturing	4	4%

Source: Labor Insight/Jobs (Burning Glass)

Education and Training

Exhibit 10 shows the typical entry-level education requirement for the occupations of interest, along with the typical on-the-job training needed to attain competency in the occupation.

Exhibit 10 – Education and training requirements

SOC	Occupation	Typical entry-level education	Typical on-the-job training
21-1011	Substance Abuse and Behavioral Disorder Counselors	Bachelor's Degree	None
21-1093	Social and Human Service Assistants	High school diploma or equivalent	Short-term on-the-job training
21-1094	Community Health Workers	High school diploma or equivalent	Short-term on-the-job training
21-1099	Community and Social Service Specialists, All Other	Bachelor's Degree	None

Source: Bureau of Labor Statistics Employment Projections (Educational Attainment)

Regional Completions and Openings

There were 194 regional completions (2017) and 817 regional openings (2017) in the South Central Coast region in programs related to the occupations identified as related to Addiction Studies.

Exhibit 11 – Completions and Openings

3 Regional Institutions had Related Programs (2017)	**194** Regional Completions (2017)	**817** Annual Openings (2017)

Source: Economic Modeling Specialists International (EMSI)

Related Programs

CIP Code	Program	Completions (2017)
51.1501	Substance Abuse/Addiction Counseling	140
44.0000	Human Services, General	54
19.0706	Child Development	0

Source: Economic Modeling Specialists International (EMSI)

Student Outcomes

The CTE LaunchBoard provides student outcome data on the effectiveness of CTE programs. The following student outcome information was collected from exiters of the Alcohol and Controlled Substances program (TOP Code: 2104.40) in the South Central Coast region for the 2015-16 academic year.

- The median annual wage for students after exiting is $25,648
- Starting salary in the region for Community Health Workers is $38,189
- 48% of students are earning a living wage
- 66% of students are employed within a year after completing a program
- Students who transfer and earn a bachelor's degree could pursue the following careers:
    - Community and Social Service Specialists, All Other

Source: CTE LaunchBoard

Sources

O*Net Online, Labor Insight/Jobs (Burning Glass), Economic Modeling Specialists International (EMSI), Bureau of Labor Statistics (BLS) Education Attainment, California Community Colleges Chancellor's Office Management Information Systems (MIS) Data Mart, CTE LaunchBoard

Notes

Data included in this analysis represent the labor market demand for relevant positions most closely related to Alcohol and Controlled Substances. Traditional labor market information was used to show current and projected employment based on data trends, as well as annual average awards granted by regional community colleges. Real-time labor market information captures job post advertisements for occupations relevant to the field of study and can signal demand and show what employers are looking for in potential employees, but is not a perfect measure of the quantity of open positions. All representations have been produced from primary research and/or secondary review of publicly and/or privately available data and/or research reports. The most recent data available at the time of the analysis was examined; however, data sets are updated regularly and may not be consistent with previous reports. Efforts have been made to qualify and validate the accuracy of the data and findings; however, neither the Centers of Excellence for Labor Market Research (COE), COE host district, nor California Community Colleges Chancellor's Office are responsible for the applications or decisions made by individuals and/or organizations based on this study or its recommendations.

APPENDIX 5

Description of the Affordable Care Act

RESPONSIBLE REFORM
FOR THE MIDDLE CLASS
DEMOCRATS.SENATE.GOV/REFORM

The Patient Protection and Affordable Care Act

Detailed Summary

The Patient Protection and Affordable Care Act will ensure that all Americans have access to quality, affordable health care and will create the transformation within the health care system necessary to contain costs. The Congressional Budget Office (CBO) has determined that the Patient Protection and Affordable Care Act is fully paid for, will provide coverage to more than 94% of Americans while staying under the $900 billion limit that President Obama established, bending the health care cost curve, and reducing the deficit over the next ten years and beyond.

The Patient Protection and Affordable Care Act contains nine titles, each addressing an essential component of reform:

- Quality, affordable health care for all Americans
- The role of public programs
- Improving the quality and efficiency of health care
- Prevention of chronic disease and improving public health
- Health care workforce
- Transparency and program integrity
- Improving access to innovative medical therapies
- Community living assistance services and supports
- Revenue provisions

Title I. Quality, Affordable Health Care for All Americans

The Patient Protection and Affordable Care Act will accomplish a fundamental transformation of health insurance in the United States through shared responsibility. Systemic insurance market reform will eliminate discriminatory practices such as pre-existing condition exclusions. Achieving these reforms without increasing health insurance premiums will mean that all Americans must be part of the system and must have coverage. Tax credits for individuals and families will ensure that insurance is affordable for everyone. These three elements are the essential links to achieve reform.

Immediate Improvements: Achieving health insurance reform will take some time to implement. In the immediate reforms will be implemented in 2010. The Patient Protection and Affordable Care Act will:

- Eliminate lifetime and unreasonable annual limits on benefits
- Prohibit rescissions of health insurance policies
- Provide assistance for those who are uninsured because of a pre-existing condition
- Require coverage of preventive services and immunizations
- Extend dependant coverage up to age 26
- Develop uniform coverage documents so consumers can make apples-to-apples comparisons when shopping for health insurance
- Cap insurance company non-medical, administrative expenditures

- Ensure consumers have access to an effective appeals process and provide consumer a place to turn for assistance navigating the appeals process and accessing their coverage
- Create a temporary re-insurance program to support coverage for early retirees
- Establish an internet portal to assist Americans in identifying coverage options
- Facilitate administrative simplification to lower health system costs

Health Insurance Market Reform: Beginning in 2014, more significant insurance reforms will be implemented. Across individual and small group health insurance markets in all states, new rules will end medical underwriting and pre-existing condition exclusions. Insurers will be prohibited from denying coverage or setting rates based on health status, medical condition, claims experience, genetic information, evidence of domestic violence, or other health-related factors. Premiums will vary only by family structure, geography, actuarial value, tobacco use, participation in a health promotion program, and age (by not more than three to one).

Available Coverage: A qualified health plan, to be offered through the new American Health Benefit Exchange, must provide essential health benefits which include cost sharing limits. No out-of-pocket requirements can exceed those in Health Savings Accounts, and deductibles in the small group market cannot exceed $2,000 for an individual and $4,000 for a family. Coverage will be offered at four levels with actuarial values defining how much the insurer pays: Platinum – 90 percent; Gold – 80 percent; Silver – 70 percent; and Bronze – 60 percent. A lower-benefit catastrophic plan will be offered to individuals under age 30 and to others who are exempt from the individual responsibility requirement.

American Health Benefit Exchanges: By 2014, each state will establish an Exchange to help individuals and small employers obtain coverage. Plans participating in the Exchanges will be accredited for quality, will present their benefit options in a standardized manner for easy comparison, and will use one, simple enrollment form. Individuals qualified to receive tax credits for Exchange coverage must be ineligible for affordable, employer-sponsored insurance any form of public insurance coverage. Undocumented immigrants are ineligible for premium tax credits. The Secretary of Health and Human Services (HHS) will establish a national public option – the Community Health Insurance Option – and permit states to opt-out. Federal support will also be available for new non-profit, member run insurance cooperatives. States will have flexibility to establish basic health plans for non-Medicaid, lower-income individuals; states may also seek waivers to explore other reform options; and states may form compacts with other states to permit cross-state sale of health insurance. No federal dollars may be used to pay for abortion services.

Making Coverage Affordable: New, refundable tax credits will be available for Americans with incomes between 100 and 400 percent of the federal poverty line (FPL) (about $88,000 for a family of four). The credit is calculated on a sliding scale beginning at two percent of income for those at 100 percent FPL and phasing out at 9.8 percent of income at 300-400 percent FPL. If an employer offer of coverage exceeds 9.8 percent of a worker's family income, or the employer pays less than 60 percent of the premium, the worker may enroll in the Exchange and receive credits. Out of pocket maximums ($5,950 for individuals and $11,900 for families) are reduced to one third for those with income between 100-200 percent FPL, one half for those with incomes between 200-300 percent FPL, and two thirds for those with income between 300-400 percent FPL. Credits are available for eligible citizens

and legally-residing aliens. A new credit will assist small businesses with fewer than 25 workers for up to 50 percent of the total premium cost.

Shared Responsibility: Beginning in 2014, most individuals will be required to maintain minimum essential coverage or pay a penalty of $95 in 2014, $350 in 2015, $750 in 2016 and indexed thereafter; for those under 18, the penalty will be one-half the amount for adults. Exceptions to this requirement are made for religious objectors, those who cannot afford coverage, taxpayers with incomes less than 100 percent FPL, Indian tribe members, those who receive a hardship waiver, individuals not lawfully present, incarcerated individuals, and those not covered for less than three months.

Any individual or family who currently has coverage and would like to retain that coverage can do so under a 'grandfather' provision. This coverage is deemed to meet the requirement to have health coverage. Similarly, employers that currently offer coverage are permitted to continue offering such coverage under the 'grandfather' policy.

Employers with more than 200 employees must automatically enroll new full-time employees in coverage. Any employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit will make a payment of $750 per full-time employee. An employer with more than 50 employees that offers coverage that is deemed unaffordable or does not meet the standard for minimum essential coverage and but has at least one full-time employee receiving the premium assistance tax credit because the coverage is either unaffordable or does not cover 60 percent of total costs, will pay the lesser of $3,000 for each of those employees receiving a credit or $750 for each of their full-time employees total.

Title II. The Role of Public Programs

The Patient Protection and Affordable Care Act expands eligibility for Medicaid to lower income persons and assumes federal responsibility for much of the cost of this expansion. It provides enhanced federal support for the Children's Health Insurance Program, simplifies Medicaid and CHIP enrollment, improves Medicaid services, provides new options for long-term services and supports, improves coordination for dual-eligibles, and improves Medicaid quality for patients and providers.

Medicaid Expansion: States may expand Medicaid eligibility as early as January 1, 2011. Beginning on January 1, 2014, all children, parents and childless adults who are not entitled to Medicare and who have family incomes up to 133 percent FPL will become eligible for Medicaid. Between 2014 and 2016, the federal government will pay 100 percent of the cost of covering newly-eligible individuals. In 2017 and 2018, states that initially covered less of the newly-eligible population ("Other States") will receive more assistance than states that covered at least some non-elderly, non-pregnant adults ("Expansion States"). States will be required to maintain the same income eligibility levels through December 31, 2013 for all adults, and this requirement would be extended through September 30, 2019 for children currently in Medicaid.

Children's Health Insurance Program: States will be required to maintain income eligibility levels for CHIP through September 30, 2019. Between fiscal years 2014 and 2019, states would receive a 23 percentage point increase in the CHIP federal match rate, subject to a 100 percent cap.

Simplifying Enrollment: Individuals will be able to apply for and enroll in Medicaid, CHIP and the Exchange through state-run websites. Medicaid and CHIP programs and the Exchange will coordinate enrollment procedures to provide seamless enrollment for all programs. Hospitals will be permitted to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

Community First Choice Option: A new optional Medicaid benefit is created through which states may offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require care in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

Disproportionate Share Hospital Allotments: States' disproportionate share hospital (DSH) allotments are reduced by 50 percent once a state's uninsurance rate decreases by 45 percent (low DSH states would receive a 25 percent reduction). As the rate continues to decline, states' DSH allotments would be reduced by a corresponding amount. At no time could a state's allotment be reduced by more than 65 percent compared to its FY2012 allotment.

Dual Eligible Coverage and Payment Coordination: The Secretary of Health and Human Services (HHS) will establish a Federal Coordinated Health Care Office by March 1, 2010 to integrate care under Medicare and Medicaid, and improve coordination among the federal and state governments for individuals enrolled in both programs (dual eligibles).

Title III. Improving the Quality and Efficiency of Health Care

The Patient Protection and Affordable Care Act will improve the quality and efficiency of U.S. medical care services for everyone, and especially for those enrolled in Medicare and Medicaid. Payment for services will be linked to better quality outcomes. The Patient Protection and Affordable Care Act will make substantial investments to improve the quality and delivery of care and support research to inform consumers about patient outcomes resulting from different approaches to treatment and care delivery. New patient care models will be created and disseminated. Rural patients and providers will see meaningful improvements. Payment accuracy will improve. The Medicare Part D prescription drug benefit will be enhanced and the coverage gap, or donut hole, will be reduced. An Independent Medicare Advisory Board will develop recommendations to ensure long-term fiscal stability.

Linking Payment to Quality Outcomes in Medicare: A value-based purchasing program for hospitals will launch in FY2013 will link Medicare payments to quality performance on common, high-cost conditions such as cardiac, surgical and pneumonia care. The Physician Quality Reporting Initiative (PQRI) is extended through 2014, with incentives for physicians to report Medicare quality data – physicians will receive feedback reports beginning in 2012. Long-term care hospitals, inpatient rehabilitation facilities and hospice providers will participate in value-based purchasing with quality measure reporting starting in FY2014, with penalties for non-participating providers.

Strengthening the Quality Infrastructure: The HHS Secretary will establish a national strategy to improve health care service delivery, patient outcomes, and population health. The President will

convene an Interagency Working Group on Health Care Quality to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.

Encouraging Development of New Patient Care Models: A new Center for Medicare & Medicaid Innovation will be established within the Centers for Medicare and Medicaid Services to research, develop, test, and expand innovative payment and delivery arrangements. Accountable Care Organizations (ACOs) that take responsibility for cost and quality received by patients will receive a share of savings they achieve for Medicare. The HHS Secretary will develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute providers to improve patient care and achieve savings through bundled payments. A new demonstration program for chronically ill Medicare beneficiaries will test payment incentives and service delivery using physician and nurse practitioner-directed home-based primary care teams. Beginning in 2012, hospital payments will be adjusted based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions.

Ensuring Beneficiary Access to Physician Care and Other Services: The Act extends a floor on geographic adjustments to the Medicare fee schedule to increase provider fees in rural areas and gives immediate relief to areas harmed by geographic adjustment for practice expenses. The Act extends bonus payments by Medicare for ground and air ambulance services in rural and other areas. The Act creates a 12 month enrollment period for military retirees, spouses (and widows/widowers) and dependent children, who are eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, who have declined Part B.

Rural Protections: The Act extends the outpatient hold harmless provision, allowing small rural hospitals and Sole Community Hospitals to receive this adjustment through FY2010 and reinstates cost reimbursement for lab services provided by small rural hospitals from July 1, 2010 to July 1, 2011. The Patient Protection and Affordable Care Act extends the Rural Community Hospital Demonstration Program for two years and expands eligible sites to additional states and hospitals.

Improving Payment Accuracy: The HHS Secretary will rebase home health payments starting in 2013 based on the current mix of services and intensity of care provided to patients. The Secretary will update Medicare hospice claims forms and cost reports to improve payment accuracy. The Secretary will update Disproportionate Share (DSH) payments to better account for hospital uncompensated care costs; Medicare DSH payments will reflect lower uncompensated care costs tied to decreases in the number of uninsured. The bill also makes changes to improve payment accuracy for imaging services and power-driven wheelchairs. The Secretary will study and report to Congress on reforming the Medicare hospital wage index system and will establish a demonstration program to allow hospice eligible patients to receive all other Medicare covered services during the same period.

Medicare Advantage (Part C): Medicare Advantage payments will be based on the average of the bids submitted by insurance plans in each market. Bonus payments will be available to improve the quality of care and will be based on an insurer's level of care coordination and care management, as well as achievement on quality rankings. New payments will be implemented over a four-year transition period. MA plans will be prohibited from charging beneficiaries cost sharing for covered services greater than what is charged under fee-for-service. Plans providing extra benefits must give

priority to cost sharing reductions, wellness and preventive care prior to covering benefits not currently covered by Medicare.

Medicare Prescription Drug Plan Improvements (Part D): In order to have their drugs covered under the Medicare Part D program, drug manufacturers will provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. The initial coverage limit in the standard Part D benefit will be expanded by $500 for 2010.

Ensuring Medicare Sustainability: A productivity adjustment will be added to the market basket update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities. The Act creates an independent, 15-member Medicare Advisory Board to present Congress with proposals to reduce costs and improve quality for beneficiaries. When Medicare costs are projected to exceed certain targets, the Board's proposals will take effect unless Congress passes an alternative measure to achieve the same level of savings. The Board will not make proposals that ration care, raise taxes or beneficiary premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

Health Care Quality Improvements: The Patient Protection and Affordable Care Act will create a new program to develop community health teams supporting medical homes to increase access to community-based, coordinated care. It supports a health delivery system research center to conduct research on health delivery system improvement and best practices that improve the quality, safety, and efficiency of health care delivery. And, it support medication management services by local health providers to help patients better manage chronic disease.

Title IV: Prevention of Chronic Disease and Improving Public Health

To better orient the nation's health care system toward health promotion and disease prevention, a set of initiatives will provide the impetus and the infrastructure. A new interagency prevention council will be supported by a new Prevention and Public Health Investment Fund. Barriers to accessing clinical preventive services will be removed. Developing healthy communities will be a priority, and a 21st century public health infrastructure will support this goal.

Modernizing Disease Prevention and Public Health Systems: A new interagency council is created to promote healthy policies and to establish a national prevention and health promotion strategy. A Prevention and Public Health Investment Fund is established to provide an expanded and sustained national investment in prevention and public health. The HHS Secretary will convene a national public/private partnership to conduct a national prevention and health promotion outreach and education campaign to raise awareness of activities to promote health and prevent disease across the lifespan.

Increasing Access to Clinical Preventive Services: The Act authorizes important new programs and benefits related to preventive care and services:

- For the operation and development of School-Based Health Clinics.
- For an oral healthcare prevention education campaign.
- To provide Medicare coverage – with no co-payments or deductibles – for an annual wellness visit and development of a personalized prevention plan.

- To waive coinsurance requirements and deductibles for most preventive services, so that Medicare will cover 100 percent of the costs.
- To authorize the HHS Secretary to modify coverage of any Medicare-covered preventive service to be consistent with U.S. Preventive Services Task Force recommendations.
- To provide States with an enhanced match if the State Medicaid program covers: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) adult immunizations recommended by the Advisory Committee on Immunization Practices without cost sharing.
- To require Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use.
- To award grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles.

Creating Healthier Communities: The Secretary will award grants to eligible entities to promote individual and community health and to prevent chronic disease. The CDC will provide grants to states and large local health departments to conduct pilot programs in the 55-to-64 year old population to evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk. The Act authorizes all states to purchase adult vaccines under CDC contracts. Restaurants which are part of a chain with 20 or more locations doing business under the same name must disclose calories on the menu board and in written form.

Support for Prevention and Public Health Innovation: The HHS Secretary will provide funding for research in public health services and systems to examine best prevention practices. Federal health programs will collect and report data by race, ethnicity, primary language and any other indicator of disparity. The CDC will evaluate best employer wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion. A new CDC program will help state, local, and tribal public health agencies to improve surveillance for and responses to infectious diseases and other important conditions. An Institute of Medicine Conference on Pain Care will evaluate the adequacy of pain assessment, treatment, and management; identify and address barriers to appropriate pain care; increase awareness; and report to Congress on findings and recommendations.

Title V — Health Care Workforce

To ensure a vibrant, diverse and competent workforce, the Patient Protection and Affordable Care Act will encourage innovations in health workforce training, recruitment, and retention, and will establish a new workforce commission. Provisions will help to increase the supply of health care workers. These workers will be supported by a new workforce training and education infrastructure.

Innovations in the Health Care Workforce: The Patient Protection and Affordable Care Act establishes a national commission to review health care workforce and projected workforce needs and to provide comprehensive information to Congress and the Administration to align workforce resources with national needs. It will also establish competitive grants to enable state partnerships to complete comprehensive workforce planning and to create health care workforce development strategies.

Increasing the Supply of the Health Care Workers: The federal student loan program will be modified to ease criteria for schools and students, shorten payback periods, and to make the primary care student loan program more attractive. The Nursing Student Loan Program will be increased and the years for nursing schools to establish and maintain student loan funds are updated. A loan repayment program is established for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents who work in a Health Professional Shortage Area, a Medically Underserved Area, or with a Medically Underserved Population. Loan repayment will be offered to public health students and workers in exchange for working at least three years at a federal, state, local, or tribal public health agency. Loan repayment will be offered to allied health professionals employed at public health agencies or in settings providing health care to patients, including acute care facilities, ambulatory care facilities, residences, and other settings located in Health Professional Shortage Areas, Medically Underserved Areas, or with Medically Underserved Populations. Authorization of appropriations for the National Health Service Corps scholarship and loan repayment program will be extended 2010-2015. A $50 million grant program will support nurse-managed health clinics. A Ready Reserve Corps within the Commissioned Corps is established for service in times of national emergency. Ready Reserve Corps members may be called to active duty to respond to national emergencies and public health crises and to fill critical public health positions left vacant by members of the Regular Corps who have been called to duty elsewhere.

Enhancing Health Care Workforce Education and Training: New support for workforce training programs is established in these areas:

- Family medicine, general internal medicine, general pediatrics, and physician assistantship.
- Direct care workers providing long-term care services and supports.
- General, pediatric, and public health dentistry.
- Alternative dental health care provider.
- Geriatric education and training for faculty in health professions schools and family caregivers.
- Mental and behavioral health education and training grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health.
- Cultural competency, prevention and public health and individuals with disabilities training.
- Advanced nursing education grants for accredited Nurse Midwifery programs.
- Nurse education, practice, and retention grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention.
- Nurse faculty loan program for nurses who pursue careers in nurse education.
- Grants to promote the community health workforce to promote positive health behaviors and outcomes in medically underserved areas through use of community health workers.
- Fellowship training in public health to address workforce shortages in state and local health departments in applied public health epidemiology and public health laboratory science and informatics.
- A U.S. Public Health Sciences Track to train physicians, dentists, nurses, physician assistants, mental and behavior health specialists, and public health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response in affiliated institutions.

Supporting the Existing Health Care Workforce: The Patient Protection and Affordable Care Act reauthorizes the Centers of Excellence program for minority applicants for health professions, expands scholarships for disadvantaged students who commit to work in medically underserved areas, and authorizes funding for Area Health Education Centers (AHECs) and Programs. A Primary Care Extension Program is established to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health.

Strengthening Primary Care and Other Workforce Improvements: Beginning in 2011, the HHS Secretary may redistribute unfilled residency positions, redirecting those slots for training of primary care physicians. A demonstration grant program is established to serve low-income persons including recipients of assistance under Temporary Assistance for Needy Families (TANF) programs to develop core training competencies and certification programs for personal and home care aides.

Improving Access to Health Care Services: The Patient Protection and Affordable Care Act authorizes new and expanded funding for federally qualified health centers and reauthorizes a program to award grants to states and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment. Also supported are grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings. A Commission on Key National Indicators is established.

Title VI—Transparency and Program Integrity

To ensure the integrity of federally financed and sponsored health programs, this Title creates new requirements to provide information to the public on the health system and promotes a newly invigorated set of requirements to combat fraud and abuse in public and private programs.

Physician Ownership and Other Transparency: Physician-owned hospitals that do not have a provider agreement prior to February 2010 will not be able to participate in Medicare. Drug, device, biological and medical supply manufacturers must report gifts and other transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital. Referring physicians for imaging services must inform patients in writing that the individual may obtain such service from a person other than the referring physician, a physician who is a member of the same group practice, or an individual who is supervised by the physician or by another physician in the group. Prescription drug makers and distributors must report to the HHS Secretary information pertaining to drug samples currently being collected internally. Pharmacy benefit managers (PBM) or health benefits plans that provide pharmacy benefit management services that contract with health plans under Medicare or the Exchange must report information regarding the generic dispensing rate; rebates, discounts, or price concessions negotiated by the PBM.

Nursing Home Transparency and Improvement: The Act requires that skilled nursing facilities (SNFs) under Medicare and nursing facilities (NFs) under Medicaid make available information on ownership. SNFs and NFs will be required to implement a compliance and ethics program. The Secretary of Health and Human Services will publish new information on the Nursing Home Compare

Medicare website: standardized staffing data, links to state internet websites regarding state survey and certification programs, a model standardized complaint form, a summary of complaints, and the number of instances of criminal violations by a facility or its employee. The Secretary also will develop a standardized complaint form for use by residents in filing complaints with a state survey and certification agency or a state long-term care ombudsman.

Targeting Enforcement: The Secretary may reduce civil monetary penalties for facilities that self-report and correct deficiencies. The Secretary will establish a demonstration project to test and implement a national independent monitoring program to oversee interstate and large intrastate chains. The administrator of a facility preparing to close must provide written notice to residents, legal representatives of residents, the state, the Secretary and the long-term care ombudsman program in advance of the closure.

Improving Staff Training: Facilities must include dementia management and abuse prevention training as part of pre-employment training for staff.

Nationwide Program for Background Checks on Direct Patient Access Employees of Long Term Care Facilities and Providers: The Secretary will establish a nationwide program for national and state background checks of direct patient access employees of certain long-term supports and services facilities or providers.

Patient-Centered Outcomes Research: The Patient Protection and Affordable Care Act establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private board appointed by the Comptroller General to provide for the conduct of comparative clinical outcomes research. No findings may be construed as mandates on practice guidelines or coverage decisions and important patient safeguards will protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference.

Medicare, Medicaid, and CHIP Program Integrity Provisions: The Secretary will establish procedures to screen providers and suppliers participating in Medicare, Medicaid, and CHIP. Providers and suppliers enrolling or re-enrolling will be subject to new requirements including a fee, disclosure of current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked. The Secretary is authorized to deny enrollment in these programs if these affiliations pose an undue risk.

Enhanced Medicare and Medicaid Program Integrity Provisions: CMS will include in the integrated data repository (IDR) claims and payment data from Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS). New penalties will exclude individuals who order or prescribe an item or service, make false statements on applications or contracts to participate in a Federal health care program, or who know of an overpayment and do not return the overpayment. Each violation would be subject to a fine of up to $50,000. The Secretary will take into account the volume of billing for a DME supplier or home health agency when determining the size of a surety bond. The Secretary may suspend payments to a

provider or supplier pending a fraud investigation. Health Care Fraud and Abuse Control (HCFAC) funding will be increased by $10 million each year for fiscal years 2011 through 2020. The Secretary will establish a national health care fraud and abuse data collection program for reporting adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB). The Secretary will have the authority to disenroll a Medicare enrolled physician or supplier who fails to maintain and provide access to written orders or requests for payment for durable medical equipment (DME), certification for home health services, or referrals for other items and services. The HHS Secretary will expand the number of areas to be included in round two of the DME competitive bidding program from 79 of the largest metropolitan statistical areas (MSAs) to 100 of the largest MSAs, and to use competitively bid prices in all areas by 2016.

Additional Medicaid Program Integrity Provisions: States must terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program. Medicaid agencies must exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation. Agents, clearinghouses, or other payees that submit claims on behalf of health care providers must register with the state and the Secretary. States and Medicaid managed care entities must submit data elements for program integrity, oversight, and administration. States must not make any payments for items or services to any financial institution or entity located outside of the United States.

Additional Program Integrity Provisions: Employees and agents of multiple employer welfare arrangements (MEWAs) will be subject to criminal penalties if they provide false statements in marketing materials regarding a plan's financial solvency, benefits, or regulatory status. A model uniform reporting form will be developed by the National Association of Insurance Commissioners, under the direction of the HHS Secretary. The Department of Labor will adopt regulatory standards and/or issue orders to prevent fraudulent MEWAs from escaping liability for their actions under state law by claiming that state law enforcement is preempted by federal law. The Department of Labor is authorized to issue "cease and desist" orders to temporarily shut down operations of plans conducting fraudulent activities or posing a serious threat to the public, until hearings can be completed. MEWAs will be required to file their federal registration forms, and thereby be subject to government verification of their legitimacy, before enrolling anyone.

Elder Justice Act: The Elder Justice Act will help prevent and eliminate elder abuse, neglect, and exploitation. The HHS Secretary will award grants and carry out activities to protect individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. Owners, operators, and employees would be required to report suspected crimes committed at a facility. Owners or operators of such facilities would be required to submit to the Secretary and to the state written notification of an impending closure of a facility within 60 days prior to the closure.

Sense of the Senate Regarding Medical Malpractice: The Act expresses the sense of the Senate that health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, states should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives.

Title VII – Improving Access to Innovative Medical Therapies

Biologics Price Competition and Innovation: The Patient Protection and Affordable Care Act establishes a process under which FDA will license a biological product that is shown to be biosimilar or interchangeable with a licensed biological product, commonly referred to as a reference product. No approval of an application as either biosimilar or interchangeable is allowed until 12 years from the date on which the reference product is first approved. If FDA approves a biological product on the grounds that it is interchangeable to a reference product, HHS cannot make a determination that a second or subsequent biological product is interchangeable to that same reference product until one year after the first commercial marketing of the first interchangeable product.

More Affordable Medicines for Children and Underserved Communities: Drug discounts through the 340B program are extended to inpatient drugs and also to certain children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers.

Title VIII – Community Living Assistance Services and Supports

Establishment of national voluntary insurance program for purchasing community living assistance services and support (CLASS program). The Patient Protection and Affordable Care Act establishes a new, voluntary, self-funded long-term care insurance program, the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. The HHS Secretary will develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides a cash benefit that is not less than an average of $50 per day. No taxpayer funds will be used to pay benefits under this provision.

TITLE IX – REVENUE PROVISIONS

Excise Tax on High Cost Employer-Sponsored Health Coverage: The Patient Protection and Affordable Care Act levies a new excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan with an annual premium that is above the threshold of $8,500 for single coverage and $23,000 for family coverage. The tax applies to self-insured plans and plans sold in the group market, and not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The tax applies to the amount of the premium in excess of the threshold. A transition rule increases the threshold for the 17 highest cost states for the first three years. An additional threshold amount of $1,350 for singles and $3,000 for families is available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.

Increasing Transparency in Employer W-2 Reporting of Value of Health Benefits: This provision requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.

Distributions for Medicine Qualified Only if for Prescribed Drug or Insulin: Conforms the definition of qualified medical expenses for HSAs, FSAs, and HRAs to the definition used for the medical expense itemized deduction. Over-the-counter medicine obtained with a prescription continues to qualify as qualified medical expenses.

Increase in Additional Tax on Distributions from HSAs and Archer MSAs Not Used for Qualified Medical Expenses: Increases the additional tax for HSA withdrawals prior to age 65 that are used for purposes other than qualified medical expenses from 10 percent to 20 percent and increases the additional tax for Archer MSA withdrawals from 15 percent to 20 percent.

Limiting Health FSA Contributions: This provision limits the amount of contributions to health FSAs to $2,500 per year.

Corporate Information Reporting: This provision requires businesses that pay any amount greater than $600 during the year to corporate providers of property and services to file an information report with each provider and with the IRS.

Pharmaceutical Manufacturers Fee: This provision imposes an annual flat fee of $2.3 billion on the pharmaceutical manufacturing sector beginning in 2010 allocated across the industry according to market share. The fee does not apply to companies with sales of branded pharmaceuticals of $5 million or less.

Medical Device Manufacturers Fee: This provision imposes an annual flat fee of $2 billion on the medical device manufacturing sector beginning in 2010 allocated across the industry according to market share. The fee does not apply to companies with sales of medical devices in the U.S. of $5 million or less. The fee also does not apply to any sale of a Class I product or any sale of a Class II product that is primarily sold to consumers at retail for not more than $100 per unit (under the FDA product classification system).

Health Insurance Provider Fee: This provision imposes an annual flat fee of $6.7 billion on the health insurance sector beginning in 2010 allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less and whose fees from administration of employer self-insured plans are $5 million or less.

Eliminating the Deduction for Employer Part D Subsidy: This provision eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

Modification of the Threshold for Claiming the Itemized Deduction for Medical Expenses: This provision increases the adjusted gross income threshold for claiming the itemized deduction for

medical expenses from 7.5 percent to 10 percent. Individuals age 65 and older would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

Tax on Elective Cosmetic Surgery. This provision imposes a five percent excise tax on voluntary cosmetic surgical and medical procedures performed by a licensed medical professional. The tax would be collected by the medical professional at the point of service. The definition of voluntary cosmetic procedures generally would be the same as the definition of cosmetic surgery or similar procedures that are not treated as included in medical care under the current Section 213(d)(9) definition. The excise tax would be effective for procedures performed on or after January 1, 2010.

Executive Compensation Limitations. This provision limits the deductibility of executive compensation for insurance providers if at least 25 percent of the insurance provider's gross premium income is derived from health insurance plans that meet the minimum essential coverage requirements in the bill ("covered health insurance provider"). The deduction is limited to $500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider.

Additional Hospital Insurance Tax for High Wage Workers. The provision increases the hospital insurance tax rate by 0.5 percentage points on an individual taxpayer earning over $200,000 ($250,000 for married couples filing jointly).

Special Deduction for Blue Cross Blue Shield (BCBS): Requires that non-profit BCBS organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the special tax benefits provided to them, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for unearned premium reserves.

Simple Cafeteria Plans for Small Businesses. This provision would establish a new employee benefit cafeteria plan to be known as a Simple Cafeteria Plan. This eases the participation restrictions so that small businesses can provide tax-free benefits to their employees and it includes self-employed individuals as qualified employees.

APPENDIX 6

Description of the Mental Health Parity And Addiction Equity Act

Overview
The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted to ensure "parity" or fairness between mental health and/or substance use disorder (MH/SUD) benefits and medical/surgical benefits covered by a health plan. Enacted in 2008, MHPAEA does not require a plan to offer MH/SUD benefits, but if the plan does so, it must offer the benefits on par with the other medical/surgical benefits it covers. In 2010, The Departments of Treasury, Labor and Health and Human Services issued Interim Final Regulations (IFR) implementing the law. On Friday November 8, 2013, the Departments issued a Final Rule (FR) implementing the law.

A simple example of a parity requirement would be the frequency of office visits. Under MHPAEA, a plan may not allow a patient to have an unlimited number of medically necessary appointments with a dermatologist, but limit patients to only 5 appointments with a psychiatrist.

However, while the premise of the law seems simple, the regulations related to the law are quite complicated, and therefore, implementation of the law has been complicated. This brief summary of the law is intended to help consumers and family members, providers and other stakeholders understand the law and the rights it affords them.

Links to key materials:

- Final regulation, available at www.dol.gov/ebsa/pdf/mhpaeafinalrule.pdf
- Interim Final Regulation, available at http://www.dol.gov/ebsa/mentalhealthparity/
- FAQs about ACA Implementation Part XVII and Mental Health Parity Implementation, available at http://www.dol.gov/ebsa/faqs/faq-aca17.html
- U.S. Department of Health and Human Services' Study: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, available at www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf
- News release, available at http://www.dol.gov/ebsa/newsroom/2013/13-2158-NAT.html
- CMS January 16, 2013 letter to State Health Officials and Medicaid Directors, available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

Effective Date
In general, the Final Rule is effective for plan years beginning on or after July 1, 2014. In practice, most plan years begin on January 1, so the effective date for a majority of plans covered by MHPAEA will be January 1, 2015. With respect to new guidance in the Final Rule, plans and issuers must continue to comply with the February 2010 IFR.

Key Definitions – Both the IFR and the Final Rule provide:

- "Mental health benefits" and "substance use disorder benefits" are defined as benefits for items and services as defined "under the terms of the plan" and in accordance with applicable Federal and State law.

- Non-Quantitative Treatment Limitations (NQTLs) are defined as treatment limits "which otherwise limit the scope or duration of benefits for treatment" and are not expressed numerically. An example of NQTLs include medical management techniques like prior authorization.

- "Scope of service" is referred to as "the types of treatment and treatment settings that are covered by a group health plan or health insurance coverage."

Covered Plans (ACA Extends Parity Coverage Beyond the MHPAEA Final Rule)

The provisions in the Final Rule apply to:

- Grandfathered and non-grandfathered large employer plans[1]
- Grandfathered and non-grandfathered individual plans
- Non-grandfathered small group plans
- Plans offered through the health insurance marketplace

The Affordable Care Act (ACA) extended MHPAEA to the individual market and qualified health plans. Additionally, the final regulations implementing the ACA's essential health benefits (EHB) requirement mandates issuers offering non-grandfathered small group and individual plans in and outside of the health insurance marketplace to comply with MHPAEA.

The Final Rule confirms that self-funded, non-federal state and local government plans may continue to opt out of compliance with MHPAEA. A list of plans that have applied for an opt-out is available here.

Financial Requirements/Quantitative Treatment Limitations

The Final Rule reiterates the standard in the IFR, which prohibits plans and issuers from imposing a financial requirement or quantitative treatment limitation on MH/SUD benefits that is more restrictive than the "predominant" financial requirement or quantitative treatment limit that applies to "substantially all" medical/surgical benefits in the same classification.

Under the IFR, "substantially all" is defined as meaning two-thirds and "predominant" is defined as meaning more than one-half of medical/surgical benefits in the same classification.

The IFR also prohibited plans and issuers from having cumulative requirements (such as deductibles or out-of-pocket maximums) or cumulative quantitative treatment limits (such as annual or lifetime day or

[1] "Grandfathered plans" are plans that were established before March 23, 2010 and have not been significantly changed since that date

visit limits) on MH/SUD that accumulate separately from the cumulative financial or quantitative treatment limits for medical/surgical in the same classification.

For example, a plan may not have a $500 deductible for medical/surgical services and a separate $500 deductible for MH/SUD services, which could result in an enrollee paying a $1,000 deductible. Rather, the deductible must be combined so the enrollee would only have to pay one $500 deductible.

Scope of Service

The IFR requested comments on the scope of services (also called a "continuum of care") that a plan must offer. The Final Rule clarified the scope of service issue by stating:

1. The 6 classifications of benefits scheme outlined in the IFR (inpatient in and out-of-network, outpatient in and out-of-network, emergency care, and prescription drugs) was never intended to exclude intermediate levels of care (intensive outpatient, partial hospitalization, residential).
2. The language in the Final Rule on scope clarifies that the Departments had intended that each classification and sub-classification must meet all parity tests within each classification. The Final Rule states that "the classifications and sub-classifications are intended to be comprehensive and cover the complete range of medical/surgical benefits and mental health or substance use disorder benefits offered by health plans and issuers."
3. The Final Rule clarifies, consistent with the IFR, that any restrictions or criteria that limit the "scope or duration of benefits" constitute an NQTL.
4. In the preamble of the Final Rule, the regulators clarified that a scope of services was expressed in the IFR by virtue of the 6 classifications of benefits: "The IFR established six broad classifications that in part define the scope of services under MHPAEA."
5. Although neither the IFR nor Final Rule mandates specific services required to be offered by plans under the 6 classification scheme, the Final Rule clarifies that plans must assign intermediate services in the behavioral health area to the same classification as plans or issuers assign intermediate levels of services for medical/surgical conditions. The Final Rule provides an example on page 68247:

   > *For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance user disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.*

   This language, coupled with the new specific examples around intermediate levels of care, makes it clear that MH/SUD services have to be comparable to the range and types of treatments for medical/surgical within each class.

   The net effect of this provision is that parity requirements (as clarified by the FAQs issued by the Department of Labor with the rule) extend to intermediate levels of MH/SUD care and that such services must be treated comparably under the plan.

> The Final Rule further provides examples of application of the NQTL rule to exclusions that affect the scope of services provided under the plan. Thus, a plan that automatically excludes certain types of treatments/ treatment settings while not automatically excluding similar types of treatments/treatment settings for medical/surgical conditions would be non-compliant with MHPAEA. Examples 9 & 10 on page 68273 in the Final Rule provide additional detail on how this rule impacts residential SUD facilities. In Example 9, a plan would violate the Final Rule if it automatically excludes coverage for inpatient substance use disorder treatment outside of a hospital but allows conditional coverage (i.e. medically necessary) for inpatient treatment outside of a hospital for other medical conditions. In Example 10, a plan would violate the Final Rule if it excludes coverage for inpatient addiction treatment in a different state but does not have a similar exclusion on the medical/surgical benefit covered by the plan.

The Final Rule defers to States to define the package of insurance benefits that must be provided in a State through the EHB package required under the ACA. In so doing, States and plans must comply with the parity requirements of MHPAEA and the Final Rule with respect to the mental health and substance use disorder EHB category of benefits.

Non-Quantitative Treatment Limitations

The IFR established that plans may not apply "non-quantitative treatment limits" (NQTLs) on MH/SUD benefits more stringently than on medical/surgical benefits. The rules define NQTLs as "limits on the scope or duration of treatment that are not expressed numerically (such as medical management techniques like prior authorization)."

Neither the IFR nor the Final Rule set a quantitative floor or formula for NQTLs like the two thirds rule for quantitative treatment limits. However the FR, consistent with the IFR, uses multiple examples that illustrate that quantity and magnitude are elements in assessing whether or not an NQTL is comparable and no more restrictive. See Example 1 in the Final Rule:

> *Facts:* "A plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given only for one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan."
>
> *Conclusion:* "In this Example 1, the plan violates the [NQTL] rules…because it is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits."

The Final Rule restates what was in the IFR that plans need to disclose the "processes, strategies, evidentiary standards and other factors used by the plan or issuer to determine whether and to what extent a benefit it subject to an NQTL be comparable and applied no more stringently for MH/SUD than for medical/surgical."

The Final Rule made several changes or clarifications to the rules around NQTLs:

- **Deleted the Recognized Clinically Appropriate Standard of Care Exemption**. The Final Rule struck the exception included in the IFR that permitted plans to apply more stringent limits on MH/SUD treatment to the extent that a "recognized clinically appropriate standard of care that permitted a difference."
- **Geographic and Facility Type Restrictions are NQTLs**. As referenced above, the Final Rule clarifies that NQTLs include restrictions on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services (including access to intermediate levels of care). This makes it clear that plans cannot require a patient to go to an MH/SUD facility in their own state, if the plan allows plan members to go out of state for other medical services.
- **Provider Reimbursement Rates are a Form of NQTL**. The Preamble Final Rule reconfirms that provider reimbursement rates are a form of NQTL. The Preamble states that plans and issuers can look at an array of factors in determining provider payment rates such as service type, geographic market, demand for services, supply of providers, provider practice size, Medicare rates, training, experience and licensure of providers. These factors must be applied comparably and no more stringently with respect to MH/SUD providers. Additional comments will be solicited, if questions persist with respect to provider reimbursement rates.
- **Plans can Use Tiered Networks.** The Final Rule allows plans and issuers to use multiple provider network tiers, but only if they are not imposing these tiered networks more stringently on MH/SUD, subject to the general test provided for NQTLs.
- **Plans can Have Multi-Tiered Prescription Drugs**. A plan may have multi-tiered prescription drug programs (i.e., a program that applies different levels of financial requirements to different tiers to prescription drugs in accordance with the NQTL rules). A plan may not apply these tiered prescription drug programs more stringently on MH/SUD prescription drugs.

Plan Documents and Disclosure

The Final Rule does not express any new disclosure requirements that were not present in the IFR and or the statute but does provide additional details and examples regarding the disclosure requirements for both MHPAEA and ERISA. MHPAEA requires that the criteria for medical necessity determinations be made available to any current or potential enrollee or contracting provider upon request. MHPAEA also requires that the reason for the denial of coverage or reimbursement must be made available upon request. With respect to employer health plans, the Final Rule incorporates disclosure requirements that plans are to provide written documentation within 30 days of how their processes, strategies, evidentiary standards and other factors used to apply an NQTL were imposed on both medical/surgical and MH/SUD benefits. The Preamble to the Final Rule also provides a reminder that regulations under the ACA and guidance under FAQs issued by the Department of Labor (DOL) require certain plans and issuers to provide the claimant, free of charge, during the appeals process with any new additional evidence considered relied upon or generated by the plan or issuers in connection with a claim.

Enforcement

The Final Rule clarifies, as codified in existing federal and state law, that states have primary enforcement authority over health insurance issuers. As such, states will be the primary means of effectuating the implementation of MHPAEA. However, the DOL continues to be the primary enforcer for all self-insured employer plans which currently represent the majority of employees affected by MHPAEA.

The Department of Health and Human Services (HHS), through its Centers for Medicare and Medicaid Services (CMS), has enforcement authority over issuers in a state that do not comply. DOL has primary enforcement authority over self-funded employer plans. We want to note, however, that the majority of beneficiaries in employer sponsored plans are self-funded and are under the sole jurisdiction of the DOL.

State Preemption

MHPAEA requirements are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of MHPAEA and other applicable provisions. For example, while MHPAEA does not require plans or issuers to offer any mental health benefits, once state-mandated benefits are offered, MHPAEA will generally apply to a given state's mandated benefits. In addition, a state that has strong consumer protections in insurance law will not have those laws preempted.

Medicaid Managed Care, CHIP and Alternative Benefit Plans

The Final Rule does not apply to Medicaid Managed Care Organizations, Children's Health Insurance Program (CHIP) or Alternative Benefit Plans (i.e. Medicaid Expansion Plans under the ACA) even though the rule states the statute applies to these entities. As stated, the January 2013 CMS State Health Official Letter will continue to govern implementation of Medicaid managed care parity. The Final Rule states more guidance on this will be forthcoming.

The CMS letter dated January 16, 2013 to State Health Officials and Medicaid Directors made it clear that sections of the IFR and now the Final Rule do apply to Medicaid managed care organizations (MCOs) - specifically CMS stated that NQTLs apply to Medicaid MCOs just as they do to commercial plans

Cost Exemption for Plans and Issuers

The Final Rule provides a formula for how plans and issuers can file a cost exemption if the changes necessary to comply with the law raise costs by at least 2% in the first year.

Health plans that comply with the parity requirements for one full plan year and that satisfy the conditions for the increased cost exemption (have an increased cost of at least two percent in the first year that MHPAEA applies to the plan or at least one percent in any subsequent plan or policy year) are

exempt from the parity requirements for the following plan or policy year, and the exemption lasts for one plan or policy year. The Final Rule confirms achieving the exemption must be based on the estimated increase in actual costs incurred by the plan or issuer that is directly attributable to expansion of coverage due to the requirements of this section and not otherwise due to occurring trends in utilization and prices, a random change in claims experience that is unlikely to persist, or seasonal variation commonly experienced in claims submission and payment patterns. When estimating costs attributable to MHPAEA, a plan or issuer must rely on actual claims or encounter data incurred in the benefit period reported within 90 days of the end of the benefit period. Determinations as to increases in actual costs attributable to implementation of the requirements of MHPAEA must be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries.

APPENDIX 7

Descriptions of Trends in the Human Services, Mental Health, and Addiction Treatment Fields

An APHSA **Innovation Center** Issue Brief

Advancing Human Services in the 21st Century—What is the Government's Role in the Transformation Effort?

Overview

This issue brief is one in a series published as part of the American Public Human Services Association's Innovation Center and is based on APHSA's *Pathways* initiative. Each issue brief is designed to introduce a critically important facet of public human services and explore promising concepts that support *Pathways,* APHSA members' vision for transforming how health and human services are provided in this country. Public human services must move in new directions—down new pathways—if we are to meet increased demand for assistance at a time of tight budgets and heightened public expectations for effective outcomes in the work we do. Through *Pathways,* APHSA is articulating a new vision for human services, identifying key outcomes such a system can help achieve, and building support for concrete action to make that vision real.

At the core of *Pathways* are four major outcomes that we seek: gainful employment and independence; stronger families, adults, and communities; healthier families, adults, and communities; and sustained well-being of children and youth. Each of these outcome areas must be undergirded by key policy frameworks and strong foundational supports that are based on a clear understanding of the role of government in achieving these outcomes. To that end, *Pathways* focuses on giving states sufficient flexibility to target resources where they are most needed and at the same time couple accountability to long-term, sustainable outcomes rather than process.

Transformation cannot occur in a vacuum. It must take place within the federalist system that has evolved as a major part of our nation's governance. Careful consideration must be given then to what this governance should look like in the future in order for those systems serving children, adults, and families to be effective.

This brief examines the role of government in how the provision of human services in this country was initially conceived, outlines how this approach has changed over the years and why, and poses questions that must be considered to provide an integrated, outcomes-focused and client-centric system for the 21st century.

Introduction

We all understand that the world has changed dramatically over the last 100 years. And we all understand that change continues at an ever-increasing pace. What is sometimes more difficult to understand is how those changes will affect the role of government in the 21st century and, in particular, the delivery of human services.

The United States is very different than it was in 1789 when the original 13 states ratified the Constitution. Since then the

Constitution has been amended 27 times, often to reflect changes in our society and the world we live in. As the country and our society have changed, so has the role of the federal government.

Anticipating what the role of government in the delivery of human services will be years from now is a difficult task. The size and scope of the federal government are contingent on too many variables to be predictable with precision: the economy, environmental issues, the international situation, changes in technology and medicine, the results of congressional and presidential elections, advances in communications, and the supply and cost of energy—to name just a few of the most obvious.

One of the most critical roles government plays in our society is to assist those in need, and there is every reason to believe that this role will continue, even if it does so in a different construct. The U.S. Constitution specially gives Congress the authority to provide for the "general welfare" of the nation. To fulfill that responsibility, a complex scheme of legislation and programs has been enacted over the years. This network helps millions of people find employment, live in a safe home and community, obtain food, have access to adequate day care, and receive medical and behavioral health care. In our federalist system of shared governance, both the federal and state levels have responsibility to provide funding for human service programs.

As the human service network has evolved over the decades, it developed "silos" in which programs serving the same populations—often with similar or overlapping objectives—had different eligibility requirements, databases, reporting requirements, and legal restraints, requiring significant resources to maintain these separate efforts. The result has been a fractured system fraught with unnecessary complexities and inefficiencies.

As discussed in more detail below, the impasse over the federal debt threatens our economy. Furthermore, demographic factors such as an aging population are putting additional demands on the health care system. Any discussion about the role of government in the 21st century must be based on an understanding of the implications of these factors and how they are interconnected.

The paper is divided into three parts. The first part examines the history of our federalist system and how recent Supreme Court decisions could impact that system. The second part examines some of the most important issues (an aging population, increased health care costs, and an unsustainable federal debt) that require a new strategy for delivering human services. The third part will discuss how these three issues must help frame a paradigm shift in the role of the federal and state governments in providing human services.

Part One: Our Federalist System

A 225-Year-Old Debate

Since ratification of the Constitution, which established a union of states under a federal system of governance, the role of the federal government in our society has been debated and litigated. A significant part of our country's history has been shaped around trying to determine what powers and responsibilities the Constitution grants to the national government and which are reserved for states. During the 200-plus-year history of the Constitution, this fundamental issue has been defined and redefined by the nation's political, social, and economic forces.

The balance of power between state and federal governments is dynamic. Even before the Constitution was drafted there was considerable disagreement among our forefathers about how much power to grant the federal government. However, there seems to have been little disagreement that even though the new federalist government would have considerably more power, that power was nevertheless, to be limited.

The doctrine of judicial review, which gave the courts the power to invalidate governmental action—and thus limit the size and scope of the federal government—was established by the seminal Supreme Court decision of Marbury v. Madison in 1803.[1] That famous decision, written by Chief Justice John Marshall, defined the basic principle that the federal judiciary is the supreme arbiter in defining the limits of federal government and thus the relationship between federal and state governments.

The Role of the Supreme Court

Today, perhaps the greatest protector of state sovereignty, and thus our federalist system, is the Supreme Court. To a large degree the role of government and the architecture of our federalist system have been determined by several Supreme Court decisions. Without a full understanding of how those decisions have interpreted the Constitution and as a consequence shaped the limits of the federal government's footprint, any meaningful analysis of the future role of government would be incomplete. This is particularly true in examining the practice that Congress has adopted of enacting programs that are funded (either in whole or in large part) by the federal government but largely state administered.The use of the spending power allows Congress to establish national policies in areas that otherwise would be left to states. The Constitution gives Congress the power to appropriate funds for the "general welfare" of the country.[2] The authority to appropriate funds is not limited to accomplishing Congress' delegated or enumerated powers; rather it is an independent source of federal power. The Supreme Court upheld this interpretation in 1936[3] and thus established the foundation upon which the federal government has since been able to expand in size and scope.

The Supreme Court has always deferred to Congress to determine what is in the "general welfare" of the nation. Consequently, no Court has ever invalidated a federal spending program on the grounds that the general welfare of the country was not being promoted. At the same time the Court has recognized that there are limits as to how far the federal government can go to compel states to act. It is well-established law that "[t]he Constitution simply does not give Congress the authority to require states to regulate."[4]

The Supreme Court also has ruled that to ensure that federal funds granted to states are spent in the intended manner, Congress can place conditions on the states receiving those funds.[5] In the human service arena, it is this conditional grant of funds to states that allows the federal government to determine who is eligible for certain benefits, the reporting requirements placed on states, how long individuals can receive those benefits, and ultimately how states administer programs or if states have to provide additional funds.

For almost a century Congress has had nearly absolute authority to spend money for the general welfare as long as state participation in administering federally funded programs was voluntary.[6] However, that may have changed in 2012. In its ruling on the section of the Affordable Care Act[7] that would penalize a state for not expanding its Medicaid eligibility, the Supreme Court (for the first time in its history) found "an exercise of Congress' spending power unconstitutionally coercive."[8] While in National Federation of Independent Business v. Sebelius,[9] the Supreme Court upheld the constitutionality of the Affordable Care Act for the most part, it ruled that Congress had exceeded its authority by coercing states to either accept the expansion of Medicaid or risk losing existing Medicaid funding. This 2012 decision, authored by Chief Justice John Roberts, sets a new benchmark for controlling federal power of state actions:

> There is no doubt that the Act dramatically increases state obligations under Medicaid. ...our cases have recognized limits on Congress's power under the Spending Clause to secure state compliance with federal objectives. We have repeatedly characterized Spending Clause legislation as much in the nature of a contract. The legitimacy of Congress's exercise of the spending power

> thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' (emphasis added) Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system. But when pressure turns into compulsion, the legislation runs contrary to our system of federalism. The Constitution simply does not give Congress the authority to require (emphasis added) the States to regulate. [10]

In determining the limits of federal control over state activities, one of the key factors is that states are free to reject participation in the federal grants. The Court stated: "The legitimacy of attaching conditions to federal grants to the States depends on the voluntariness of the States' choice to accept or decline the offered package. Therefore, if States really have no choice other than to accept the package, the offer is coercive, and the conditions cannot be sustained under the spending power." The mere fact that the Congress gives the states the option to reject participation is insufficient; the decision whether to comply with the federal condition "remains the prerogative of the States not merely in theory but in fact." [11]

Chief Justice Roberts relied in part on a 1981 Supreme Court ruling that "legislation enacted pursuant to the spending clause is in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending clause thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' " [12]

While states and localities remain free to reject the federal monies and the conditions that go along with those funds, the political reality is that no state government can fully reject participating in federally funded human service programs. The idea that states are free to drop out of federally funded human service programs, is little more than a de facto technicality that acts as a gateway for the federal government to place mandates, both funded and unfunded, on states in the administration of those programs.

It is too early to know the full impact of the Court's decision that Congress exceeded its constitutional role and in doing so violated sovereignty of the states. In her dissent, Associate Justice Ruth Bader Ginsburg criticized enforcing new limitations on coercion without clarifying when permissible persuasion gives way to undue coercion. She wrote:

> When future Spending Clause challenges arrive, as they likely will in the wake of today's decision, how will litigants and judges assess whether "a State has a legitimate choice whether to accept the federal conditions in exchange for federal funds"? Are courts to measure the number of dollars the Federal Government might withhold for noncompliance? The portion of the State's budget at stake? And which State's—or States'—budget is determinative: the lead plaintiff, all challenging States (26 in this case, many with quite different fiscal situations), or some national median? Does it matter that Florida, unlike most States, imposes no state income tax, and therefore might be able to replace foregone federal funds with new state revenue? Or that the coercion state officials in fact fear is punishment at the ballot box for turning down a politically popular federal grant? [13]

These questions are worth remembering in analyzing the issues discussed below, which almost certainly will require re-prioritizing federal spending and policies.

If the majority decision in National Federation requires a fundamental shift in the relationship between the federal government and states, then, as Ginsburg argues, there may be a myriad of new decisions that have to be made to redefine that relationship. If Ginsburg is correct, it may be reasonable to argue that protecting the states' sovereignty limits the ability of Congress to make significant adjustments to the original demands and funding requirements placed on the state. Only future decisions by the Court will answer that question.

Part Two: Catalysts for Change

Why A New Model is Necessary

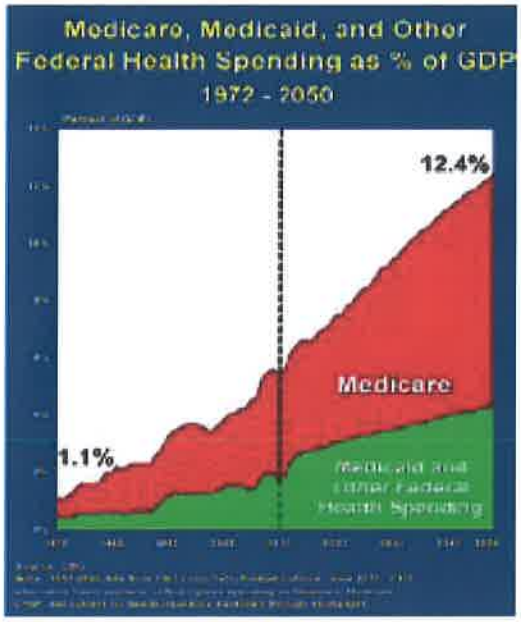
Change is often difficult. As has been the practice over the last several years, it is easier for our political system to focus on short-term solutions rather than implementing the kinds of changes that are necessary to find suitable long-term remedies to some of our more complex issues. Regardless of how entrenched the current system of delivering human services has become, there are forces at work that will—in time—require a new paradigm. An older American population that results in an increased demand for medical services, coupled with the increased costs of those services, and an unsustainable level of the federal government's debt, are three highly interrelated issues that work with such strong synergy that they also contribute to the need for a new architecture in human service delivery.

An Aging Population

The United States is in the midst of a major demographic shift that is highly predictable and thus inescapable. America is getting older—a lot older. The definition of a Baby Boomer is someone born in the United States between 1946 and 1964. This means that starting in 2011, the first baby boomers turned 65. For the next 20 years, on average, 10,000 boomers will retire every day.[14] Instead of paying into Social Security and Medicare, they will be collecting benefits from these two retirement programs. On top of that, as they retire and leave their peak earning years, they reduce their income tax liability significantly. The result is that the federal government will collect less and spend more as this population comes of age.

In 2050, the number of Americans age 65 and older is projected to be 88.5 million, more than double this group's 2010 population of 40.2 million.[15] This older America will almost certainly impose additional fiscal burdens on federal and state governments, especially as they relate to health and long-term care. According to the Centers for Disease Control and Prevention, the cost of caring for aging residents by 2030 will add 25 percent to the nation's overall health care costs.[16]

Increased Health Care Costs



Congress faces some difficult decisions over both short- and long-term health care issues. Currently there is no clear policy addressing how the country will pay for the increased demands for health care of an older population. The average health care cost for someone age 65 or older is $9,744, which is about $7,000 higher per year compared to people ages 25–44.[17] As the population gets older there will be more people in need of more expensive care: an unsustainable combination.

Expenditures for health care represent nearly one-seventh of the nation's GDP,[18] and they continue to be one of the fastest-growing components of the federal budget. Although the rate of growth in health care costs slowed somewhat in the mid-1990s, it has once again started to rise at a rate that exceeds other sectors of the economy.[19] The Congressional Budget Office predicts that "if

current laws remained in place, spending on the major federal health care programs alone would grow from more than 5 percent of GDP today to almost 10 percent in 2037 and would continue to increase thereafter." [20]

One thing is certain: absent major policy changes, the demand for health care for the elderly will require more resources from the federal government. From 2000 to 2030, the number of people on Medicare is projected to rise from 39 million to 79 million, while the number of workers to support beneficiaries is projected to decline from 4.0 workers per beneficiary to 2.4 workers per beneficiary. [21]

It is not difficult to see how this phenomenon of a changing demographic will affect the costs of federal programs such as Medicare. The Social Security Advisory Board put it this way:

> In 2008, the public share of total national health expenditures was about 47 percent, of which the federal government's share is almost three-quarters. Medicare (funded primarily by the federal government as well as enrollees' premiums) accounts for about 20 percent of total health expenditures in 2008, while Medicaid, funded by both federal and State governments, accounts for about 15 percent. [22]

The Hospital Insurance portion of Medicare (Part A) already has significant financing issues. In 2011 expenses exceeded revenues and are expected to do so for years to come. If current predictions hold true, in just four years (2017) the trust fund will be totally depleted, putting increasing pressure on the government's general revenues to cover benefits and expenses. [23]

The 2012 Annual Report of the Board of Trustees for Medicare contains the following summary as to why the status quo is unsustainable:

> The Medicare projections reflect (i) continuing growth in the volume and intensity of services provided per beneficiary throughout the projection period; (ii) the impact of a large increase in beneficiaries, which started in 2011, as the 1946–1965 baby boom generation reaches age 65 and becomes eligible to receive benefits (thereby increasing the growth in the number of beneficiaries from the previous 2 percent per year to about 3 percent); and (iii) other key demographic trends, including future birth rates at roughly the same level as the last two decades and continuing improvements in life expectancy. The projections also reflect current law which includes the Affordable Care Act, the Budget Control Act of 2011, and other applicable legislation. [24]

The Federal Debt

The National Commission on Fiscal Responsibility and Reform, appointed by President Obama during his first term, concluded the following:

> Our nation is on an unsustainable fiscal path. Spending is rising and revenues are falling short, requiring the government to borrow huge sums each year to make up the difference. We face staggering deficits. [25]

The Congressional Budget Office determined that "the growth of noninterest spending as a share of gross domestic product (GDP) results entirely from projected increases in spending on several large programs: Social Security, Medicare, Medicaid, and (to a lesser extent) the insurance subsidies that will be provided through the health insurance exchanges established by the Affordable Care Act." [26]

Estimates of the total unfunded liability created by Social Security and Medicare differ, but most are between $60 trillion and $100 trillion.[27] This is not a new problem; it has been known for years that the two programs most directly affected by an aging population are underfunded given the current structure of the programs. In 2009, the Social Security Advisory Board warned: "We believe that the rising cost of health care represents perhaps the most significant threat to the long-term economic security of workers and retirees."[28] Without any changes in the current benefits or revenues, Social Security will be able to pay 100 percent of benefits until 2037 but only about 70 percent of promised benefits after that.[29]

Even though recent economic data show an improvement in the federal government's deficits, those gains are only temporary. According to the Congressional Budget Office:

> If the current laws that govern federal taxes and spending do not change, the budget deficit will shrink this year to $845 billion, or 5.3 percent of gross domestic product (GDP), its smallest size since 2008. In CBO's baseline projections, deficits continue to shrink over the next few years, falling to 2.4 percent of GDP by 2015. Deficits are projected to increase later in the coming decade, however, because of the pressures of an aging population, rising health care costs, an expansion of federal subsidies for health insurance, and growing interest payments on federal debt. As a result, federal debt held by the public is projected to remain historically high relative to the size of the economy for the next decade. By 2023, if current laws remain in place, debt[30] will equal 77 percent of GDP and be on an upward path.[31]

What makes these projections even more worrisome is that they do not include the possibility of a major fiscal crisis, military action, or natural disaster requiring massive amounts of federal funds. Any number of possible scenarios could cause unforeseen demands for additional federal spending or reduced revenues.

The current debate over how to re-allocate resources to meet the increased demand for ever-more expensive health care from an aging population is, in part, constrained by our reliance on the current system and the notion, particularly among voters, that something will be lost or given up if programs are changed or dollars shifted.It is therefore extremely challenging politically to balance the increased demand for and cost of providing health care with lowering future deficits. As Congress and the President continue working on a compromise approach to the budget situation, it is clear that no easy solution is readily available, and that agreement may be impossible at least for the near term. Nevertheless, there is urgency to finding common ground and how Congress ultimately resolves these seemingly counterbalancing issues will affect the role of government in providing human services.

Part Three: A New Paradigm Is Needed

It seems almost certain that states will be required to increase their human service budgets to offset the loss of federal assistance, or make considerable cutbacks in those programs. Reduction in services might have to include reduced eligibility, coverage of fewer services, lower payments to providers, or increased co-payments to beneficiaries where appropriate. Yet another innovation that can be a major element of transformation is the use of Social Return on Investment or SROI. It is not always obvious how successful a human service program has been in assisting individuals or families due to the number of factors involved. Measuring and showing the impact of a specific program or services can be challenging, but such measurements provide vital information on the effectiveness of various approaches to delivering services. (For more information on APHSA's work on Social Return on Investment, go to *http://innovationcenter.aphsa.org/docs/SROI-Issue-Brief.pdf/.)*

While states vary in their constitutional and statutory requirements, the National Conference of State Legislatures has concluded that 36 states have "rigorous budget requirements."[32] Many states have had to respond to a slow economy by reducing expenditures in order to meet their balanced budget requirements.[33] After years of tight budgets with accompanying cuts in programs, the loss of federal funding in human service programs will be difficult for states to make up. State and local governments are deeply tied to federal finances, and they will feel the pain from federal cost cutting.

The Budget Control Act of 2011 (BCA)[34] provided only a downpayment on what many believe will be needed. The BCA put in place caps on aggregate appropriations as well as the across-the-board cuts known as the sequester. Between the sequester and caps on appropriation levels between FY 2013 and FY 2021, the BCA reduced the federal debt by about $1.2 trillion. About half of the savings came from caps on appropriations. The currently scheduled reduction in future spending is not likely to be sufficient in solving the problem. Additional budget cuts (as well as possible additional revenues) seem almost inevitable in the coming years.

Unless Congress overrides BCA's provisions, federal spending will be virtually frozen for the next 10 years at or below current levels (after factoring in inflation).

Limits on Discretionary Budget Authority for FY 2013–2021									
(Millions of Dollars)	2013	2014	2015	2016	2017	2018	2019	2020	2021
Defense	546,000	501,351	511,351	522,350	535,350	548,349	561,349	575,349	589,348
Non-Defense	501,000	472,063	482,063	493,432	504,782	517,352	531,328	544,699	557,090
Total	1,047,000	973,414	944,030	1,015,782	1,040,131	1,065,702	1,092,677	1,120,048	1,146,438

Source: Congressional Budget Office[35]

The first round of sequestration occurred on March 1, 2013. At this time, there is virtually no congressional support to allow another nine years of across-the-board cuts under the BCA's sequestration provisions. As the President and Congress work to find a path forward, additional savings are likely to come from human service programs that are now exempt from sequestration, increasing the impact on state human service budgets.

Congress and the President continue to struggle over how to enact policies to address the economic threats posed by unsustainable federal deficits with no indication that a solution is possible in the near future. Unless changes are made in the BCA provisions, many of the programs that are federally funded and state administered are scheduled

to lose significant amounts of federal funding. Some of these cuts will be automatic as a result of sequestration, while others will be in response to the limits on appropriations levels over the next ten years. As a result, a shift in the roles played by federal and state governments is undergoing a significant change that carries the potential of redefining our current federalist system of governance.

In part, the reason this debate seems endless is not just the political divide that engulfs almost every issue. There are hundreds of federal programs long past due for reauthorization and modernization. Over the last decade congressional oversight hearings designed to examine the functionality and efficiency of federal programs have become nearly extinct. And, as the current network of federal programs becomes older, it becomes more cumbersome and less responsive to the needs of those they serve.

The world we live in and citizens' needs for government assistance constantly change and the design and delivery of human services need to reflect those changes. Our ability to instantly and continuously communicate with each other individually, and collectively; the availability of 24-hour news that immediately makes any issue a national issue; and our nation's changing energy situation; changing population demographics; new and far-reaching advances in medical care and all of the accompanying quality of life and life expectancy issues; the ability for anyone with access to a computer (or even a smart phone) to gather information on any topic at any time without leaving their office or home; are just a few of the characteristics of our modern society that have affected how governments at all levels have to function.

As Congress reprioritizes its spending in response to changing demographics and budgetary constraints, pressure to reform human service programs will continue to increase. The core principles of reform outlined in *Pathways* will require changing health and human service programs and funding streams so that they become integrated, outcomes-focused, and centered on how we can support people to achieve sustainable, meaningful changes in their lives rather than comply with bureaucratic outputs.

The concepts embedded in *Pathways* attempt to offer an alternative to reducing benefits by restructuring how the government spends its current resources in a more efficient manner. The reforms in human service policy and governance embodied in *Pathways* must include viable alternative financing approaches that allow for more effective use of resources to help ensure that public investments result in far better client outcomes. Such reforms may include, for example, a more aggressive use of social impact bonds. These bonds are outcome-based contracts between public-sector agencies and private investors for specific programs or initiatives under which the government agency returns the investors' contributions if programs meet expectations. (For information on alternative financing and social impact bonds go to APHSA's web page at *http://innovationcenter.aphsa.org/docs/AlternativeFinancingBrief.pdf/.)*

Congress will have to go beyond just reducing budgets to enact meaningful reforms that produce savings at both the federal and state levels. Meaningful reforms must give states real options on how best to utilize federal funds while maintaining reasonable and meaningful accountability standards. Reforms need to include new rules and procedures that govern the use and accountability of federal dollars that place a greater emphasis on outcomes than on compliance.

Conclusion

Our human service system is built on the belief that many issues are best addressed when the federal government and states work together. The size and scope of the federal government would have grown significantly if it were

not for the active assistance and involvement of states in addressing a wide range of issues. When President Lyndon Johnson called for a War on Poverty in his first State of the Union address in 1964, he said, "Poverty is a national problem, requiring improved national organization and support. But this attack, to be effective, must also be organized at the State and the local level and must be supported and directed by State and local efforts." [36]

President Johnson understood that our federalist system had evolved to a point where states and the federal government are indivisible partners in providing human services. What affects the federal government's budget is felt by states' budgets as well. That is as true today (if not more so) than it was in 1964, and it will remain true in the years to come.

Presidents in the past have tried to implement new programs designed to give states additional control and flexibility. And while the balance of power between the federal government and states swings back and forth, it seems that inevitably, power moves in favor of the federal government. Ronald Reagan tried to create a movement called "New Federalism," which introduced a practice of giving block grants to states, thus freeing them to spend the funds at their own discretion but within certain limits. He outlined his thinking in his first inaugural address:

> It is my intention to curb the size and influence of the Federal establishment and to demand recognition of the distinction between the powers granted to the Federal Government and those reserved to the States or to the people. All of us need to be reminded that the Federal Government did not create the States; the States created the Federal Government. [37]

Reagan was successful in reducing the number of federal subsidy programs, but that trend was only temporary. To date, Congress has struggled to find a long-term solution to the current financial situation, in which the federal debt is unsustainable. Part of why this has been so challenging is that cutting back on spending and programs is often politically difficult. Congress tends to focus on advancing new ideas and designing new programs to address emerging issues, or on increasing existing programs size and scope. Only rarely has Congress reduced spending from the year before, and mostly due to the end of a major war as in the case of 1920, 1921, and 1922, or a major depression. [38]

The 112th Congress will always be remembered as the Congress that created and then nearly fell over the so-called fiscal cliff. The combination of tax increases and budget cuts, coupled with several other related issues, created a vortex of legislative proposals and finger-pointing among politicians. Virtually every member of Congress and the President agreed that action was needed, but their ability to deliver a satisfactory, comprehensive solution remained unattainable. In the end Congress and the President agreed to a bill that avoids the worst consequences of the fiscal cliff, [39] but they could not come together on a comprehensive agreement.

The agreement at the end of 2012 that kept the economy from falling over the fiscal cliff was more about different visions for the role of government than any individual tax or spending issue that contributed to creating that artificial crisis. The current debate over the role of government continues unabated.

For all the reasons stated above, the role of the federal government is changing, and will continue to do so. In the same way that policymakers in the early 1900s never could have foreseen the changes in government that brought us to today, neither can we predict what changes lie ahead. For now, we must keep the following questions and issues in mind:

- What role will future Supreme Court decisions play in the delivery of human services?
    - As federal funding of state-administered public human service programs decreases significantly in the future—with no abatement in the number of unfunded mandates or administrative requirements placed on states as a condition of participation—will future congressional action be challenged as well?

- Does the majority opinion in the ACA case indicate a new, emerging relationship between federal and state governments?

- How will Congress and the President respond to the current budget situation?
  - What reforms are necessary to ensure that populations in need of assistance get the necessary support to become active and contributing citizens?
  - Are there federal programs that can and should be combined, streamlined, and aligned?
  - How would realignment of program eligibility standards transform human services?
  - How can the current array of programs be changed so that they deliver more effective outcomes as the same or reduced levels of expenditure?
- What can states do to be ready for tomorrow?
  - Are states ready to assume a greater share of the financial responsibility for funding human service programs? Are there new funding partners that states should actively seek?
  - To what degree will advances in technology and communications play to make the delivery of human services more efficient?
  - How should states respond to the loss of federal assistance to administer human service programs?
  - What can states do to advance the Pathways initiative within the current set of laws and administrative requirements?

APHSA's members developed *Pathways* as a catalyst for focusing on outcomes, prioritizing prevention, eliminating duplicate administration of related programs, and mapping a new kind of human service network to enable more self-sufficiency by addressing needs in a more holistic and economical manner. The *Pathways* strategy asks national policymakers to evaluate current programs and practices to determine if they are sustainable and if they are producing desirable outcomes in the most cost-efficient manner. Recognizing that change is inevitable and the status quo is not sustainable, policymakers need to commit themselves to a national solution that incorporates new approaches to public investment, to outcomes over process, and to a more equitable partnership with states and communities in the delivery of human services.

The country is at a turning point and will soon be faced with the reality that changes (and sometimes painful changes) are necessary. When and how those changes are made will determine, for years to come, the role of government in shaping the kind of society we live in and in providing for the general welfare of the nation.

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The Next Generation of Human Services:

REALIZING THE VISION

A Report from the
2010 Human Services Summit
at Harvard University









Leadership For A Networked World

Introduction

In 2008, U.S. Marshals found four children slain by their mother in a Washington apartment. A review of this case revealed that multiple human services organizations had contact with the family in the preceding months. While signs of impending danger might have been noticed if these agencies had collaborated, each organization worked in a "silo" – no integrated processes, systems or structures were in place to share information and enable a concerted response. This preventable case is rare. Yet it illuminates the challenges facing human services – complicated issues that reach across traditional boundaries and jurisdictions and that require human services leaders to rethink, reform and reactivate service delivery in the near future.

Clarence Carter, the director of human services in Washington DC, advanced a plan to transform the city's services. "The intention of the old system was to deliver a benefit or service someone was eligible for. This is the fatal flaw of our system – we have focused on transactions and haven't been intentional about effectively working across organizations and using resources to grow human capacity," he says. "The new objective in DC is to align the human services system in order to actually grow the capacity of the customers that we serve – so that those people can then be free of public dependence and achieve their highest potential."

The improvement of human services is vitally important for cities like Washington, and imperative for states and the nation as human services programs and staff are on the front lines of the country's most pressing social and economic challenges. Human services programs are varied and diverse, meeting needs for food and income supports, mental health, medical assistance, child protection and support, drug addiction and rehabilitation, job training, disability care, senior citizen care and many others. These programs are also working within a set of challenging environmental factors:

1. Demand is Increasing: Nationwide, more than 43 million people are in need of human services. Near term, demand for services has run parallel to the rate of unemployment[1], putting pressure on food assistance and temporary aid programs. Long term, demographic shifts such as aging baby boomers and structural unemployment will squeeze the entire system.
2. Cases are Intensifying: Client challenges are becoming more complex. Many cases are multi-need families who are receiving services from more than one agency or program. And often the root causes of their challenges cut across traditional program or jurisdictional lines and communities – putting a premium on integrated, cross-boundary solutions.
3. Cost is Escalating: After national defense and education, human services programs make up the largest portion of the US federal budget – more than $900 billion projected for 2011[2]. In states and regions, the cost is relatively even higher – $10.8 billion in Oregon, $11.7 billion in Minnesota, $54.3 billion in Florida, and $83 billion In California.
4. Resources are Dwindling: Federal and state budget shortfalls are forcing extreme choices. According to the Center on Budget and Policy Priorities, 46 states have made "cuts that hurt families and reduce necessary services.[3]" Service cuts are only the beginning, as many governments no longer have the capacity to balance service needs with cost.

When these factors are combined, they threaten our nation's social well-being, community health, economic development and individual equity. "We've been doing more for less for years, but it's at a point where if we don't come up with some innovations and new ways of delivering more effectively and efficiently we risk being inhumane because we won't be able to deliver services," warns Tracy Wareing, executive director of the American Public Human Services Association.

What the human services community faces is a "capacity challenge": Organizations must grow their capacity to improve current services, to deliver new services, to decrease organizational costs and - most importantly - to help people, families and communities realize their full potential.

Experimentation and progress are already happening. In Allegheny County, Penn., creative program alignment is improving results for multi-need families. In Louisiana, modernization of entire organizations, processes and systems is reducing costs and increasing customer service. In Massachusetts, new methods of developing, collecting and reporting outcomes are driving innovation and results across organizational boundaries. In Oklahoma, a focus on healthier families is leading a move to integrated services and improving community outcomes. In New York City, streamlined citizen access, case management and other systems are transforming the city's ability to meet future demands.

Yet critical questions remain: What is the vision for the future? How can human services leaders grow their organization's capacity? And how should the innovation and change be implemented and brought to scale?

"There are risks and costs to a program of action. But they are far less than the long-range risks and costs of comfortable inaction."

– President John F. Kennedy

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Leaders from federal, state and local human services organizations met at Harvard University to share insights and lessons, identify best practices, define the opportunities and challenges in adopting innovations and new business models, and ideate the future of human services.

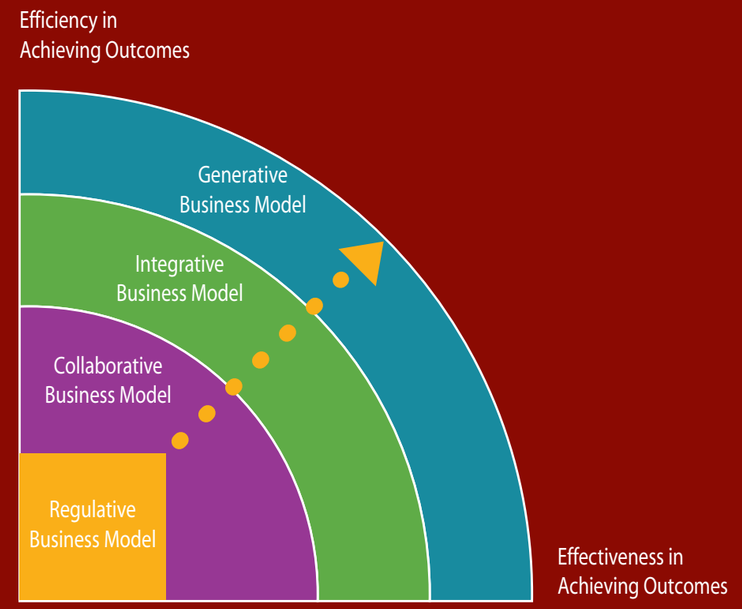
The Human Services Summit

The capacity challenge has moved the human services community to an inflection point. A central demand is for programs to provide a high level of "public value" [4] – a measure of how effective and efficient a program is in achieving outcomes. Across the political spectrum, citizens desire this transparency in reporting public value. Yet the capacity challenge has many organizations struggling. Their effectiveness is at risk in relation to short and long-term demands.

To help human services leaders form and realize a vision for their organizations, Leadership for a Networked World and Accenture, in collaboration with the American Public Human Services Association (APHSA) convened senior human services policy makers and executives at for the 2010 Human Services Summit at Harvard University.

Leaders at the Summit agreed that addressing the capacity challenge will require a new vision for designing and delivering human services. The new business models will have a family centric mission, will work across organizational boundaries to align goals and will pursue a laser-like focus on outcomes. The policies, programs, production and provision of services will enable the mission and continually adapt to changing circumstances – all while striving to generate the highest level of capacity for the organization, employees, clients and the broader community.

As a product of the Summit, Leadership for a Networked World is pleased to present this whitepaper, The Next Generation of Human Services: Realizing the Vision. This paper will help human services leaders envision a transformation journey for their own organization and realize their vision through concrete actions. To inspire and guide efforts, the paper couples insights from the Human Services Summit at Harvard with case-based examples from human services executives nationwide.



Generating Capacity: The Human Services Value Curve

"We need to renew our focus on outcomes for the customer – that's what resonates and what cuts across all other issues. It's a different environment now," says B.J. Walker, former commissioner of the Georgia Department of Human Services. "Our clients are different people. They're different in that they are not just showing up for services – they want to be part of the solution. We really need to think about capacity building and life-changing tools, and how we must change our organizations and culture to get there."

What does "capacity" really mean in human services? At an organizational level it's about delivering outcomes that individuals, communities and society at large value. At an individual level it means providing solutions that empower people to reach their fullest potential in an independent and sustainable way. Capacity is grown in three ways:

- First, an organization can become more efficient at delivering outcomes – i.e., it can produce more of the desired outcomes with a level or reduced amount of resources.
- Second, an organization can become more effective at attaining outcomes – i.e., it can measurably improve its ability to reach goals.
- Third, and most important, an organization can develop entirely new competencies – i.e., it can respond in new ways to create and deliver previously unattainable outcomes.

Thus, renewing focus on generating the capacity to reach client and family centric outcomes is the central thread to meeting demands today and in the future. But to get there, human services organizations must first improve their business models. Broadly, this is done by transforming their business model over time by adopting organizational innovations and harnessing advances in information and communication technologies that enable increased efficiency, effectiveness and the development of new competencies.

Collectively, these actions enable high-performance delivery of current programs and services, and provide a foundation for forecasting needed outcomes and designing forward-looking solutions.

To help apply these concepts and guide efforts, Leadership for a Networked World researched best practices and developed a framework referred to as the "Human Services Value Curve" represented as:

- **Regulative Business Model:** The focus is on serving constituents who are eligible for particular services while complying with categorical policy and program regulations.
- **Collaborative Business Model:** The focus is on supporting constituents in receiving all the services for which they're eligible by working across agency and programmatic boundaries.
- **Integrative Business Model:** The focus is on addressing the root causes of client needs and problems by coordinating and integrating services at an optimum level.
- **Generative Business Model:** The focus is on generating healthy communities by co-creating solutions for multi-dimensional family and socioeconomic challenges and opportunities.

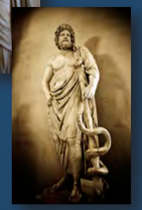
The Human Services Value Curve is not a one-size-fits-all solution, but rather a guide to help leaders envision a path for their organization. In traversing the curve, the enabling business models and competencies of the human services organization mature and improve the organization's ability to deliver broader and more valuable outcomes.

The rest of this paper will examine the Human Services Value Curve and how leaders are applying it in the field, and help you chart your own human services transformation journey. As you'll learn from their experiences, progress is feasible, but requires sound strategy and leadership to create the environment for success.

The History of Human Services: Implications for Today

Civilizations have always grappled with how to respond to the needs of the most vulnerable, and "human services" often mirrored the cultural, philosophical, theological and technological leanings of the time. These views formed how the collective understood an individual's needs and how those needs should be addressed. Yet at every point in time, great advances in service delivery - and steps backward - were tempered by the value societies placed on those in need and the resources available to serve them. While not following a straight trajectory, human services as we know it evolved out of this tension, along the way both advocating for more humane treatment of the fragile and responding to public demands for greater sensitivity and accountability.

Hygeia

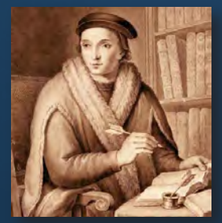


Asklepios

An Ancient Practice

The ancient Greeks looked to their god Asklepios and his daughter Hygeia (precursor to the word hygiene) for inspiration on how to help those in need. As a result, the Greeks offered prayer and cleansing with fragrant water at hundreds of xenodocheum – "a house for strangers" - to which the mentally and physically ill would journey for care. Many of these principles and methods transferred to the hospice model still in place today. As Greco-Roman cultures melded, more than 500 aesculapius shrines for bathing, diet, medicine and basic mental disorders were developed. The vast Roman armies later erected thousands of smaller, "incubatorium" which – similar to a hospice – also reflected the empire's attention to order. There, many services were routinized through formal job descriptions for caregivers and tasks for patients.

During the early Middle Ages, the spiritualization of services rose in prominence. Virtually every town had a church and/or hospice and it was generally understood that people should volunteer time and resources in maintaining care for the ill, hungry, or spiritually needy. Yet for all the local benefits, the lack of national systems took a toll. Dramatic increases in poverty, sickness and disease strained the parish-based system to the breaking point. In addition, the growing belief in "malefa-ction" – that some mental and physical illnesses were a sign of deadly sin – led to the execution of many in severe need. Even more were imprisoned. This "menacization" of needy people reached a crescendo between 1400 A.D. – 1550 A.D as resistance to religious orders during the Reformation led to the destruction of many hospices.



Juan Luis Vives

Towards a National System of Care

Out of the Medieval period arose a newfound respect for and theory on services for those in need. In 1526 Juan Luis Vives, a Spanish scholar and humanist wrote "De Subventione Pauperum Sive de Humanis Necessitatibus," (On Assistance to the Poor), which laid the foundation for converting the private, voluntary charity system into a systematized and centralized public system based on taxation. As countries began to adopt his vision, they implemented various methods of local taxation along with a system of eligibility and registration to differentiate those they deemed the worthy, deserving poor from the rest. Many of these laws, rules and systems were formalized and refined in England and Wales under the Act for the Relief of the Poor (commonly referred to as the Elizabethan Poor Laws) in 1601. A central thread in this new Act was national funding, with individual towns or jurisdictions responsible for system implementation and administration, still the dominant method today. Yet despite advances of the time, many facets of the law and administration were appalling. The determination of eligibility was woefully subjective, fraught with nepotism and left to interpretation by the local overseer. Many with mental disabilities who were unable to work were cast away to prisons or left to die in the streets. Children of "paupers" were regularly taken from their parents, assumed by the government and sent to apprentice.

From Injury to Advocacy

Another dark point came in the late 1800s and early 1900s as the Eugenics movement and social Darwinism influenced policy makers across Europe and the United States. Their ideas held that there was a hierarchy of usefulness and utility among humans and that better ability could be "engineered in or out." This trend of devaluing certain populations took hold among many and spawned depersonalization, segregation, racism, brutalization and even genocidal policies. This mindset held strong for years as exemplified by Louisiana Gov. Huey Long who in 1929 bragged, "We forced a few people to be hanged and reduced the death rate in charity hospitals from 40 percent to only 30 percent," and by official government policy which led to the sterilization of 60,000 mentally ill in the United States. While in many ways deplorable, this movement also cultivated a new era of advocacy on behalf of the most vulnerable, and promoted a sense of accountability from human services to the general public and particularly clients. Professional training also came to the fore, as the first social work training program was created at Columbia University and researchers began to understand and teach the contextual and system views of cases. The formalization of job training, a focus on behavioral education and the "case-worker" model also became more entrenched practices.

Over the past century, policy makers in the United States have made gains in balancing equity in access with cost and societal priorities. The 1933 Social Security Act instituted federal and state systems of care for the elderly, unemployed and others in need. President Dwight Eisenhower formalized many social service goals with the implementation of the Federal Department of Health, Education and Welfare in 1953. The inception of Medicare and Medicaid in 1965 brought health care to the elderly and poor as part of President Lyndon Johnson's "Great Society," and subsequent laws and reforms enabled resources for foster care, adoption, immigrant services and other progressive programs. Current human services policy makers and workers are in the midst of more change as federal and state governments continue to decipher the advantages and disadvantages of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (Welfare Reform) and the near-term implementation of the 2010 Patient Protection and Affordable Care Act, which will drive new opportunities and challenges across government and private care providers.

President Lyndon Johnson signing Medicare into law

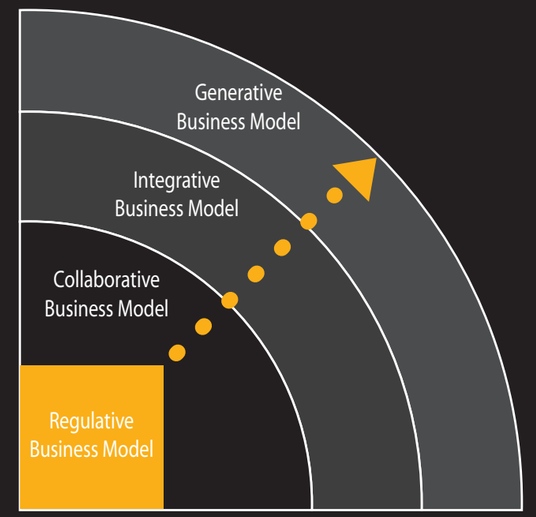
Defining the Next Generation

As history has demonstrated, the next generation of human services policy makers will have opportunities to reform practice. A driving force for the coming generation will be the relentless growth of information and communication technologies. Organizational technologies will bring new ways of forming, managing and evaluating human services agencies. Information technologies will generate massive amounts of data that will reveal societal, social, community and familial patterns that impact human services. Networks and mobile systems will enable an unprecedented ability to communicate with communities and clients. Yet good intentions do not liberate us from historical processes and deeply held customs, biases and beliefs; advances will also bring tough choices and tradeoffs on organizational design, jurisdiction, equity and privacy.

At no other time has the ability of the human services community to promote self-sufficiency, productivity, integration, inclusion and capacity for the pursuit of happiness been so ripe. How we harvest it will define our generation.

Regulative

This level serves as a baseline – all human services organizations start here and must meet this level in order to comply with program requirements. With this basic business model, programs and processes are developed and managed categorically and are usually aligned with discrete funding streams. Information technology and support tools are designed to support program-specific management, funding, eligibility, case management and client interactions.



Regulative Business Model

When Ruth Johnson stepped into her role as Secretary of Louisiana's Department of Children and Family Services she faced some tall orders: Gov. Bobby Jindal wanted improvements in responsiveness, efficiency and customer service. "We looked and we found that there were significant inefficiencies. One agency didn't talk to another one," she says. "We have four agencies, the Office of the Secretary and the Office of Family Support which did food stamps, cash assistance, Child Care Assistance and Child Welfare. Many of the parents of families need the same services that are in family assistance; however, they were not linked to those services. Our client interaction was almost all face-to-face and it was extremely paper-intensive. So, we said it's one pot of money. It shouldn't be seen as a series of agencies. It should be seen as a series of services. And we decided to fix that," recalls Ruth.

Ruth Johnson
State of Louisiana

Ruth's story presents the challenges of many organizations at the "Regulative" level. As human services administrators like Ruth look to achieve better outcomes, they'll have to inspect under the hood of their organizations – and many will find plenty to work on. At the Regulative level, this often means fixing something that isn't fundamentally broken. Every human services organization starts with a call to solve a particular challenge and their business model is built around that mandate or goal. The organization begins life with a regulative posture and the focus is on serving constituents who are eligible for particular services while complying with categorical policy and program regulations. In practice, operating at this level enables an organization to respond to near-term and acute problems – a valuable capability – yet too much emphasis on regulative competencies will diminish the organization's ability to collaborate across agencies to meet greater demands. The organization quickly finds that in order to meet the most pressing challenges it has to improve coordination and the flow of work with complementary organizations.

Ruth is making headway by focusing on three major fixes: First, she's realigning the departments into one agency that leverages all resources and centers them on client needs. Second, work flow and processes are being redesigned to create greater collaboration between existing "siloed" programs. Third, her team is identifying methods and opportunities to restructure in order to reduce the workload and associated costs. "In our Business Reengineering, we wanted to speed up our processing for our eligibility services," explains Ruth. "Our targeted areas of improvement are increasing the access, improving the customer flow, automation for our staff - true automation that helps their work, not increases their workload because we've given them something they can't manage - reducing duplication of effort and gaining efficiencies."

The end product of the reorganization and reengineering will be a system called Common Access Front End (CAFÉ). CAFÉ will integrate management and delivery of social service programs through a customer service call center, electronic case record management, an online client portal and a worker portal that enables a cross-program view of the customer.

Clarence Carter relates his experience during his tenure in Washington: "When I got to the D C's Department of Human Services, I found an agency that was highly regulative. It was a community and culture of protection. We were actually counter-collaborative over the course of years. We had a 20th Century infrastructure – it was all paper-based. We had 22 million paper records, and we couldn't serve you in any other part of the city than that which you live because that's where your case file was located."

Clarence Carter
Washington DC

This has been a significant challenge for years. Since the mid 1900s most human services programs, processes and systems have been formed in "silos" – the categorical agency lines of business. Historically this served a good purpose, as categorical management made it easier to match services to distinct constituents and to raise and track funding. But as the silos have grown, so have the difficulties in collaboratively addressing an individual's or family's comprehensive needs. The inability to effectively communicate and work across traditional agency and program boundaries has brought challenging consequences not only in terms of case management, but also from redundant costs and efficiency perspectives – depleting the capacity to truly focus on the client and outcomes.

The Washington DC plan will focus on developing and aligning staff around outcome measures. The goal is to reform processes and workflow to reduce the number of compliance staff from 35 percent to 18 percent and shift people to client-facing, outcome-generating work.

Moving Up the Human Services Value Curve

As a leader begins the journey to a more collaborative business model, they'll find it's partly an organizational challenge, partly a system challenge and partly a political challenge. From an organizational view — a single agency or program — the primary levers a leader has in increasing the organization's operational capacity are in the internal value chain: the people and culture, management and operational processes, and capital and technology that enable it to perform more efficiently and effectively. When an organization improves capacity and successfully achieves its mission and outcome goals, it solidifies legitimacy and support. That's what keeps the organization "in business."

From a system view — across organizational and program boundaries — the primary levers to increase capacity are to align policies and goals horizontally across programs, and improve managerial and operational processes and divisions of labor vertically by leveraging and sharing capital (infrastructure, systems, tools and technologies) and human resources. When leaders can balance and optimize these levers, the human services system will become not only more efficient and effective but also improve its ability to deliver new services and outcomes sought by communities, groups and individuals.

Thus when making the first moves beyond a Regulative business model, one should look to the mission of the organization and the outcomes desired from programs. Then, take a portfolio view by scanning programs to assess where collaborative connections can be made. At every level of the Human Services Value Curve, organizing around outcomes and measures is paramount[1]. This is especially true for organizations starting with a Regulative Business Model as they emphasize measuring compliance, i.e., did we verify a client was eligible and did that client get their benefit? In Washington, "the three things that we measured in the administration of the Supplemental Nutrition Assistance Program are, did we get the benefit to that individual or family that was entitled to receive it? Did we get it to them in the appropriate amount, and did we get it to them in the right time?" Clarence says, adding that the agency is now looking to take the next step. "I believe that we can continue to measure accountability for a program to ensure for the taxpayers that the dollars are expended for the intended purpose. But, I would argue for balancing what we measure by adding measures of human well-being, for us to determine at the end of the day, did anybody get better because of it? And if not, what do we do to achieve that objective?"

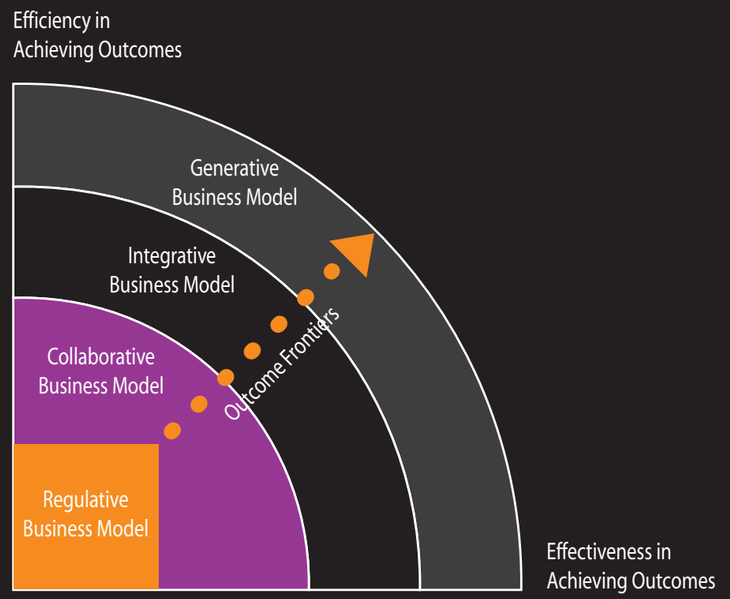
Moving up the Human Services Value Curve – Key Strategic Steps:

Starting with an outcomes view, prime areas for advancement are the programmatic measures, basic managerial and operating processes and program infrastructure.

- **Define and extend enterprise-wide measures:** Make an attempt to extend measures across programs and assess if the results have been beneficial. A key theme is to not only measure the results that are important to program operations, but also results that are important to achieving outcomes.
- **Start reforming managerial and operating processes:** Shift the organization's employees to capacity-oriented work. Basic process reengineering is valuable if it can enable employees to orient their work around assessing and managing the degree to which a program actually grows the capacity of the customer served.
- **Collaborate on program technology and tools:** Develop a basic plan to share more infrastructure across programs and if possible, across organizational lines. Good places to start are on routine technologies such as document imaging, digitizing and storage, allowing employees across programs to access and update client files, and enabling clients to submit basic applications for services online. Like Clarence and Ruth, make sure to tie infrastructure investment to key outcome goals.

Collaborative

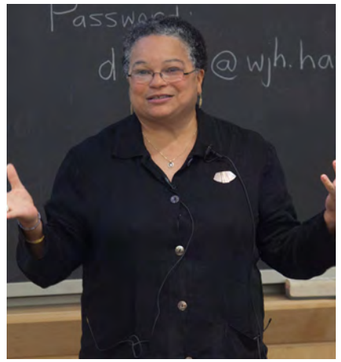
As a human services organization progresses to a "Collaborative Business Model," the focus expands beyond program "silos" and categorical management to support constituents in receiving all the services for which they are eligible and helping them address immediate needs. In action, entities collaborate on some policy and programs and may have some common intake, eligibility and team-based case planning. The technologies and tools adopted facilitate limited cross-organization information sharing and decision making.



Collaborative Business Model

"We need to transform to a culture that is outcomes-focused, not just budget or process-focused. We need to talk more often and openly about what our policy and program goals are, and use performance information that communicates how well we are achieving those goals as the starting point for our management discussions, rather than an after-the-fact reporting requirement. This change in culture is not easy, and will take several years." From Massachusetts' EHSResults Mission Statement

What distinguishes the Collaborative Business Model from the Regulative is the degree of alignment among the desired outcomes, policies and processes and the extension of that alignment across organizations and programs. The enterprise-wide alignment helps the entire human services system respond to a client in a coordinated and comprehensive way. In moving to a Collaborative Business Model, the primary leadership responsibility is to work diligently across organizational boundaries in order to find points of program collaboration and apply a governance model that keeps stakeholders engaged and committed.



Judy Bigby
Commonwealth of Massachusetts

In Massachusetts, Judy Bigby, secretary of the Executive Office of Health and Human Services, started the move to collaboration by focusing on an area that makes ears perk up – agency budgets. With the executive sponsorship of Gov. Deval Patrick, Judy created an initiative to measure outcomes across state agencies and programs in order to find areas for improved efficiency and effectiveness. To start, she directed conversations to the following questions: What are we doing with taxpayer money and why? How do we know whether or not we're reaching the outcomes we want to achieve? Initially, the answers weren't what she was looking for. "What I got from agency after agency for the most part was I need this line item, this line item, this line item," recalls Judy. "So, I started asking about the results we're achieving from these programs that are divided up in all these line items and I found out that there really wasn't that much information about results or outcomes."

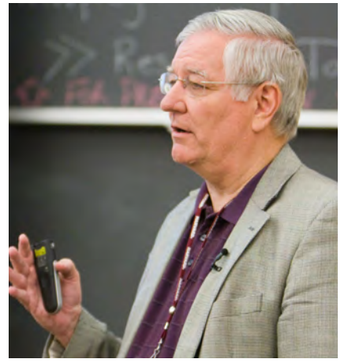
From this kernel of insight the EHSResults initiative was jumpstarted. The goal of EHSResults is to maximize achievement of human services outcomes. To make this happen, Judy's team collects data and metrics for every human services program the state runs, then incorporate the analysis into cross-agency policy and program decision making. It's changed how they do business. "We use the information in leadership meetings to look at the progress we're making toward the goals," explains Judy. "People actually can see how we're using the measures to make decisions about what we're doing, about policies, about budget decisions and it also allowed us to do a better job of looking at how we align functions and work across agencies in order to achieve common goals and system-wide outcomes."

A key leadership lesson from Judy's experience is to gain the buy-in of both the leadership level and program level executives. On the senior leadership side, the goals of EHSResults align concretely with the governor's agenda for improved outcomes and increased transparency, and program staff develops the goals and measures with their peers. From the executive to caseworker levels, people can see how they're performing simply by looking at the metrics, which solidifies and validates the initiative. The new level of transparency "closes the loop," as citizens can go to the web and look at measures that are understandable and relevant. Lastly, and importantly, the increased visibility into the effects of changes to policies or programs drives improvement across the entire human services system, and this will enable Massachusetts to move to a fully Integrative and Generative Business Model faster.

In Oklahoma, Howard Hendrick, director of the Oklahoma Department of Human Services, is leveraging a strong Collaborative Business Model to make a move to increased integration. For the State of Oklahoma and Howard's team service integration isn't an option – the new reality they're working in demands it. From 2002 to 2010, the human services system lost eight percent of its employees. The number of children on various subsidized programs and in the adoption program has increased by more than 100 percent. There has been a 73 percent rise in elderly care, 62 percent increase in food stamps, 55 percent increase in paternity establishment for child support and a 43 percent increase in Medicaid participation. Overall there's higher demand, fewer resources, and 80 percent of the families served are in more than one program –the perfect storm for human services.

Howard's vision is clear. "It really gets down to our mission statement. We try to drive that as far in the organization as we can. 'We help individuals and families lead safer, healthier and more independent productive lives.' And if we really believe that and see that as our job, then we have to work collaboratively and integrate systems. It's better for us, better for customers, and better for outcome achievement," he says. To realize the vision, Howard launched an enterprise-wide program called MOSAIC. This initiative will consolidate three legacy systems into one integrated system, replace a 30 year old development platform, and reform program-based (silo) operations to functional based. Most important, the new combination of cross-boundary collaboration and technology-enabled integration will streamline eligibility so that customers only have to apply for services once. The state will confirm eligibility and enable caseworkers to collaborate on client solutions – bringing improvements in effectiveness, efficiency and outcomes.

For Howard and his team, aligning policy and process has been instrumental in moving forward. In many organizations the opposite is true – innovations get held up or stopped by outdated processes that have become calcified across the organization. Thus the common question, "why does it take 10 people and 45 days to process this form?" is met with the common answer, "because that's the way it's always been done." When you have clear policy goals and can translate those to organizational actions, it becomes obvious how to change operational processes. Howard has used policy goals to "rationalize" (optimizing workflow to achieve goals such as improving accuracy or speed, reducing cost, improving customer services, etc.) processes and process-related definitions. "When policy drives process, you'll find performance gaps that clearly need to be fixed," he explains. "For example, you'll probably find that the definition of a 'household' for food stamps is not the same definition of 'household' for some other program, a 'case' in child welfare is not the same thing as a 'case' in child support enforcement, or a 'case' in the food stamps program. So you have to harvest all this data, get a common understanding about what the data means, and then synchronize it across organizations and programs." This isn't easy work, but it's "the roll up your sleeves and get it done work" that underpins cross-boundary work and integration.



Howard Hendrick
State of Oklahoma

The result of Howard's efforts will also bring a strong return on investment to the state. Projected costs are $6.2 million annually for nine years. Projected savings include an $8.5 million increase in child support collections, $3.7 million in administrative savings, $5.2 million savings in staff hours and nearly $1 million in decreased system maintenance costs.

Moving Up the Human Services Value Curve – Key Strategic Steps:

Starting with an outcomes view, prime areas to move forward are alignment of policy and program strategy, basic integration of case information and adoption of technologies that enable collaborative decision making.

- **Develop policy and program strategies across programs:** As in Massachusetts, drive the collection and analysis of measures and metrics deeper within organizations and across programs. Set up a team to analyze and determine what is working well and what could be improved and then map the areas of improvement to specific policies and programs. In particular, find the intersections of new value, i.e., where agencies and programs can collaborate in order to improve outcomes. Then, with strong executive sponsorship, remove the barriers to improved collaboration and institutionalize the new model of performance.
- **Share eligibility, service delivery and case information across programs:** Multi-need individuals and families are a critical area to address as solutions tend to be more complex and take longer to work. Find ways, both procedurally and technically, to share information, processes and case information. Oklahoma, for example, is integrating applications for TANF, SNAP, CHIP and Medicaid with single intake processes supporting all programs and with technology and business processes to support integrated eligibility for those programs. This will allow caseworkers to collaborate on solutions and help clients move to self-sufficiency faster.
- **Utilize technology and tools that enable decision making across organizations:** Organizations, programs and staff can collaborate in basic ways without the use of technology and systems, but in today's world, information and communication technologies dramatically enhance collaborative capability. Even if you're not ready for a full integration project, make smaller strides by adopting technologies such as digital records, enterprise content management and document storage, customer self-service modules, and basic staff communication tools. Not only will you improve workflow and collaboration, but also your trajectory to long-term integration.

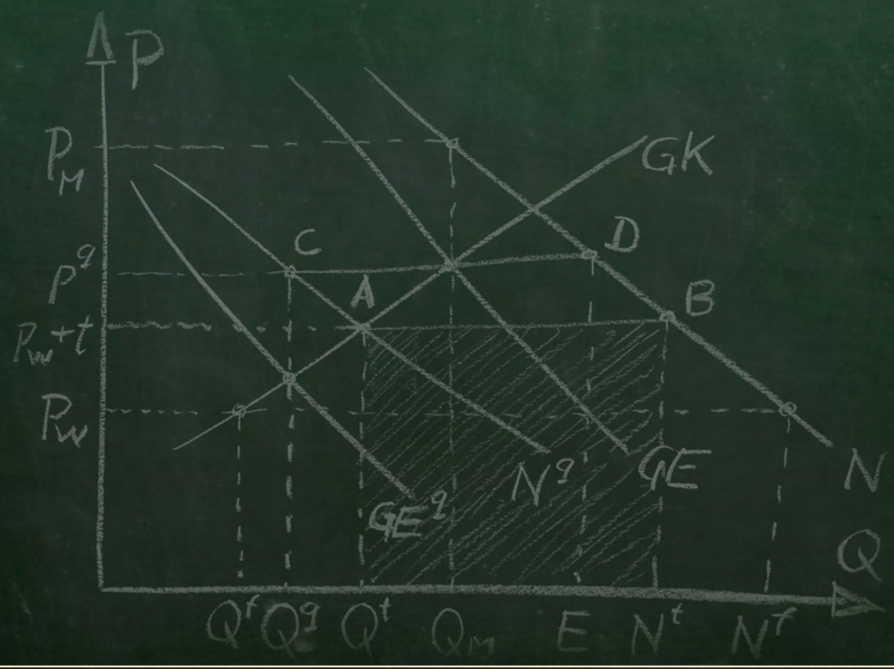
Economics of Human Services Integration

Since the mid 1900s most human services programs, processes and systems have been formed in "silos" – the categorical agency lines of business. Historically this served a good purpose, as categorical management made it easier to match services to distinct constituents and to raise and track funding. But as the silos have grown, so has complexity. Agencies and programs developed their own infrastructure, processes and systems, and as complexity increased, tradeoffs were made between efficiency and effectiveness in the production of services. This led not only to system-wide inefficiencies but also to less cohesive customer service.

Managers historically had two broad options for optimizing this "production function." [6] They could pull resources (capital and labor) in and focus on maximizing efficient production through standardization of processes and technologies and direct central control – but this limited flexibility and responsiveness at the local agency level. Alternatively, they could push resources out and provide extensive customization and local control of production to agencies – yet this option ignored volume efficiencies, produced duplication and raised overall costs to taxpayers. It was a lose-lose proposition.

Now the formula has changed. In just the last few years, the combination of new organizational structures, network-enabled business models and shared services platforms has created a new level of optimization – one in which overall capacity has grown and can be extended across an enterprise. These innovations interrelate and include:

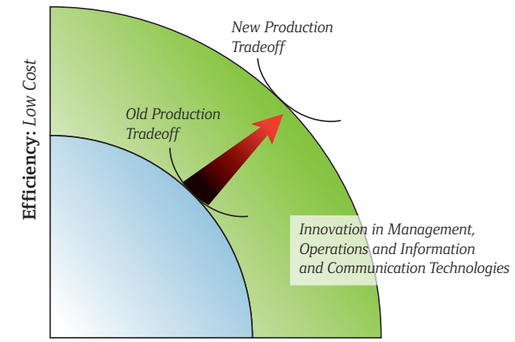
- **Organizational Structures:** Advances in management theory – particularly around management and business process - have led to new ways in which an organization can enact policy. The series of activities that form how an organization designs, produces, markets, delivers and supports its services have been subjected to collective knowledge (such as time and motion studies) and are now able to be done faster, leaner and in "flatter" organizational structures.
- **Network-Enabled Business Models:** Networks and information flows – in particular "Web 2.0" technologies and "cloud computing " – make cooperation and coordination possible in configurations where the transaction costs would have been prohibitively high in the past. The hardware, software and networks that enable an organization to create, store and use information in all its forms have advanced to a point where people can work "virtually" and processes can be streamlined, integrated and synchronized over any distance. Networked government can now provide control, accountability and predictability, while also accommodating flexibility and innovation.



- **Shared Expertise, Processes and Technologies:** Shared services – a method of ordering work so that business processes and the people who do those processes are brought together in new and more efficient and effective ways allow workers to specialize in processing transactions quickly and effectively. This drives down cost and enables the organization to transfer costs from back-office business processes to programs that really impact clients.

Underpinning the above innovations are continual advances that make collaboration and coordination more efficient (Metcalfe's Law) and that make information processing more powerful (Moore's Law). Collectively, this enables more granular standards so that standardized systems can support customizable solutions. Standards need no longer mean "one size fits all." Information infrastructure can now share the data and processing needed to customize agency and citizen services efficiently and effectively in real-time. This has fundamentally changed the equation and shifted the capacity curve up and to the right as managers can gain both efficiency (low unit costs) and effectiveness (high quality) by moving to new and/or better production methods.

New Production Possibilities = Increased Capacity



Extending this increased capacity across human services agencies and programs can amplify the effects of these laws. This amplification is based on increasing the return on labor (through specialization of management and operational processes) and increasing the return on capital (through higher utilization from the volume of production). The total potential for increased capacity depends on the number and size of organizations in the collaboration and the depth of integration in programs, production and provision.

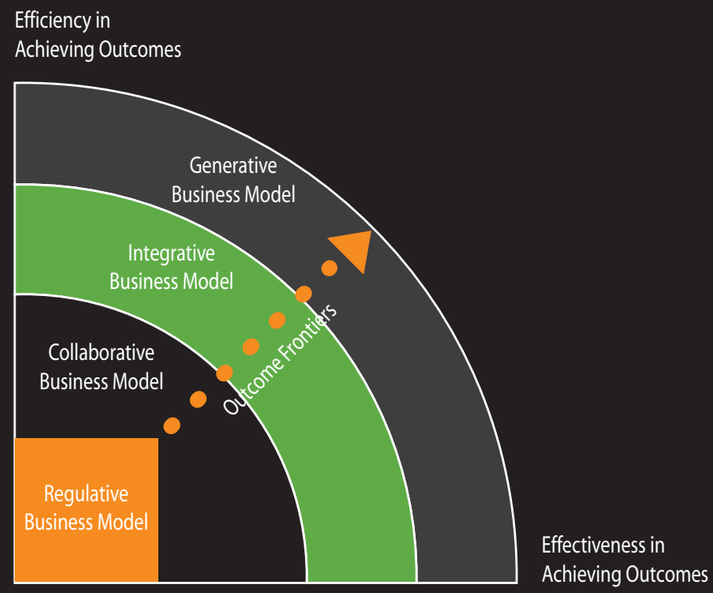
Human services enterprises that adopt these new models of doing business will be better able to meet demands for improved services and lower costs through:

- **Greater Returns to Scale –** organizations can produce more with a constant proportion of inputs, i.e., "We can do more with the same amount of resources." The consolidation and combination of certain functions can reduce fixed costs by removing duplicate departments or operations and lowering the cost of services, thus increasing taxpayer return on investment and public value.
- **Greater Economies of Scale –** organizations can produce more when input proportions are variable, i.e., "We can double our output with less than a doubling of cost." Instead of multiple agencies working at less than full capacity, a single (shared service center) or smaller set of agencies can leverage processes and technologies, maximize existing capacity and decrease overall costs.
- **Greater Economies of Scope –** organizational outputs by a single entity are greater than outputs that could be achieved by two different agencies each producing on their own, i.e., "We can share expertise and processes to get more for less." In these cases, human services organizations can gain efficiencies associated with demand-side functions, such as implementing new business models for intake and case management, eliminating unnecessary duplication and adopting new shared technologies.

In sum, harnessing newfound capacity with the combination of new organizational structures, network-enabled business models and shared services and extending it across boundaries increases capacity and public value in human services.

Integrative

With an "Integrative Business Model," the focus broadens to complete integration of multiple programs and services in order to improve customer service, increase participation and support data- driven policy and decision making. Strategically and operationally, the enterprise addresses family centric outcomes through seamless, cross-boundary collaboration. Information technologies support enterprise-wide back-office processes, as well as front-office innovations such as individualized client services focused on self-sufficiency, improved health outcomes and social inclusion.



Integrative Business Model

"We're very big on looking at capabilities as opposed to disabilities. Our goal is client self-sufficiency. We do services in the community. We go to people's homes. It's not about 8:30 to 4:30, Monday through Friday. It's about where people are and what they need. Cultural and community competency is important and everybody is a unique individual so you have to have some individually tailored services. The cookie-cutter approach doesn't work and with so many people in multiple systems, you have to integrate and provide holistic services," says Marc Cherna, director of the Allegheny County, Pa. Department of Human Services.

Marc Cherna
Allegheny County PA

Moving to an Integrative Business Model is born from the recognition that the world is giving us more complex problems and we need more robust ways to respond. There are countless stories of a parent working to become self-sufficient, receiving temporary assistance, employment services and finding a job, but then not receiving child care assistance. The parent can't keep the job, has to reapply for nutrition assistance, and winds up in a worse place than before. With integrated services, caseworkers from multiple organizations work together to solve complicated cases. An Integrative Business Model lays the foundation for providing truly customized services that address complex challenges and lead to family centric outcomes. Customization is the caseworkers' ability to mix and match services from an array of programs and synchronize them so they reinforce and strengthen each other. This level of integration relies on the ability to share data across multiple entities, and make decisions with a full-service view.

In Allegheny County, Marc has worked hard at achieving an Integrative Business Model. His goal has been to provide a holistic, consumer-centric service delivery model around specific client groups. There's a lot riding on success. The county has 1.3 million people - and some 250,000 of them are receiving human services. Within the county, 41 percent of clients (as of 2009) are multi-need – receiving services from three or more programs. Multi-need clients put enormous stress on human services systems as costs are higher, solutions more complex, and often they're reliant on the system for a longer time.

When Marc took the reins of the children and youth system, it was in complete disarray. There were highly publicized child deaths, vicious public hearings and community confidence was at an all-time low. He took immediate steps to stabilize the agency through a number of internal and external actions, including getting the largest law firm in town to do pro-bono adoptions to reduce the backlog. Within the year, The County Commissioners asked Marc to take five discrete departments and form a department of human services. To get support and buy-in from the leaders of the private and public sectors, he created an oversight committee of community leaders to assist in the development of a new human services management structure and advise on the organizational change process. Using technical assistance from the Chamber of Commerce and financial support from the local foundations, the county was able to consolidate its fiscal, human resources and information management functions, its community relations and public information functions, and its data analysis, research and evaluation functions . In addition, the policies, programs and processes of previously separate organizations were aligned to permit coordination of services for multi-need consumers through its five program offices. Very importantly, Marc engaged the community and key stakeholders in the transformation effort – they developed the vision and operating guidelines and were an integral part of the redesign process.

Allegheny County is a strong example of the importance of innovative governance and strong executive sponsorship. "This really becomes adaptive work," says Marc (see sidebar on the Adaptive Challenge on page 34). "We have to invent new ways of doing things, and new ways of working. There's little formal authority when you're going across boundaries unless you create a new boundary and then a new form of authority." When transforming an entire human services system, one person can't possibly redraw all the lines; it takes a coalition of like-minded people. In this case, community businesses, churches, non-profit organizations and a mix of elected officials were all at the table. This helped de-politicize the reform, an important ingredient to gaining buy-in.

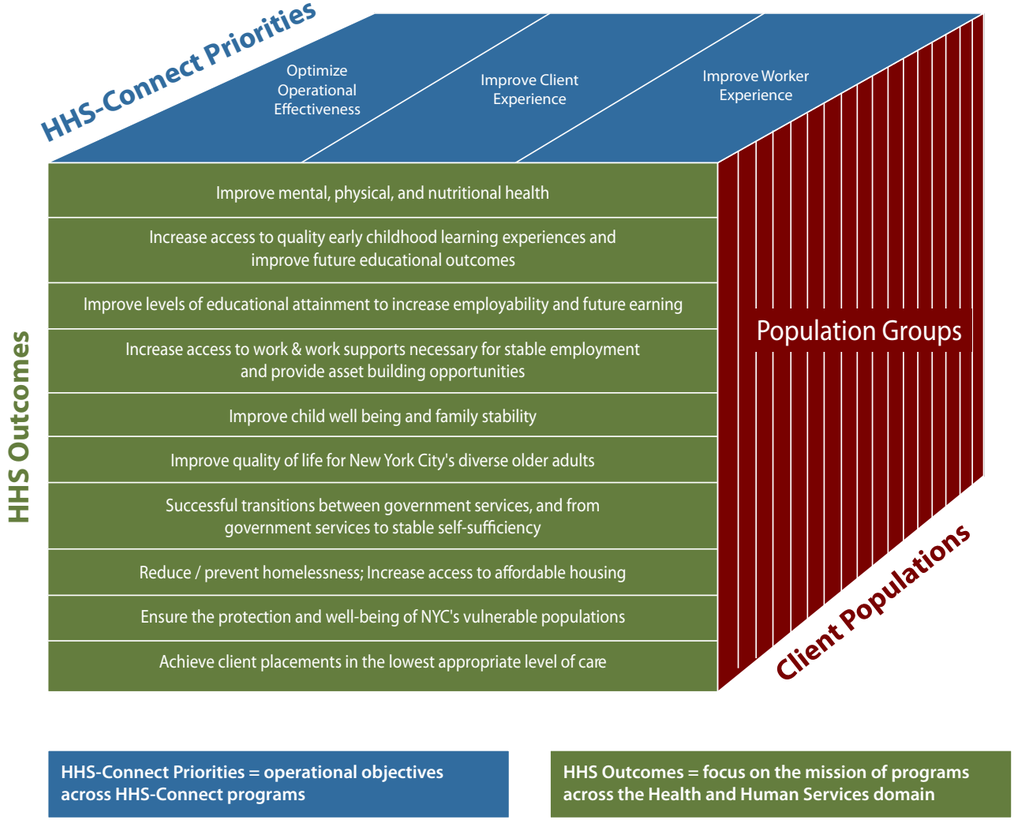
Beyond the client-facing benefits, consolidation and automation also helped to reduce administrative staff by 50 percent. "We used to have the assembly line and silos – 17 people had to touch a piece of paper to make a payment. Now it's two people, and we are much more efficient," explains Marc. The new business model also helped the county maximize utilization of existing funding streams and create opportunities for new and flexible funding sources. In addition, greater accountability was brought to the system through increased transparency, inclusive public participation and openness and accessibility for all stakeholders.

New York City is another shining example of the Integrative Business Model, and by many measures it's the most advanced in the nation. New York City's HHS-Connect system integrates 35 programs offered by 15 different agencies. Robert Doar, director of the New York City Department of Social Services provides some history. "This is about information access that gets outcomes. We had all this data in multiple agencies, and not enough people could see it, and we wanted a single consolidated view of information. We wanted a worker at the Public Housing Authority, or a worker at the Administration for Children's Services who has the child protective report, to be able to see quickly whether a family was on food stamps, on Medicaid, on cash assistance, and other information we could synthesize in order to make better decisions and provide improved service."

Integrating all the agencies and programs was a monumental task. New York City is the largest municipal government in the nation; approximately $20 billion is allocated annually to human services and its more than 50,000 employees. Thus, a strong vision and dedicated leadership from the top was imperative. Fortunately, Mayor Michael Bloomberg and the deputy mayor of health and human services were of like mind and resolve – they knew New York City had to stay ahead of the curve. Mayor Bloomberg and his deputy mayors have always been proponents of performance management and they wanted health and human services agencies to share client data where appropriate, and use it to generate business analytics. Much like New York City's award-winning COMPSTAT and 311 systems, data and metrics could take the pulse of the city in order to improve service delivery and outcomes.

HHS Outcome Model

The HHS Outcome Model was defined in the Summer of 2008 to develop a cross-agency means of measuring success. The model illustrates the interconnectedness of the HHS Outcomes, the HHS-Connect Priorities, and impacted Client Population Groups.



HHS-Connect Priorities = operational objectives across HHS-Connect programs

HHS Outcomes = focus on the mission of programs across the Health and Human Services domain

To gain a solid understanding of the data and analytics needed, officials first started with the citizen view to determine what service features would be most valuable and lead to the best outcomes. They then turned to the caseworker view to determine what information would lead to the best formulation of services. The resulting HHS Outcome Model illustrates the interconnectedness of outcomes desired, the HHS-Connect priorities, and impacted client population groups. The city uses the outcomes model as a sounding board and measuring stick for every health and human services initiative they undertake. In addition, the model helps determine return on investment. For HHS-Connect, every aspect of the project was evaluated in terms of return on investment and outcome generation, and each initiative had to pay for itself through savings, reduced headcount or greater productivity.

Robert Doar
New York City

As with every major human services transformation, establishing a new cross- boundary governance framework was integral to success. "I cannot emphasize enough the importance of governance structure. It's boring, it's painful, it's very much 'process,' but it is essential to running one of these projects successfully, and I think we got that right," explains Robert. "Integration ends up being deeper into the production process, not just the eligibility and delivery but also the policy development and the formulation of programs. So the more legitimacy through governance we give to this, the bigger and broader problems our organizations will be able to address."

The results generated from HHS-Connect speak for themselves. City residents can see whether they're eligible for multiple programs on one site, which also provides online access to benefits. The system decreases cultural barriers through seven different language formats. Customer surveys show that people are using it in libraries, at home and in community-based organizations. There's also a worker portal that allows staff from multiple agencies to see (with appropriate privacy standards at each level) metrics and analysis across agencies and programs.

With all of this success, officials in New York City are looking to the future. "Here's where we get into the second generation –the generative level," projects Robert. "Eventually we're going to have adaptive enterprise case management practices where we're all learning how to work in real-time and how to adapt services to special conditions, especially on those hard-to-solve cases of children or families who are in numerous programs and stuck in the system. We're going to solve this, and our families, communities and city will be stronger," he says.

Moving up the Human Services Value Curve: Key Strategic Steps:

High-performance governments and human services agencies use customer-generated data and metrics to provide better services and improved outcomes. Integrated human services are dependent on these forms of metrics. Prime areas to move forward are linking overall government performance to human services measures, developing deeper governance structures and deploying a complete, single-view system for customers and caseworkers.

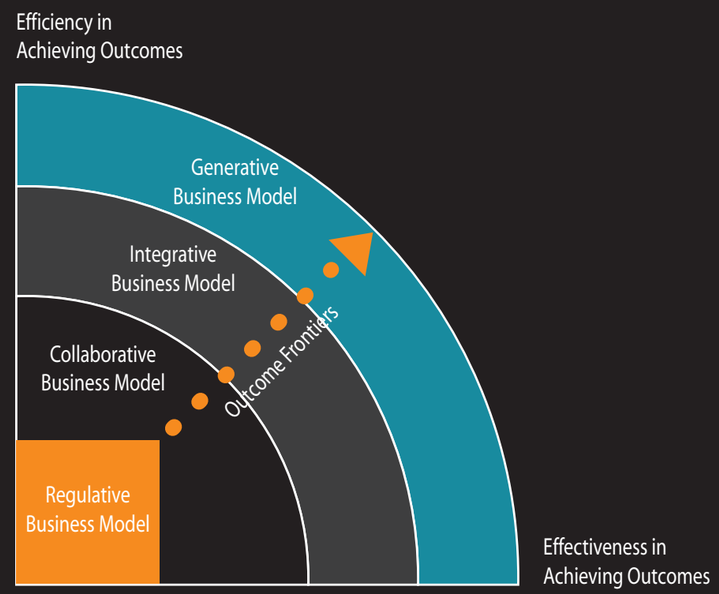
- **Develop a performance management system that supports fully integrated, client-centric service delivery:** Formulate a human services model that connects desired outcomes to overall community priorities and expand the focus to include cross-agency outcomes, metrics and real-time situational awareness. Analyze the data at regular meetings (New York City has weekly reviews) and adjust policies and programs to improve client and outcome focus.
- **Develop governance structures and business processes that focus on common outcome goals and the support of cross-organization coordination:** Utilize the new performance management system to drive cross-boundary governance changes deeper into agencies and wider into programs. Then leverage the governance model to eliminate agency vertical silos and replace them with horizontal, cross-boundary services.
- **Implement an integrated, single-view system for case management across programs and organizations:** Break information silos through the use of modernized technology that enables coordinated agency processes through multiple access channels for customers and an enterprise-wide view for caseworkers. Strive for a system that provides client service information and pre-screening, application filing, client intake, needs assessment and referral, eligibility determination and benefit processing, case maintenance, reporting, performance monitoring and outcome tracking.

"During the next phase of human services transformation, the unit of change is becoming larger, extending across policy domains and traditional jurisdictional boundaries."

Jerry Mechling
Founding Director, Leadership for a Networked World.
Lecturer in Public Policy, Harvard Kennedy School

Generative

At this level the focus of the human services organization expands to address multi-dimensional family problems, socioeconomic issues and opportunities required to generate long-term individual and community success. In action, the culture, managerial and operational processes and technology of the organization will likely be adaptive and modular, allowing multiple programs and institutions to build, share, and deploy services on an ongoing and evolving basis. Additionally, social networks and advanced information analytics will help organizations synthesize information and trends across the ecosystem of organizations, jurisdictions and communities in order to become predictive in nature – enabling co-creation of policy and adaptation of programs in response to real-time conditions.



Generative Business Model

"When I look to a Generative Business Model I see a human services platform that's completely seamless. We're still building on integration – but everything will be interconnected," says Greg Wass, CIO of Cook County, Ill. "The challenges we'll face in the future will be more complicated and our employees will have grown up working and thinking differently. This all has to be fused together somehow in a way that leads to improved public value and outcomes. As leaders, we need to figure out how to get ready for this future."

To address these challenges and the opportunities of a Generative Business Model, a dynamic panel of practitioners took to the stage at the Human Services Summit to discuss how leaders should prepare and respond.

Greg Wass
Cook County IL

Moving to a Generative Business Model is first a response to the rapid evolution of the human services "insular system" to an "ecosystem" of complex social challenges, changing customers, a new generation of workers, streamlined government and the information-intensive thread that weaves through all of these. While no human services organization has achieved this vision and business model in its entirety, some are touching it with innovative pilots, and much can be learned from other public and private sector examples.

As leaders look to this future, they see one where services will have to meet the demands of a massive number of retirees, a new generation of people who have grown up "digital," and a swath of people in the middle continually renewing their skills in order to remain middle class. Public sector organizations, following the private sector lead, will have to boost productivity by magnitudes in order to stay viable. Organizational structures will be lean and modular; perhaps even abandoning physical workspaces for digital access points and regional one-stop centers where an array of public programs all coexist. Human services workers and processes will wrap around and adapt to a "portfolio pattern" where work will comprise actively managing a set of resources, clients and programs, often without the constraint of jurisdictional and programmatic boundaries. Human services programs will be modular – assembled, disassembled, combined and packaged dynamically depending on the profile of the customer - and benefit levels will dynamically adjust as a digital record keeps track of the customer's patterns, usage and outcomes. Accountability, transparency and efficiency will be visibly magnified and quantified, as metrics and measures of resources and outcomes will be ubiquitous.

What are the underpinnings of this future? What should the human services community be thinking about when preparing for this horizon, and how should leaders lay the groundwork for responding?

Organizational Model

Karen Beye
State of Colorado

First, a Generative Business Model will reshape the structure of human services organizations. The most fundamental change will be the network-intensive focus of the organization and the ecosystem within which it works. As a result, organizations will be much flatter and leaner and the traditional hierarchies we've been used to will be gone. Managerial and operating processes and decision making will flow through flexible networks that cut across internal and external boundaries in order to develop and deliver services. Rita Landgraf, past director of the Delaware Department of Human Services, reflects on this future: "I think to actually advance into this model, the strategy has to go beyond the government, it has to go beyond just our respective departments, and it has to be a universal, social impact agenda that not only involves government, but also the communities where they are, the provider networks and the associations and advocacy organizations."

An example is the National Aeronautics and Space Administration's (NASA) deployment of Spacebook[7] – a social network that links together disparate groups, experts and communities of interest both inside and outside the organization. NASA is successfully using the system to share content, form and manage teams around projects, and facilitate peer-to-peer information sharing. Intellipedia – a collaboration across intelligence and defense agencies to share information and expertise - provides another example. Intellipedia is essentially "mashed-up" (various tools melded together to create customized functionality and user experience) Web 2.0 technologies such as wikis, blogs, document sharing etc. The agencies and communities of interest using Intellipedia have reported improved information sharing, idea generation and organizational learning. Many private sector companies are using networks such as this, as well as extending the networks to their business partners and customers. As these technologies and processes mature and become part of the Generative Business Model, caseworkers will get up-to-speed faster on client issues, share insights and co-develop solutions with external care and resource providers (such as local housing agencies, schools, churches, etc.) and generally become more efficient and effective.

Rita Landgraf
State of Delaware

Data, Analytics and Predictive Modeling

A Generative Business Model will be driven in large part by the digital future that awaits us. Massive amounts of data will be flowing through our communities, organizations and devices. This will not only force, but also enable new ways of doing business. In particular, pattern recognition and predictive analysis will become a core competency of human services systems. By continually analyzing data from communities and individuals, human services organizations and caseworkers will be able to forecast coming changes and respond faster and more efficiently.

For a glimpse of this future, we can look to the New York City Police Department (NYPD). The NYPD gathers information from systems, networks and sensors in order to find patterns and predict crime "hot spots." The department will then preemptively respond with resources in hot-spot areas. Furthermore, department leadership meets weekly to take the macro view and assess how successful they've been. All of this is driven by the stream of real-time data and metrics. The State of Illinois is experimenting in this area now. Researchers are analyzing large datasets across multiple jurisdictions to better understand multi-system families and their patterns and dynamics of service use. Based on the analysis of family and social patterns (a parent being incarcerated for example) researchers are able to effectively predict future challenges and opportunities for the family as well as resources needed to generate positive outcomes. Likewise, client outcome data can help inform the development of case service plans based on success variables related to services and presenting problems.

This predictive future that a Generative Business Model addresses will enable human services organizations to make smarter decisions and deliver better programs as information will turn into actionable knowledge. Policymaking will also be enhanced throughout the human services community as the measures and metrics that show what's working and what isn't working will help policymakers at the regional, state and federal levels to change program guidelines and rules faster and with keener insight on outcomes.

Client Interaction and Co-creation

While continuing to work in static ways with clients of the baby boom generation, human services organizations will dramatically change the ways they interact with the next generation. This next generation of client will be used to communicating virtually and with tools that are integrated into their daily flow of activity. The private sector is responding to this change (and in part driving the change) now as consumer-focused companies are increasingly allocating resources to communication technologies that align with customers' digital lifestyles. For example, some innovative consumer finance companies are integrating their traditional credit card businesses with mobile devices and shopping, and adjusting a customer's service depending on monthly patterns.

Tim O'Connor
U.S. Department of Agriculture

Experimentation on new ways of communicating with clients and the community is happening. The US Health and Human Services agency is using "crowd-sourcing" and peer-to-peer networks to generate ideas and solutions for pressing challenges[8]. Many human services organizations are using social networks and communication tools (Facebook and Twitter primarily) to communicate directly with the community about programs as well as track "service loads" across the city – enabling case workers to shift priorities and resources, create new solutions in real-time and link complementary programs in response to community needs. And recently, the US Department of Agriculture has approved waivers to allow dissemination of client notices using secure social media tools. The next phase of addressing these communication and interaction patterns will likely lead to benefits (food assistance, daycare payments, training credits, etc.) that are mobile, traceable and adjustable at regular intervals.

One could argue that a human service program shouldn't adapt in such ways – that customers should adapt to the service as they're the ones in need. But the point is that whatever human services programs can do to move a customer to self-sufficiency faster will lead to increased effectiveness and valued outcomes, and a positive return on investment.

Infrastructure and technology

As part foundation, and part response to the future, the infrastructure and technology of human services will adapt to the fluid, network-intensive landscape. As human services policy, programs and provision will be modular and adaptive, so will the information systems. Cloud Computing (accessing computer resources provided through networks rather than running software or storing data on a local computer), Web Services (software that makes it easier to exchange information and conduct transactions) and advanced social networks will hold together and run the organization. This approach is already happening in many private companies and is moving into the public sector. Many corporations, for example, use "cloud based" applications for email, documents and spreadsheets, customer relationship management, etc., bypassing the need for capital investments in servers and software and saving time and money. Greg Wass relates how this could impact his state. "In Illinois, we spend $150 million a year, not on new systems but on just maintaining the big IT systems we have across all these silos. We need to become person-centric, not silo-centric, and modular evolution could help us get there with better service at a lower cost."

Moving up the Human Services Value Curve: Key Strategic Steps:

To harness the advances of a Generative Business Model, leaders will need to prepare the entire value chain of human services, from policy to programs to production and provision. While the most profound changes will take place in the distant future, building towards integration and experimenting with generative tools will help readiness. Key areas to focus on are:

- **Foster an adaptive organizational culture that can anticipate changing community and client circumstances and shift priorities to maximize outcome achievement:** Start working now to identify program "portfolios" such as population subsets within a program or a group of people who work in a certain industry. Assess if your organization has methods to understand the dynamics of the portfolio and can respond to large changes. Based on your findings, run scenarios that would test readiness, such as responding to an influx of new immigrants or an employer laying off a large number of people.
- **Synthesize information enterprise-wide to support predictive analysis and policy and program innovation:** Establish a team to look at the current data stream your organization produces. Try to identify the patterns in the community of people you serve and the employees of the human services organization. Assess if these information patterns inform new ways (perhaps as a pilot project) to structure programs, processes and rules so that outcome-oriented innovation becomes the norm.
- **Extend the integrated-view system to all stakeholders and utilize social media and communication tools to co-create solutions with the community:** As a pilot initiative, connect (with appropriate privacy and security controls) key service providers to your integrated system. Look for ways to streamline processes or transactions, such as information sharing with daycare providers on attendance and payments. As a separate initiative, start a new method of communicating with clients, media, partners and the broader community via social networks. Analyze the feedback and communication you receive to see if there are opportunities for improving programs and services.

"Ultimately, your role as leader is to move your organization to ever higher levels of value."

Amy Edmondson
Novartis Professor of Leadership and Management, Harvard Business School

The APHSA CEO Retreat: Ideas for the Present and Future

In October, the American Public Human Services Association (APHSA) combined its annual health and human services commissioners' retreat with the 2010 Human Services Summit at Harvard University. The Summit's theme of service integration figures prominently in the thinking of these state administrators, who face unprecedented challenges as demand for program services and benefits escalates, state budgets are cut or frozen, and federal oversight and accountability tightens. The commissioners identified service integration, program simplification, communication across artificial turf and silo barriers, and a shared focus on outcomes as among solutions to these challenges that must be quickly developed and implemented.

APHSA CEOs also explored a number of potential routes to arriving at the solutions promoted above:

Share ownership and responsibility – A vigorous health and human services system is a necessary component of a functioning community. A sound health and human services system can help every other department avoid unnecessary expenditures and duplicated efforts. If all parts of the community act as allies and supporters, HHS departments across the nation can make remarkable strides. It is our goal to encourage more allies to align with our efforts.

Pursue health care reform opportunities – State health and human services departments have managed the challenges of supporting the health and well-being of our communities for decades. The new health care reform law presents challenges to this model but also offers unprecedented service integration opportunities. For example, moving toward a seamless health care system for all regardless of income can- if well managed - provide commissioners greater opportunity to link the most vulnerable citizens at the bottom of the income ladder to other types of assistance needed to transition to self-sufficiency. As states build information systems in support of the new health care system, these systems must be constructed with the capacity to exchange information across departments, have applications that function across programs and require a single "electronic home" for all health and human services customers.

Make connections across government – Our work cuts across many government divisions and silos and all affected parts of government must begin sharing data, case information, staff, ideas and responsibility for dealing with the issues we face. This is especially true for closely related systems such as public health, labor, juvenile justice and education.

APHSA is a bipartisan, nonprofit organization representing appointed state health and human service agency commissioners. APHSA was founded in 1930 as the American Public Welfare Association and changed its name to APHSA in 1997. APHSA is the only association of the nation's top government human service executives from all 50 states, the District of Columbia, and the territories – and their key state program managers, plus hundreds of county-level directors of human services throughout the nation – for the exchange of knowledge, data, best practices, policy review and development, networking and advocacy. APHSA houses nine affiliate organizations, whose members are the administrators which operate human service agency divisions or departments in the states and for the most part report to a state commissioner. The affiliates cover a variety of program specializations such as child welfare and income assistance programs as well as support functions such as program evaluation and staff training.

APHSA is committed to carrying out our work through strong connections and partnerships among the many areas of government and the broader community that affect the well-being of our citizens.

Move to immediate service integration – There is broad agreement that the federal health and human services policy and funding system is fragmented and disconnected. Required to work with separate federal agencies and congressional committees, states are continually frustrated in their efforts to provide holistic, person-centered services. The federal agencies and state systems must create new models that eliminate categorical inefficiencies and dysfunctional processes that have accumulated over decades. Reform will take time. But there is much that can be done now – through greatly expanded waiver procedures, fresh funding flexibility and transfer authority, steps to make accountability more rational and aggressive state action to implement known solutions. Work toward policy integration and operability at the national level must move urgently ahead, but currently available "work-arounds" must also be immediately employed.

Communicate the health and human services story – One of our greatest obstacles is the stubborn "welfare myths" around the programs we administer that persist. As those responsible for these programs and the results they achieve for vulnerable individuals and families, we know our programs provide essential support, improve health outcomes and are helping to move thousands toward self-sufficiency. We also know that they are among the most tightly managed programs in government. What we must do better is communicate our success stories to the public. We commit to working with local and national media, as well as on-the-ground organizations, to spread the word to constituents about the difference we make.

Submitted by the

APHSA
American Public Human Services Association

Human Services Transformation: the Adaptive Challenge

Moving to higher levels of collaboration and integration provides clear fiscal benefits, increased efficiencies and enhanced effectiveness – so why is it that some human services initiatives fail to launch and grow?

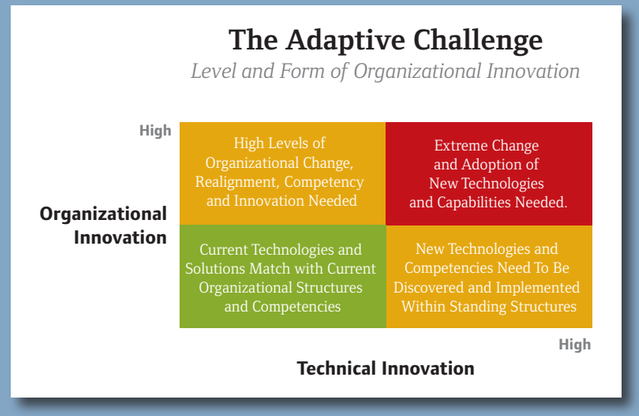
A fair guess would be that leaders underestimate the level, form and duration of change required to launch and sustain the effort. Yet the full answer is that leaders must recognize integration initiatives for what they are – a transformational change effort. Transformational change in human services goes beyond change management – and has some significant differences.

The differences reside in the necessity of innovating along two dimensions simultaneously – technical and organizational – and how the resulting tension impacts the social system and environment within which the human services enterprise operates. Broadly, the dimensions can be described as:

- **Technical Innovation:** This form of change is what we're most used to. Organizations and people experience this when implementing incremental change (such as updating a process, technology or management method) within their current organizational structure, authority lines and knowledge set.
- **Organizational Innovation:** This form of change is where most people and institutions get uncomfortable, as it requires the development and adoption of new competencies and capabilities – often within a new environment, governance structure and organizational design.

Combine these two dimensions and you have an "adaptive challenge" on your hands. According to Ron Heifetz, founder of the Center for Public Leadership at Harvard Kennedy School, an adaptive challenge "requires experiments, new discoveries, and adjustments from numerous places in the organization. Without learning new ways – changing attitudes, values and behaviors – people cannot make the adaptive leap necessary to thrive in the new environment. The sustainability of change depends on having the people with the problem internalize the change itself." Heifetz suggests transformational change cannot be affected completely through authority or (change) management. Rather, it takes someone exercising leadership to actively mobilize stakeholders to address real and perceived loss of important ideals, values and competencies that have been in place for years (if not for a lifetime) while also actively learning new competencies, capabilities and culture.

When people and social systems are working through an adaptive challenge, high levels of personal and organizational cognitive dissonance can arise. This state of psychological distress is caused by the variance between a projected or required future and the current reality. At high levels, the stress and fear of loss can spur people to work against the change. Thus the capacity of people and organizations to move through adaptive challenges and end up on the positive side of transformational change is largely dependent on planning for and exercising leadership by mobilizing groups to work through their adaptive challenges.



What happens when adaptation does not go well or when people exhibit maladaptive behavior? When personal and organizational dissonance rises to a level where such behavior occurs, the resulting disturbance can be enough to derail a human services initiative. Common examples of maladaptive behavior include:

- Avoidance: People disengage from the initiative – consciously or unconsciously – as they avoid the pain, anxiety or conflict that comes with actively working through the gains and losses.
- Direct push-back: People actively fight the changes taking place – often creating artificial barriers or arguments against the new ways of doing business.
- Circumvention: People bypass or work around the human services sponsors and lobby agency heads, legislators or whoever will lend a sympathetic ear in order to delay, distract or derail the initiative.
- Shadow Processes: People secretly keep past processes and operating models – duplicating work in some cases – in order to retain a sense of control. Shadow processes are particularly destructive to achieving new levels of efficiency and effectiveness as they undermine the performance that comes from a new business model.

Methods to Exercise Leadership and Mobilize the Human Services Stakeholders

Clearly the importance of exercising leadership through the human services adaptation is critical to success. Here are some recommendations for mobilizing individuals and organizations – and yourself:

- Understand and Assess the Psychology of "Gains and Losses": The first step is to understand the perceived and real value gains and value losses to each category of stakeholder, i.e., data center managers will perceive the value vastly different than an authorizing body or a senior executive in the initiative. It is important to discover both sides of the gain/loss equation as perceived losses affect adoption as much as perceived gains.
- Identify the Adaptive Challenges: Be in a position where you know what will happen next. If you assess and forecast where the adaptive challenges will arise you can start working with the people and units affected – moving them to surface and resolving the difficult tensions and tradeoffs related to their changing roles, capabilities, loyalties and identity.
- Pace the Innovation and Adaptation: Realize that people need time to work through adaptive challenges – and get to know their limits. As the saying goes; "Keep it hot enough but don't let it boil over." One way you can achieve this is by creating a "holding environment" (the term originated in psychoanalysis to describe the relationship between the therapist and the patient) for groups to discuss all of the issues related to the change in a non-judgmental atmosphere. The intent is to understand people's underlying fears and address adaptive questions such as: What do we have to give up to make this work? Are we competent enough for this new model? How will this change the identities of our current organizations? Do we believe in this new way of doing business?
- Protect Voices of Leadership: It's critical to find and protect the people who exercise leadership but who don't have the cover of formal authority. These people are the "change-makers" within an organization and usually have a high capacity for mobilizing themselves and their peers. Make sure you funnel them timely information, engage them in helping to voice the necessity of change, and protect them during the process.
- Hold Steady: Last – and most important – protect yourself. Realize that you are affected by the change and adaptation as much as others. Make sure you work through your personal adaptation- and even better if you can do some of it with others. A key element is clearly separating yourself from your role and understanding that maladaptive people will attack your role and your authority – don't take it personally.

For more information on exercising leadership and adaptive challenges please see:

"A Survival Guide for Leaders," Ronald Heifetz and Marty Linsky, Harvard Business Review, June 2002. [9]

"Leadership on the Line – Staying Alive Through the Dangers of Leading," Ronald Heifetz and Marty Linsky, Harvard Business School Press, 2002. [10]

"Leadership Without Easy Answers," Ronald Heifetz, Harvard University Press, 1994.[11]

"The Practice of Adaptive Leadership," Ronald Heifetz, Alexander Grashow, Marty Linsky, Harvard Business School Press, 2009[12]

Summary

The human services community has a capacity challenge. The environment of increased demand, compressed resources, complex social challenges and changing demographics has challenged the ability to deliver "public value" – the measure of how effective and efficient a program is in achieving outcomes.

Renewing capacity to reach client and family centric outcomes is the central thread to meeting demands today and in the future. But to get there, human services organizations must first improve their business models.

To help human services leaders improve their business models, Leadership for a Networked World and Accenture, in collaboration with the APHSA, convened the 2010 Human Services Summit at Harvard University. As an organization moves progressively through the Regulative, Collaborative, Integrative and Generative levels of the Human Services Value Curve, enabling business models and competencies mature and improve the organization's ability to deliver broader and more valued outcomes.

What's clear throughout is that new human services business models will have a family centric mission, will work across organizational boundaries to align goals, and will pursue a laser-like focus on outcomes. The policies, programs, production and provision of services will enable the mission and continually adapt to changing circumstances – all while striving to generate the highest level of capacity for the clients, organization, employees and the broader community.

In traversing the curve, leaders will have to guide their organizations and stakeholders to new models of governance, new organizational structures, new enabling technologies and new methods of delivering services.

The successful improvement of human services is vitally important to our nation's social fabric, economic competitiveness and equity in the American dream. We now have the strategies and technologies for high-performance. It's time to realize the vision.

About Accenture

Accenture is a global management consulting, technology services and outsourcing company, with approximately 211,000 people serving clients in more than 120 countries. Combining unparalleled experience, comprehensive capabilities across all industries and business functions, and extensive research on companies around the world, Accenture collaborates with clients to help them become high-performance businesses and governments.

Human services agencies worldwide are delivering family first human services. Many are moving toward high performance with integrated delivery approaches that center on families' needs – so people get the right services at the right time with the right outcomes. These agencies rely on Accenture's policy and business understanding, technical know-how and experience to realize their family first vision.

The 2010 Human Services Summit: Integrated Service Delivery - Realizing the Vision, held at Harvard University, was developed in collaboration with Accenture. Find more information and videos from the summit at www.accenture.com/integratedservicedelivery.

About Leadership for a Networked World

Leadership for a Networked World (LNW) helps those exercising leadership to better understand and respond to the challenges and opportunities created by information and communication technologies and network-enabled business models. Founded in 1987 at Harvard Kennedy School by Dr. Jerry Mechling, LNW now works across the Harvard community and globally to provide uniquely powerful executive education, research and advisory services.

Current LNW efforts are focused on the challenges of innovation and change moving across traditional organizational boundaries: departments, jurisdictions, branches of government and sectors of society. These cross-boundary reforms represent the next wave of the many opportunities and challenges opened by information and communication technologies and network-enabled organizational models.

Leading successfully in this networked world requires executives to collectively make difficult decisions and choices about the level and pace of reform and change. By bringing together leading practitioners, academics and executives to share ideas and learn about governance, LNW strives to deliver creative solutions to real-world problems and enable lasting public value for pressing challenges. Find more information at www.lnwprogram.org.

About the Author

Antonio Oftelie is the executive director of the Leadership for a Networked World Program (LNW) where he guides overall program development, produces research on innovation in policy and technology, and teaches cases on leadership and strategic management. In addition, Mr. Oftelie advises senior government and business executives on organizational transformation by helping them to evolve their mission and strategy, ideate new business and service models, build adaptive capacity, and create performance and value measures.

Mr. Oftelie is a recognized expert in technology-enabled innovation and organizational adaptation and has directly advised and written for four governors, federal agencies, states, and numerous private and public companies on topics ranging from homeland security and pandemic response to economic development to product and service design to organizational collaboration, government relations, and public-private partnership strategies.

Mr. Oftelie holds a BS in Management and Ethics from Crown College and an MPA with a Business and Government Policy concentration from Harvard University where he focused his studies on leadership, finance, and public policy at the Harvard Kennedy School, and on strategic management, technology, and innovation at the Harvard Business School. He can be reached at antonio.oftelie@post.harvard.edu.

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12 The Practice of Adaptive Leadership," Ronald Heifetz, Alexander Grashow, Marty Linsky, Harvard Business School Press, 2009

Supplementary Resources

- For information on human services interoperability please see "Human Services 2.0: Implementing InterOptimability" and "From Field to Fed: Building an Interoperable Continuum of Care," both by Stewards of Change and accessed at www.stewardsofchange.org.
- For information on high performance in human services and in the public sector, please see Accenture's latest research at www.accenture.com/integratedservicedelivery.
- For strategies on transformation public policy and government operations, please see "The End of Government as We Know It – Making Public Policy Work," by Elaine C. Kamarck.
- For broad insight on digital trends in government, please see "Governance.com – Democracy in the Information Age," by Elaine C. Kamarck and Joseph S. Nye Jr.
- For research and national initiatives in human services, please see the American Public Human Services Association at www.aphsa.org.

"The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty, and we must rise to the occasion. As our case is new, so we must think anew and act anew."

– Abraham Lincoln

AMERICAN HOSPITAL ASSOCIATION
JANUARY 2012

TRENDWATCH

Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes

One in four Americans experiences a mental illness or substance abuse disorder each year, and the majority also has a comorbid physical health condition.[1] In 2009, more than 2 million discharges from community hospitals were for a primary diagnosis of mental illness or substance abuse disorder.[2,3]

The range of effective treatment options for behavioral health disorders—which encompass both mental illness and substance abuse disorders—is expanding. Research indicates that better integration of behavioral health care services into the broader health care continuum can have a positive impact on quality, costs and outcomes.

Mental illnesses are specific, diagnosable disorders. Each is characterized by intense alterations in thinking, mood and/or behavior over time. Substance abuse disorders are conditions resulting from the inappropriate use of alcohol, prescription drugs and/or illegal drugs.[4] Behavioral health disorders may also include a range of addictive behaviors, such as gambling or eating disorders, characterized by an inability to abstain from the behavior and a lack of awareness of the problem.[5]

Health reform creates new impetus and opportunity for better managing the care delivered to individuals with these conditions. Expansion of health insurance generally, along with improved coverage of behavioral health treatment under parity laws, will broaden access to needed services. At the same time, increased provider accountability will spur efforts to coordinate care across currently fragmented settings to improve the efficiency and effectiveness of care delivered to individuals with behavioral health conditions.

Many providers already are working with private payers to meet these same goals. Initiatives span value-based purchasing, accountable care organizations, patient-centered medical homes, and efforts to reduce readmissions. These initiatives will have important implications for the delivery of behavioral health care. And as the demand for behavioral health services is likely to continue to outstrip capacity, improving care integration can help to better manage this need.

Highly Prevalent, Behavioral Health Disorders Have a Significant Economic and Social Impact

Behavioral health disorders affect a substantial portion of the U.S. population. Nearly half of all Americans will develop a mental illness during their lifetime.[6] An estimated 22.5 million Americans suffered with substance abuse or dependence in 2009,[7] and 27 percent of Americans will suffer from a substance abuse disorder during their lifetimes.[8] While behavioral health disorders primarily affect adults, they also are prevalent among children. Among children, mental health conditions were the fourth most common reason for admission to the hospital in 2009.[9] Studies reveal that approximately 17 percent of Medicare beneficiaries have a mental illness.[10] An analysis of Medicaid beneficiaries across 13 states found that more than 11 percent of beneficiaries used behavioral health services in a year.[11]

The economic and social costs associated with behavioral health are significant, underscoring the importance of treating these conditions.[12] In the majority of cases, behavioral health conditions are serious enough to cause limitations in daily living and social activities.[13] For example, behavioral health conditions hinder worker productivity and raise absenteeism, resulting in reduced income

American Hospital Association

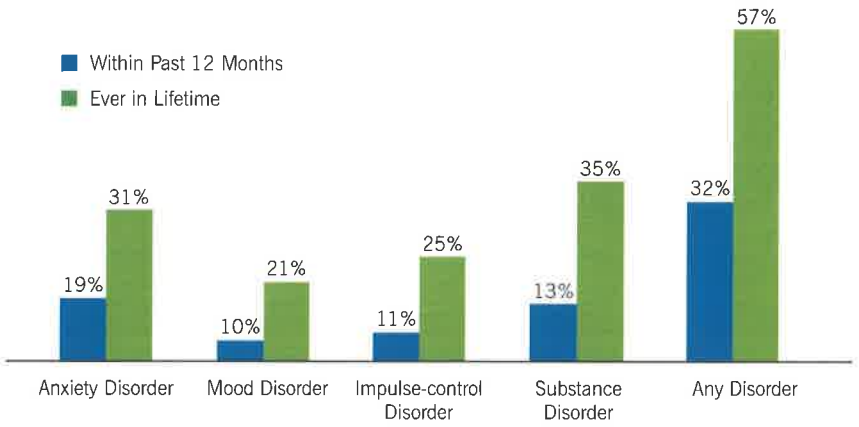
or unemployment.[14] In 2007, persons diagnosed with serious mental illness had annual earnings averaging $16,000 less than the general population.[15] Each year, approximately 217 million days of work are lost or partially lost due to productivity decline related to mental disorders, costing United States employers $21.7 billion annually.[16, 17]

Behavioral health disorders also can have a profound social impact. Individuals with behavioral health conditions are more likely to live in poverty, have a lower socioeconomic status, and lower educational attainment.[18] Lack of treatment amplifies these outcomes and increases the likelihood that individuals will end up homeless or incarcerated.[19]

These social impacts, in conjunction with treatment costs, present a significant and growing economic burden that has made mental illness one of the five most costly conditions nationwide.[20] In 2008, the U.S. spent nearly $60 billion on mental health services, up from $35 billion in 1996.[21] In contrast to general health care services, in which public and private payers account for roughly equal shares of spending, public payers account for the majority of behavioral health expenditures. In 2005, Medicaid and state and local governments accounted for 61 percent of behavioral health care expenditures, compared with 46 percent for all health services.[22]

Behavioral health conditions are prevalent among adults in the U.S.

Chart 1: Percent of U.S. Adults Meeting Diagnostic Behavioral Health Criteria, 2007



Note: Anxiety disorder includes panic disorder, agoraphobia, specific phobia, social phobia, generalized anxiety disorder, post-traumatic stress disorder, obsessive compulsive disorder, and adult separation anxiety disorder. Impulse-control disorder includes oppositional defiant disorder, conduct disorder, attention deficit/hyperactivity disorder, and intermittent explosive disorder. Substance disorder includes alcohol abuse, drug abuse, and nicotine dependence.
Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer.* Washington, DC.

Behavioral Health Disorders and Medical Conditions Often Co-occur, Raising the Risk of Suboptimal Outcomes

Individuals with behavioral health disorders often have co-occurring physical health conditions. In the past year, 34 million adults—17 percent of American adults—had comorbid mental health and medical conditions.[23] Mental health and medical conditions are risk factors for each other and the presence of one can complicate the treatment of the other. For example, a recent study found that individuals with bipolar disorder, on average, have a greater number of medical conditions than individuals without claims for mental illness.[24] And a study of Medicaid beneficiaries in New York State determined that, among patients at high risk of hospitalization, 69 percent had a history of mental illness and 54 percent had a history of both mental illness and alcohol and substance use.[25]

Individuals with co-occurring physical and mental health conditions present many treatment challenges. A physical condition may exacerbate a mental health condition, while a mental health condition may hinder treatment for a physical ailment. Medical conditions with a significant symptom burden, such as migraine headaches, chronic bronchitis, and back pain are associated with increased incidence of major depression.[26] About one fifth of patients hospitalized for a heart attack suffer from major depression, which roughly triples their risk of dying from a future heart attack or other heart condition.[27] Depressed patients also are three times more likely than non-depressed patients to be noncompliant with treatment recommendations.[28] Moreover, individuals with mental illness more frequently have risk factors, such as smoking and obesity, which contribute to increased likelihood of chronic conditions such as stroke and diabetes.[29]

Patients with comorbid mental health and medical conditions experience higher health care costs, with much of the difference attributable to higher medical, not mental health, expenditures. One analysis found that although the presence of comorbid depression or

anxiety boosts medical and mental health care costs, more than 80 percent of the increase stems from medical spending. Monthly costs for a patient with a chronic disease and depression are $560 more than for a person with a chronic disease without depression.[30]

The presence of comorbid conditions also can lead to suboptimal patient outcomes. Research indicates that individuals with mental illness die younger than people without such diagnoses, but from the same leading causes of death as occur nationwide, such as heart disease and cancer.[31] Individuals with serious mental illness die, on average, 25 years earlier than the general population.[32] Such poor outcomes may be linked to lack of appropriate care. One study found that almost one third of patients with schizophrenia did not receive appropriate medical treatment for their diabetes, and 62 percent and 88 percent, respectively, did not receive appropriate treatment for high blood pressure and high cholesterol.[33]

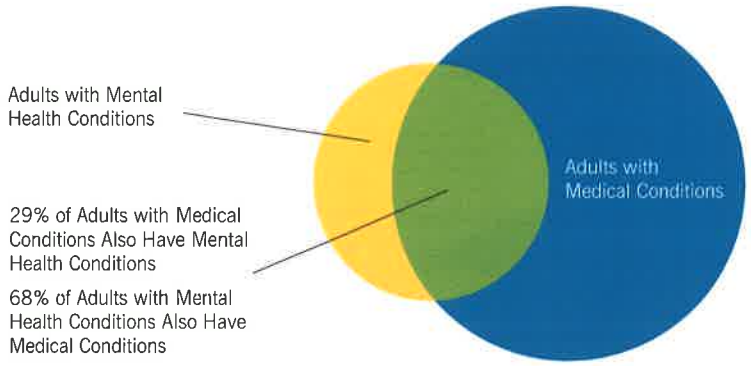
Individuals with comorbid conditions are at heightened risk of returning to the hospital after discharge. A Canadian study found that 37 percent of patients with mental illness discharged from acute care hospitals were readmitted within a period of one year, compared with only 27 percent of patients discharged without a mental illness.[34] In addition, individuals with substance use disorders are among the highest-risk populations for medical and psychiatric rehospitalizations.[35]

Patients with comorbid mental and physical health conditions are readmitted for a broad range of reasons. Specifically, these patients have multiple health conditions, may lack a strong support system, and may not adhere to treatment regimens. These factors can impede recovery and increase the likelihood that patients will return to the hospital. One study found that heart attack patients who were depressed were more likely to be readmitted in the year after discharge.[36] Another study concluded that patients with severe anxiety had a threefold risk of cardiac-related readmission, compared to those without anxiety.[37]

Among children, the risk of rehospitalization was highest during the first 30 days following a first psychiatric hospitalization and remained elevated until about 90 days post-discharge.[38] This finding underscores the vulnerability of patients during the immediate post-discharge period and highlights the importance of integrated care and post-discharge support services.

Individuals with behavioral health conditions frequently have co-ocurring physical health conditions.

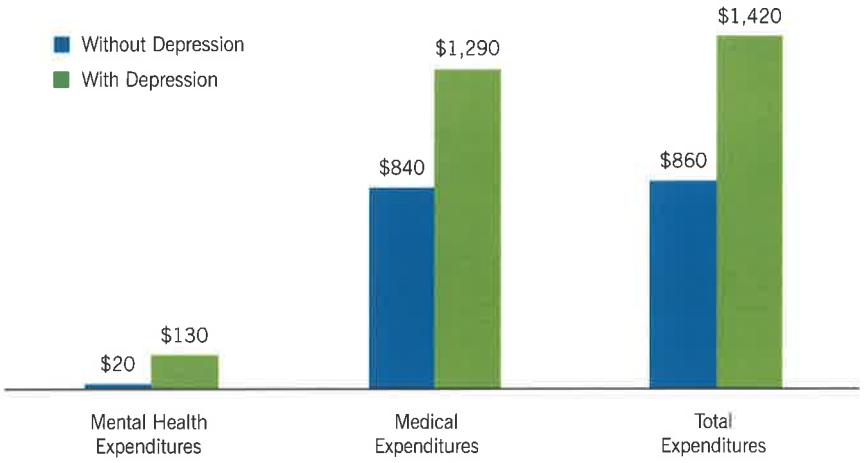
Chart 2: Percentage of Adults with Mental Health Conditions and/or Medical Conditions, 2001-2003



Source: Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity.* Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

The presence of a mental health disorder raises treatment costs for chronic medical conditions.

Chart 3: Monthly Health Care Expenditures for Chronic Conditions, with and without Comorbid Depression, 2005



Source: Melek, S., and Norris, D. (2008). *Chronic Conditions and Comorbid Psychological Disorders.* Cited in: Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity.* Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

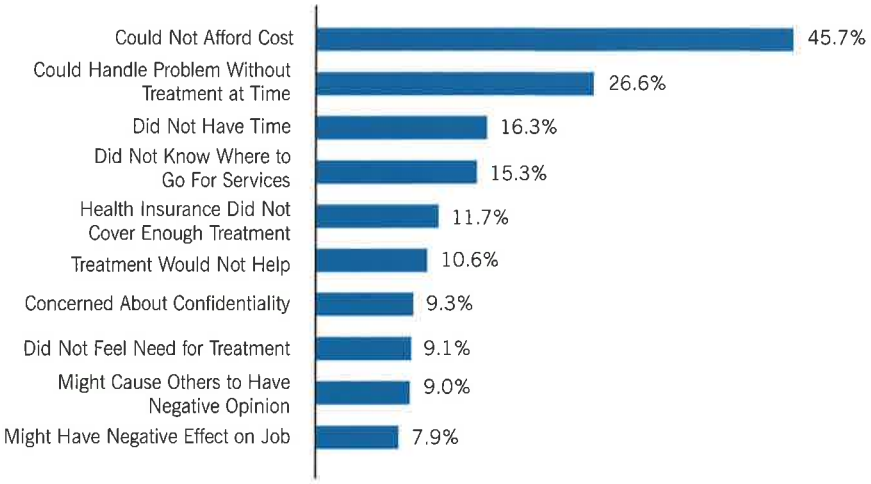
Fragmented Care Delivery and Provider Shortages Impede Effective Treatment for Behavioral Health Conditions

Behavioral health care is fragmented. Individuals who seek behavioral health care often receive treatment in both the inpatient and outpatient settings from generalists and specialists, and rely on a myriad of community resources.[39] Patients with physical health conditions can receive care from yet another group of providers who do not have linkages to those delivering behavioral health care. Even more troubling, the majority of adults with a diagnosable behavioral health disorder do not get any treatment for their behavioral health conditions.[40]

One of the biggest barriers to accessing behavioral health services is a critical shortage of treatment capacity. Currently, 55 percent of U.S. counties have no practicing psychiatrists, psychologists or social workers.[41] There also is a shortage of facilities formally providing behavioral health care. Only 27 percent of community hospitals have an organized, inpatient psychiatric unit,[42] while state and county psychiatric hospitals are closing due to state budget and other funding constraints.[43] Many states have slashed their mental health budgets.[44] Twenty-eight states and Washington, DC reduced their mental health funding by a total of $1.6 billion between fiscal years 2009 and 2012.[45]

Cost is a common barrier to receiving mental health care services.

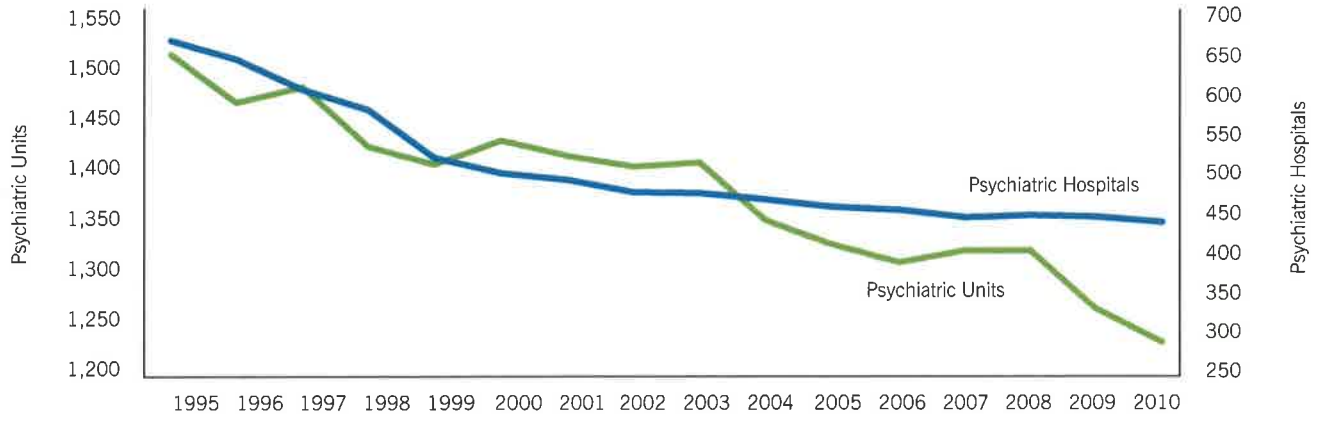
Chart 4: Reasons for Not Receiving Mental Health Services, Among Adults Reporting Unmet Need, 2009



Note: Excludes those who reported unmet need but received some services.
Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

The health care system's capacity to deliver mental health services has been shrinking.

Chart 5: Total Number of Psychiatric Units(1) in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals(2) in U.S., 1995-2010



Note: Includes all registered and non-registered hospitals in the U.S.
(1) Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.
(2) Freestanding psychiatric hospitals also include children's psychiatric hospitals and alcoholism/chemical dependency hospitals.
Source: Health Forum, AHA Annual Survey of Hospitals, 1995-2010.

To achieve these cuts, states have eliminated or downsized emergency and long-term hospital treatment, and community mental health treatment programs, among other services. Colorado, for example, has reduced payment rates for mental health providers and cut funding for residential treatment.[46] States are making decisions to reduce services as demand for behavioral services is increasing. Emergency department (ED) visits involving a primary diagnosis of mental illness or substance abuse disorder increased from about 4.2 million in 2006 to more than 5 million visits in 2009.[47, 48]

Due to this increased utilization and a shortage of beds, ED boarding—the practice in which admitted patients are held in the ED until inpatient beds become available—is growing for patients with behavioral health care needs at hospitals nationwide. In 2008, 80 percent of ED medical directors surveyed reported that their hospitals board psychiatric patients and 42 percent reported a rising trend.[49] Boarding can adversely affect psychiatric patients by exacerbating their conditions, as patients are held in typically loud, hectic environments not conducive to their recovery.

Treatment Settings for Behavioral Health Care

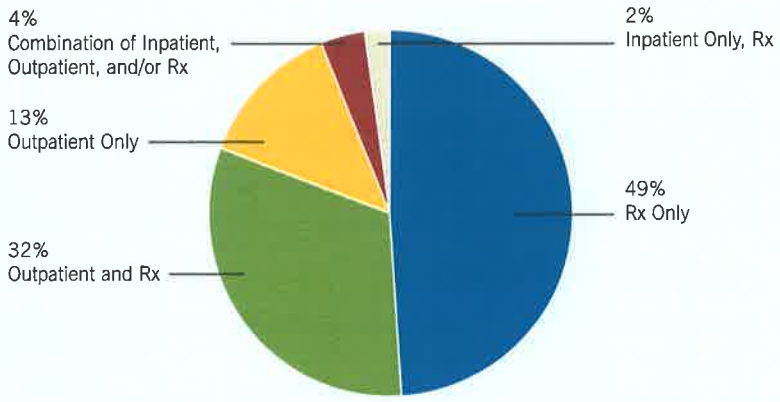
The first point of contact for individuals seeking mental health care is typically a primary care provider.[50] In fact, primary care is the sole form of health care used by more than one third of patients receiving care for a mental health condition.[51] Patients also may access mental health care through specialists (e.g., psychiatrists), social service providers (e.g., counselors) and informal volunteers (e.g., support groups).[52] Mental health services are delivered at a range of locations, including hospitals, outpatient clinics and community settings. Of the 30 million adults receiving mental health services in 2009, the most common services were outpatient therapy, outpatient prescription drugs or a combination of the two.[53]

Although mental health care is most frequently delivered on an outpatient basis, community and psychiatric hospitals remain a vital source of care for behavioral health patients.[54] Nearly all hospitals report that they provide care to patients with mental health and substance abuse disorders.[55] The most common behavioral health conditions treated in hospitals include mood disorders, substance-related disorders, delirium/dementia, anxiety disorders and schizophrenia.[56] Hospitals treat these and other conditions by stabilizing patients, establishing treatment regimens and transitioning patients to outpatient and community-based services.

Overall, about 27 percent of behavioral health care expenditures in 2005 went toward hospital-based services—inpatient care provided by community and psychiatric hospitals.[57] Psychiatric hospitals offer inpatient psychiatric and nursing services, conduct procedures and observe patients so that they do not harm themselves. Notably, the vast majority of inpatient behavioral health services are provided in community hospitals.

Treatment for behavioral health problems is most frequently delivered on an outpatient basis.

Chart 6: Types of Mental Health Services Used in Past Year, Among Adults Receiving Treatment, 2009



Note: Excludes treatment for substance abuse disorders.
Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer.* Washington, DC.

Treatment Works

Despite the challenges of delivering and coordinating behavioral health care within the broader health care system, effective treatment for behavioral health conditions does exist. For instance, pharmacotherapy has become an increasingly important part of behavioral health treatment. A wave of new, effective drug treatments for depression, anxiety and schizophrenia has boosted medication as a share of mental health expenditures from 7 percent in 1986 to 27 percent in 2005. Effective drug treatments also have allowed more patients to receive care in the outpatient setting, which accounted for 33 percent of mental health expenditures in 2005, up from 24 percent in 1986.[58]

Pharmacologic treatments, such as antidepressants have been shown to improve quality of life for mental health patients.[59] Medications also are often enhanced with psychosocial treatments. Cognitive behavior therapy, in combination with psychotropic medication, has decreased symptoms of principal generalized anxiety disorder, panic disorder and social anxiety disorder.[60]

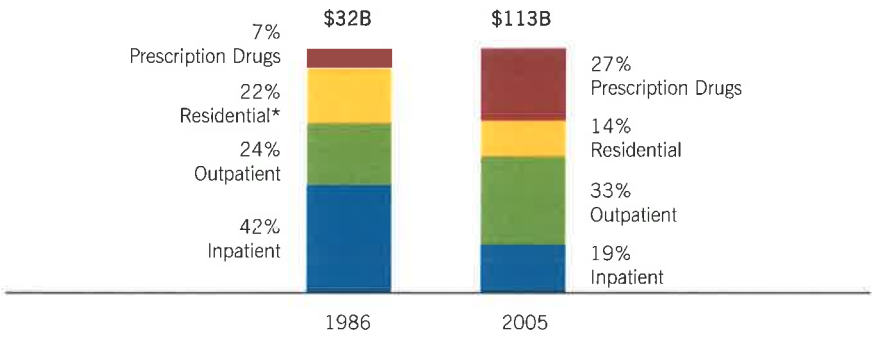
The relative ease of seeking treatment in ambulatory settings, along with shifting perceptions of behavioral health, may encourage more individuals to seek treatment. A survey comparing perceptions of major depression found that more individuals attribute the condition to neurobiological causes and endorse treatment for depression in 2006 than did in 1996.[61]

Treatment has been shown to have a positive economic impact by reducing employer costs and boosting worker productivity. In one study, work impairment of employees with mental illness (defined as when emotional distress has an impact on day-to-day functioning) was cut nearly in half after three weeks of outpatient treatment, from 31 percent to 18 percent.[62] Employer-based initiatives to increase access to mental health treatment have also proven beneficial. For example, Employee Assistance Programs have been shown to reduce medical, disability, and workers' compensation claims, improve worker productivity and decrease absenteeism.[63]

Treatment also has evolved to meet patient needs. Technological advances, such as telepsychiatry, have improved care for patients in rural and other underserved areas. Telepsychiatry—a form of video conferencing that can be used to provide psychiatric services—has been shown to be as effective as face-to-face communication,[64] as well as to increase access and diagnosis and enhance care coordination.[65]

Increased utilization of prescription drugs and decreased reliance on inpatient services has shifted spending over time.

Chart 7: Distribution of Mental Health Expenditures by Type of Service, 1986 and 2005



Note: Excludes spending on insurance administration. Data not adjusted for inflation.
* Residential treatment includes spending in nursing home units of hospitals or in nursing homes affiliated with hospitals.
Source: Substance Abuse and Mental Health Services Administration. (2011). National Expenditures for Mental Health Services & Substance Abuse Treatment 1986-2005. Washington, DC. As cited in Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

South Carolina Telepsychiatry Network

The South Carolina Department of Mental Health and the South Carolina Hospital Association received funds to develop a statewide telepsychiatry network. The program allows mental health providers to conduct psychiatric consultations via telephone and video conferencing, giving patients in 27 participating hospital EDs greater access to mental health specialists.[66] The program has produced measurable results, both in terms of patient outcomes and cost savings. The statewide average length of stay for patients experiencing a behavioral crisis across participating hospitals declined from six days to three days. One hospital, Springs Memorial, reported a savings of $150,000 in the first eight months of its participation in the service.[67]

Aleda E. Lutz VA Medical Center, Saginaw, MI

The Aleda E. Lutz Veterans Administration (VA) Medical Center in Saginaw, MI has been using telepsychiatry for the past five years to provide individual therapy and counseling as well as ongoing evaluation and assessment for behavioral health patients.[68]

Before initiating telepsychiatry, one onsite visit with the mental health professional is recommended to complete a psychosocial exam and establish a relationship. After that visit, patients are offered the option of receiving follow-up sessions using telepsychiatry. Before a telepsychiatry session begins, there is a reconciliation of all critical patient information from the electronic medical record and from recent tests and medication adjustments. The telepsychiatry technicians (THTs), who are onsite with the patients, and the health care provider at the remote site have protocols for how to handle specific situations or emergencies. For example, if a patient with post-traumatic stress disorder needs direct intervention during a session, the provider, who may be up to 150 miles away, may immediately call the THT (usually a nurse) on his/her cell phone and tell him/her to provide immediate hands-on care and evaluate the patient for appropriate care.

The number of VA rural sites using telepsychiatry is skyrocketing. Patients are very satisfied with the use of telepsychiatry especially because it can reduce their time spent driving to a medical care session by as much as three hours each way. Patient concerns about confidentiality of information being shared over the lines are allayed by the T3 encryption system as well as the very solid firewalls that are in place to protect their privacy.

The VA's 1,100 sites of care in the U.S., South Pacific and Puerto Rico are connected by an electronic medical record that allows health care providers to share information and coordinate care across sites. Substantial resources are required to support the technology and infrastructure as well as to train health care workers to use the equipment. The VA home telepsychiatry program served approximately 35,000 patients in 2009 and had $72 million in expenditures. By 2011, expenditures reached $163 million.

Integrating Behavioral Health into the Broader Care Continuum Can Reduce Costs and Improve Outcomes

The delivery of behavioral health services is usually separate from and uncoordinated with the broader health care delivery system. For individuals with comorbid behavioral and physical health conditions, this fragmentation compromises quality of care and clinical outcomes. Integration of care between the behavioral health and general medical care treatment settings and providers, can reduce costs and improve outcomes for these patients.

Integration of care can range from brief screening and intervention for comorbid conditions, to coordinated communication between medical and behavioral health providers, to full integration of care delivery across the care continuum with respect to all of the medical and behavioral health care needs of a particular patient. Integration entails both improving the screening and treatment for behavioral health care needs within primary, acute and post-acute care settings, as well as improving the medical care of people receiving services in behavioral health care settings.

One study of an integrated care model found that 44 percent of adults with a serious mental illness who received primary care services within the mental health setting had diabetes and hypertension screenings, while none of the patients without integrated care were screened. Additionally, ED visits were 42 percent lower among the group that received integrated primary care services.[69]

Another study of administration of a brief screening and intervention for substance abuse among patients admitted to a large urban hospital found a nearly 50 percent reduction in re-injuries requiring an ED visit and in injuries requiring a hospital readmission within three years.[70]

Similarly, individuals with serious mental illness enrolled in a Veterans Affairs mental health clinic who were randomized to receive integrated care were more likely to receive primary and preventive care, and demonstrated superior outcomes compared to their counterparts not receiving integrated care. Integrated care included primary care and case management given on site at the mental health clinic, patient education

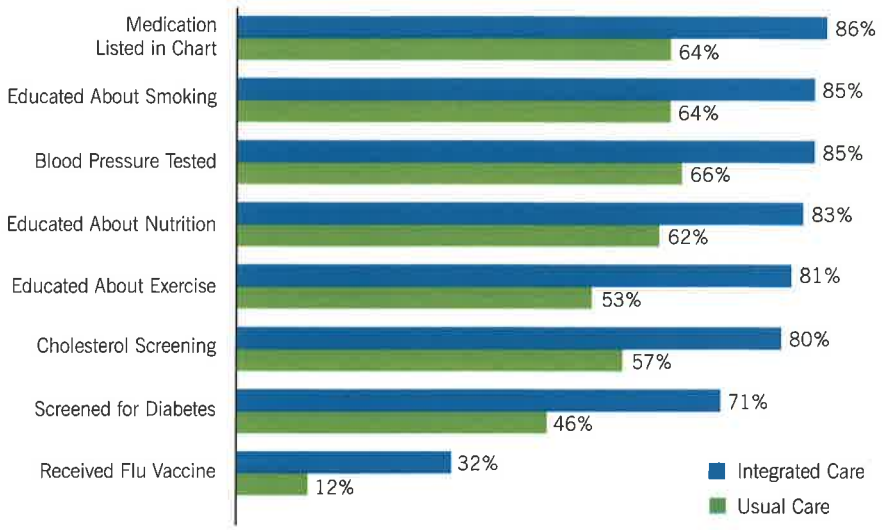
and close collaboration between physical and mental health providers.[71]

A substantial body of clinical evidence has demonstrated the benefits of collaborative care for patients with depression, in particular. A literature review of 45 studies found that patients with major depressive disorder treated with collaborative care interventions experienced enhanced treatment outcomes—including reduced financial burden, substantial increases in treatment adherence, and long-term improvement in depression symptoms and functional outcomes—compared with those receiving usual care.[72]

Integration of care across treatment settings can reduce readmission rates for patients with behavioral health conditions. In Florida, eight psychiatric hospitals partnered with a health plan to improve patients' transitions to outpatient care, with the goal of reducing preventable readmissions.

Integration of behavioral and physical health care can improve access to appropriate care.

Chart 8: Receipt of Preventive Care Services in 12 Months among Patients with Serious Psychiatric Illness Receiving Integrated Care vs. Patients Receiving Usual Care



Source: Druss, B., et al. (2001). Integrated Medical Care for Patients with Serious Psychiatric Illness. A Randomized Trial. *Archives of General Psychiatry*, 58, 861-868.

Mayo Clinic, Rochester, MN

The Mayo Clinic in Rochester, MN is delivering integrated primary and behavioral health care to more than 140,000 patients—including clinic employees, their dependents and other patients seen by Mayo's primary care physicians—using a team-based approach.[73] Mayo's employed primary care physicians, clinical nurse specialists, psychiatrists, psychologists, nurses, social workers and clinic administrators make up the patient's health care team. This team collaborates using a common patient screening tool and electronic health record to ensure the patient is receiving comprehensive primary and behavioral health care. The team also is linked with existing community-based services to ensure continuity of care for the patient.

At the initial mental health visit, patients complete self-rated scales—known as the PHQ-9 and used in a variety of health care settings nationwide—for depression, anxiety, bi-polar disorder and substance abuse which help assess the severity and urgency of the patient's condition. The patient's score on the PHQ-9 helps inform the health care team of the type of care the patient requires. The PHQ-9 also is completed at all follow-up visits for patients with depression. The health care team can adjust the patient's medication, start or increase therapy and address suicide risks based on the patient's score. Patients that receive a score of 10 or higher on the PHQ-9 are added to a registry and monitored for up to 12 months by one of Mayo's 11 registered nurse care coordinators. The care coordinators monitor the patient's condition, share their findings with the patient's psychiatrist and the health care team, assist patients with referrals to other community resources and develop a relapse prevention plan with the patient. The patients also have the opportunity to participate in a depression improvement program offered in Minnesota known as DIAMOND (Depression Improvement Across Minnesota Offering a New Direction).

Mayo's implementation of the team-based approach, the use of the PHQ-9 and the registered nurse care coordinators have significantly improved outcomes and continuity of care for patients. In 2010, two of Mayo's clinics reported the best patient outcomes in the state.

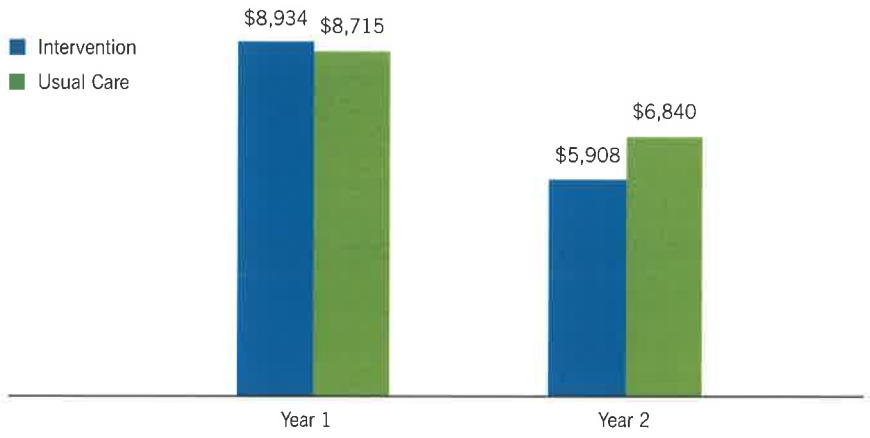
The hospitals focused on coordinating care in the inpatient setting with support services post-discharge. Their efforts cut readmission rates at the eight hospitals. After implementing the program, the readmission rate among the participating hospitals fell from 17.7 percent to 10.4 percent.[74]

Beyond improving quality of care and outcomes for patients, integrating care also can save money. In the Florida program, instituting a visit from a physician on the day of discharge reduced costs by 14 percent. Another study of a care coordination and education program, which deployed medical case managers to assist psychiatric outpatients at a community mental health center, found that participating patients had lower costs by the second year of the program than non-participating patients.[75]

Further, integration has been shown to reduce health care costs in the long term. One study found that older patients with depression who received collaborative care management from both a primary care physician and a nurse or psychologist care manager had lower mean health care costs across four years compared with patients receiving usual primary care.[76] Another study found that coordinating care for patients with diabetes and comorbid major depression through a nurse intervention reduced 5-year mean total medical costs by $3,907, compared with patients receiving usual primary care.[77]

Coordination of care can reduce costs for individuals with behavioral health conditions.

Chart 9: Total Costs at 1 and 2 Years for Patients with Serious and Persistent Mental Illnesses Receiving a Medical Care Management Intervention vs. Usual Care



Source: Druss, B.G., et al. (2011). Budget Impact and Sustainability of Medical Care Management for Persons with Serious Mental Illness. *American Journal of Psychiatry*, AiA, 1-8.

St. Anthony Hospital, Oklahoma, OK

St. Anthony Hospital in Oklahoma City, OK is an acute care inpatient hospital that serves as a regional referral facility in behavioral medicine and also offers residential inpatient care for adolescents and children. In 2008, St. Anthony initiated a number of changes to its internal processes to address the high rates of behavioral health patients admitted through its ED and to reduce the time mentally ill patients spent in the ED in a crisis situation.[78]

The hospital established a mental health admissions office in the ED and began conducting behavioral health evaluations of patients prior to bed placement in the ED. De-escalation training was conducted for all ED and security staff and the Oklahoma City Police Department was enlisted to improve and assist in the transfer of patients to the behavioral health crisis center. St. Anthony also focused on avoiding unnecessary admissions and readmissions of behavioral health patients by ensuring patients are connected with the right resources and provided the appropriate care in the appropriate setting.

As a result of these changes St. Anthony's average wait time for patients to see a mental health professional decreased from two hours to 20 minutes, and patients now see a mental health professional before seeing an ED physician. Additionally, the average wait time for patients in the ED has decreased from 44 minutes to 28 minutes. Furthermore, the average length of stay in the ED for mental health patients has dropped from 254 minutes to 177 minutes.

Although St. Anthony has recently seen an increase in patients seeking services through the ED—on average 83 more patients a month seek care in the ED—they have experienced a 12-20 percent reduction in admissions.

APPENDIX 8

Human Services Student Learning Outcomes

COURSE	Student Learning Objectives
HUSV 101	SLO1 - Explain their motives for becoming a helping professional and how these motives may affect their job performance.
	SLO2 - Define the steps required to pursue training to become a member of a specific helping profession.
HUSV 102	SLO1 - Define ethical and culturally competent approaches to interviewing clients, assessing their strengths and problems, and recommending ameliorative services.
	SLO2 - Appropriately to document their provision of these services.
	SLO3 - Be familiar with a professional association's code of ethics and demonstrate the ability to behave in accord with it. They will be able to define appropriate professional relationship boundaries and detect when these boundaries are crossed or violated. They will be able to maintain client confidentiality and know the conditions under which confidentiality must be broached.
HUSV 103	SLO1 - Develop safe and trusting relationships with simulated clients, assess their strengths and problems, and recommend appropriate interventions and/or referrals. They will demonstrate the ability to manifest the core conditions of helping relationships, including empathy, non possessive warmth, genuineness, and congruence.
	SLO2 - Be familiar with a professional association's code of ethics and demonstrate the ability to behave in accord with it. They will be able to define appropriate professional relationship boundaries and detect when these boundaries are crossed or violated. They will be able to maintain client confidentiality and know the conditions under which confidentiality must be broached.
HUSV 104	SLO1 - Manifest the core conditions of helping relationships, including empathy, non possessive warmth, genuineness, and congruence, in a group service setting.
	SLO2 - Interact in a group setting so as to encourage the development of a positive, problem-solving, working group process.
HUSV 105	LO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV 106	SLO1 - Understand and explain family system dynamics from at least one theoretical perspective and list many of the effects of child abuse and neglect.
	SLO2 - Describe their own families of origin and how they were personally affected by the dynamics of these families.
HUSV 107	SLO1 - Define the core components that constitute culturally competent practice.
	SLO2 - Explain how to apply the core components of cultural competence to working in the helping field with members of at least one oppressed minority culture.
HUSV 108	SLO1 - Define what constitutes a crisis, both in terms of the situation giving rise to the crisis and the state of mind of the person in crisis.
	SLO2 - Explain how to intervene with a client who is in one of two different types of crisis.
HUSV 110	SLO1 - Define the short-term and long-term effects of several categories of substances that are frequently abused.
	SLO2 - Explain the differences between substance use, substance abuse, and substance dependence.
HUSV 111	SLO1 - Explain the core competencies of addiction counseling as listed in TAP 21 (Center for Substance Abuse Treatment. Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice. Technical Assistance Publication (TAP) Series 21. DHHS Publication No. SMA 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.)
HUSV 112	SLO1 - Possess communication skills that will enable them, in a collaborative manner and without creating resistance, to influence people with problems to begin to participate in a constructive change process.
	SLO2 - Be able to interact with angry, dissatisfied people in a manner that reduces anger and engenders cooperation.
HUSV 113	SLO1 - Explain the unique addiction treatment needs of women.
	SLO2 - Define and describe perinatal addiction treatment.
HUSV 120	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV 121	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV 122	SLO1 - Explain why it is difficult to define consciousness and compare and contrast different states of consciousness.

	SLO2 - Describe how states of consciousness change or switch, and how these transitions influence and are influenced by individual functioning.
	SLO3 - Describe and discuss societal and cultural mechanisms designed to alter or control consciousness.
HUSV 124	NONE
HUSV 126	SLO1 - Practice meditation, mindfulness, and/or relaxation as a self-management and health-promotion strategy.
	SLO2 - Teach others to practice meditation, mindfulness, and/or relaxation as a self-management and health-promotion strategy.
HUSV 127	SLO1 - Explain the neurobiology of emotions and "emotional hijacking."
	SLO2 - Define emotional intelligence in terms of specific emotional skills and explain their benefits.
HUSV 128	SLO1 - Describe the history of the study of well-being in the Western world.
	SLO2 - List several factors that predict or enhance personal well-being and fulfillment.
HUSV 130	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV 131	SLO1- Apply the knowledge and skills developed in the classroom in an appropriate workplace setting that relates directly to addiction studies.
HUSV 132	SLO1 - Describe and distinguish between the mental and physiological effects associated with stimulant, sedative, narcotic, hallucinogen, inhalant, and anabolic steroid use.
	SLO2 - Understand dependence, withdrawal, and the different forms of tolerance from drugs.
HUSV 135	SLO 1 - Identify the two most common ethics violations committed by helping professionals and explain how to avoid them.
	SLO 2 - Apply an ethical decision-making model to various real-world scenarios and ethical dilemmas for human services professionals.
HUSV 140	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV 141	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV 142	SLO1 - Describe the schism that exists between the mental health and substance dependence treatment communities.
	SLO2 - Describe how to screen for and assess co-occurring mental illness and substance use disorders.
HUSV 143	SLO1 - Describe at least one model of treatment of co-occurring mental illness and substance use disorders.
	SLO2 - Describe at least one emerging approach to treatment of co-occurring mental illness and substance use disorders (such as specialty courts, assertive community treatment, etc.)
HUSV 144	SLO1 - Possess a thorough understanding of the Twelve Steps of Alcoholics Anonymous.
	SLO2 - Be able to explain the benefits of the Twelve Steps to individuals who may be able to benefit from them.
HUSV 145	SLO1 - Upon completion of this course, students will be able to prepare written human services documentation accurately, correctly, and in a professional manner.
	SLO2 - Upon completion of this course, students will be familiar with American Psychological Association style requirements.
HUSV 148	NONE--Not in Course Catalogue but in Course Outline of Record
HUSV 150	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV 151	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV 160	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.

	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV 161	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV 170	SLO1 - Receive real-world applied practice of knowledge and skills already acquired in the classroom, thus solidifying previous learning and demonstrating competence with real clients.
	SLO2 - Practice ethically, demonstrate interpersonal helping skills, and appropriately document the services they provide in a real-world setting with real clients.
HUSV 189	SLO1 - Development of sound research techniques
	SLO2 - Recognize the value of independent study and enhance proficiency in a particular area of study by accumulating the knowledge and skills beyond the regular class offering.
	SLO3 - Realize his/her individual responsibility in acquiring knowledge.