Broward County Human Services Department

Comprehensive Community Needs Assessment

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TABLE OF CONTENTS

List of Exhibits

List of Tables

List of Charts

BROWARD COUNTY COMPREHENSIVE COMMUNITY NEEDS ASSESSMENT

1. INTRODUCTION

This report is a beginning. It is intended to be the starting point and foundation for the Broward County human services community, and the Human Services Department in particular, to begin a comprehensive planning process that will benefit the most vulnerable residents of the County.

The report is called a Comprehensive Human Services Needs Assessment. And while the following pages provide a significant amount of information and 39 recommendations to address services, funding decisions, and the delivery of human services in Broward County, it can only be the starting point because a strategic planning process is, by its very nature, a dynamic process and must be embedded into a system of continued review and refinement.

This report would not have been possible without the commitment of many. HSD managers and staff devoted countless hours to provide reports, data, historical perspectives, and offer insights on the challenges they face. They are a dedicated and professional group that works tirelessly for their community. The larger human services community – providers, advisory board members, state agencies, and other key stakeholders – also gave of their time to allow us to understand their services, challenges, and thoughts on the changing environment in human services. All had one purpose in mind – to make the system better.

The result is the following report, divided into the following sections:

- **Section 2: Methodology**. This section details the methods used to collect data and input from key stakeholders throughout Broward County. We used secondary data sources such as existing reports, strategic plans, and documents provided by the Human Services Department (HSD), state agencies, and non-profits in the community. Primary sources included: interviews of key stakeholders, a Provider Town Meeting, Provider E-Survey, Resident Telephone Survey, and three Consumer Focus Groups.

- **Section 3: Demographic Profile of Broward County**. In this section we provide information on the demographic profile of Broward County. We focused

on those demographics most relevant to human service providers such as income, race/ethnicity, housing, and physical and behavioral health.

- **Section 4: Current Community Capacity and Delivery System**. This section contains an extensive analysis of current human services spending, both county-wide from all of the major funders, as well as the Broward County Human Services Department.

- **Section 5: Documenting the Human Services Needs in Broward County.** This section includes a review of the 25 existing community needs assessments available, as well as summaries of the primary data collection activities – Provider Town Hall Meeting, Provider E-Survey, Consumer Focus Groups, and Resident Telephone Survey. Detailed reports from each of these activities are included in the report appendices. This section concludes with a prioritized list of human services needs in the community.

- **Section 6: Strategic Analysis**. The final section brings it all together. We discuss major issues identified related to service gaps and the delivery system in Broward County with a focus on the role and responsibilities of HSD. Each topic area includes background that describes the current situation, findings that discuss our analysis of the challenges and issues facing HSD and the community, and recommendations on actions HSD can take to improve the delivery system for human services.

2. METHODOLOGY

Over the course of six months starting in November 2013, **Public Works** launched a comprehensive, multi-pronged approach to collect data and solicit insights and opinions about the human services system in Broward County. We:

- Completed a comprehensive review of documents;
- Conducted interviews with representatives of Broward County agencies, community organizations and stakeholder groups;
- Held a Provider Town Hall meeting;
- Conducted a Provider Electronic Survey;
- Completed a Resident Telephone Survey in targeted zip codes; and
- Held three Consumer Focus Groups of individuals receiving services from the Broward County Human Services Department.

We paid particular attention to the Florida Department of Economic Development Community Action needs assessment requirements in order to ensure we met those requirements through this initiative.

Following is a summary of each approach used to gather data.

2.1 Comprehensive Document Review

Public Works compiled and reviewed documents provided by the Broward County Human Services Department (HSD) and service providers throughout the County, as well as documents identified through independent research and internet research. Secondary data sources included, as available:

- Strategic plans
- Business plans
- Annual reports
- Program and/or organizational reviews completed in the past five years
- Audits completed in the last three years
- Surveys completed by several Broward County agencies
- Broward County Ordinances and Administrative Code
- Florida statutes
- Budget documents
- Program allocation/contracting reports from major funders including: HSD, Broward Sheriff's Office, Children's Services Council, ChildNet, Early Learning

Coalition, Broward Behavioral Health Coalition, United Way and two major foundations (Community Foundation and Jim Moran Foundation)

- HSD Request for Proposal samples and procedures
- Performance measures and outcome reports
- HSD policies and procedures
- Needs assessments completed by Broward County agencies and other jurisdictions
- Advisory Board minutes
- Provider handbooks
- Organizational charts

2.2 Interviews with Agencies, Organizations and Key Stakeholders

Public Works' project team members met with a wide range of both public and private sector stakeholders over the course of this needs assessment. Information was gathered through individual interviews, small group meetings, on-site visits, and attendance at advisory board meetings. In addition to meeting with managers and staff in all divisions in HSD, we also met (in some instances multiple times) with community providers, other community stakeholders, health care providers, state agencies, and city representatives.

The **Public Works'** team conducted hundreds of hours of interviews both in-person and by telephone. The project team worked closely with the leadership and staff throughout HSD to understand County policies and operations. Some individuals and groups were visited multiple times to ensure sufficient understanding of the issues discussed. We compiled, with the help of HSD, a comprehensive list of stakeholders throughout the community and created extensive opportunities for them to provide not only factual data, but also insights and opinions on a range of topics. **Exhibit 2-1** below lists the types of agencies, individuals, and groups with whom we met. Appendix A identifies the individuals who participated from these groups. Providers attending the Providers Town Meeting (listed in Exhibit 5.3) and participating in the E-survey also added insights into services and system delivery. The information we collected during the interviews is incorporated throughout this report.

Exhibit 2-1: Agencies, Organizations, Providers and Stakeholder Groups Interviewed

Representatives from County Government	Representatives from Health Care Providers
Broward County Human Services Department Broward Addiction Recovery Center (BARC) Board Broward County Children's Services Board Broward County Community Action Board Broward County Planning Council Broward Sheriff's Office County Administration County Commissioner Drug Court Homeless Initiative Partnership Board Mental Health Court	Broward Community and Family Health Center (FQHC) Broward Regional Health Planning Council, Inc. Care Resources (FQHC) Hospital District (North) Hospital District (South)
Representatives from Community Stakeholders	**Representatives from State Agencies**
211 Broward Aging and Disability Resource Center Broward Behavioral Health Coalition Broward County School District Children's Services Council ChildNet Early Learning Coalition Henderson Behavioral Health Hispanic Unity South Florida Regional Planning Council United Way	Florida Department of Children and Families Florida Department of Health (DOH) Florida Department of Juvenile Justice South Florida State Hospital Career Source Broward
Representatives from Cities	
Coral Springs Ft. Lauderdale Pompano Beach	

2.3 Resident Telephone Survey

Public Works, through its subcontractor, Lake Research Partners, conducted a telephone survey of residents in targeted zip codes in Broward County from February 10 to February 15, 2014. The survey targeted zip codes with high densities of elderly and low-income residents and included both cell phone and landline phone numbers – 34 percent of the respondents were reached by cell phone. Interviews were completed with 415 adults. Data were weighted by gender, age, education, region, and race. The survey has a +/- 4.8 percent margin of error.

The survey contained questions to solicit information both from residents who have received services from HSD, as well as from those who have not. Questions covered the following topics:

- Awareness of County services
- Perceptions of quality and accessibility of County services
- Respondent or family member receipt of any County services in the past 12 months
- Services of greatest need

  For users:
- Likelihood of continuing to use County services
- Whether services were denied or could not be accessed
- Whether respondent or family members were able to receive needed services or were put on a wait list
- Reasons for service denial or inaccessibility

  For non-users:
- Likelihood of seeking services in the future
- Most likely services to access in the future
- Interest in range of services available
- Awareness and knowledge of the Affordable Care Act (ACA)
- Insurance status
- Likelihood of seeking insurance through the ACA marketplace

Section 5.2 is a summary of survey results. Appendix E contains the survey questionnaire and Appendix F provides the full survey report.

2.4 Consumer Focus Groups

Public Works conducted three focus groups on March 12, 2014 with 26 Broward County consumers who were recruited by HSD. To recruit participants, HSD distributed flyers throughout their service sites, and screened those who responded. The flyer included information about the purpose and location of the focus groups, with contact information for interested consumers. **Public Works** provided brief screening questions asking consumers interested in participating about their age, gender, ethnic/racial background, length of residence in the County, the categories of services they receive, and length of time receiving services. The purpose of the screening was to ensure that consumers selected for participation in the focus groups would represent consumers across these variables.

The three focus groups consisted of: consumers receiving services through the Family Success Center (seven participants); consumers receiving services through the Broward Addiction Recovery Center (seven participants), and consumers receiving mental health services directly or representing a family member/child) (12 participants).

Each 90-minute focus group discussed: 1) the need for services; 2) the process for obtaining and accessing services; 3) the services consumers are receiving; 4) the helpfulness, quality, and responsiveness of services; 5) satisfaction with services; 6) additional services needed; 7) whether other family members also receive services; and 8) changes in services over time. Consumers were also asked about their awareness and understanding of the ACA, whether they have applied for insurance through the ACA, and their perceptions of the impact the ACA may have on the services they receive.

Section 5.3 is a summary of the focus group discussions. Appendix G contains the focus group guide and Appendix F is a report on each focus group.

2.5 Town Hall Meeting with Broward County Providers

Providers of services in Broward County were invited to a Town Hall meeting that took place on January 15, 2014. Thirty-one providers attended the meeting during which they heard an overview of the project from **Public Works**, including the methodology and expected outcomes. Following the presentation, the 31 providers attending the meeting were divided into four groups – **Health Care** (five participants), **Children's Services** (eight participants), **Behavioral Health** (eleven participants) and **Criminal Justice** (seven participants). The breakout groups discussed issues such as:

- Populations served: current situation, trends, and changes over the past three years.
- Services provided: responsiveness to needs, efficiency of service delivery, challenges in providing services, service gaps, and duplication of services.
- Provider resources including funding sources, staff resources, resource gaps, and adequacy of resources.
- Current priorities with regard to population(s) served, resources, and services.
- Data that providers collect and use to track service outcomes.
- Provider relationships with the Broward County Human Services Department.
- Use of collaborative initiatives and partnerships in service delivery.

Following the small group discussions, representatives from each group presented a summary of the issues discussed. At the conclusion of the meeting, **Public Works** distributed paper copies of the Provider E-Survey (see below) and 15 participants completed and turned in the survey.

Section 5.4 contains a summary of the discussion from the Town Hall Meeting.

2.1 Provider E-Survey

Public Works conducted an E-Survey (electronic, internet-based survey) of Broward County service providers, funders, government agencies, and other community stakeholders during the month of February 2014. We purposely chose to include a broad range of stakeholders – providers, funders, advisory boards, County and state agencies – in order to gather the broadest possible input on services, gaps and the delivery system. To conduct the survey, we compiled a comprehensive list of 363 e-mail addresses from the resource list used by Broward 211, key stakeholders, and community partners identified by each division of HSD. The list consisted of publicly and privately funded organizations, as well as those that operate with a combination of funds, including: 1) community providers; 2) advisory board members related to various functions within HSD; 3) major funding sources such as the Broward Behavioral Health Coalition, the Children's Services Council, ChildNet, and United Way; 4) foundations and associations that may provide funding for health or human services directly to non-profit agencies; 5) hospital districts, FQHCs, and other health care providers; 6) County organizations such as the Broward Sheriff's Office, the School Board, and adult and juvenile court systems; and 7) state offices such as the Florida Department of Health, Florida Department of Juvenile Justice, and Florida Department of Children and Families.

The E-Survey contained questions about services provided, service populations, staffing, financial resources, and source of funds. The survey solicited insights and opinions about gaps in services, duplication of services, the changing environment, and challenges facing funders and service providers. A total of 363 surveys were distributed and 133 surveys were completed – representing a 36.7 percent response rate.

Section 5.5 is a summary of the survey results. Appendix C includes the survey questionnaire and Appendix D contains the survey report.

3. DEMOGRAPHIC PROFILE

The following Broward County profile uses existing data sources such as the U.S. Census Bureau, the American Community Survey, Broward County Regional Health Planning Council, and the Florida Department of Health. The data presented in this section are the most recent available, primarily from 2011, however more recent data are included when available. Variables selected for this demographic overview are those that are most likely to have an effect on residents' ability to be self-sufficient and, therefore, have an impact on services offered by Broward County and its community partners.

3.1 Overview: Area Size, Population, and Municipalities

At 1,230 square miles, Broward County is geographically among the largest of the Florida counties and the 16th largest county in the nation. The Broward County population has grown from 1,623,018 in 2000 to 1,742,511 in 2011. The U.S. Census Bureau estimated the population to grow to 1,838,844 in 2013. In 2011, the largest age groups, according to the American Community Survey were 45 to 54 year olds (279,892), 35 to 44 (249,096), and 25 to 34 (233,773).[1] The County has nearly 100,000 part-time residents at the peak of its "snowbird season," and more than 9 million tourists annually.[2]

Broward County contains 31 incorporated municipalities and eight unincorporated areas. The municipalities vary in size from 13 acres and a population of 39 (Lazy Lake) to more than 36 square miles and a population of 178,400 (Fort Lauderdale).[3]

3.2 Broward County Has a Diverse Population

Race and Ethnicity

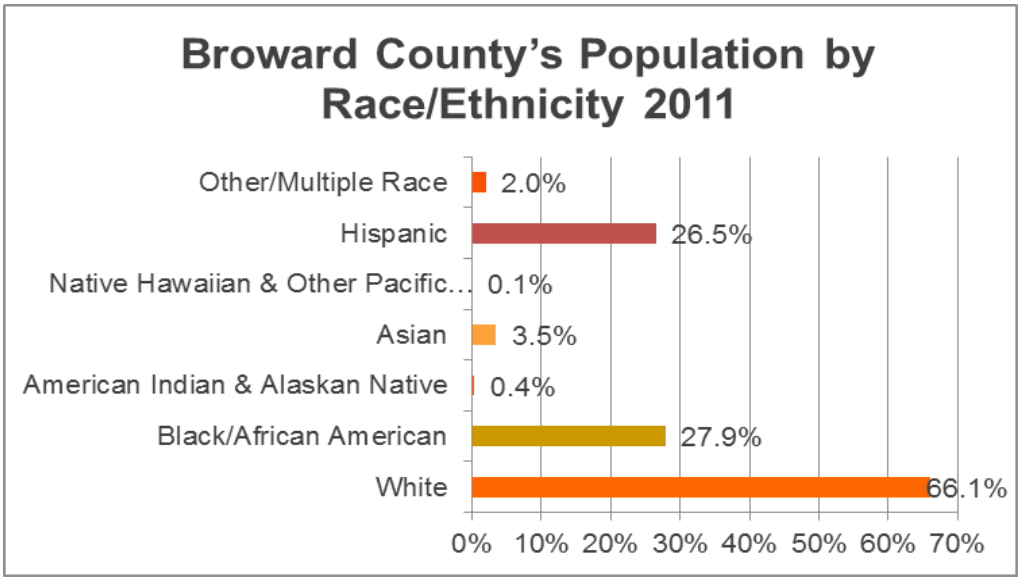
The racial and ethnic diversity in Broward County has rapidly increased from the sixteenth (1990) to the third (2010) most racially diverse Florida county (surpassed only by Hendry and Orange counties) according to the Broward County Department of Urban Planning and Redevelopment. As shown in **Table 3-1 and Chart 3-1,** the 2012 County population was 64.3 percent White, 27.0 percent Black, and 25.8 percent Hispanic.[4]

Table 3-1: Broward County and Florida Population by Race/Ethnicity 2012

Race/Ethnicity*	Broward County	Florida
One race reported		
White	66.1%	78.3%
Black/African American	27.9%	16.6%
American Indian and Alaskan Native	0.4%	0.5%
Asian	3.5%	2.7%
Native Hawaiian and Other Pacific Islander	0.1%	0.1%
Two of more races	2.0%	1.0%
Hispanic	26.5%	23.2%

Source: U.S. Census Bureau, 2011 American Community Survey.

Chart 3-1: Broward County Population by Race/Ethnicity 2011



In 2012, Broward County had a higher percentage of African Americans, Hispanics, and Asian Americans than Florida; the White population was 12.2 percentage points lower than the state of Florida.

Age Distribution

In 2012, Broward County had 392,658 children under the age of 18, representing 22.2 percent of the population. [5] For children's age distribution, see **Table 3-2**.

Table 3-2: Children's Age Distribution
2009 – 2012

	Children's Ages			
	<5	5-9	10-14	15-17
2009	103,256	104,071	112,207	71,815
2010	103,724	104,693	111,328	71,384
2011	104,366	105,825	110,909	71,558
2012	103,256	104,071	112,207	71,815

Source: KIDS COUNT Data Center: Florida KIDS COUNT.

Between 2007 and 2011 Broward County had an average of 233,211 persons 65 years old or older, representing 13.4 percent of its population. In 2012, the U.S. Census Bureau reported 14.7 percent of Broward County residents were 65 or older. **Table 3-3** shows the age distribution of senior residents.

Table 3-3: Seniors' Age Distribution – 2012

	Total	65-74	75-84	85+
Population	252,716	127,191	82,358	43,167
Percent	14.3% (of total population)	50.3% (of all seniors)	33% (of all seniors)	17.1% (of all seniors)

Source: U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates.

Other Characteristics

Broward County has a high percentage of foreign-born residents – 31.4 percent of the population between 2008 and 2012 were foreign-born, according to the U.S. Census Bureau. Latin American countries and the Caribbean Islands, including Haiti, are the primary sources of international migration.[6]

Veterans account for 7.3 percent of the County population, which is lower than the national average of 9.6 percent.[7]

3.3 Broward County Has Experienced an Increase in Poverty Rates

While some prosper in Broward County, the other side of the income picture is shown in poverty rates. In 2011, poverty statistics for the County show that:

- 14.8 percent of all residents and 12.4 percent (82,392) of all households lived in poverty. [8]
- The County poverty rate is lower than the 17.0 percent of Florida residents and 15.9 percent of U.S. residents living in poverty.[9]
- Poverty rates increased from 9.8 percent in 2000 to 14.9 percent in 2011.
- 23.5 percent of female-headed households lived in poverty. [10]
- 78,640 children lived in poverty.[11]
- 17.2 percent of children ages 0 to 17 lived in poverty compared with 19.5 percent in Florida and 19.2 percent nationally. [12]

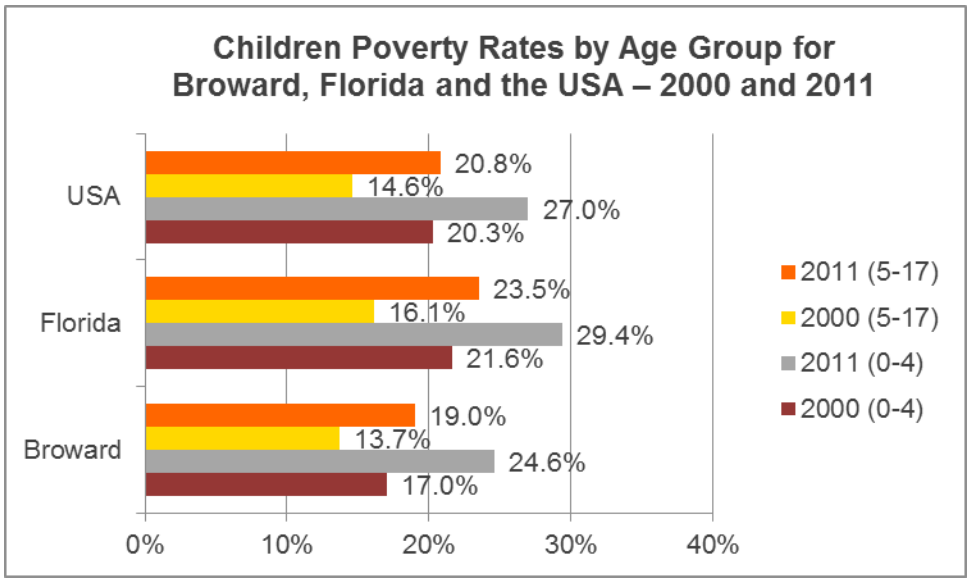
Table 3-4 and Chart 3-2 show the growth in poverty rates for children in Broward County, Florida, and the United States.

Table 3-4: Child Poverty Rates by Age Group for Broward County, Florida and the U.S. – 2000 and 2011

	0-4			5-17		
	2000	**2011**	**Percentage Change in Poverty Rate 2000-2011**	**2000**	**2011**	**Percentage Change in Poverty Rate 2000-2011**
Broward County	17.0% 20,577	24.6% 25,598	+24%	13.7% 38,646	19.0% 53,929	+40%
Florida	21.6% 236,368	29.4% 314,862	+33%	16.1% 427,487	23.5% 670,753	+57%
U.S.	20.3% 4,050,543	27.0% 5,409,513	+34%	14.6% 7,536,575	20.8% 10,976,987	+46%

Source: U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 2011.

Chart 3-2: Child Poverty Rates by Age Group



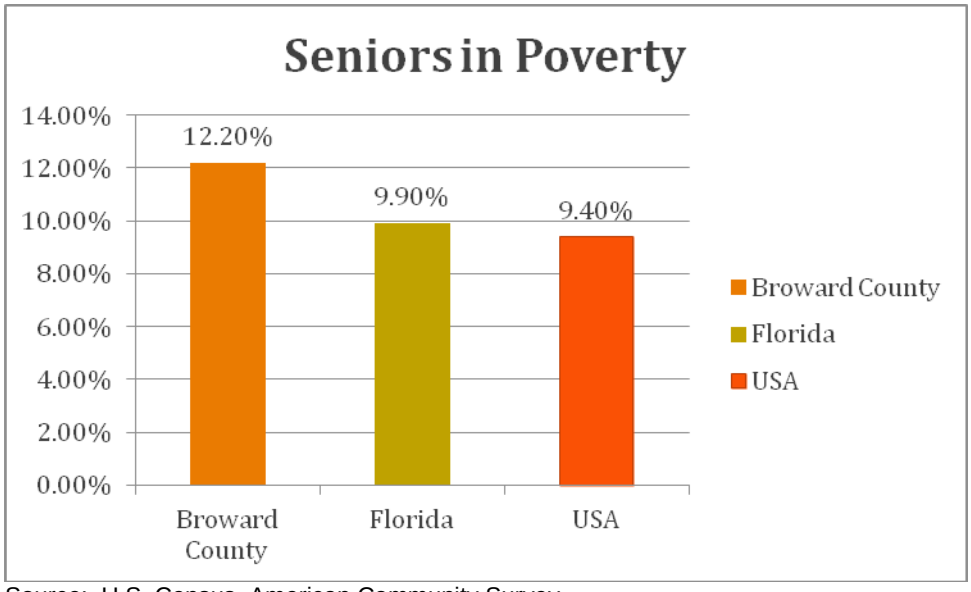
According to the 2011 American Community Survey, 8,337 Broward County households were headed by 12,500 grandparents of whom 18 percent were below the poverty line. Nearly 2,000 of these households had no parent present.[13]

Between July 2012 and February 2013, 13,802 children under the age of 13 had financially-assisted child care. The Early Learning Coalition reports that by the end of February 2013, 7,892 children from birth to 12, including 6,591 who were younger than 5, were on waitlists for financially-assisted child care.[14]

According to the National Center for Educational Statistics (NCES), in 2009-2010, 135,363 out of 256,794 students in Broward County (52.7 percent) were on free or reduced lunch, a slightly lower rate than the 53.5 percent of students statewide, but higher than the rate of 46.6 percent nationally.[15]

A greater percent of seniors live in poverty in Broward County compared to the state as a whole and to the U.S. As shown in **Chart 3-3**, between 2007 and 2011, an average of 29,647 (12.2 percent) of seniors (65 or older) lived in poverty compared with the Florida rate of 9.9 percent and the national rate of 9.4 percent.[16]

Chart 3-3: Seniors in Poverty



Source: U.S. Census, American Community Survey.

The Supplemental Nutrition Assistance Program (SNAP) offers nutrition assistance to eligible, low-income individuals and families. In 2011, 8.5 percent (25,394 households) received SNAP, less than the 9.8 percent statewide and 10.3 percent nationally that received these benefits.[17]

Despite this relatively low rate, the amount of food purchased through SNAP has increased, both in terms of dollars spent and the number of recipients.[18] Broward County residents purchased $33.8 million worth of food with SNAP benefits in September 2011 and $38.2 million in August 2012, a 13 percent increase.[19] Florida was among seven states with statistically significant higher household food insecurity rates than the U.S. national average from 2009 to 2011. According to Feeding America, in 2010 Florida was among the top five states with the highest rate of food insecure children under the age of 18.[20]

3.4 Broward County Has a High Cost of Living, Especially the Cost of Housing

Many Broward County residents enjoy above average income levels that have improved over recent years:

- Median household income in 2011 in Broward County was $48,478, higher than the state median household income for Florida of $44,250, but lower than the national median household income of $50,502.[21]
- Per capita personal income in 2011 was $42,768 compared to $39,636 for Florida as a whole.[22]
- Per capita income has been consistently higher in Broward County compared to Florida as a whole for the 2000 to 2010 period, according to the U.S. Census Bureau.

The other side of the story is that Broward County has a higher cost of living. In 2011, the total cost of living index in Broward County was higher than the state average, as well as the average in Miami-Dade and Monroe counties. Broward County residents spent $14.12 more for every $100 spent by other Florida residents, $23.19 more than Miami-Dade County residents and $22.34 more than Monroe County residents.[23]

Median home prices are relatively high in Broward County and the housing stock is older than the statewide average. In 2011, the U.S. Census reported Broward County had 809,226 housing units with a median age of 32 years. The median housing age was five years above the Florida median age of 27 but below the national housing median age of 36.[24] In 2013, Broward County had 812,565 housing units with a homeownership rate between 2008 and 2012 of 67.2 percent, slightly lower than the statewide homeownership rate of 68.1 percent, but higher than the national rate of 65.5 percent. From 2008 to2012 the median value of owner-occupied housing units in Broward County was $199,000, compared with $170,800 for Florida as a whole, and $181,400 for the nation.[25] A single family home in Broward County had an average value in 2012 of $209,150 compared with $160,174 in Florida as a whole. [26]

Renters searching for affordable housing encounter rental rates that have increased significantly over the past decade. Prior to the 2008 financial crisis, the housing boom in South Florida led to dramatic rental price increases. In Broward County, the average lease for a rental apartment increased from $757 in 2000 to $1,159 per month in 2005, an increase of 53 percent.[27] Rental prices have continued to increase since the financial crisis, though not at the same pace. From 2005 to the third quarter of 2011, rental prices further increased to $1,253, or an additional nine percent since 2005.[28]

In Broward County and the surrounding metro area, the Housing and Urban Development (HUD) Fair Market Rent in 2014, representing rent for a typical modest

apartment, was $762 for a studio apartment, $992 for a one-bedroom, $1,260 for a two-bedroom, $1,737 for a three-bedroom, and $2,232 for a four-bedroom unit.[29]

Studies have shown that a great majority of renters in Broward County are housing-burdened (spending more than 30 percent of income on housing). According to the Broward County Housing Needs Assessment, 62 percent of all renters are housing-burdened. Seventy-eight percent of owners with incomes below $35,000 are housing-burdened; 95 percent of renters with incomes below $35,000 are housing-burdened.[30] Additionally, the Florida Housing Data Clearinghouse reports in 2009, 33.5 percent of elderly households were housing-burdened.

The number of Broward County residents experiencing homelessness has decreased over time from an average of 3,154 individuals experiencing homelessness in 2007 to 2,810 individuals in 2013.

Table 3-5: Broward County Homeless Count

Location	2007	2008	2009	2010	2011	2012	2013	Average
Unsheltered	701	701	800	800	1,268	1,268	829	910
Sheltered	2,453	2,453	2,425	2,425	2,533	1,915	1,981	2,312
Total	3,154	3,154	3,225	3,225	3,801	3,183	2,810	3,222

Source: Homelessness in Broward County, 2013 Point-In-Time Count Report, Broward Regional Health Planning Council (BRHPC).

3.5 Broward County Has a Relatively Small Public Transportation Infrastructure

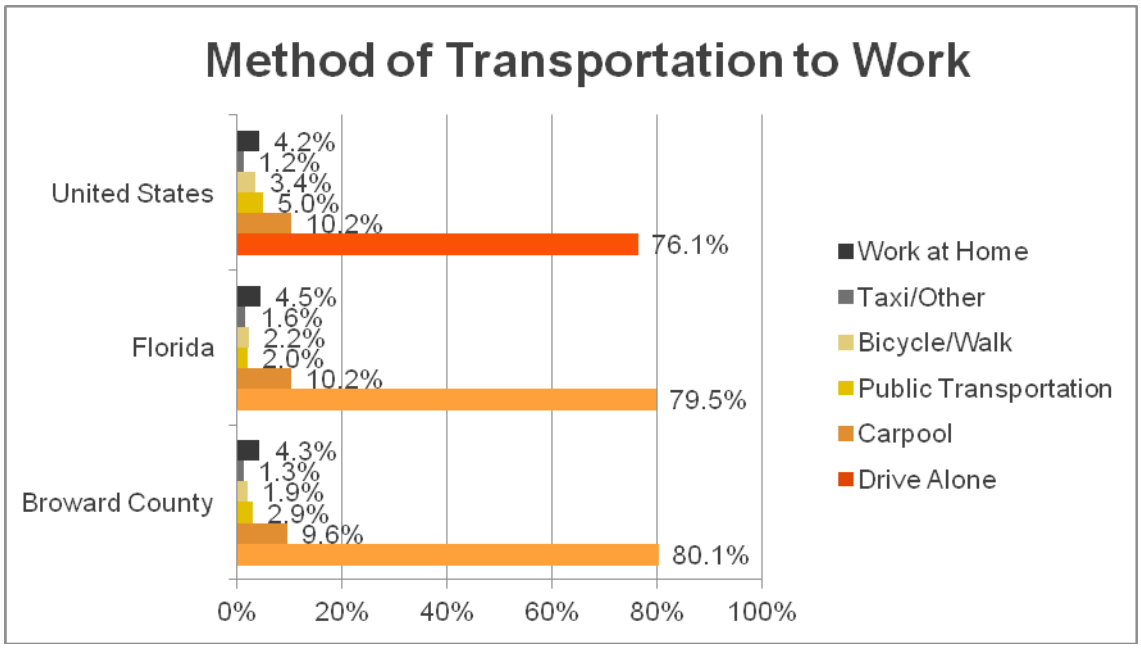
In 2011, just over three-quarters of workers in Broward County used private cars to travel to work. According to the U.S. Census Bureau American Community Survey, Broward County residents use public transportation at a significantly lower rate (2.9 percent) compared to the national rate of 5.0 percent, although Broward County has a higher rate than Florida as a whole.[31] The percentage of residents driving alone to work – 80.1 percent – is higher than the national rate of 76.1 percent (**Table 3-6 and Chart 3-4**).

Table 3-6: Method of Transportation to Work – Broward County, Florida and the U.S.

Geographic Area	Workers 16 and Older	Method of Transportation to Work					
		Drive Alone	Carpool	Public Transportation	Bicycle/ Walk	Taxi/ Other	Work at Home
Broward County	825,581	80.1%	9.6%	2.9%	1.9%	1.3%	4.3%
Florida	8,127,157	79.5%	10.2%	2.0%	2.2%	1.6%	4.5%
U.S.	139,488,208	76.1%	10.2%	5.0%	3.4%	1.2%	4.2%

Source: U.S. Census Bureau, American Community Survey, 2011 Data Release, December 2012.
*Data is a five-year average for the 2007 to 2011 period.

Chart 3-4: Method of Transportation to Work – Broward County, Florida and the U.S.



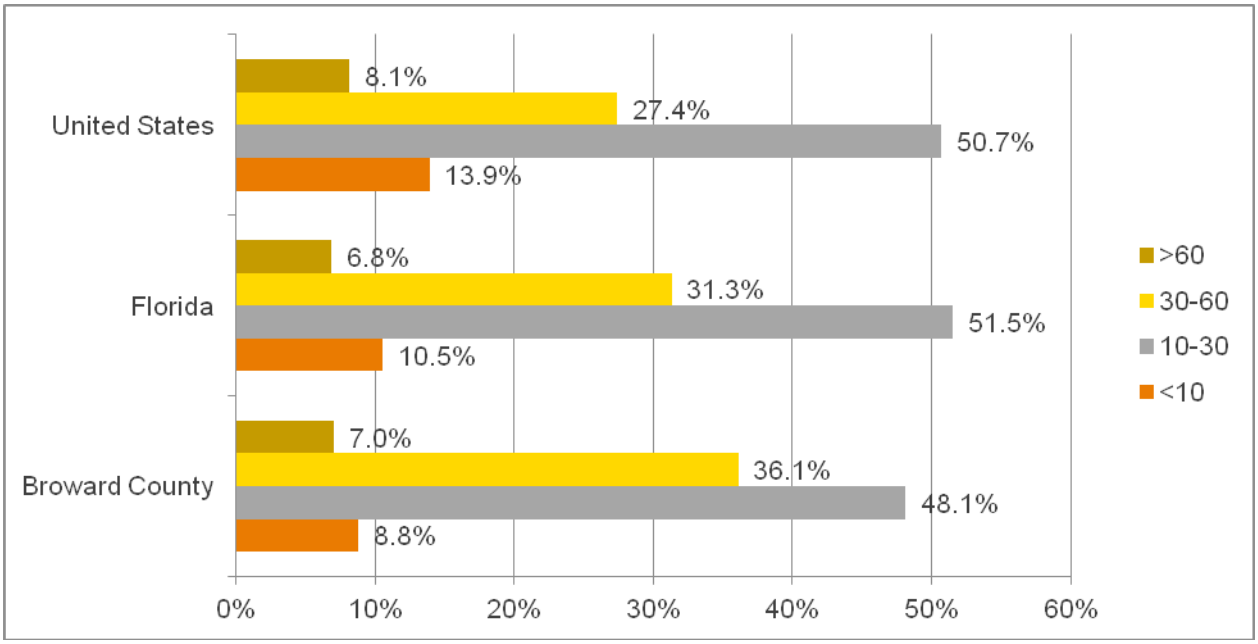
Broward County workers have a longer commute to work compared to commuters in Florida as a whole or nationally. On average, Broward County workers spend nearly 26 minutes commuting to work, slightly above the state and national averages (**Table 3-7 and Chart 3-5**). A larger percentage of workers in Broward County – 43.1 percent – spend 30 or more minutes commuting to work compared to 38.1 percent of Florida commuters and 35.5 percent of commuters nationally.[32]

Table 3-7: Travel Time to Work – Broward County, Florida and the U.S.

Geographic Area	Workers 16 and Older	Travel Time to Work (Percent of Workers)				
		Less than 10 Minutes	10 to 30 Minutes	30 to 60 Minutes	More than 60 Minutes	Average Commute Time (in Minutes)
Broward County	825,581	8.8%	48.1%	36.1%	7.0%	25.7
Florida	8,127,157	10.5%	51.5%	31.3%	6.8%	24.6
U.S.	139,488,208	13.9%	50.7%	27.4%	8.1%	24.3

Source: U.S. Census Bureau, American Community Survey, 2011 Data Release, December 2012.
*Data is a five-year average for the 2007 to 2011 period.

Chart 3-5: Travel Time to Work – Broward County, Florida and the U.S.



Source: U.S. Census Bureau, American Community Survey, 2011 Data Release, December 2012.

In its *2013 Public Transportation Fact Book,* the American Public Transportation Association (APTA) ranked Broward County 38 among the 50 largest transit authorities in the number of unlinked passenger trips and 41 in terms of passenger miles, based on 2011 data reported to the Federal Transit Administration. Miami-Date was rated 15 and 14, respectively.[33]

The public transportation infrastructure in Broward County is smaller in capacity than that of counties/cities of comparable size. For example, according to the Broward County Transit Division Transit Development Plan FY2014-2023, Broward County – with a population of 1.7 million – had 320 fixed route buses (an increase of 28.4 percent since 2009), 76 community buses and no rail system. In comparison, the Marta public transportation system in Atlanta, Georgia, (population 1.5 million) has 700 buses and 185 railcars, Miami-Dade County had 771 buses and 136 railcars for a population of 2.4 million, and King County (Seattle, Washington) with a population of 1.9 million had 1,413 buses and no rail system.[34]

3.6 Challenges Exist with Access to Health Care in Broward County

The economic environment in the U.S. and the decline in employer-sponsored health insurance coverage have contributed to the increase in the number of people without insurance. The impact in Florida and Broward County reflects what happened throughout the country. According to the U.S. Census Bureau, 2012 Small Area Health Insurance Estimates:[35]

- Florida is ranked third in the nation in the percent of residents who are uninsured.
- Broward County had a higher percentage of uninsured residents (25.9 percent) than the state of Florida (24.1 percent) and the nation (17 percent). (Note: these percentages reflect data prior to implementation of the ACA.)
- The percentage of uninsured was highest among non-elderly adults (ages 18 to 64): 30.5 percent in 2012.
- 52,637 (12.9 percent) children and youth younger than 19 are uninsured.
- For adults between the ages of 19 and 64, males were uninsured at a higher rate (27.4 percent) than females (24.4 percent); this pattern also holds for Florida (25.8 percent vs. 22.4 percent) and the U.S. (18.3 percent vs. 15.7 percent).

As shown in **Table 3-8,** adults ages 18 to 64 have the highest uninsured rate in Broward County (30.5 percent), Florida (28.7 percent), and the U.S. as a whole (20.8 percent).

Table 3-8: Uninsured Rate by Age: Broward County vs. Florida vs. U.S. – 2011

	Under 19	18-64	Under 65
Broward County	12.9%	30.5%	25.9%
Florida	11.4%	28.7%	24.1%
US.	7.5%	20.8%	17.0%

Source: U.S. Census Bureau, Small Area Health Insurance Estimates, 2012.

The Broward County Community Health Assessment conducted by the Florida Department of Health reports that poverty, poor health literacy, and lack of health insurance may limit access to health care.[36] The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health Professionals (BHP) designated 125 Broward County census tracts (45 percent of all census tracts in Broward County) and 12 low-income population groups, comprehensive health centers, and Native American tribal populations as Health Professional Shortage Areas (HPSAs) that are lacking a sufficient supply of primary medical care providers. Four zip codes are dental HPSAs and three are mental health HPSAs. HRSA designated 104 Broward County census tracts (34 percent of all tracts) and 10 low-income population groups as Medically Underserved Populations who face economic, cultural, or linguistics barriers to health care.[37]

Broward County has a lower ratio of licensed physicians per 100,000 people than the state. In 2010, Broward County had 289.3 licensed physicians per 100,000 people compared with 342.0 for Florida; 350.0 is the HRSA goal.[38]

3.7 Substance Abuse Remains a Challenge for Prevention and Treatment Services

Prescription drug abuse is high, with Broward County tying Hillsborough County for the highest number of prescription deaths in the state of Florida in 2011.[39]

According to the Substance Abuse Mental Health Services Administration (SAMHSA) DAWN report released in October 2012, the substance abuse landscape is changing. Increased control over the nonmedical use of prescription opioids has led to an increase in heroin use. SAMHSA projects a 78 percent increase in individuals in Broward County seeking primary heroin addiction treatment between 2011 and 2012 (actual 2012 data available through October).[40]

In 2010, according to the Behavioral Risk Factor Surveillance System, 16.1 percent of adults in Broward County reported heavy or binge drinking compared with 15.0 percent statewide and 22.1 percent nationally. Heavy or binge drinking was higher among Hispanics – 25.1 percent in the County compared with 15.3 percent statewide.[41]

South Florida was designated by the U.S. Drug Enforcement Agency (DEA) as a "high intensity drug trafficking area" in 2008 because of its geographic proximity to Latin America.[42] **Table 3-9** displays drug-related deaths in 2011 by type of drug.[43]

Table 3-9: Broward County Drug-Related Deaths 2011

Drug	Number of Deaths
Alprazolam	199
Oxycodone	174
Cocaine	115
Diazepam	85
Morphine	72
Methadone	51
Hydrocodone	31

Source: 2011 Florida Medical Examiners Commission Drug Report

3.8 Infant and Child Health Indicators are Strong Except for Low Birth Weight Babies

Broward County had a higher live birth rate per 100,000 and a lower infant death rate than Florida from 2010 to 2012 (**Table 3-10**). The County also had a lower percentage of teen mothers ages 15 to 19; however the County has a higher percentage of babies with low birth weight. A higher percentage of two-year olds in Broward County were fully immunized.[44] However, neither Broward County nor Florida meet the 95 percent state goal for immunization of kindergarten and seventh grade students.[45]

Table 3-10: Maternal and Child Health (2010 – 2012)

	2012		2011		2010	
	Broward County	Florida	Broward County	Florida	Broward County	Florida
Total Live Birth Rate per 1,000 Population	12.1	11.2	12.0	11.3	12.2	11.4
Infant Death Rate per 1,000 Population	5.2	6.0	6.1	6.4	6.3	6.5
Birth to Mothers Age 15-19 (%)	20.3%	27.2%	22.6%	29.1%	28.2%	37.4%
Repeat Birth to Mothers 15-19 (%)	16.9%	16.9%	18.1%	17.4%	17.1%	18.4%
Low Birth Weight – Under 2,500 Grams (%)	9.2%	8.6%	9.3%	8.7%	9.1%	8.7%
Two Year Old Children Fully Immunized	84.2%	83.0%	90.0%	86.1%	84.8%	81.8%

Source: Florida Department of Health, FloridaCharts,
http://www.floridacharts.com/charts/DisplayHTML.aspx?ReportType=7200&County=6&year=2012&tn=25
http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndRateOnlyDataViewer.aspx?cid=0081

For the 2011-12 school year, 26 percent of Broward County Public School (BCPS) students (60,239 out of 227,517) had specific health conditions. An estimated 66,907 children (29.4 percent) ages 2 through 19 were obese.[46]

In 2012-13, according to the BCPS 20th Day Enrollment Report, the school district had 30,889 students with disabilities: 13,937 in pre-K and elementary schools; 6,137 in middle schools, 6,913 in high school, 1,531 in centers, and 2,371 in charter schools.[47]

3.9 Rates of Infectious Diseases are Relatively High in Broward County

Broward County rates of HIV, AIDS, chlamydia, gonorrhea, and syphilis were higher than the statewide rates from 2009 to 2011 (**Table 3-11**). Broward County had about twice the rate of HIV, AIDS, and syphilis than Florida as a whole.[48] About 17 percent of persons living with HIV and/or AIDS in Florida resided in Broward County in 2011, although the County had 9.2 percent of the state population.[49]

Table 3-11: Infectious Disease Rates per 100,000 in Broward County and Florida 2009 – 2011

	2011		2010		2009	
	Broward County	Florida	Broward County	Florida	Broward County	Florida
HIV	48.6	26.9	50.6	27.7	54.7	29.8
Aids	33.1	17.4	36.2	18.4	46.8	23.5
Chlamydia	404.1	401.3	398.8	397.6	397.4	387.5
Gonorrhea	121.7	104.0	123.1	107.3	112.6	111.0
Syphilis	13.4	6.6	12.6	6.3	9.8	5.5
Tuberculosis	4.3	4.0	4.0	4.4	4.5	4.4

Source: Florida Department of Health, FloridaCharts; http://www.floridacharts.com/charts/DisplayHTML.aspx?ReportType=7200&County=6&year=2012&tn=25

In 2011, Broward County had 14.7 percent of the statewide reported chronic Hepatitis B cases with 9.2 percent of the statewide population. Broward County had the 21st highest rate of reported chronic Hepatitis C cases among the 67 Florida counties.[50]

3.10 Mortality Rates in Broward County Have Declined – Racial and Ethnic Disparities Are Evident

In 2011, the age-adjusted death rate in Broward County was 640.3 per 100,000 population, 731.6 for Black/African Americans, 635.9 for Whites, and 471.4 for Hispanics. Heart disease and cancer accounted for nearly one-half of all deaths in 2011. Heart disease was the leading cause of death across all racial/ethnic groups. **Table 3-12** shows the major causes of death.[51]

Table 3-12: Broward County Major Causes of Death 2011

Cause of Death	# of Deaths	Percent of Total Death	Age-Adjusted Death per 1000,00
All causes	14,123	100.0%	640.3
Heart Disease	3,486	24.7%	150.9
Cancer	3,320	23.5%	154.2
Stroke	791	5.3%	34.4
Chronic Lower Respiratory Disease	724	5.1%	32.5
Unintentional Injuries	629	4.5%	33.0
Kidney Disease	293	2.1%	13.0
Alzheimer's Disease	220	1.6%	9.0
Diabetes	316	2.2%	14.7
Suicide	233	1.6%	12.2
Chronic Liver Disease and Cirrhosis	209	1.5%	10.0
AIDS/HIV	137	1.2%	7.1
Septicemia	150	1.1%	6.9

Source: Florida Department of Health, FloridaCharts; http://www.floridacharts.com/FLQUERY/Birth/BirthRpt.aspx

The age-adjusted death rates from all causes declined in Broward County from 2010 to 2012 (**Table 3-13**). While the death rate increased in 2012 over 2011 for heart disease, cancer, and unintentional injuries, the rate decreased for stroke and chronic lower respiratory disease. In 2012, Broward County had a lower age-adjusted death rate than Florida for heart disease, stroke, chronic lower respiratory disease, and unintentional injuries, but not for cancer.[52]

Table 3-13: Broward County and Florida Major Causes of Death 2010-2012

Cause of Death	2012			2011			2010		
	Broward County		Florida	Broward County		Florida	Broward County		Florida
	# of Deaths	Age-Adjusted Death per 100,000	Age-Adjusted Death per 100,000	# of Deaths	Age-Adjusted Death per 100,000	Age-Adjusted Death per 100,000	# of Deaths	Age-Adjusted Death per 100,000	Age-Adjusted Death per 100,000
All causes	14,299	642.9	680.7	14,123	640.3	667.9	14,603	672.4	687.4
Heart Disease	3,561	153.4	160.3	3,486	150.9	159.9	3,752	165.3	161.3
Cancer	3,405	158.1	155.3	3,320	154.2	153.0	3,349	158.3	158.3
Stroke	755	32.5	39.1	791	34.6	38.6	773	34.1	39.3
Chronic Lower Respiratory Disease	657	30.0	31.2	629	32.5	31.5	637	33.4	32.0
Unintentional Injuries	678	33.7	39.7	724	33.0	40.2	697	32.0	41.8

Source: Florida Department of Health, FloridaCharts, http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0269

The age-adjusted death rates from colorectal, prostate, and breast cancer, as well as stroke in Broward County were higher than the Florida rates but lower than the U.S. rates (**Table 3-14**).[53]

Table 3-14: Cancer and Stroke Age-Adjusted Death Rates – Broward County, Florida and the U.S.

Death Cause	Broward County	Florida	U.S.
Colorectal Cancer*	15.1	14.0	15.8
Prostate Cancer**	18.1	17.5	21.9
Black	43.4	42.5	48.2
White	16.6	16.3	9.4
Breast Cancer**	21.9	20.9	22.1
Stroke*	32.6	31.2	39.1

Source: Florida Department of Health, FloridaCharts, http://www.floridacharts.com/charts/DisplayHTML.aspx?ReportType=7226&County=6&year=2012&tn=33
*2012 data – **2009-2011 data.

3.11 Educational Attainment and Employment Levels are Higher than the State of Florida

Broward County Public Schools (BCPS) is the sixth largest public school system in the nation and the largest fully accredited district with more than 250,000 students attending 298 schools and education centers. As of January 2013, total enrollment (pre-kindergarten to grade 12) for the 2012-2013 school year was 221,379 students; with 2,029 fewer students than in the 2011-12 school year.[54] In 2011-12, 51.0 percent of enrolled students were White, 39.8 percent were African American, and 28.6 percent were Hispanic (race and ethnic categories are not mutually exclusive so percentages add to more than 100).[55]

In 2011-12, a high percentage of BCPS students performed below grade level: 43 percent of 8th graders and 51 percent of 10th graders were not reading on grade level; 37 percent of 8th graders were not on grade level for math, and 54 percent of 8th graders were not on grade level for science.[56]

Between 2009 and 2011, despite these challenges, BCPS decreased its dropout rate and increased its high school graduation rate. BCPS had a slightly higher dropout rate (2.0 percent) than Florida (1.9 percent) in 2011. According to BCPS, high school graduation rates increased from 74.2 percent in 2009 to 76.5 percent in 2011, while during the same timeframe the high school graduation rate in Florida decreased from

78.6 percent in 2009 to 74.5 percent in 2011. Broward County has a higher percentage of residents who are high school and college graduates than Florida (**Table 3-15**).[57]

Table 3-15: Educational Attainment (ages >25) – 2008 -- 2012

	Broward County	Florida
Percent with high school diploma or higher	87.6%	85.8%
Percent with Bachelor's degree or higher	29.9%	26.2%

Source: U.S. Census Bureau, 2012

Broward County has a diverse labor force. The three most common industries in 2011 – which employ about one-half of the labor force – were education, health care, and social services (22.0 percent); professional, scientific, management, administrative and waste management services (13.7 percent); and retail trade (13.5 percent).[58]

According to the U.S. Bureau of Labor Statistics and the Florida Bureau of Labor Market information, the unemployment rate in Broward County – at 9.0 percent in 2009 and 9.6 percent in 2010 – decreased to 9.2 percent in 2011 and to 7.8 percent in 2012. Between July 2012 and July 2013, the unemployment rate in Broward County decreased further, to 6.2 percent, well below the statewide rate of 7.4 percent and national rate of 7.7 percent.[59] By December 2013, the unemployment rate had decreased to 5 percent – putting Broward County among the five lowest counties for unemployment rates in the state.[60]

3.12 Crime Rates Are Higher than the State of Florida and Disparities Exist Among Juveniles Referred for Delinquency

Broward County's index crime rate has been higher than Florida's rate since 2009, according to Florida Department of Law Enforcement data. In 2011, Broward County had a crime index of 4,546 per 100,000 people, compared with Florida's rate of 4,070 per 100,000. The crime rate in 2011 in Broward County increased 3.5 percent over its 2010 rate of 4,393.[61]

According to the Florida Department of Juvenile Justice Profile of Florida Delinquencies, Broward County Black youth are referred for delinquency more often than White, Hispanic, or youth from other race/ethnic groups. Referrals of White youth have declined; there was no change in the level of referrals of Hispanic youth or youth from other race/ethnic groups from 2007-08 to 2011-12.[62]

4. CURRENT COMMUNITY CAPACITY AND DELIVERY SYSTEM

4.1 Countywide Human Services Spending Analysis

A. Overview

The following sections provide a comprehensive look at the major sources of funding for human services in Broward County. Funding data was collected from the following major funders:

- **Aging and Disability Resource Center of Broward County (ADRC):** The ADRC is a non-profit organization administered by the Areawide Council on Aging of Broward County, Inc. ADRC plans, develops, coordinates, and evaluates programs; funds services; and is the prime advocate for residents of Broward County 60 years of age or older. It receives funds from the Florida Department of Elder Affairs and is responsible for the coordination and distribution of federal funds for programs for the elderly.

- **Broward Behavioral Health Coalition (BBHC):** The BBHC was created in 2011 and selected by the Florida Department of Children and Families (DCF) as the entity responsible for planning and distributing state funding for mental health and substance abuse services in the County.

- **Broward Sheriff's Office (BSO):** For individuals in custody, the BSO offers substance abuse, life skills, and mental health programs. It provides outpatient addiction treatment services for adult participants of Drug Court. It also operates youth intervention and diversion programs, anti-domestic violence programs, and programs that provide supportive services to crime victims. Additionally, when there is a report of suspected child abuse, neglect or abandonment by a caregiver or other person responsible for a child in Broward County, BSO, under contract with the state of Florida, investigates the allegation.

- **ChildNet (CN):** ChildNet was chosen by DCF to manage the system of foster care and related services for Broward and Palm Beach County's abused, abandoned, and neglected children. It is the single, private non-profit entity responsible for managing the local system of services and supports for the community's most vulnerable children.

- **Children's Services Council (CSC):** The CSC of Broward County is an independent taxing authority established by the voters in 2000. Its mission is to provide leadership, advocacy, and resources to enhance the lives of the children of Broward County and empower them to become responsible, productive adults. The CSC works with community partners on issues such as: maternal and child health, family strengthening, after-school and out-of-school programs, kinship care, youth leadership, advocacy and employment, and support for youth and families with special needs.

- **Community Foundation (CF):** The mission of the Community Foundation of Broward is to provide leadership to find community solutions to social issues and to foster philanthropy that connects people who care with causes that matter. It provides funding to support programs in many areas, including education, youth and family, and health and wellness.

- **Early Learning Coalition (ELC):** The ELC, formerly Broward County School Readiness Coalition, Inc., is responsible for developing and administering a comprehensive school readiness program that prepares children to succeed in school and in life, as described in the Local School Readiness Coalition Plan approved by the Office of Early Learning. The Coalition assesses the early care and educational resources available in Broward County and develops local plans to address identified needs.

- **Florida Department of Children and Families (DCF):** DCF is the state agency charged with protecting child welfare and providing support services to families across the state. In Broward County, in addition to the programs it administers, it provides funding to other local programs including BSO's Child Protective Investigations and the Homeless Initiative Partnership, among others.

- **Housing and Homeless Funding:** In addition to funding provided by Broward County, housing and homeless programs are primarily funded by the federal government, state government, and local housing authorities. The Broward Housing Council's Annual Report provides a summary of the federal, state, and housing authority resources and programs administered countywide that provide affordable housing to residents. Additional funding for housing and homeless services is provided by, and accounted for within, the funding allocations of other funders included in this report.

- **Broward County Human Services Department (HSD):** HSD is the County government agency that provides funding and services for adult behavioral health, children and family services, housing and homeless services, health care, emergency assistance, basic needs, elderly and veterans services.

- **Jim Moran Foundation (JMF):** The mission of JMF is to improve the quality of life for the youth and families of Florida through the support of innovative programs and opportunities that meet the ever-changing needs of the community. It provides funding to support programs for seniors, child and adult literacy, the prevention of domestic violence, and emergency food assistance, among others.

- **United Way of Broward County (UW):** The UW is a non-profit organization that works with a coalition of charitable organizations to pool efforts in fundraising and support. The focus of UW is to identify and resolve pressing community issues, as well as effect measurable changes in the community through partnerships with local organizations.

Not all spending by the funders listed above is included in this analysis. Exemptions include:

- Funding spent on administration, data collection, provider training, provider capacity building, advocacy or public awareness since the focus on this analysis is the provision of human *services*. For similar reasons, in the area of housing and homeless programs, funding for parcel acquisition, rehabilitation, and/or construction is not included.

- Funding spent on employment-related services such as job training is not included because the area of workforce development services is beyond the scope of this project.

Funding provided from one funder to another is accounted for in the recipient agency's funding. For example, BBHC provides funding to HSD. To reduce the incidence of double-counting, funding that was provided from BBHC to HSD is accounted for in HSD's total and deducted from BBHC's total. In this way, we are able to be consistent in identifying which agency ultimately distributes the funds or provides the service.

Funders not included in this analysis are: North and South Broward hospital districts; individual cities (with one exception that is noted in Table 4-1 below); the Broward Health Department/Florida Department of Health; the Broward County Public School District; and funds received by non-profits through individual agency fundraising or donations.

The spending data presented below is intended to provide an overview of total spending and funding priorities within the County. However, it should not be considered an exact estimate of all human services funding for several reasons:

- We utilized the most recent data available from each source. Due to reporting differences, the data from different organizations may be for different fiscal or calendar years. For example, HSD provided us with budgeted amounts for the current fiscal year, which is October 1, 2013, through September 30, 2014 (FY 2014), whereas the ELC provided information from FY 2013 and the Broward Housing Council provided information from FY 2012.

- Some sources provided actual spending data (such as the countywide affordable housing and homeless data compiled by the Broward Housing Council), whereas others provided budgeted allocations (HSD).

B. Total Countywide Human Services Funding by Service Area and by Funder

Table 4-1 below identifies approximately $515.3 million in funding for human services from the providers listed above. The top two funders – the Housing Authorities and HSD – provide roughly 47 percent of the funding identified, 27 percent and 20 percent, respectively.

Table 4-1: Countywide Human Services Funding by Funder (in millions)

Funder	Total Funding Identified (in millions)	Total Funding Minus Transfers to Other Funders (in millions)	% Total Net of Transfers
Housing – Housing Authorities	$137.2	$137.2	27%
Human Services Department	$104.9	$103.6	20%
Early Learning Coalition	$72.3	$72.3	14%
ChildNet	$62.6	$62.6	12%
Children's Services Council	$51.7	$44.7	9%
Broward Behavioral Health Coalition	$42.9	$38.4	7%
Broward Sheriff's Office	$27.3	$27.3	5%
BSO Housing – Federal Funds	$21.3	$13.5	3%
Aging and Disability Resource Center	$14.9	$8.0	1%
United Way	$4.1	$3.5	1%
Community Foundation	$3.2	$3.2	1%
Jim Moran Foundation	$0.5	$0.5	<1%
Florida Department of Children and Families	$124.2	$0.4	<1%
Housing – State	$0.3	$0.2	<1%
Total	**$670.8**	**$515.4**	

Source: Human services budget/spending data provided by funders.

To examine how human services funding is spent, we grouped spending into seven common service categories described below:

- **Housing and Homeless:** Includes affordable and subsidized housing, Homeless Initiative Partnership (HIP), temporary or transitional housing, housing for special populations (such as transitioning youth or teens, persons with HIV/AIDS), mortgage and rent assistance, community development, foreclosure prevention, and emergency housing. It does not include funding related to the acquisition, rehabilitation, development, or construction of affordable housing properties.

- **Children and Family Services:** Includes childcare subsidies, education support, family support services, children/family outpatient counseling and therapy, adoption and foster care support services, addiction services for children and youth, training for childcare providers, juvenile justice programs, crisis services, case management and respite care.

- **Adult Mental Health:** Includes outpatient counseling and therapy, crisis stabilization, residential services, supportive services, specialized courts, counseling and therapy for persons with HIV/AIDS, prevention, adult day care and respite services , and Broward Sheriff's Office (BSO) pretrial services and supervision and custodial behavioral health services. (Note: BSO also provides custodial substance abuse programs, however, budget detail was insufficient to pull out funding for that program. As a result, all funding for BSO programs is included under Adult Behavioral Health). Note: For this analysis we separate adult mental health and addiction services rather than combine them into the commonly referred title of behavioral health.

- **Health Care:** Includes primary care, health care for persons with HIV/AIDS; health care for other special populations (such as victims of domestic abuse or dating violence, expectant mothers and infants, individuals experiencing homelessness or who are indigent, people with disabilities or persons with long-term illnesses, and at-risk families); assistance accessing insurance, swimming safety and drowning prevention~~,~~; general health and safety~~,~~; and emergency preparedness.

- **Adult Addiction Services:** Includes residential services, outpatient counseling and therapy, detoxification programs, and prevention programs.

- **Basic Needs:** Includes HSD's Family Success Centers, wealth building, job training and employment assistance, emergency services, food and nutrition services, utility assistance, and legal aid.

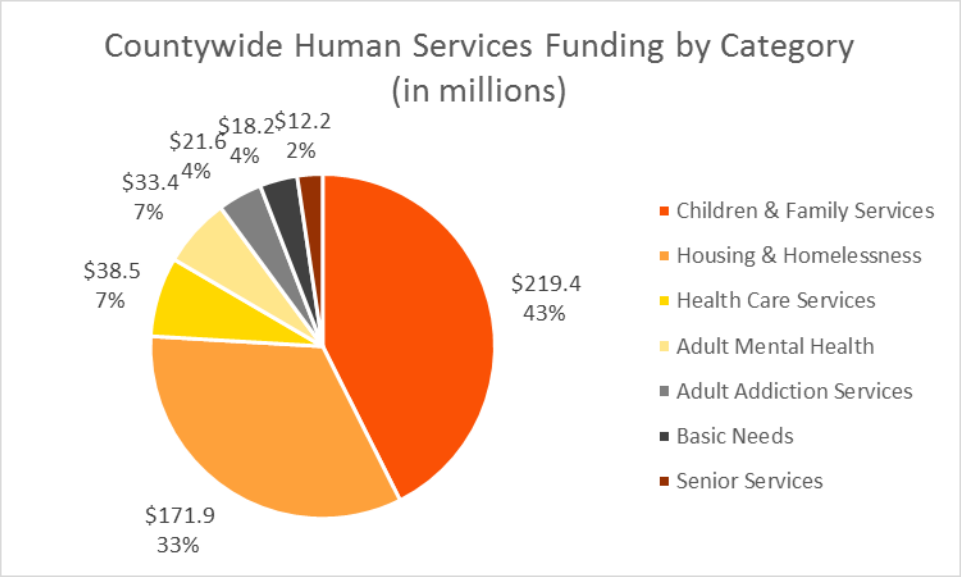
- **Senior Services:** Includes services to support independent living (such as homemaker, personal care, and chore services, emergency alert devices), adult day care, and respite care.

HSD spending by category as shown in this report *does not equal* the appropriation for each corresponding division in County documents. As described above, for this

spending analysis, we considered the *services* for which the funding was used, not the *division or program* to which the funding is allocated. For instance, HSD allocates funding for health care services to the Health Care Services Section, Children's Services Administration, the Homeless Initiative Partnership, and the Elderly and Veterans Services Division. In this analysis, that funding is all included in the Health Care category. Similarly, HSD allocates some adult behavioral health funding to the Health Care Services Section; in our analysis, that funding is *not* counted under Health Care Services; it is included in Adult Mental Health.

Chart 4-1 and Table 4-2 below illustrate the distribution of countywide human services funding across the seven service categories. Two categories account for just over three-quarters of all identified funding: Children and Family Services (43 percent) and Housing and Homeless programs (33 percent).

Chart 4-1: Countywide Human Services Spending by Service Category (in millions)



Source: Human services budget/spending data provided by funders. Percentages have been rounded.

Table 4-2: Countywide Human Services Spending by Service Category (in millions)

Countywide Spending by Service Category (in millions)		
Children and Family Services	$219.4	43%
Housing and Homelessness	$171.9	33%
Health Care	$38.5	7%
Adult Mental Health	$33.4	6%
Adult Addiction Services	$21.6	4%
Basic Needs	$18.2	4%
Senior Services	$12.2	2%
Total	**$515.4**	

Source: Various sources of budget data provided by funders. Percentages have been rounded.

Appendix I presents additional detail on countywide human services spending by category by funder.

C. Funding Detail by Service Category

This section examines in greater detail how funds are spent in the seven service categories: Children and Family Services; Housing and Homelessness; Health Care; Adult Mental Health; Adult Addiction Services; Basic Needs; and Senior Services. For each category, we identify funding by funder and the amount and types of various services provided.

C.1. Children and Family Services

Children and Family Services received 43 percent ($219.4 million) of all funding resources identified. This large percentage is not unexpected given that the residents of Broward County voted to create an independent taxing authority – the Children's Services Council – to fund an array of children's services. Specifically, the majority of resources are spent on subsidized child care, foster care, educational support, children's behavioral health, and child protective services investigations. **Table 4-3** below shows countywide Children and Family Services funding by funder.

Table 4-3: Countywide Children and Family Services Funding by Funder (in millions)

Countywide Spending for Children and Family Services by Funder (in millions)		
Early Learning Coalition	$72.3	33%
ChildNet	$62.6	29%
Children's Services Council	$38.5	18%
Broward Sheriff's Office	$19.2	9%
Human Services Department	$12.1	6%
Broward Behavioral Health Coalition	$10.8	5%
Community Foundation	$2.9	1%
United Way	$1.1	1%
Total	**$219.4**	

Source: Various sources of budget data provided by funders. Percentages are rounded.

ELC, with 33 percent of total spending ($72.3 million), is the largest Children and Family Services funder. Its funding is targeted for child care subsidies.

ChildNet funding ($62.6 million) is primarily spent on foster care services, including residential programs for youth ($55.7 million), with a smaller portion being utilized for family strengthening programs ($6.9 million).

CSC funding ($38.5 million) is distributed across several different types of services. The largest portion ($25.6 million) is spent on education-related supports, such as school and summer programming and other educational programs. These programs are targeted to high-risk children or those with serious behavioral health needs or disabilities. Family Support Services received $9.2 million in funding, with most spent on family strengthening services, such as family interventions to prevent out-of-home placements, abuse and neglect and parent training. The remainder of CSC's funding is spent on school health services ($1.1 million), juvenile diversion programs ($1.5 million), early childhood programs ($0.8 million), respite care associated with juvenile behavioral health ($0.2 million), and adoption/foster care programs ($0.1 million).

BSO funding is primarily used for child protective investigations ($15.1 million), with some funding allocated to the Juvenile Assessment Center ($2.1 million) and diversion programs ($2.0 million).

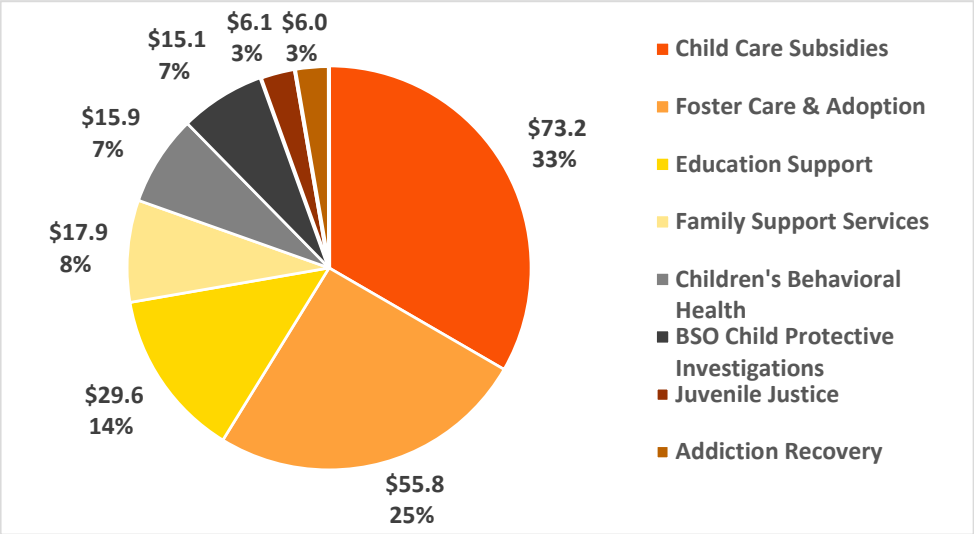
HSD spent $12.1 million on Children and Family Services. Most of this funding ($10.1 million) is for children's behavioral health services, including case management,

outpatient counseling and therapy, respite services, and other support services. Other services funded include child care subsidies for homeless families ($1.0 million), residential substance abuse treatment ($538,000), Civil Citation (juvenile justice program, $434,000), and family support services (parental visitation, $40,000).

BBHC spent a total of $10.8 million on Children and Family Services. This funding is nearly evenly split between addiction services and mental health services (including outpatient counseling and therapy, residential treatment, crisis mitigation, and prevention services).

Chart 4-2 and **Table 4-4** illustrate countywide spending detail on Children's Services by service category. Nearly three quarters of the funding was spent on three types of services: Child Care Subsidies received the largest share of funding, 33 percent ($73.2 million), followed by Foster Care and Adoption, 25 percent ($55.8 million), and Education Support, 14 percent ($29.6 million).

Chart 4-2: Countywide Children and Family Services Spending (in millions)



Source: Various sources of budget data provided by funders. Percentages are rounded.

Table 4-4: Countywide Children and Family Services Funding (in millions)

Countywide Children and Family Spending by Service (in millions)		
Child Care Subsidies	$73.2	33%
Foster Care and Adoption	$55.8	25%
Education Support	$29.6	13%
Family Support Services	$17.9	8%
Children's Mental Health	$15.9	7%
Child Protective Investigations	$15.1	7%
Juvenile Diversion Programs	$6.1	3%
Addiction Recovery	$6.0	3%
Total	**$219.4**	

Source: Various sources of budget data provided by funders.

C.2. Housing and Homeless Services

Housing and Homeless Services accounted for 33 percent of all funding identified – a total of $171.9 million. That Housing and Homelessness Services received such a large percentage is likely a result of both the great demand for these services in Broward County and the fact that these services are more expensive per person or per family to deliver in a given time frame than most, if not all, other types of services. Subsidized Housing and Rental Assistance received the largest share of this funding, 78 percent. The process to sort funding into different categories was challenging in some cases; for example, funding for affordable housing, subsidized housing, transitional housing, and other housing and homeless services sometimes overlapped.

Our analysis does not include funding related to the acquisition, rehabilitation, development, or construction of affordable housing properties. Our research found that $16.9 million spent on those services was from state ($10.3 million) and federal ($6.6 million) programs (**Table 4-5** below).

Table 4-5: Countywide Housing and Homeless Funding by Funder (in millions)

Countywide Housing and Homeless by Funder		
Housing Authorities	$137.2	80%
Human Services Department	$18.7	11%
BSO Housing – Federal Funds	$13.5	8%
Children's Services Council	$1.6	1%
United Way	$0.3	<1%
Jim Moran Foundation	$0.2	<1%
Florida Department of Children and Families	$0.2	<1%
Total	**$171.9**	

Source: Various sources of budget data provided by funders. Percentages are rounded.

The **Housing Authorities** provide 80 percent of the total funding ($137.2 million). Their funding is primarily directed to Affordable/Subsidized Housing and Rental Assistance ($134.5 million), with some funding dedicated to housing subsidies for veterans ($2.7 million).

HSD spent $18.7 million on Housing and Homeless services. The largest HSD allocation is for Homeless Initiative Partnership (HIP) programs ($8.8 million) and Temporary and Transitional Housing ($7.5 million). The remainder of the funding from HSD in this category is spent on housing opportunities for special populations, including seniors ($1.2 million), persons with substance abuse addiction ($0.5 million), transitioning or at-risk youth ($0.3 million), homeless families ($0.3 million), and battered women ($47,000).

Federal Funding for housing is primarily for Housing Assistance for Persons with HIV/AIDS ($9.3 million). Other areas of funding include HIP Programs ($2.3 million), Purchase Assistance ($1.5 million), emergency housing ($0.3 million), and foreclosure prevention ($10,000).

Table 4-6 below provides a detailed breakdown of the amount of funding provided for various types of services in the Housing and Homeless Services category countywide.

Table 4-6: Countywide Housing and Homeless Spending

Affordable and Subsidized Housing and Rental Assistance	$134.5	78%
Housing for Special Populations	$16.2	9%
Homeless Initiative Partnership (HIP)	$11.2	6%
Temporary or Transitional Housing	$7.8	5%
Purchase Assistance	$1.7	<1%
Emergency Housing	$0.4	<1%
Foreclosure Prevention	$0.1	<1%
Total	**$171.9**	

Source: Various sources of budget data provided by funders. Percentages are rounded.

C.3. Health Care Services

Health Care Services accounts for seven percent of all funding resources identified ($38.5 million). Our analysis does not include funding for indigent health care services provided by the Broward North and South Hospital Districts through their taxing authority or federal Medicaid funds. The primary providers of health care are the Broward North and South Hospital Districts and the two Federally Qualified Health Centers (FQHCs) - Broward Community and Family Health Center and Care Resources. **Table 4-7** below shows actual health care expenditures for the most recent fiscal year available for the hospital districts and the FQHCs.

Table 4-7: Actual Expenditures by County Primary Health Care Safety Net Providers

Primary Health Care Expenditures		
Broward North Hospital District	$1.1 billion	FY 2013
Broward South Hospital District	$1.4 billion	FY 2013
Broward Community and Family Health Center	$4.2 million	FY 2012
Care Resources	$14.3 million	FY 2013

Source: FY 2013 data is from Audited Financial statements for each organization. FY 2012 data is from the organization's Annual Report.

Table 4-8 below identifies Health Care Services spending by the funders included in this report.

Table 4-8: Countywide Health Care Services Funding by Funder (in millions)

Countywide Health Care Funding by Funder (in millions)		
Human Services Department	$33.2	86%
Children's Services Council	$3.5	9%
United Way	$0.7	2%
Aging and Disability Resource Center	$0.4	1%
Community Foundation	$0.4	1%
Florida Department of Children and Families	$0.3	1%
Broward Sheriff's Office	$0.1	<1%
Total	**$38.5**	

Source: Various sources of budget data provided by funders. Percentages have been rounded.

HSD accounts for the largest portion of health care spending – 86 percent of all funding in this category. Almost half of all HSD spending on Health Care Services is for primary care (48 percent or $15.8 million). The remaining Health Care Services funding supports health care for various special populations, including persons with HIV/AIDS ($12.3 million), victims of domestic violence or sexual assault ($3.3 million), children's medical home ($1.0 million), individuals who are disabled or have a long-term illness ($0.3 million), pregnant women and infants ($0.2 million), and seniors ($0.2 million).

Countywide health care funding is divided almost entirely among three areas: Primary Care (41 percent), Health Care for Persons with HIV/AIDS (32 percent), and health care for other specialized populations (23 percent). **Table 4-9** shows total countywide funding by service category.

Table 4-9: Countywide Health Care Services Spending by Service Category (in millions)

Countywide Health Care Services Spending (in millions)				
Primary Care		$15.9		41%
Health Care for Persons with HIV/AIDS		$12.4		32%
Health Care for Other Special Populations		$8.9		23%
	Domestic Violence/Sexual Assault		$3.5	
	Prenatal/Maternal/Infant Health		$2.8	
	Children's Medical Home		$1.0	
	Disabled or Long-term Illness		$0.8	
	Seniors		$0.6	
	Homeless/Indigent		$0.1	
	At-risk Families		$0.1	
General Health and Safety		$0.9		2%
Other Health Care Programs*		$0.4		1%
Total		**$38.5**		

Source: Various sources of budget data provided by funders.
*Other Health Care Programs is funding for unspecified health and wellness programs funded by the Community Foundation.

C.4. Adult Mental Health Services

Adult Mental Health Services accounts for six percent of all funding resources identified ($33.4 million). The majority of funding (63 percent) is provided by BBHC.

Table 4-10 below shows countywide Adult Mental Health funding by funder.

Table 4-10: Countywide Adult Mental Health Funding by Funder (in millions)

Countywide Adult Mental Health by Funder (in millions)		
Broward Behavioral Health Coalition	$21.2	63.5%
Human Services Department	$8.2	24.6%
Broward Sheriff's Office	$3.5	10.5%
United Way	$0.1	<1%
Total	**$33.4**	

Source: Various sources of budget data provided by funders. Percentages have been rounded.

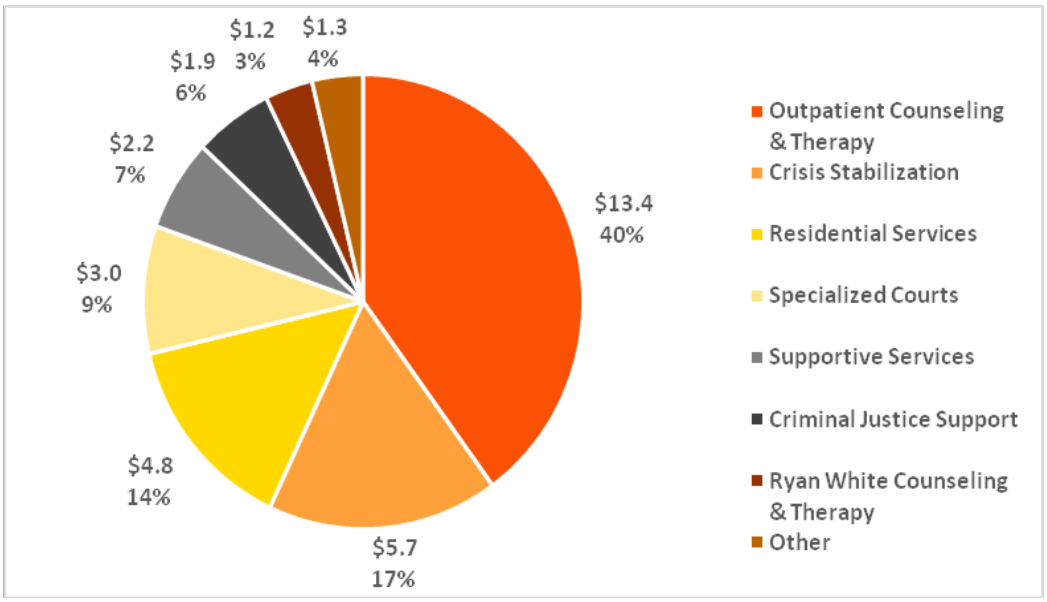
BBHC funded services include: outpatient counseling and therapy ($8.6 million), crisis stabilization ($5.3 million), residential services ($4.8 million), supportive services ($1.7 million), forensic services ($0.7 million), and prevention services ($38,000).

HSD Adult Mental Health funding totals $8.2 million and is primarily spent on outpatient counseling and therapy ($4.5 million), specialty courts ($1.8 million), counseling for Ryan White consumers ($1.2 million), and supportive services ($0.4 million), and crisis stabilization ($0.4 million).

BSO funding totals $7.5 million for a range of criminal justice support services ($1.9 million), as well as funding specialized courts ($1.2 million) and mental health programs for individuals remaining in custody ($0.4 million).

Chart 4-3 and Table 4-11 display Adult Mental Health spending by category of service. The largest portion of expenditures (40 percent, $13.4 million) is spent on outpatient counseling and therapy.

Chart 4-3: Countywide Adult Mental Health Spending by Service Category (in millions)



Source: Various sources of budget data provided by funders. Percentages have been rounded.
Note: The "Other" category includes funding for: Forensic Services ($0.7 million), BSO custodial mental health care ($0.4 million), adult day care and respite services ($0.1 million), and prevention programs ($38,000).

Table 4-11: Countywide Adult Mental Health Spending by Service Category (in millions)

Countywide Adult Mental Health Spending (in millions)				
Outpatient Counseling and Therapy		$13.4		40%
Crisis Stabilization		$5.7		17%
Residential Services		$4.8		14%
Specialized Court Programs		$3.0		9%
Supportive Services		$2.2		7%
Criminal Justice Support		$1.9		6%
Ryan White Program Services		$1.2		4%
Other Services		$1.2		4%
	Forensic		$0.7	
	BSO Custodial Behavioral Health Services		$0.4	
	Adult Day Care / Respite		$0.1	
	Prevention		$0.04	
Total		**$33.4**		

Source: Various sources of budget data provided by funders. Percentages have been rounded.
Note: The "Other" category includes funding for: forensic services ($0.7million), adult day care and respite services ($0.1 million), and prevention programs ($38,000).

C.5. Adult Addiction Services

Adult Addiction Services received four percent of all funding resources identified ($21.6 million). Half of all funding identified came from HSD; the remaining funding came from BBHC (30 percent) and BSO (20 percent). **Table 4-12** below shows countywide Adult Addiction Services funding by funder.

Table 4-12: Countywide Adult Addiction Services Funding by Funder (in millions)

Countywide Adult Addiction Services Funding (in millions)		
Human Services Department	$10.8	50%
Broward Behavioral Health Coalition	$6.4	30%
Broward Sheriff's Office	$4.4	20%
Total	**$21.6**	

Source: Various sources of budget data provided by funders. Percentages have been rounded.

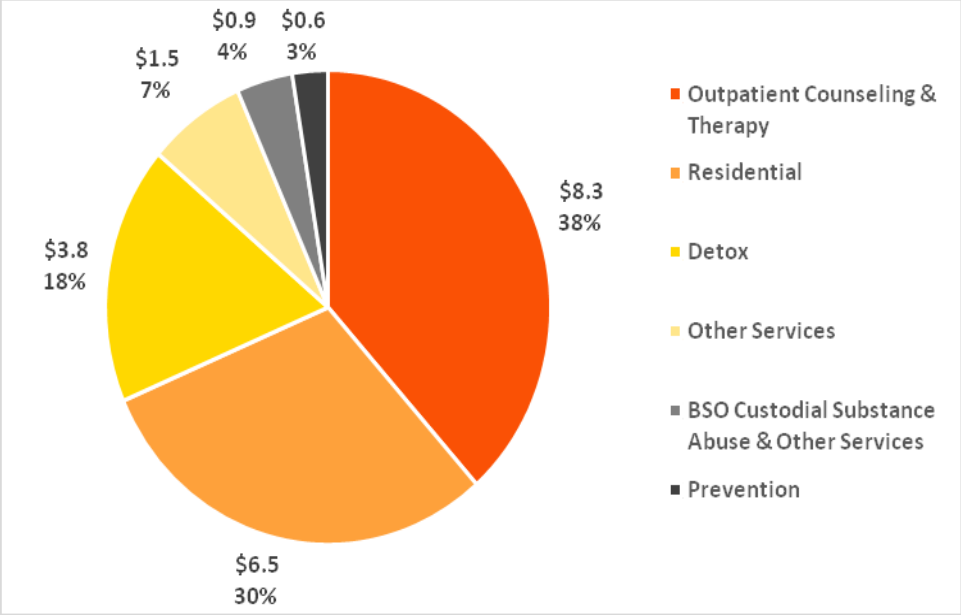
HSD Adult Addiction Services primarily funds the Broward Addiction Recovery Center (BARC). Funding is allocated to residential services ($5.1 million), detox ($3.4 million), outpatient counseling and therapy ($1.9 million), a state grant program ($0.3 million), and a grant to provide services to the elderly ($52,000).

BBHC funding is allocated for outpatient counseling and therapy ($2.9 million), residential treatment ($1.4 million), special projects ($0.9 million), prevention ($0.6 million), detox ($0.4 million), and services for TANF recipients ($0.3 million).

BSO funding is primarily used for outpatient counseling and therapy for individuals participating in drug court ($3.5 million), with some funding directed to substance abuse services for those in custody ($0.9 million).

Chart 4-4 and Table 4-13 display Adult Addiction Services spending by category of service. The largest percentage of expenditures is for outpatient counseling and therapy (38 percent, $8.3 million) and residential treatment (30 percent, $6.5 million).

Chart 4-4: Countywide Adult Addiction Services (in millions)



Source: Various sources of budget data provided by funders. Percentages have been rounded.
Note: The "Other" category includes HSD funding from a state grant program ($0.3 million) and a grant for providing services to the elderly ($52,000), and BBHC funding for special projects ($0.9 million) and services for TANF recipients ($0.3 million).

Table 4-13: Countywide Adult Addiction Services Spending (in millions)

Countywide Adult Addiction Services Spending (in millions)				
Outpatient Counseling and Therapy		$8.3		38%
Residential Treatment		$6.5		30%
Detox		$3.8		18%
Other Services		$1.5		7%
	BBHC Special Projects		$0.9	
	TANF Recipients		$0.3	
	HSD Grant		$0.3	
	Elderly Services		$0.05	
BSO Custodial Substance Abuse Treatment		$0.9		4%
Prevention		$0.6		3%
Total		**$21.6**		

Source: Various sources of budget data provided by funders. Percentages have been rounded.

C.6. Basic Needs

Basic Needs received four percent of all funding resources identified ($18.2 million). The majority of the funding (70 percent) is from HSD. **Table 4-14** below shows countywide Basic Needs funding by funder.

Table 4-14: Countywide Basic Needs Funding by Funder (in millions)

Countywide Basic Needs Funding (in millions)		
Human Services Department	$13.0	71%
Aging and Disability Resource Center	$3.1	17%
Children's Services Council	$1.1	6%
United Way	$0.9	5%
Jim Moran Foundation	$0.2	1%
Broward Sheriff's Office	$0.1	<1%
Total	**$18.2**	

Source: Various sources of budget data provided by funders. Percentages have been rounded.

Just over half of **HSD** funding for Basic Needs is provided for energy assistance ($6.7 million); the other major HSD expenditure in this category is Family Success Centers ($4.2 million). The remaining funding is allocated for wealth building/savings programs ($1.2 million), 211 Broward referral service ($0.4 million), legal aid ($0.3 million), and food assistance ($0.2 million).

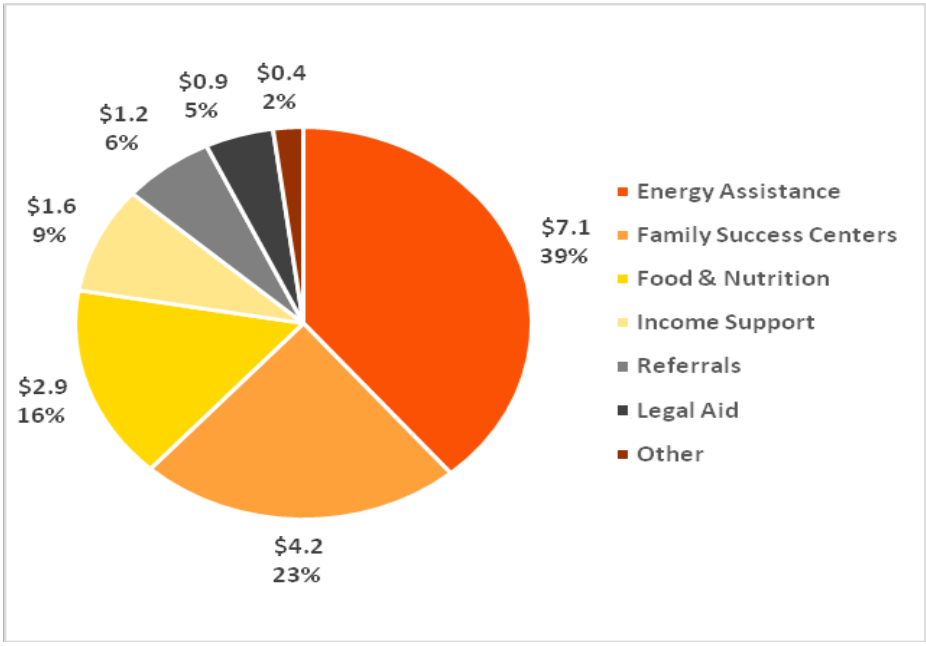
ADRC funding in this category is primarily spent on food assistance ($2.4 million). Other expenditures include energy assistance ($0.4 million), legal aid ($0.3 million), and material aid ($0.05 million) (food assistance, home products, minor home repairs, etc.).

CSC expenditures include 211 Broward referral services ($0.5 million), juvenile legal aid ($0.3 million), wealth building and savings programs ($0.3 million), and food assistance ($0.05 million).

UW expenditures include emergency services ($0.3 million), 211 Broward referral services ($0.3 million), food assistance ($0.2 million), income support ($0.1 million), and emergency preparedness ($25,000).

Chart 4-5 and Table 4-15 display Basic Needs spending by category of service. Energy assistance received the greatest share of funding (40 percent), followed by the Family Success Centers (23 percent) and food assistance (16 percent).

Chart 4-5: Countywide Basic Needs Spending (in millions)



Source: Various sources of budget data provided by funders. Percentages have been rounded.
Note: The "Other" category includes funding for emergency services ($0.3 million), support for crime victims ($63,000), emergency preparedness ($25,000), and adult literacy ($13,000).

Table 4-15: Countywide Basic Needs Spending (in millions)

Countywide Basic Needs Spending (in millions)				
Energy Assistance		$7.1		39%
Family Success Centers		$4.2		23%
Food Assistance		$3.0		16%
Income Supports		$1.6		9%
Referrals		$1.2		6%
Legal Aid		$0.9		5%
Other		$0.4		2%
	Emergency Services		$0.3	
	Support for Crime Victims		$63,000	
	Emergency Preparedness		$25,000	
	Adult Literacy		$13,000	
Total		**$18.2**		

Source: Various sources of budget data provided by funders. Percentages have been rounded.

C.7. Senior Services

Seven categories of service for seniors – independent living, adult day care, Alzheimer's services, respite care, recreation, transportation, and home improvements – received two percent of all funding resources identified ($12.2 million).

Table 4-16 below shows countywide Senior Services funding for these services by funder. HSD provides 63 percent of the funding and ADRC provides 35.8 percent.

Table 4-16: Countywide Senior Services Funding by Funder (in millions)

Countywide Senior Services by Funder		
Human Services Department	$7.7	63.1%
Aging and Disability Resource Center	$4.4	35.8%
United Way	$0.1	<1%
Jim Moran Foundation	$0.1	<1%
Total	**$12.2**	

Source: Various sources of budget data provided by funders. Percentages have been rounded.

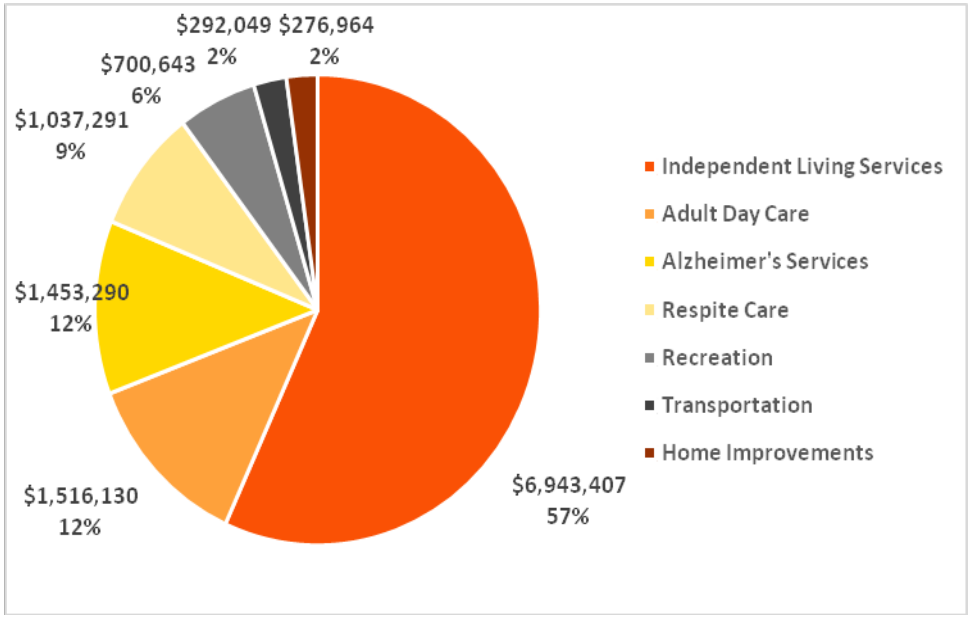
HSD funding is allocated primarily to assist seniors with independent living, such as homemaker and other in-home support services ($4.5 million), personal care ($2.0

million), and emergency alert devices ($0.05 million). Additional funding is allocated for respite care ($0.8 million) and adult day care ($0.4 million).

ADRC funding is allocated for a variety of services, including: support services for persons with Alzheimer's Disease ($1.5 million), adult day care ($1.1 million), recreation programs ($0.6 million), homemaker and other in-home support services ($0.3 million), transportation ($0.3 million), home improvements ($0.3 million), respite care ($0.3 million), and personal care ($18,000).

Chart 4-6 and Table 4-17 display Senior Services spending by category of service.

Chart 4-6: Countywide Senior Services Spending (in millions)



Source: Various sources of budget data provided by funders. Percentages have been rounded.
Note: The "Independent Living" category includes funding for homemaker and other in-home services ($4.8 million), personal care ($2.0 million), emergency alert devices ($52,000), and daily check-in calls from Broward 211 ($48,000).

Table 4-17: Countywide Senior Services Spending (in millions)

Senior Services Spending (in millions)				
Independent Living Services		$6.9		6.0%
	Homemaker and Other In-home Support Services		$4.9	
	Personal Care		$2.0	
	Emergency Alert Devices		$52,000	
	Broward 211 Daily Calls		$48,000	
Adult Day Care		$1.5		13.0%
Alzheimer's Services		$1.5		13.0%
Respite Care		$1.0		8.7%
Transportation		$0.3		2.6%
Home Improvements		$0.3		2.6%
Total		**$11.5**		

Source: Various sources of budget data provided by funders. Percentages have been rounded.

4.2 Human Services Department (HSD) Spending Analysis

The following sections examine the HSD budget and spending patterns in greater detail, beginning with budget trends from 2008 through the current fiscal year. We then present an overview of current funding from all sources and a General Fund spending summary.

A. Human Services Department Budget Trends

Since the national economic recession in 2008, government entities across the country have seen declines in revenue and ability to spend. This pattern is true in Broward County. **Table 4-18** below shows the HSD budget trends since FY 2008. The budget data in this table are from adopted budgets which do not include budget modifications made during the fiscal year. Also, in order to capture consistent budget items in the current and historical HSD budgets, the table excludes major one-time funding changes that occurred due to a restructuring or a transfer of a budget line item to other accounts. For example the Medical Examiner's Office was moved from HSD to County Administration in FY 2010; funding is removed from all budget years so that the reduction does not skew comparisons.

Table 4-18: Summary of HSD General Fund Budget (in millions) and Positions, FY 2008 – FY 2014

Fiscal Year	Total General Fund	% Change	$ Change	Positions	Percent Change	Position Change
2008	$80.6			382		
2009	$78.8	(2%)	($1.8)	350	(8%)	(32)
2010	$72.4	(8%)	($6.4)	279	(20%)	(71)
2011	$69.1	(5%)	($3.3)	273	(2%)	(6)
2012	$69.1	0%	0.05	272	0%	(1)
2013	$69.9	1%	0.8	290	7%	18
2014	$69.9	0.01%	0.01	282	(3%)	(8)
Total Change		**(13%)**	**($10.7)**		**(26%)**	**(100)**

Source: Historic HSD budget data provided by HSD budget staff.

The department's General Fund budget has declined 13 percent since 2008. During this period, staff levels declined at a greater rate, from 382 positions to 282, a reduction of 26 percent.

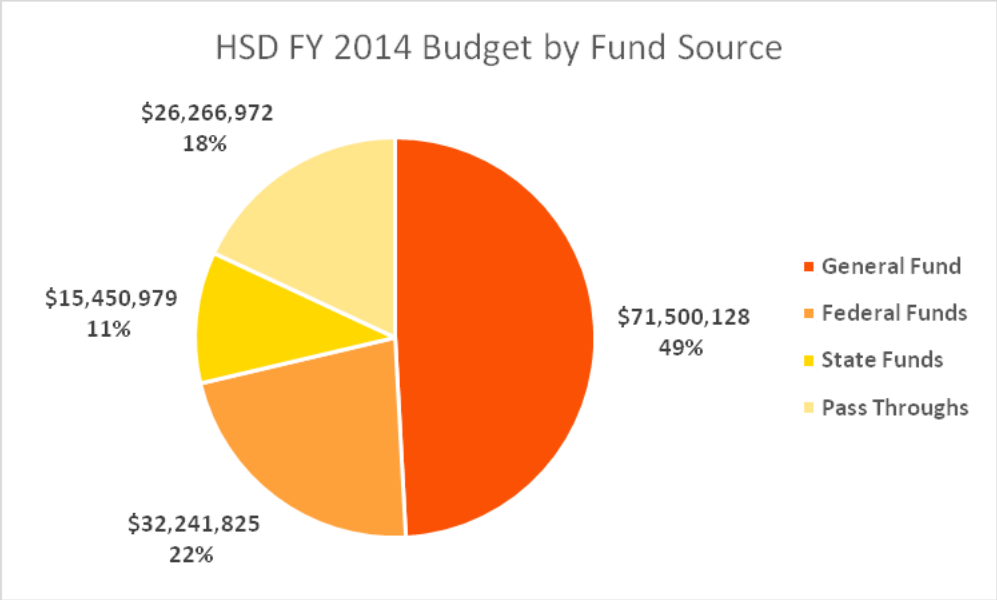
B. HSD Current Budget Overview

The current HSD FY 2014 budget for services is $104.9 million. As illustrated in **Table 4-19** and **Chart 4-7** below, General Fund appropriations make up almost half of the HSD budget (49 percent or $71.5 million), federal funds constitute 22 percent of the budget ($32.2 million), and state funds make up 11 percent ($15.5 million). The department is also appropriated $26.3 million in pass-through funds for financial management purposes, over which it has no control. Pass-through funds are comprised of $23.4 million in state Medicaid funds, $1.9 million in Pay Telephone Trust Fund monies, and $950,000 in Driver's Education Safety Trust Fund monies.

Table 4-19: HSD FY 2014 Budget by Source

HSD FY 2014 Budget by Fund Source (in millions)		
General Fund	$ 71.5	49%
Federal Funds	$ 32.2	22%
State Funds	$ 15.5	11%
Pass Throughs	$ 26.3	18%
Total	**$ 145.5**	

Chart 4-7: Human Services Department Budget by Fund Source

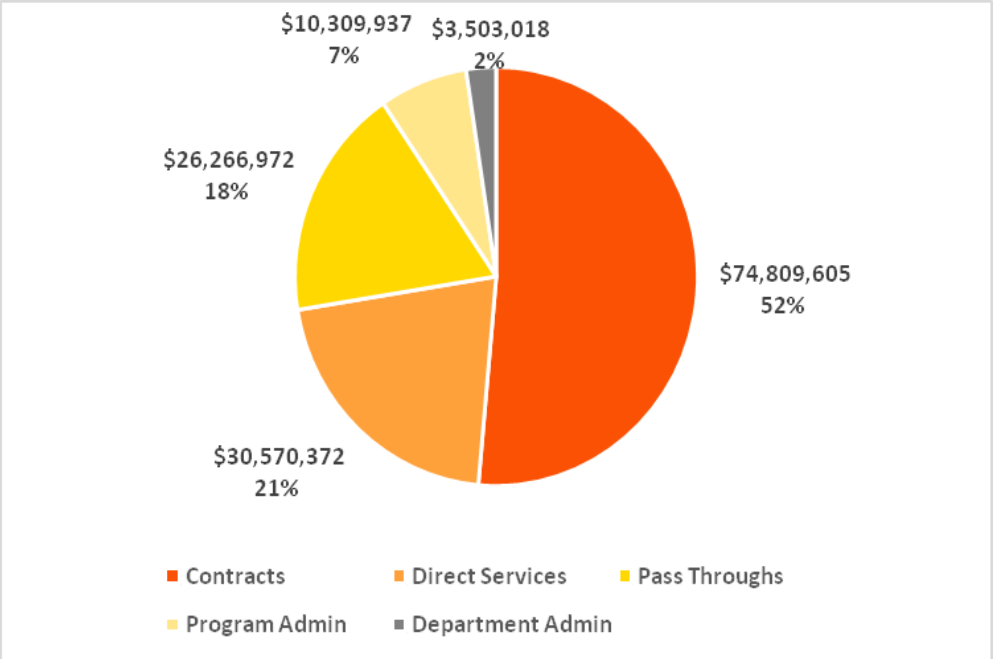


Source: Current FY 2014 budget data provided by HSD budget staff.

Chart 4-8 illustrates the cost categories of the FY 2014 budget. Contracts for services are the largest share, comprising 52 percent ($74.8 million). Direct services are those that the department provides to consumers directly, such as: substance abuse treatment at BARC; sexual assault and abuse services at the Nancy J. Cotterman Center; Family Success Centers and related case management, Elderly and Veterans Services case management, behavioral health and veterans' services; and the Civil Citation program. Direct Services is the second largest cost category, 21 percent ($30.6 million). Program Administration includes the costs for administering both direct and contracted programs. Since Child Care Licensing and Enforcement is more of a regulatory responsibility than a

service, it is included with Program Administration costs, not Direct Services. Program Administration costs comprise seven percent of the budget ($10.3 million). Department Administration includes the Director's Office; budget, purchasing, and personnel services; and departmental planning and evaluation staff and accounts for two percent of the budget ($3.5 million).

Chart 4-8: Human Services Department Budget by Cost Category



Source: Current FY 2014 budget data provided by HSD budget staff.

C. HSD Total Spending by Service Category

Table 4-20 and Chart 4-9 provide a breakdown of HSD's FY 2014 total budget from all fund sources for contracting and direct services spending by service category. Health Care Services received the most contract and direct services funding ($33.2 million, 32 percent) of the total. This amount is slightly greater than the funding spent on the next two largest service categories combined: Housing and Homeless and Children and Family Services which received $18.7 million and $13.5 million, respectively.

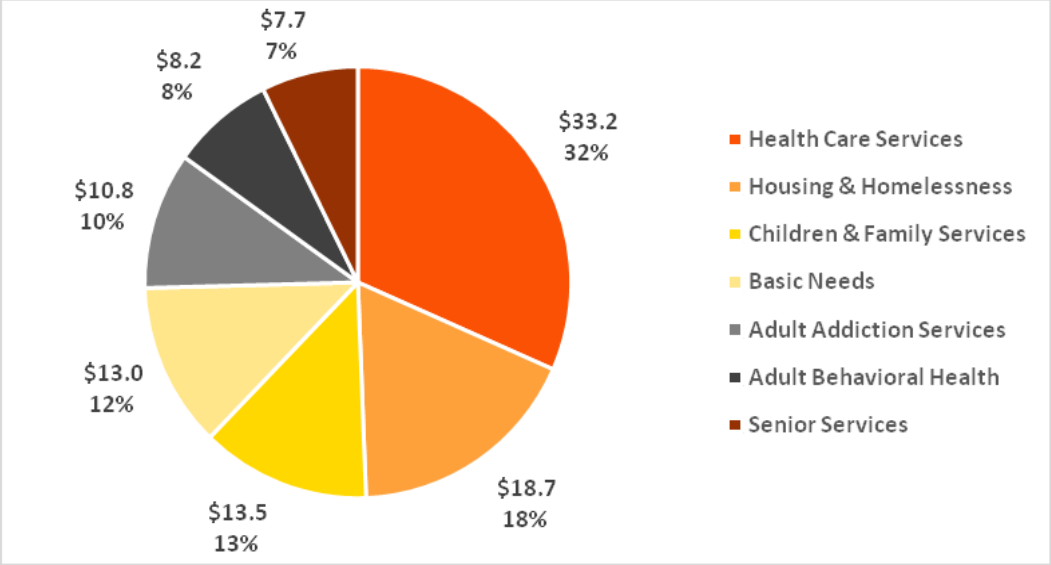
Appendix J details HSD's total allocations for each service category.

Table 4-20: HSD FY 2014 Total Budget for Contracted and Direct Services by Service Category (in millions)

HSD FY 2014 Budget by Service Category (in millions)				
Service Area	**Contracted Services**	**Direct Services**	**Total Spending**	**Percent of Grand Total Spending**
Health Care Services	$29.9	$3.3	$33.2	32%
Housing and Homeless	$17.5	$1.2	$18.7	18%
Children and Family Services	$13.1	$0.4	$13.5	13%
Basic Needs	$1.0	$12.0	$13.0	12%
Adult Addiction Services	$0	$10.8	$10.8	10%
Adult Mental Health	$8.2	$0	$8.2	8%
Senior Services	$5.2	$2.5	$7.7	7%
Total	**$74.8**	**$30.1**	**$104.9**	

Source: Current FY 2014 budget data provided by HSD budget staff.

Chart 4-9: HSD FY 2014 Total Budget for Contracted and Direct Services by Service Category (in millions)



Source: Current FY 2014 budget data provided by HSD.

D. HSD General Fund Spending by Service Category

Table 4-21 and Chart 4-10 provide a breakdown of HSD contracting and direct services spending by service category for *General Fund only*.

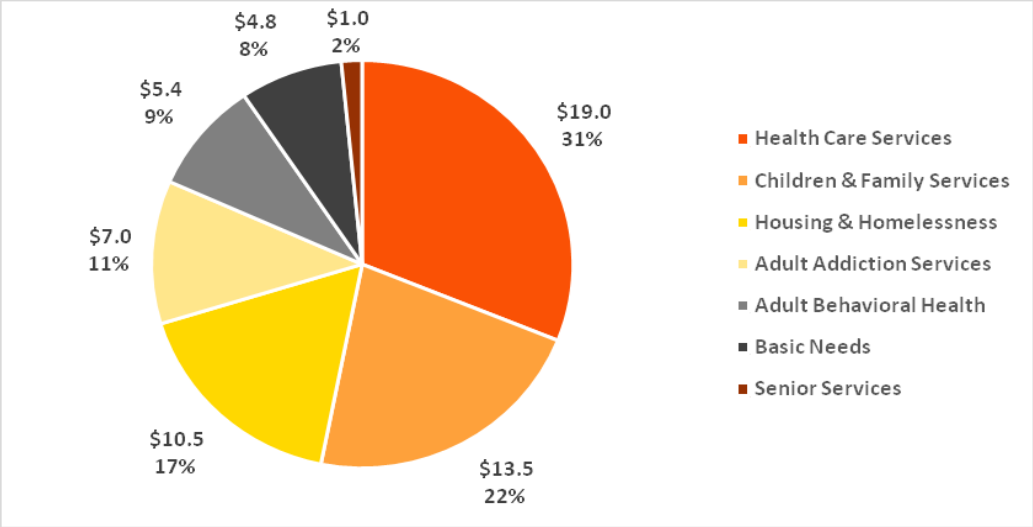
Appendix K includes additional details on the General Fund allocations for each service category.

Table 4-21: HSD FY 2014 General Fund Budget for Contracted and Direct Services by Service Category (in millions)

HSD General Fund (in millions)				
Service Area	**Contracted Spending**	**Direct Services Spending**	**Total Spending**	**Percent of Grand Total Spending**
Health Care Services	$17.4	$1.6	$19.0	31%
Children and Family Services	$13.1	$0.4	$13.5	22%
Housing and Homelessness	$9.4	$1.1	$10.5	17%
Adult Addiction Services	$0	$7.0	$7.0	11%
Adult Mental Health	$5.4	$0	$5.4	9%
Basic Needs	$0.6	$4.2	$4.8	8%
Senior Services	$0.7	$0.3	$1.0	2%
Total	**$46.6**	**$14.6**	**$61.2**	

Source: Current FY 2014 budget data provided by HSD budget staff.

Chart 4-10: HSD FY 2014 General Fund Budget for Contracted and Direct Services by Service Category (in millions)



Source: Current FY 2014 budget data provided by HSD budget staff.

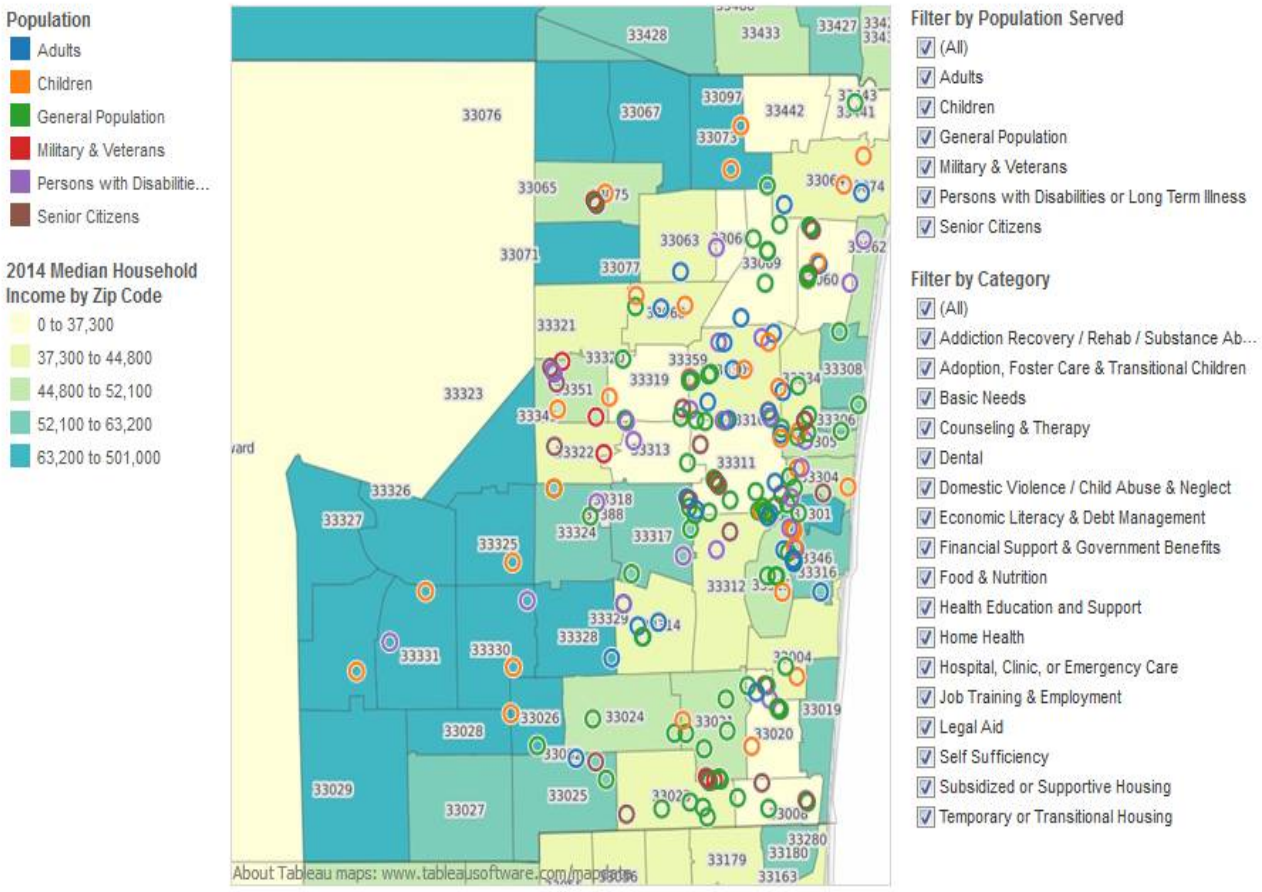
4.3 Location of Services within Broward County

A final analysis conducted as part of this needs assessment is the mapping of services in Broward County. The map provides a visual representation of where services are provided.

Exhibit 4-1 below is a screen shot of an online, interactive map developed for this initiative. Users can search by population and category of service to find the location of services. When online, hovering over a map circle displays a pop-up box identifying the name, address and telephone number of the service provider.

As part of our review of the services and funding provided countywide, we created the map to identify the location of safety net services throughout Broward County. The map identifies 212 social service providers throughout the County that have a primary mission to provide services to County residents. The service providers included in the map either receive funding through one or more of the major funders discussed above or are funded through private foundations or donations.

Exhibit 4-1: Service Locations



5. DOCUMENTING THE HUMAN SERVICES NEEDS IN BROWARD COUNTY

Early in this initiative it became clear that a significant amount of information, from a wide range of groups, is available to document a variety of needs in Broward County. Our challenge was not only to gather these reports, but also to use our primary data collection activities to enhance and further develop an assessment of the needs and service delivery system within the County.

The following section summarizes the numerous needs assessments already in existence and outlines the additional mechanisms we used to gather insights and opinions on services provided throughout the County – Resident Telephone Survey, Consumer Focus Groups, Provider Town Hall Meeting and Provider E-Survey.

5.1 Secondary Data Collected – Summary of Existing Needs Assessments

Broward County has a wealth of data available to assess the needs of the community and plan for how government and non-profits can work together to meet those needs.

Our review identified 25 needs assessments, strategic plans, and other reports that provide information on a range of needs for various target populations (**Exhibit 5-1**). We are sure there are even more. These plans reflect much of what was discussed in the many interviews and meetings held with County officials, providers, and other stakeholders, as well as in the surveys and focus groups conducted for this initiative.

Exhibit 5-1: Existing Needs Assessments

CHILDREN'S SERVICES		
Report Title	**Report Source**	**Date Issued**
Initiative on Access to Children's Behavioral Health: Parent Survey	Children's Services Council	October 2012
Broward County High School Youth Risk Behavior Study	Broward County Public Schools	2011
Children's Services Advisory Board Strategic Plan	Children's Services Advisory Board	FY 2014-2016
Broward Children's Strategic Plan: Success for All Broward's Children	Children's Services Council	2012
Turning the Curve	Children's Services Council	February 2012
Survey Results: Access to Children's Behavioral Health Services	Needs Assessment Committee	March 2, 2012
ADULT BEHAVIORAL HEALTH		
Report Title	**Report Source**	**Date Issued**
BARC Business Plan	BARC	FY2014
Strengthening Florida's Behavioral Health System	Florida Council for Community Mental Health Florida Council for Behavioral Healthcare	2013
Behavioral Health Programmatic Allocation Plan	Broward Behavioral Health Coalition	December 30, 2013
Legislative Budget Request: Crisis Stabilization Beds	South Florida Behavioral Health Network	December 18, 2013
Legislative Budget Request: Statewide Inpatient Psychiatric Program	South Florida Behavioral Health Network	December 18, 2013
Legislative Budget Request: Short-Term Residential Treatment Program	South Florida Behavioral Health Network	December 18, 2013
ELDER SERVICES		
Report Title	**Report Source**	**Date Issued**
Assessing the Needs of Elder Floridians: PSA 10	Florida Department of Elder Affairs	January 2012
Aging and Disability Resource Center Public Hearing – 2014 Area Plan on Aging	Aging and Disability Resource Center	August 28, 2013
Broward County Population by Place	Florida Department of Elder Affairs	2013

HOUSING AND HOMELESS		
Report Title	**Report Source**	**Date Issued**
Broward County Affordable Housing Needs Assessment	Broward Housing Council Metro Center Florida International University	2011
Rental Market Study: Affordable Housing Needs	Florida Housing Finance Corp.	2013
Homelessness in Broward County: Point-in-Time Report	Broward County, Homeless Partnership Board, Broward Regional Health Planning Council	2013
Broward County 10-Year Plan to End Homelessness 2.0	Broward County, Homeless Partnership Board	August 2013
Broward Partnership for the Homeless Annual Report	Broward Partnership for the Homeless	2013
HEALTH		
Report Title	**Report Source**	**Date Issued**
Community Health Assessment Broward County	Florida Department of Health	June 2013
Broward County Comprehensive HIV Health Services Plan	Broward County HIV Health Services Planning Council	FY2012-2015
BASIC NEEDS		
Report Title	**Report Source**	**Date Issued**
Hunger Survey: Food Security Report	Broward Regional Health Planning Council Children's Services Council Coordinating Council of Broward County	2007
COMMUNITY-WIDE INFORMATION		
Report Title	**Report Source**	**Date Issued**
211 Broward Reports	211 Broward	2013
Quality of Life Assessment Report	Coordinating Council of Broward County Memorial Healthcare Systems	2011

Following are highlights from the reports listed above.

A. Children's Services

The Children's Services Council (CSC) has a very robust, structured, and on-going strategic planning process in place and has produced several reports on needs and

barriers to service, including recommendations and action steps. Highlights of the ***Children's Services Advisory Board Strategic Plan*** and other reports produced by CSC indicate:

- While the majority of parents found it somewhat or very easy to learn about agency services for children in need of behavioral health services, they learned of the services through friends, not any referral system or 211 Broward.

- Seventy percent of parents surveyed had to wait between one and four weeks to get services.

- Some barriers to obtaining services identified in the ***Survey Results: Access to Children's Behavioral Health Services*** include:

- Wait lists/full caseloads.
- Wait times for specific services.
- Lack of services in primary language.
- Services too far from work or home.
- Lack of transportation.
- Inability to afford co-pays.
- Private insurance did not cover all needed services.

- The ***Children's Services Strategic Plan*** and ***Turning the Curve*** reports identify a range of data points that describe both the progress being made and the areas of continued concern in children's services. The reports also identify partners, best practices, and action steps planned to reverse negative trends or barriers that continue to exist. Highlights of needs/issues include:

- Slight increase in verified evidence of child abuse/neglect reports.
- Suicide rate for 19-21 year olds in Broward County remains higher than state in general.
- Almost 50 percent of youth attempting suicide do not receive follow-up mental health care.
- Some health risk factors for children continue to increase – diabetes and obesity in particular.
- African American youth continue to be arrested at disproportionally higher rates than other racial and ethnic youth.

- Lack of treatment for young girls who have been traumatized increases their representation in the delinquency system.
- Mortality rates for African American babies are almost three times the rate of white babies.
- Haitian babies represent only 12 percent of births but 24 percent of deaths.

CSC also produced an *Indicators of Community Need Workbook* that contains two years (FY 2011 and FY 2012) of data on 17 indicators: Abuse and Neglect, Prosperity, Delinquency Prevention, Delinquency Diversion, Independent Living, Early Care, Out of School, School Health, Health and Safety, KidCare Outreach, Maternal and Child Health, SN MOST and Respite, SN STEP, Simplified Point of Entry, Data, Research and Planning, Capacity Building, and Public Awareness.

The **Children's Services Advisory Board**, staffed by HSD and charged with advising the Broward County Commissioners on the allocation of funds for children's intervention services, identified six strategic areas recommended for funding:

- Behavioral Health Services.
- Special Needs.
- Independent Living.
- Deep-End, Acting-Out Youth.
- System of Care.
- Child Care.

The ***High School Youth Risk Behavior Study*** (from 2005 to 2011) shows:

- An increase in the number of students who skipped school because of feeling unsafe on the way to or at school.
- While smoking cigarettes is down, overall use of tobacco products is relatively the same because of the increased use of chewing tobacco and snuff.
- Percent of youth engaged in sexual activity is about the same, however, the use of condoms and birth control is down.
- 3,027 youth ages 12 to 17 needed drug treatment and did not receive it.
- 3,766 youth ages 12 to 17 needed alcohol treatment and did not receive it.

B. Adult Behavioral Health

The Broward Behavioral Health Coalition's ***Programmatic Allocation Plan*** and **Legislative Budget Requests** prepared jointly with the South Florida Behavioral Health Network identify priority issues that jeopardize the System of Care initiative:

- Insufficient funds for inpatient psychiatric beds for non-Medicaid eligible children.
- Insufficient forensic, short-term, secure residential placements for adults.
- Insufficient crisis stabilization beds.
- No adult or juvenile receiving facilities to provide secure detox services.
- Need for expedited access to Medicaid application and eligibility determinations.
- No inpatient maternal addiction program (Plantation Hospital program closed).

Based on data from the ***National Survey on Drug Use and Health Sub-State Data (2008-2010)***, the Broward Addiction Recovery Center (BARC) Strategic Plan estimates that:

- 25,770 residents ages 18 and older needed drug treatment and did not receive it.
- 83,991 residents ages 18 and older needed alcohol treatment and did not receive it.

C. Elder Services

Broward County elderly residents have a strong advocate in the Aging and Disability Resource Center (ADRC). The ADRC serves as the central point for planning and resource allocation, monitoring and evaluating programs for senior citizens. The **ADRC's yearly plan and public hearing**, as well as the ***Florida Department of Elder Affairs Report for PSA 10 (Broward County)***, note:

- 20 percent of the Broward County population (369,251) is age 60 or older.
- 20 percent of elders report they do not receive the medical care they need.
- 27 percent report that a lack of money is the largest barrier to receiving medical care.
- Only one-third of elderly individuals who are eligible for SNAP (food assistance) actually receive it.
- Only 64 percent of elders surveyed report always eating all the food they need.
- 26 percent of seniors report difficulty finding affordable housing in which they feel safe, and an inability to keep up with repairs so they can age in their homes.

D. Housing and Homeless

The ***Broward County Housing Needs Assessment*** reflects data that is consistent with statewide assessments such as the ***Rental Market Study: Affordable Housing Needs***, conducted by the Florida Housing Finance Corp. In Broward County:

- Monthly owner-occupied housing costs increased by 54 percent between 2000 and 2011.
- Median gross rent increased from $757 to $1,253 – increasing the number of renters considered housing-burdened (spending more than half of their income on housing) to 62 percent.
- The median sales price for new single-family homes ($251,851) is well out of reach for the majority of residents.

The Homeless Initiative Partnership Board, as well as other agencies and advocates around the County, have worked over the past several years to greatly increase the awareness of homeless issues and to address the needs in a coordinated way. The identification of needs related to homelessness, as well as plans to end homelessness, are well documented in several publications such as: ***Point-in-Time Report, Ten Year Plan to End Homelessness,*** and the ***Broward Partnership for the Homeless Report***. While the number of sheltered and unsheltered individuals and families has decreased recently according to the 2011-2012 Point-in-Time count, there are significant needs that remain. These plans recognize the complex issues facing those who are at-risk of becoming homeless and that a continuum of care must be in place to stabilize housing and support for individuals and families to become self-sufficient. The reports note that:

- 2,810 individuals and families were counted as homeless in the 2013 count.
- An additional 783 were considered at-risk.
- Three percent of those counted were youth who aged out of foster care.
- 56 percent of the homeless are identified as having a disability.
- 45 percent of the homeless report having mental health problems; 25 percent having serious, chronic mental illness.
- More than 60 percent of homeless individuals entering the Partnership Center have diagnosable mental health and/or substance abuse issues.
- 20 percent of those counted reported having a substance abuse problem.
- The homeless population is growing older – with an average age of 48.
- Health issues are exacerbated, and new health problems occur, when people live on the streets.
- Homeless families are an increasing proportion of the homeless population.

E. Health

The ***Broward County Community Health Assessment*** completed by the Florida Department of Health identified major health risks in the community as well as the following barriers to accessing health care:

- Residents have to navigate a complex system to obtain needed health care and links to other services.
- A lack of health literacy, especially in the minority, disabled, and elder communities.

The ***FY 2012-2015 Broward County Comprehensive HIV Health Services Plan*** presents an in-depth analysis of HIV/AIDS demographics, services, and needs. The report profiles the status of HIV/AIDS in Broward County: one in 104 residents is HIV positive – a cumulative total of 27,549 individuals through 2010, including 358 children. During the first nine months of 2010, newly reported AIDS cases increased by 14 percent; HIV increased 35 percent. On average, Broward County sees three new HIV/AIDS cases each day. Unmet needs identified in the report include:

- Additional screening that is sensitive to issues surrounding HIV/AIDS.
- Eliminating disparities in access to and services for minority and homeless populations.
- Affordable housing.

F. Basic Needs

The Broward Regional Planning Council's ***Hunger Survey: Food Security Report***, produced with support from the Children's Services Council and the Coordinating Council of Broward County, surveyed residents on issues of food security. "Food insecurity" is defined as households that report reduced food intake with moderate to severe hunger, typically meaning both children and adults have reduced food intake to the extent they experience hunger. Households with incomes below $35,000 were included in the survey.

The survey found:

- 49.9 percent of households with children reported food insecurity with moderate to severe hunger.
- 52.5 percent of households without children reported food insecurity with moderate to severe hunger.

- Only 14 percent of those surveyed reported being food secure.

G. Community-wide Information

To support this needs assessment initiative, **211 Broward** provided reports of calls received during 2013 on several data points: total calls by zip code, unmet needs by zip code, age range of callers, reasons for calls, and reasons for unmet needs.

Appendix L contains summaries of reports that show:

- Just over 90 percent of all calls and unmet needs originate in 30 of the County's 53 zip codes.
- The majority of callers are age 21-54 (86.8 percent), very few are 20 or younger, and 12.2 percent are 55 and over.
- Of 133,075 calls received in 2013:
- 64,821 (48.7 percent) were for basic needs.
- 28,112 (21.1 percent) were for behavioral health services.
- 12,277 (9.2 percent) were for health.
- 16,845 calls were coded as an unmet need for one of eight reasons: Caller declined referral, caller lacks transportation, caller was not eligible, caller terminated call, provider funds exhausted, provider language barrier, provider had no such service available, and provider had a wait list for services. Of these, the primary reasons callers could not be referred include:
- Of 5,489 calls for basic needs, the vast majority of calls (87 percent) were not referred because of wait lists or exhausted funding.
- 6,310 (36.9 percent) were not referred because wait lists existed or the provider had exhausted funds.
- 4,648 callers (27.6 percent) were not eligible for services requested. Of those callers, 93.8 percent (4,361) were requests for basic needs.
- 956 calls (5.7 percent) requested help with behavioral health services that could not be met. Of the behavioral health calls, 630 (65.9 percent) were for mental health services; 136 (14.2 percent) were for substance abuse services.

5.2 Primary Data Collected

A. Resident Telephone Survey Summary

The telephone survey of County residents in targeted zip codes provides insights into residents' use of County services, their understanding of available services, and possible

need for services in the future. **Appendix E** contains the Resident Telephone Survey report. Highlights from the report include:

- A majority (59 percent) of respondents express satisfaction with the quality of services available to Broward County residents.

- Respondents register high levels of awareness of many of the services offered throughout Broward County.

- Sizeable majorities are both aware of, and hold favorable opinions of, County public transportation services (65 percent favorable), childhood shots and immunizations (62 percent favorable), affordable health care (59 percent favorable), and services for the elderly (58 percent favorable).

- This trend does not extend across the board, however. Respondents express less favorable opinions of – and also tend to be slightly less familiar with – cash assistance programs (31percent favorable), mortgage and rent assistance (37percent favorable), and juvenile delinquency intervention services (38 percent favorable).

- The most favorably regarded services also tend to receive the highest overall marks for satisfaction among County residents, marks that are consistently higher among those who have received County services over the past year (by an average of 12 points, but by as much as 20-25 points higher in some cases).

- The biggest discrepancies in the satisfaction ratings between recent recipients of County services and non-recipients is with regard to HIV prevention and treatment (63 percent of recipients were satisfied vs. 38 percent of non-recipients satisfied); after-school programs (69 percent satisfied vs. 48 percent satisfied, respectively); nutrition programs (59 percent satisfied vs. 43 percent satisfied, respectively); and infant, toddler, and child care services (62 percent satisfied vs. 46 percent satisfied, respectively).

- For those who have received County services in the past year, public transportation is the most common service used (20 percent), followed by affordable health care (16 percent), services for the elderly (15 percent), child care services (14 percent), and after-school programs (14 percent). The remaining services are used by smaller portions of adults.

- Affordable health care (27 percent) and dental care (25 percent) are the services adults indicate they need most, followed by public transportation (13 percent), cash assistance (13 percent), and mortgage and rent assistance (13 percent).

- The reasons respondents cited for using County services were: because they are effective in meeting their needs (28 percent) and are convenient (24 percent). Fully three-quarters (75 percent) of those who receive services are likely to continue using services.

- It is important to note that there is room to expand public awareness of, and satisfaction with, even the most popular and recognized services, as roughly one-third of respondents had either no opinion of, or are completely unfamiliar with, all of the services described.

- Moreover, while majorities of respondents are satisfied with many of the services discussed in this survey, none registers overwhelmingly high satisfaction ratings, even among those who have received County services over the past year.

- A majority of those who have not used County services in the past 12 months expressed interest in doing so, saying they would be either extremely or very likely to seek out those services if they needed them in the future.

- Nearly half (48 percent) of respondents showed high interest in programs that offer low-cost health care to individuals and families in need. This is followed by interest in after-school programs, nutrition and healthy living programs, public transportation services, financial planning, services for children and adults with disabilities, and services for the elderly.

- Residents not currently receiving services who expressed a strong interest in seeking them out in the future tend to be lower-income white women without children, living in northern Broward County.

- By contrast, residents who currently receive services tend to be younger, non-college educated, lower-income African Americans or Latinos.

- While overall perceptions about the quality of County services are largely positive, addressing concerns over accessibility will be key to ensuring

consumers know of the County's services. Those who have not recently obtained services, in particular, are uncertain about ease of access.

B. Consumer Focus Groups Summary

Participants in three Consumer Focus Groups held in March 2014 – Family Success Center consumers receiving social services, consumers receiving mental health services, and BARC consumers – discussed their experiences accessing and receiving services through HSD. **Exhibit 5-2** is a summary of the discussions from each focus group.

Exhibit 5-2: Consumer Focus Group Highlights

Focus Group	Discussion Highlights
Social Services **12 participants**	Focus group participants most commonly sought assistance due to job loss and subsequent income loss. Assistance sought ranged from help with paying rent/mortgage and utility bills to help with finding housing. Focus group participants typically learned where to go for help from family and friends, through referrals from organizations such as 211 Broward, through a food kitchen, and through advertising. The majority of participants had difficulty with the application process: • Five of the seven focus group participants considered the application process arduous, frustrating and "a vicious cycle." • Participants described the numerous telephone calls they had to make just to find out how to apply for services and a lack of responsiveness on the part of the service provider staff. • The process for getting assistance, according to some participants, took a long time, and during that time they moved from place to place, ran out of food stamps, unemployment insurance ran out, and they became increasingly frustrated and desperate. • The application process was fast and smooth for two applicants. • The requirements for eligibility are confusing and inconsistent, according to some participants. • The system is described as more responsive to adults or families with children than to single adults. "If you have kids, it is easier to get in." • Services are fragmented. • Service providers are not aware of the range of services that are available through other programs or even within their own program. • Service providers do not network: "Providers here are not well connected – they do not know what else is out there and what is available." • Applicants must fill out multiple applications depending on their needs. Participants provided several suggestions on how to improve the application process: • Increase public awareness of the Broward County HSD and of the service centers throughout the community. • Distribute brochures listing services and telephone contact information for each service, similar to the brochure for homeless people titled "How to Survive." The brochure lists shelters, food pantries, food kitchens, and medical help. • Have a comprehensive database that can be accessed by all service providers and allow the system to keep track of what services each recipient is receiving. • Develop an intake form that has a list of all services available in the County, not just through a specific program, so the applicant can check off what he/she needs. Publish a telephone number for reporting problems. Currently, applicants are not able to reach supervisors to complain.

	• Focus on short-term help. The system is set up for people who need continuous services but not for people who just need "little bits of help" or "one-time" short-term assistance. "I need a little help. I do not want to be on assistance for long." Focus group participants identified housing as the key service they needed and had difficulty getting. Participants who are homeless or are in temporary housing need help with finding a longer-term solution. Participants who are older also identified the need for help with transportation. Focus group participants are aware of the Affordable Care Act but know little about it. Participants find the law confusing, and they do not know whether they should sign up.
Focus Group	**Discussion Highlights**
Mental Health **7 participants**	Focus group participants received a variety of services in addition to mental health services, including housing, rental assistance, food stamps, child care, and assistance with utility bills. Three of the participants have children who receive mental health/behavioral services. Several participants indicated that their child or other members of their family also received services. Participants who received services several years ago think that the current services are of better quality, can be obtained faster, and that a better range of services is available. Participants needed assistance for a variety of reasons. For example, a young parent needed daycare for her child so that she could get a GED. Another parent wanted counseling for her child who used marijuana. Several of the participants struggled with homelessness because they are on fixed income or lost their jobs and were not able to find new jobs. One participant has been staying at shelters for almost two years. Other participants needed medical help after they lost their health insurance or were not insured and needed surgery. Participants used different information sources to find help. Sources included another parent who received services in the past, a church minister, the child's school, a friend, the Florida Power and Light Company, and ChildNet. Participants who called 211 Broward had mixed experiences with regard to the helpfulness of the organization. Overall, participants considered 211 Broward friendly and helpful; however, several participants indicated that 211 is not always helpful because "they are not able to direct you to services. They are limited in the amount of information they have; they gave out the wrong number." The length of time it took focus group participants to get the assistance they needed varied considerably from one day to several months. Participants who needed help with housing received it within one day through the Homeless Task Force. The participant who needed assistance with paying his utility bill got the assistance in two days. The participants who needed assistance with child care had to wait a couple of months because of the preschool schedule. Getting access to mental health services took longer – from several weeks to three months because of limited availability of mental health staff. The most challenging part of the application process was proving the need for assistance and meeting the paperwork requirements. One participant remarked, "You need to be about dead or suicidal before things happen." A participant was informed after she completed the paperwork that she does not qualify for the services because she has "not been diagnosed with anything." The service provider staff "tell you what you need but you are on your own; when you bring it in, they may tell you that you need something else and you have to come back."

	Three of the participants were put on wait lists. One participant who needed surgery was put on a wait list for a month because it took so long for her paperwork to be processed. Most participants were satisfied with the services they or their children have received. A participant whose child received mental health services considered the service provider her "rock and safety net;" she had been trying to get services for her child and had to fight the school and go to court. Another participant, while thankful for the help with housing, complained that the doctor he sees does not spend any time with him and does not listen to what he says. However, several participants indicated that while they are grateful, the assistance they receive is marginal and their caseworker does not seem to help. One participant indicated that the services he gets are enough to keep him "above water" but not enough to where he feels "like 100 percent." Participants made the following suggestions to improve services: • Make the application process and the paperwork easier by developing a list of the information and documentation required and suggesting how to go about getting the information, and what ~~will~~ constitutes sufficient proof. • Open more shelters for women, especially shelters where women can stay temporarily until they find work. • Train staff at the homeless shelters to better recognize the need for more serious mental health interventions. • Develop more affordable housing for older adults and seniors. • Provide services for women who do not have children and who are between the ages of 35 and 65. There is a gap in services for people "who have fallen between the cracks;" that is, people who just want a little help, not a handout, and are not easily classified. "If you are not an addict or HIV positive, it is hard to get services…you have to be labeled something to get services…If you live right they do not help you at all." The process of applying for assistance does not empower people. "As soon as you start getting on your feet, you do not qualify for anything; whenever you go somewhere the responsibility falls on you when all you're trying to do is empower yourself to get back on your feet." Housing for people 55 or older was one of the primary needs participants identified. Participants remarked "you have to be homeless for a year before you qualify for housing." The level of assistance provided is often not sufficient; "It is only enough to keep your head above water." This creates a sense of dependency. Participants indicated that they know little about the Affordable Care Act (ACA), have many doubts about its ability to improve their access to health care, and are concerned that it might actually limit their options and subsequently the health care services they can get. Participants who do not have any income were most concerned.

Focus Group	Discussion Highlights
Broward Addiction Recovery Center (BARC) **7 participants**	Participants came to BARC from a variety of avenues – four were court -ordered, one came to services after a family intervention, and two were self-referrals who sought services on a voluntary basis. Four participants went through detox; one went directly to inpatient treatment (having been detoxed at a hospital and referred from the hospital); two started receiving non-residential/outpatient treatment. The three self-referral participants had some difficulty finding services. All three reported having to research options that took between three days and one week to find BARC services. Most participants reported waiting for service from one day to one week. The participants needing detox waited approximately one week – a wait time that was particularly difficult for this group. One participant needing detox reported she had to wait almost 30 days and had to call on several occasions before finding an open detox bed. Since the majority of participants were court-ordered there were no issues concerning referrals for services. The three self-referred participants, once they found where to go for services, did not report difficulty in applying for services. One participant reported problems in producing proof of residency, since identification papers were confiscated when arrested and not returned for weeks. One participant felt that she needed inpatient treatment, but was advised that she would be able to receive outpatient treatment only. Participants generally rated services and staff at BARC as excellent or good. They commented that staff will work to "figure out what is needed" and to help find services that are beyond what is directly provided at BARC. Examples of helpful services included: • Accommodations were made for special meals for a participant with diabetes. • Counselor worked with probation officer to make sure there were no issues related to meeting court requirements. • Staff were flexible in accommodating work schedules and counseling sessions. • Staff had time for one-on-one sessions that were helpful in supplementing group work. Focus group participants made the following observations: • Self-referred participants thought initial services should be different for them compared to those court-ordered. They expressed initial confusion about services, expectations, and the purpose of some therapeutic activities since they had not "been in the system" before. • One self-referral participant knew he needed more structure. After weeks of working with a counselor, they were able to identify specific targets that must be met (like passing a drug test weekly) that helped him to be successful. • The majority of participants expressed frustration with being able to obtain referrals for services once completing their BARC program. Some were homeless when they entered the program and needed help with housing when leaving, which proved difficult. The most significant problem facing participants is the need for financial help and assistance in meeting basic needs. Additionally, participants reported: • Obtaining primary care services is often difficult. Participants expressed frustration in having to

	sometimes wait all day to see a doctor even when they had an appointment. The simple task of picking up medications took hours. Once in to see a doctor, the examination was superficial and the doctor did not spend sufficient time to really understand the physical and mental condition of the participant. • The referral system using the W72 and W80 forms is difficult at best. One participant reported having an ear infection and still not being able to obtain health care services for three months. • Affordable housing was cited as the most significant gap. • One participant shared the difficulty she had in applying for Medicaid even though she had a very ill child at the time of application. The delay in eligibility determination required her to seek help for payment of her child's medications from a non-profit agency. Focus group participants know about the Affordable Care Act. Five participants applied for health care (three were denied and two approved); one participant did not apply and one participant was on Medicaid. Concern was raised that having little or no income made paying premiums and copays for a health plan impossible. One participant was pleased that her premiums for health insurance are now lower. There was also some skepticism that obtaining insurance would make health care any better. One participant reported being able to go back to her primary care doctor once she became eligible for an insurance subsidy through ACA.

C. Provider Town Hall Meeting Summary

Thirty-one Broward County providers participated in a town hall meeting on January 15, 2014. The providers were divided into four discussion groups: a children's services group, an adult behavioral health group, a health care group, and a criminal justice group. **Exhibit 5-3** below is a summary of issues highlighted by each group in discussions about service availability, access to services, funding and staff resources, collaborations and partnerships among providers, gaps in and duplication of services, and priorities and challenges. **Appendix B** contains a Provider Town Hall Meeting report.

Exhibit 5-3: Provider Town Hall Meeting Summary

Children's Services Group Highlights

Participants:

Lisa Bayne, Kids in Distress
Marsha Currant, The Starting Place
Barbara Walton, Harmony Development Center
Dion Smith, Children's Services Council
Shari Thomas, Henderson BH
Shawn Preston, ARC Broward
Barbara Weinstein, Family Central
Kim Praitano, Family Central

Children's Services **8 participants**	More early intervention programs for children and youth are needed to provide services before problems escalate and become more complex. While there is discussion of continuity of care, the reality is that services are not available for the full range of services needed. This is especially the case for complex, "deep-end" issues and when family income guidelines prohibit the delivery of needed services. The Children's Services Council has a mechanism in place to provide waivers for contracted income and service level targets when justified. This is very difficult with HSD contracts. All providers noted that the restrictive HSD contracting process hinders their ability to provide needed services. Providers discussed the numerous meetings they must attend with little real collaboration taking place.

Behavioral Health Group Highlights

Participants:

Andrea Katz, Archways
Dwight Stephens, Broward Sheriff's Office
Paul Jacquith Mental Health Association
Aaron Maraj, Court Administration
Shana Williams, Center for Hearings & Communication
Andrea Busada, Broward County, EVSD
Dave Freedman, Community Solutions
Pamela Galan, Henderson Behavioral Health
Nick Trunzo, OIC of South Florida
Pat Palmieri, Silver Impact
Kim Schur, Center for Hearings & Communication

Behavioral Health **11 participants**	The large number of people deemed incompetent in court is putting a burden on the behavioral health system. In addition, it is hard to find placements for individuals coming out of prison because of their criminal justice history and history of violence. Drug court is seeing a younger population (ages 18 to 25) with first time arrests. This group is not serious about treatment and often leaves treatment. The many funders of behavioral health treatment have different administrative requirements for data tracking, reporting, and invoicing. At the same time, all funders are cutting back on funds for administration. The Broward County bureaucracy is slow to approve contracts (a process than can take nine months). It also invoices and approves budget amendments only once per year. More flexibility is needed. The biggest needs for the adult behavioral health population are health care, housing, employment or income assistance, and case management. There are not enough substance abuse treatment programs for pregnant women. The move to Medicaid managed care means that some providers – particularly small organizations – are unable to meet requirements (such as having a psychiatrist on staff) for entering into a contract with the managed care entities. There is generally a high level of collaboration among providers of behavioral health services.

Health Care Group
Highlights

Participants:

Michael De Lucca, Broward Regional Health Planning Council
Michael Kahane, Aids Healthcare Foundation
Julie Price, ARC Broward
Sandra Lozano, Light of the World Clinic
Ann Mercer, Florida Department of Health

Health Care

5 participants

Broward County has significant resources and its commissioners have been very responsive to community health care needs. The Broward County health care system works well. There are good working relationships and "true" collaboration among the key players in the system.

There is a collaborative network with organizations that serve small sub-population groups. The HIV network has been recognized as a best practice.

Service delivery challenges include the following:

- For the population with developmental disabilities, access to dental care is a challenge.
- Specialty care is limited and not easily accessible.
- Vision care for the uninsured is also a challenge.
- One in 87 people in Broward County has HIV. The number of people with HIV is "staggering." Broward County is an "epicenter for HIV."

According to focus group participants there is no duplication of services in Broward County, but there are gaps in services.

- There is an insufficient number of primary care physicians in the County.
- There are not sufficient services for specialty care and adult dental care. There are few dentists who are trained to work with children and adults with developmental disabilities.
- There are between 2,000 and 2,500 individuals with developmental disabilities in Broward County who are on wait lists for services.
- There is also a shortage of dentists trained to treat adults with HIV.
- Long-term care is becoming an issue as the population ages. There are not enough affordable nursing homes in Broward County. There are not sufficient doctors, nurses, and caregivers to serve this population.
- There is a deficiency of services for undocumented residents.

Current priorities include: testing everyone for HIV and sexually transmitted diseases (STDs) in light of the high prevalence of these two conditions; addressing obesity and Type 2 Diabetes; and performing prenatal screenings.

Since Florida is not expanding Medicaid, there are no services for people who are ineligible for Medicaid.

The Broward County health care system is in flux. Broward County has eight insurance companies with 132 health plans. Some hospitals have not yet signed up with all of the insurance companies.

With regard to the Affordable Care Act:

- Residents buy plans that they cannot afford.
- Residents cannot afford co-pays.
- The Spanish ACA web site is not working.

Criminal Justice Group Highlights	
Participants: Jeane Potoff, State Court Administration, Mediation, Teen Court Paula Maudlin-Smith, Broward Sheriff's Office, Community Programs Gordon Weekes, Public Defender's Office, Juvenile Division Cassandra Evans – Florida Department of Juvenile Justice Regina Walker – HSD – Civil Citation Catherine Baez – Children's Services Council Myriam Campos, Harmony Development Center	
Criminal Justice **7 participants**	The participating providers offer some direct services, but also interact with adults and children in the criminal justice system in other ways and try to obtain services for them. Finding the appropriate services can be challenging. There is a need for a better clearinghouse of information for people doing referrals. There is also a need for a centralized database where one could look up all the places where someone has interacted with the system and received services. Despite talk of accountability, HSD contracts need to be outcome-based in order to actually increase accountability. Too many providers who do not produce good results get contracts renewed because they are known in the community, have popular programs, or know how to work the system. Building provider capacity is a priority in order to increase the range of options and competition among service providers. Currently, there is little competition so providers are not motivated to show good results. They know that they are the only option, so they will continue to be funded. There is a need to bring best practices to the County, either by recruiting those using best practices and getting them to locate here, or by sending providers out to get best practices training in other locales.

D. Provider E-Survey Summary

The Provider E-Survey report (available in **Appendix D**) presents the results of the Internet-based survey (e-survey) of Broward County providers conducted by Public Works as part of this initiative.

The 133 service providers who responded to the survey represent the range and diversity of services available to Broward County residents. Providers vary greatly in number of employees, financial resources, range and type of services, and number of people they serve. Providers rely on multiple funding sources; about 37 percent of providers get funds from the Broward County HSD. Providers have experienced changes in their financial resources in the past three years with 19.5 percent having their budget decreased and 31.6 percent having budget increases. However, 63.2 percent saw an increase in the number and categories of service needs of consumers they serve. Nearly 60 percent of providers either added services or expanded services to new categories, while about 30 percent stopped services. About two-thirds of providers

collaborate or partner with a variety of organizations in order to serve more consumers and to give their consumers access to a wider range of services.

Nearly 40 percent of providers have wait lists. Providers with wait lists tend to provide more services than providers with no wait lists, more of them had an increase or no change in the number of clients they serve, and more faced reduced budgets in the past three years. In light of increased demand and community needs, the primary challenge providers face is lack of or inadequate funding.

Nearly three-quarters of the providers see gaps in services. The most common service gaps are affordable housing and access to transportation. Nearly one-quarter of the providers believe that there is a duplication of services in the community.

Providers vary in their expectations of the impact that the Affordable Care Act will have on their organizations. About 22.6 percent expect significant or moderate increases and between 13.6 percent expect moderate to significant decreases in the number of clients, funding levels, services, and collaboration with other organizations.

5.3 Summary of Needs Identified

The gaps and/or issues in the current system fall into seven categories mentioned most often by providers in our primary data gathering activities – the Consumer Focus Groups, Provider Town Hall Meeting, Provider E-Survey, and the numerous interviews and meetings conducted throughout the project. The most commonly mentioned needs are:

- **Basic Needs.** Our analysis found that meeting basic needs (i.e., food, rent and cash assistance) is a major issue. Almost half of 211 Broward calls are for basic needs, with about 80 percent going unreferred either because no services are available or there are wait lists for services. According to the provider survey, over half of basic needs providers have wait lists. According to the telephone survey, when residents were asked what services they need most, basic needs were at the top. Existing surveys and needs assessments indicate 49.9 percent of households with children are food insecure with moderate to severe hunger; 37 percent of elders report not eating all of the food they need.

- **Early intervention.** Both providers and consumers noted the lack of services available at the “front-end” of the system. Services or one-time interventions needed to prevent a personal or family issue from escalating into a crisis are

insufficient. About 40 percent of E-Survey respondents (providers) reported that they have wait lists that prevent them from helping families immediately when they apply for assistance. Consumers talked about not being eligible for services because they were not "sick enough" or "poor enough." Providers discussed struggles to offer services to prevent a crisis when resources were already targeted for on-going interventions. Consumers report sometimes having to wait three months for mental health services and surveys report 50 percent of youth attempting suicide do not receive follow-up mental health services.

- **Access to services.** Consumers expressed frustration that multiple applications are required for each program and that eligibility requirements are confusing and inconsistent.

- **Transition services.** Consumers and providers identified service gaps for people transitioning out of mental health treatment facilities and the criminal justice system. Focus group participants expressed the need for more structured support and housing when leaving BARC inpatient services. Providers were particularly concerned that the continuity of care concept could not be fully implemented because services are limited based on income and insurance. Providers also noted the need for secure residential treatment facilities, as well as transitional and permanent supportive housing for individuals who have received treatment and need step-down services in order to reenter the community. Affordable housing and support services are also a need for teens and young adults transitioning out of foster care as well as the juvenile justice system.

- **Flexible approach to health care.** Access to low-cost health care is a top need indicated by residents in the telephone survey, however, participants in both the telephone survey and focus group expressed reluctance to apply for health insurance available through the Affordable Care Act (ACA). Focus group participants said they were concerned that an ACA health plan would limit their options for receiving health care services. Current HSD policies penalize insured residents with high needs by limiting services only to individuals without health insurance. According to providers – particularly behavioral health providers – services are especially needed for families with health insurance, as benefits are often limited or exhausted to treat family members in need of intensive services. Families may also be unable to afford co-pays and deductibles. As more County residents are insured through the Affordable Care Act, this may become a more

pressing issue. At least one hospital district has a policy of not providing any services to individuals who qualify for an ACA health plan, regardless of whether the individual continues to pay their premiums or can afford the co-pays and deductibles.

Transportation. Transportation remains a constant issue for those struggling to remain self-sufficient while working in low-paying jobs, as well as for those who must travel to sites around the County to receive services. Participants in every consumer focus group noted they are often not able to afford transportation to apply for benefits or take advantage of on-going support services. In particular, older adults in the focus groups expressed difficulty affording transportation. Three-quarters of the provider E-Survey respondents noted transportation as a major barrier to services. Broward County's smaller transportation infrastructure (compared to cities of comparable size) contributes to this problem.

- **System management and collaboration.** Focus group participants believe providers are not well connected to each other and that finding out the full array of services available is a difficult task. Providers expressed frustration over interactions with the County, especially around contracting, which is seen as rigid and inflexible. The County's role and commitment to collaboration was often questioned – providers are looking for a stronger leadership role from the County. Additionally, HSD is not using all of the tools available through contract management and monitoring to focus the system on priority areas.

Exhibit 5-4 below displays a summary list of needs identified from the above sources. Some of these gaps or needs are clearly beyond the capacity of the County – some are responsibilities that must be addressed through policy and funding decisions at the state level. In Section 6 of this report we discuss the needs that can be addressed by HSD.

Exhibit 5-4: Source of Identified Needs

Identified Need	Source				
	Existing Needs Assessment	Provider Survey and Town Hall Meeting	Stakeholder Interviews/Meetings	Consumer Focus Groups	Resident Telephone Survey
Access					
Affordable public transportation options	✓	✓	✓	✓	✓
Awareness of available services	✓	✓	✓	✓	✓
Early intervention programs to help before issues escalate to crisis	✓	✓	✓	✓	
Understanding and accessing ACA marketplace		✓		✓	✓
Access to primary health care and dental services		✓		✓	✓
Access to services outside of regular work hours	✓		✓	✓	
Assistance for residents to apply for benefits			✓	✓	
No common application			✓	✓	
Understanding of availability and use of 211 Broward			✓	✓	
Access to services close to home	✓			✓	
Long wait times for services from Family Success				✓	
Adults did not know of services available for veterans			✓	✓	
Service Gaps					
Children's Services					
Services on continuum of care for long-term, chronic mental health issues	✓	✓	✓		
Wait list for behavioral health services	✓		✓	✓	
Services for complex, "deep-end" youth	✓		✓		
Child care services that allow parent to continue to work			✓	✓	
Resources to cover needed services when gaps exist in private insurance coverage		✓		✓	
Inpatient services for children with behavioral health, psychiatric and detox needs	✓		✓		
Kinship services for grandparents caring for young grandchildren			✓		
Housing and other support services for youth aging out of foster care system			✓		
Services for immigrants			✓		
Summer employment for youth			✓		
More affordable child care				✓	
Services for children in foster care system			✓		

Identified Need	Source				
	Existing Needs Assessment	Provider Survey and Town Hall Meeting	Stakeholder Interviews/Meetings	Consumer Focus Groups	Resident Telephone Survey
Behavioral Health					
Substance abuse services for teens and young adults	✓		✓		
Residential treatment beds	✓		✓		
Inpatient detox services for pregnant women and women with children			✓		
Quality of services when using interns and students				✓	
Services for homeless who are mentally ill resulting in contact with criminal justice system			✓		
Step down options for consumers leaving behavioral health inpatient services			✓		
"Incompetent to Proceed" system improvements needed		✓	✓		
Intensive family counseling					
Insufficient forensic, short-term, secure beds	✓				
Primary Health					
Inability for consumers to afford co-pays or premiums		✓	✓	✓	
Long wait times at community health centers			✓	✓	
Access to specialty care			✓	✓	
Integration of primary health and behavioral health services			✓		
HIV/AIDS primary care	✓				
Services for Adults and Elderly					
Services to provide basic needs and home repairs to prevent elderly from entering nursing homes	✓		✓		
Services for frail elderly			✓		
Basic medical care near home	✓				
Services for adults 35-60 with no children				✓	
Housing and Homeless					
Affordable housing	✓		✓	✓	
Transitional housing	✓		✓		
Shift in focus for homeless services to longer-term more permanent housing has reduced resources for needed emergency shelter options			✓		
Shelter beds for single women, teens and women with children			✓		
Mental health services for homeless	✓				

Identified Need	Source				
	Existing Needs Assessment	Provider Survey and Town Hall Meeting	Stakeholder Interviews/Meetings	Consumer Focus Groups	Resident Telephone Survey
Basic Needs					
Resources to help people with basic needs	✓		✓	✓	✓
Food programs not sufficiently connected to other needed services			✓	✓	
Delivery System					
Training to properly implement evidence-based initiatives		✓	✓		
Little collaboration on strategic planning and funding despite numerous committees and meetings		✓	✓		
Tapping resources of higher education institutions in community		✓	✓		
Lack of transparency in funding sources		✓	✓		
Funding decisions not matching strategic plan		✓	✓		
Outcome-based contracting options		✓	✓		
Standard reporting tools		✓	✓		
More effective contract monitoring		✓	✓		
More flexibility in contract process		✓	✓		
Improve RFP and contracting process		✓	✓		
Engagement of business community			✓		

6. STRATEGIC ANALYSIS

This section brings together the data, insights and opinions gathered throughout this initiative organized around 10 categories that will strengthen and define the role of the Broward County Human Services Department (HSD) and have a significant impact on improving the system of services in the community. These are:

1. Streamline Access to Services
2. Develop Single Stop Service Centers
3. Monitor Impact of the Affordable Care Act and Medicaid Reform
4. Review Direct Services for Efficiencies and Increased Revenue
5. Address Competency Determinations Policy and Procedures
6. Lead Collaboration among Providers and Funders
7. Better Connect Strategic Planning and Budgeting
8. Simplify the RFP Process and Make It More Strategic
9. Strengthen Contract Design and Oversight
10. Continue and Expand the Positive Efforts in HSD Reorganization

Each topic is presented with **Background** information describing the current status, **Findings** outlining our analysis, and **Recommendations** identifying actions HSD can take to address the challenges and issues described. The recommendations will help to improve services to all individuals and families needing services in the community, as well as those served through the Community Action Agency.

Exhibit 6-1: Identified Needs and Related Recommendations

Recommendations	Identified Need							
	Basic Needs	Access	Early Intervention	Transition Services	Health Care	Transportation	Affordable Housing	Delivery System
Streamline Access to Services (Section 6.1)								
Establish an HSD call center using current phone center technology that would allow HSD to track information to monitor for quality of services, as well as to manage and plan for resources. (R6.1-1)	✓	✓	✓					
Develop initiatives in conjunction with 211 Broward and community providers to improve the marketing of the service (R6.1-2)	✓	✓	✓					
Develop Single Stop Service Centers (Section 6.2)								
Rename and establish Family Success Centers as Single-Stop Service Centers. (R6.2-1)	✓	✓	✓					
Establish all HSD sites as state-designated community partners to assist consumers in applying for Medicaid, TANF, and SNAP (food stamps). (R6.2-2)	✓	✓	✓		✓			✓
Support the continuation and expansion of the One E-Application initiative so that all HSD sites can help consumers identify the range of benefits for which they are eligible. (R6.2-3)	✓	✓	✓		✓			✓
Establish more flexible hours at Single-Stop Service Centers and co-locate with community providers, where possible, to accommodate working individuals and families and those having trouble with transportation. (R6.2-4)	✓	✓				✓		✓
Provide resources to expand public transportation reduced fare options and increase marketing efforts through the non-profit community. (R6.2-5)		✓				✓		
Elevate the profile of Veterans Services, move management and oversight to FSAD, and offer veterans' services in the newly structured Single-Stop Service Centers. (R6.2-6)	✓	✓	✓					✓
Refocus Elderly and Veterans Services Division to the Office of Elder Services. (R6.2-7)	✓	✓	✓					✓
Conduct a pilot project to assist consumers in applying for federal SSI/D benefits. (R6.2-8)	✓	✓	✓				✓	

	Basic Needs	Access	Early Intervention	Transition Services	Health Care	Transportation	Affordable Housing	Delivery System
Monitor Impact of Affordable Care Act (Section 6.3)								
Consider a policy similar to that of the BBHC (and currently in use by BARC) that allows County funds to be used to meet copays and deductibles and cover services when insurance benefits have been exhausted. (R6.3-1)					✓			✓
Monitor contracted providers, as an integral component of each monitoring visit (or at least quarterly), for the impact of ACA and Medicaid managed care on their operations, including changes in the number of Medicaid and ACA clients and revenue. (R6.3-2)					✓			✓
Facilitate collaboration among safety net providers to include them in existing and developing integrated networks. (R6.3-3)					✓			✓
Ensure the new HSD billing unit (see also Recommendation 6.4-1) pursues contracts with the 4 MCOs and 10 ACA exchange health plans for BARC, EVSD, and NJCC. (R6.3-4)					✓			✓
Engage in a marketing campaign to attract Medicaid and ACA enrollees to choose HSD services provided through BARC, EVSD and NJCC. (R6.3-5)					✓			✓
Review Direct Services for Efficiencies and Increased Revenue (Section 6.4)								
Create a centralized billing unit within HSD to contract with and more aggressively bill Medicaid and private insurers for the direct services provided by HSD, including BARC, EVSD and NJJC. (R6.4-1)					✓			✓
Increase the operating efficiencies within BARC to manage County resources better. (R6.4-2)					✓			✓
Expedite plans and resolution of issues to move BARC into a new facility. (R6.4-3)								✓
Return responsibility for Child Care Licensing and Enforcement to the State of Florida and redirect the County general funds to the priorities for funding identified in this report. (R6.4-4)	✓	✓	✓	✓	✓	✓	✓	✓
Address Competency Decisions Policy and Procedures (Section 6.5)								
Lead a collaborative effort to develop an effective diversion program in the felony mental health court. (R6.5-1)		✓		✓				✓

	Basic Needs	Access	Early Intervention	Transition Services	Health Care	Transportation	Affordable Housing	Delivery System
Lead Collaboration Among Providers and Funders (Section 6.6)								
Facilitate restructuring the Coordinating Council of Broward County (CCB) and the Funders Forum to establish one group to focus on countywide strategic planning and funding decisions. (R6.6-1)								✓
Establish a Community Engagement Office that gives HSD the needed resources to take on the leadership role to implement collaborative strategic planning and funding efforts. (R6.6-2)								✓
Refocus the Children's Services Board to address the range of services needed for children and youth involved in the juvenile justice system. (R6.6-3)		✓	✓	✓				✓
Redefine membership, as needed, to address this new focus, and establish term limits on membership. (R6.6-4)								✓
Expand the CSB planning process to include key stakeholders and providers. (R6.6-5)								✓
Better Connect Strategic Planning and Budgeting (Section 6.7)								
Develop a new HSD Strategic Plan that addresses all categories of service and includes relevant and clear performance measures. (R6.7-1)	✓	✓	✓	✓	✓	✓	✓	✓
Base funding decisions on the new Strategic Plan. (R6.7-2)								✓
Reconsider the support to the hospital taxing districts and divert funds to the priorities identified in this report. (R6.7-3)	✓	✓	✓	✓	✓	✓	✓	✓
Prioritize funding for the FQHCs over the hospital districts since FQHCs are expected to see increased demand, are a good investment to draw additional federal funds and have no ability to generate tax revenue. (R6.7-4)					✓			✓
Use primary care funding to support the integration of primary health care and behavioral health care. (R6.7-5)					✓			✓
Simplify RFP Process and Make It More Strategic (Section 6.8)								
Improve RFP documents by simplifying RFP instructions, requiring only the information essential to program evaluation and automating the RFP process. (R6.8-1)								✓
Work to expand the number of providers participating in the RFP process and create a streamlined RFP process for applicants seeking less than $100,000. (R6.8-2)								✓
Develop policies to rely on staff expertise, allow more flexibility in the RFP evaluation process and streamline the review by eliminating the use of volunteer evaluators, eliminating mandatory applicant interviews, and reducing the number of fatal flaws in the initial review. (R6.8-3)								✓
Focus proposal scoring on outcomes and cost. (R6.8-4)								✓
Use the RFP process to encourage interagency collaboration. (R6.8-5)	✓	✓	✓	✓	✓	✓	✓	✓

	Basic Needs	Access	Early Intervention	Transition Services	Health Care	Transportation	Affordable Housing	Delivery System
Strengthen Contract Design, Oversight and Management (Section 6.9)								
Increase use of performance-based contracting, including using incentives and penalties to improve outcomes and drive innovation. (R6.9-1)								✓
Fully centralize contracting staff and adjust staffing levels and responsibilities to meet contract oversight demands. (R6.9-2)								✓
Establish a new Contracting Office and organize contract management around services. (R6.9-3)								✓
Develop a fully automated database and contract management process. (R6.9-4)								✓
Continue and Expand the Positive Efforts in the HSD Reorganization (Section 6.10)								
Organize HSD to support new roles and responsibilities (see functions in chart). (R6.10)								✓

6.1 Streamline Access to Services

The range of services available throughout Broward County is both a tremendous benefit to residents and a complex network of information to navigate. There are numerous points of entry into the system, including those operated directly by HSD and other public and private sector networks of services.

Background – Access

Currently there are numerous places a consumer might go to find out about the availability of services and receive help in applying for them. Each division providing direct services within HSD has its own telephone number and handles calls from consumers either for initial information about services available or to contact staff. In addition, information on services is found through:

- The Aging and Disability Resource Center (ADRC). ADRC is the Broward County location for the Areawide Council on Aging. ADRC operates a centralized telephone system for residents to call for access to any aging services provided throughout the County. It also funds and/or operates services at sites around the County for seniors to access in person.

- 211 Broward is a non-profit agency designated as the 24/7 information and referral service permitted to use the FCC three-digit designation. 211 Broward receives about 116,000 calls per year from residents seeking help with a wide range of needs. Trained counselors are available to provide support and information and referral services to help residents connect with the services needed either in crisis or on an on-going basis. Additionally, specific helplines (accessed through 211) provide assistance specifically for veteran's services, homeless services, and autism.

- The majority of non-profit providers maintain intake and eligibility determination for their individual programs.

- Broward Regional Health Planning Council manages a Centralized Intake and Eligibility Program for the Ryan White Part A funded services.

> Participants described numerous calls they had to make just to find out how to apply for services. One participant described it as a "vicious cycle."
>
> **Consumer Focus Group comment**

Findings – Access

F6.1-1: Accessing information on services provided by HSD through the Family Success Centers Division (FSAD) and Elderly and Veterans Services (EVSD) is complicated. There are at least eight telephone numbers used by HSD for consumers to access information – FSAD, the Community Action Agency (CAA) and EVSD – each maintaining different telephone numbers for residents to call. Despite the wide array of services available throughout the County, consumers and providers in every primary data collection method – consumer focus groups, the resident telephone survey, the Provider Town Meeting, stakeholder interviews, and the provider survey – mentioned confusion and uncertainty about where to find information on the availability of services.

F6.1-2: HSD receives almost 19,000 calls per month with little information available on the reason for the call, disposition, wait times for callers to talk to someone, and other metrics that are important to manage such a large system. Residents seeking services can call FSAD's main number or one of the five Family Success Centers. Callers to the main number are referred to the center nearest to them. Residents also can call the Community Action Agency switch board to inquire about help with utilities and other services. Seniors and veterans can call the central phone number for Elderly and Veterans Services. **Table 6-1** shows the volume and length of calls,

indicating HSD receives almost 19,000 calls per month. Except for calls to the CAA number, HSD has no tracking and information system to manage this large volume of calls or ability to use call data to inform strategic planning.

Table 6-1: Calls Received by HSD

	Calls – Year 2013	Average Calls per Month	Average Length of Call
Family Success	94,683 (Does not include Davie)	7,890	Unknown
Community Action Agency	61,412	5,118	2:37 minutes
EVSD	68,754	5,730	38 seconds
Total	224,849	18,738	

Source: Reports sent in email dated April 8, 2014 from FSAD and EVSD.

F6.1-3: 211 Broward is not sufficiently marketed and promoted throughout the County. Focus group participants mentioned hearing about services primarily from friends or relatives, searching the internet; a few by calling 211 Broward. Providers expressed mixed opinions about 211 Broward; their opinion most likely determines how rigorously the providers are promoting the service to their clients. As a result, residents seeking services must navigate a complex system of multiple phone numbers to find help. 211 Broward reported experiencing a significant increase in the complexity of calls requiring calls of longer duration to resolve issues. Call wait times have increased as a result.

Nationally, many 211 call centers are moving away from providing only information and referral services to offering a deeper front-end assessment of callers and needs and helping callers with applications for various benefit programs. 211 Broward has adopted this policy and is making an investment in staff capable of assisting callers beyond information and referral. Operators currently have some capability to complete the One E-Application for special needs and behavioral health consumers, although this assistance is limited.

Recommendations – Access

There are several actions that HSD can take to improve access to services. The following recommendations are intended to streamline some of the entry points to the

system, primarily those in HSD, and simplify the mechanisms for residents to obtain information on services.

R6.1-1: Establish an HSD call center using current phone center technology that would allow HSD to track information to monitor for quality of services better, as well as to manage and plan for resources.

One central number that is widely publicized as the entry point for information on HSD services will simplify the system for access to information. Having an HSD centralized call center will not only make it easier for residents, it can also be a cost-effective structure for HSD to better utilize staff throughout the divisions who are now answering phones.

HSD is in the process of updating the FSAD phone system. In addition to upgrading, consideration should be made to consolidate all phone systems to have a more efficient system for receiving calls through an established call center that would also provide reports and call management software to ensure the quality of services.

R6.1-2: Develop initiatives in conjunction with 211 Broward and community providers to improve the marketing of the service.

HSD should work with 211 Broward to lead a campaign to engage all agencies in promoting 211 Broward. Around the country local communities are working with 211 on promotional campaigns – Rhode Island United Way developed a public services video played by local television stations; Sioux Falls, North Dakota developed a volunteer day for the National 211 Day on February 11th and agencies including United Way prominently feature 211 in all marketing and on web sites. Additionally, HSD and the non-profit community can work more closely with 211 Broward as a resource to coordinate front-end help for consumers to complete applications for benefits.

6.2 Develop Single Stop Service Centers

The Family Success Centers can and should be places where individuals and families can get help to remain secure and stable in the community, including help with basic needs and emergency assistance. However, they also need to play a more significant role in helping people to be self-sufficient by accessing the full array of benefits for which they may be eligible, and as an information and referral service for longer-term, more intensive services when needed.

Background – Single Stop Service Centers

The five Family Success Centers (four centers and a satellite in Davie) conduct intake and eligibility determinations for rent/mortgage and utility assistance and provide case management services to help individuals or families access shelter services, housing options, legal aid, budget counseling, child care, and other family support services.

Each center has a different mix of services (as displayed in **Exhibit 6-2**) directly available to consumers on-site; for services not provided on-site, referrals must be made to other locations.

Exhibit 6-2: Services Available by FSAD Site

	North	Northwest	South	Mills Center	Davie
Emergency case management	♦	♦	♦	♦	♦
Self-sufficiency case management	♦	♦	♦	♦	
Health Department	♦			♦	
Aging and Disability Resource Center	♦				
Elderly and Veterans Services Division		♦	♦	♦	
Legal Aid	♦	♦	♦		
Mortgage foreclosure	♦	♦			
BARC			♦	♦	
Career Source Broward		♦			
Women, Infants and Children (WIC)		♦			
GED program			♦		
Meals on Wheels			♦		
Community Action Agency				♦	
Housing Options				♦	
HOPE (non-profit financial assistance program)					♦

Source: FSAD handout at meeting held December 9, 2013.

Services for seniors and veterans can be accessed at three Family Success Centers and at the Elderly and Veterans Services Division (EVSD) office. EVSD conducts intake for programs directly administered by them – Community Care for the Elderly, Behavioral Health Services, and Veteran's assistance. The division also refers consumers to other housing and support services primarily provided through the Aging and Disability Resource Center.

County residents wishing to apply for federal and state benefits such as Medicaid, Temporary Assistance for Needy Families (TANF), and Supplemental Nutrition Assistance Program (SNAP-food stamps) must apply on-line or through a paper application/mailing process accessed through the Florida Department of Children and Families (DCF) Automated Community Connection to Economic Self-Sufficiency (ACCESS). DCF has recruited 151 community partner sites in Broward County to assist residents with this application process.

Applications for Florida KidCare (children's health insurance provided through the State of Florida) must be completed on-line at a web site administered by the Healthy Kids Corporation.

Findings – Single Stop Service Centers

To be a true "one-stop," a system must be designed so that a consumer only has to go to one place or make one phone call to access services. Through the one contact, the consumer should either receive all the information or services needed or seamlessly be connected with services.

F6.2-1: While Family Success Centers' stated goal is to be a one-stop shop for residents needing assistance, in practice they are not. Opinions about services provided at Family Success Centers were mixed. Consumer focus group participants and providers expressed some confusion about what services are available at which centers. Consumers talked about the need to travel to different offices for services.

"It took three months to process my application. I had to come back multiple times without any consideration for the cost of gas for the trips that did not yield any results."
Consumer Focus Group comment

A Casey Foundation study of successful models for integrating human services identified seven elements that contribute to the success of single stop centers:[63]

- **Regionalization**: Offices are located throughout the County.
- **Matrix Management:** Managers are chosen who can be responsible for both day-to-day operations and for subject-area expertise.
- **Access:** A range of services are available, as well as easy and facilitated access for referrals.
- **Common Intake**: Staff are trained in multiple programs and use a comprehensive screening tool to assess need and eligibility.

- **Multidisciplinary Teams**: Staff and other providers meet regularly to review cases and recommend services.
- **Information Technology Support**: Automated systems are in place to support referral and tracking of services, including information management to provide data for decision-making.
- **Collaboration with Community Providers**: Systems are in place to facilitate referrals for services that cannot be provided on site.

This model does not exist in the current structure and operations of the Family Success Centers and other HSD divisions. Services as currently structured require consumers to travel to different sites to obtain the array of services needed. Consumers also mentioned long wait times at the centers and frustration at often having to devote an entire day to apply for benefits. They also noted that hours are not convenient requiring them to take off from work in order to apply for benefits.

F6.2-2: The Broward County Transit (BCT) reduced fare bus pass programs are important but reach a limited number of people who need the assistance. All groups – consumer focus groups and resident telephone survey participants, providers and key stakeholder interviews – noted affordable transportation as a major obstacle in being able to obtain needed services.

BCT's reduced fare programs are available to youth, seniors, people with disabilities, Medicare recipients, and college students. Additionally, BCT sells reduced fare tickets for veterans through EVSD and to the homeless through non-profit agencies who serve the homeless. Over a five-month period (December 2013 – April 2014) EVSD issued an average of 183 passes per month; in FY2013, non-profits issued on average 5,357 reduced fare passes.[64] Providers noted that they do not have sufficient funding to purchase all of the reduced fare passes needed and that the limitations on the program hinder their ability to provide this assistance to a broader population in need. Marketing of the reduced fare options may not be reaching targeted groups sufficiently to allow them to take advantage of this opportunity.

F6.2-3: Despite the positive human and economic return on investment, Family Success Centers are not structured to assist residents in applying for the full range of benefits for which they may be eligible. Nearly half of 211 Broward calls were from residents seeking help with basic needs; over three quarters of unmet needs are designated as basic needs. Focus group participants talked of their struggle to meet basic needs – some receiving assistance with housing but not with income supports.

According to a 2010 U.S. Department of Agriculture report about one-quarter of those eligible for food stamps (Supplemental Nutrition Assistance Program – SNAP) do not sign up. Broward County providers estimate that about 20 percent of those eligible for Medicaid are not enrolled. There is no question that receiving these benefits will have a positive impact on individual and family stability. In addition, these programs have an economic impact on a community that benefits the entire local economy. The U.S. Department of Agriculture estimates that food stamps generate twice the amount spent in economic activity.[65]

In July 2010, the South Florida Regional Planning Council, on behalf of the Coordinating Council of Broward County, identified: 1) benefits paid to Broward County residents, 2) the positive economic impact to the County, 3) savings to local service providers, and 4) the increased buying power of residents.[66] Benefits were estimated to be between $97.2 and $358 million if more people were enrolled in some basic needs and health insurance programs.[67] This included:

- $6.7 to $16.8 million for the Earned Income Tax Credit.
- As much as $160.3 million in food stamps buying power.
- $2.9 to $5.8 million in purchasing power in the Women, Infant and Children Program.
- $54.4 to $108.8 million for children's health insurance.
- $33.1 to $66.3 million for adult health insurance.

Other benefits for children and adults who are disabled that yield a positive return on investment – in both financial and human terms – are SSI (Supplemental Security Income) or SSDI (Social Security Disability Insurance) benefits. Currently, monthly benefits are $808, providing income that can lead to greater stability for an individual or family; recipients are also eligible for Medicaid. Becoming eligible for these programs, however, can be complicated and frustrating. In 2010, 65.2 percent of claims were denied on first application, 87 percent were denied on first appeal, 85 percent at second appeal and 62 percent *approved* by third appeal.[68]

Studies and pilot projects have demonstrated that there are significant benefits to the individual and community when consumers are helped to apply for these benefits. After a two-year pilot project assisting consumers apply for benefits, San Francisco Department of Public Health helped 227 applicants obtain awards totaling over $3.2 million in new revenues. The cost to the County was $643,234, resulting in a return on investment of more than $5 gained for every $1 spent.[69]

F6.2-4: Only one Family Success Center (Northwest – Coral Springs) is a state-designated community partner site helping residents apply for Medicaid, TANF, and food stamps. At all other locations, staff refer consumers to other places for assistance in applying for these benefits. In the consumer focus groups, no one reported having received help applying for these other public assistance programs; they report only having been given information on where to apply. We found no provider or County program that helps individuals apply for SSI or SSDI.

F6.2-5: HSD is not making sufficient use of the One E-Application, a tool developed through the Department of Children and Families (DCF) that has been available through a pilot project started in March 2013. Several funders, including a small contribution from the County, supported the development of this IT solution that allows staff to input individual and family data once for the system to calculate an applicant's eligibility for a number of benefits. Nine sites in Broward County have 73 staff trained to use this system; no County or HSD site participates.

DCF's recent year-end report[70] for the project indicates that 553 applications were completed, covering 1,629 individuals. Applications were processed for:

- Earned Income Tax Credit – 89
- Medicaid -- 960
- Temporary Assistance for Needy Families – 667
- Supplemental Nutrition Assistance Program – 1,040
- Women, Infants and Children – 197
- Florida KidCare – 71
- LIHEAP -- 473

The total of 3,497 applications submitted for these individuals and families (some individuals and families were eligible for multiple benefits) have resulted in another step toward financial stability for them.

Recommendations – Single Stop Service Centers

R6.2-1: Rename and establish Family Success Centers as Single Stop Service Centers.

Based on the workforce development system of one-stops, Single Stop Service Centers in human services are emerging as effective models for integrating and coordinating

services for both income support services and more long-term, intensive individual and family supports.

A comprehensive planning effort should be conducted to determine a new way for Family Success Centers to operate. The new model might be a combination of strategies that focus center services on prevention and recovery (basic needs) and assisted referrals for more long-term services or specialized counseling that may be needed. The mix of services at the centers themselves might be economic and/or basic needs services such as: emergency financial assistance, housing services, income support (applying for state and federal benefit programs), employment services, child support assistance, child care, and any other service that helps an individual or family to be self-sufficient. Equally important is the need for *assisted* referrals to other services to ensure consumers make the connection and actually receive services from the agencies to which they are referred. Ideally, co-location of as many services as possible is the best model; however, a detailed analysis will be needed to determine the extent to which services can be co-located.

In practice, Family Success Centers are more focused on emergency interventions and one-time assistance when their focus should be on helping individuals and families with more lasting and permanent support to move to self-sufficiency.

Whatever the long-term outcome, Single Stop Service Centers will require a more uniform set of services provided at each center than is now offered. In the short term, HSD can make positive changes at Family Success Centers that will establish them as accessible Single Stop Centers for residents needing services. Three immediate actions that can take place are recommended below: becoming a state-designated community partner, using the One E-Application, and establishing more flexible hours of operation.

In the long-term, a complete revamping and refocusing of the goals, purpose and service mix at each center needs to be considered.

R6.2-2: Establish all HSD sites as state-designated community partners to assist consumers in applying for Medicaid, TANF, and SNAP (food stamps).

Although the state does not provide funding to agencies that assist residents with the on-line eligibility process, increasing eligibility for these programs not only benefits individuals and families it benefits the local economy and would allow HSD funds to

stretch farther. At meetings, providers estimated that as many as 20 percent of those eligible for Medicaid have not applied. Assisting with enrollment in Medicaid and other benefit programs would reduce the number of uninsured residents seeking subsidized services in the County and help individuals and families with basic needs – an unmet need noted in all of the data sources.

R6.2-3: Support the continuation and expansion of the One E-Application initiative so that all HSD sites can help consumers identify the range of benefits for which they are eligible.

Admittedly, the completion of an application for a family can take several hours. The first year pilot program outcomes, however, clearly show the benefits of this approach.

R6.2-4: Establish more flexible hours at Single Stop Service Centers and co-locate with community providers, where possible, to accommodate working individuals and families and those having trouble with transportation.

Low-income working individuals and families needing assistance have difficulty accessing services if they must take off from work to do so. These consumers, living paycheck to paycheck, cannot afford to leave work to apply for assistance or to access other services that they need. Extending hours can give them access to services that are not currently available to them.

Additionally, HSD should consider other ways to locate workers at sites more accessible to consumers, for example partnering with community non-profits around the County to outstation FSAD workers. This should be a consideration as HSD updates its IT systems, providing mobile technology connections to support working off-site.

HSD also should consider mobile units that partner with community-based agencies to bring services to targeted neighborhoods most in need.

R6.2-5: Provide resources to expand public transportation reduced fare options and increase marketing efforts through the non-profit community.

County Commissioners and Broward County Transit have provided resources for reduced fares to help residents travel to sites to access services. The fact that the need for affordable transportation was mentioned in every primary data collection method would indicate that programs need to be expanded and marketed more extensively.

R6.2-6: Elevate the profile of Veterans Services, move management and oversight to FSAD, and offer veteran's services in the newly structured Single Stop Service Centers.

> **"I didn't even know that the County provided help to veterans."**
>
> **Provider comment at Town Hall Meeting**

Veterans' services are universally seen as extremely positive by those who have had the opportunity to receive services. At the same time, they are the least known services. Moving Veterans Services to the newly structured Single Stop Service Center will enable the County to market these services more broadly in the community and provide easier access to both veterans and their families to the array of services provided in these centers. Moving the administration of Veterans Services to FSAD will help facilitate the integration of these services with the Single Stop Service Centers.

R6.2-7: Refocus Elderly and Veterans Services Division to the Office of Elder Services.

The removal of Veterans Services from EVSD will also better focus elder services on core competencies. The new Office of Elder Services can be more clearly defined for the services provided to seniors and its collaboration with the Aging and Disability Resource Center's array of services.

R6.2-8: Conduct a pilot project to assist consumers in applying for federal SSI and SSDI benefits.

While this may take dedicated resources, the return on investment is well documented. A pilot project will allow Broward County to assess the return on investment and determine if the service should be provided on a permanent basis.

6.3 Monitor the Impact of the Affordable Care Act and Medicaid Reform

Broward County leadership is faced with two major system changes that may have a significant impact on service delivery in the County – the Affordable Care Act (ACA) and the transition to Medicaid managed care.

This section addresses several issues related to these changes with a focus on how the reforms impact the direct services provided by HSD as well as the services funded by the department.

Background – ACA and Medicaid Reform

Implementation of the Affordable Care Act in Broward County. As of April 19, 2014, 983,775 Florida residents had enrolled in Affordable Care Act (ACA) plans offered through the health care exchange.[71] Approximately 10 percent of the population of Florida resides in Broward County; applying that same ratio to the number of ACA enrollees for the state suggests that approximately 98,378 (40 percent) of the approximately 250,000 Broward County residents who were eligible for the ACA may have enrolled during the first open enrollment period.[72] If so, enrollment in ACA has reduced the number of uninsured in Broward County by approximately 25 percent (from 25.9 percent to 19.4 percent).[73] Demographic data about new enrollees, such as income, age, and county-specific data are not yet available.

An estimated 76,400 uninsured individuals in Broward County are ineligible for Medicaid or ACA.[74] These residents are primarily parents with incomes between 35 and 100 percent of the Federal Poverty Level (FPL) and childless adults with incomes at or below 100 percent of the Federal Poverty Level.[75] Because Florida did not expand Medicaid, these residents are not eligible for Medicaid coverage or for subsidized premiums through the Affordable Care Act (ACA). Subsidized premiums for ACA are available to residents with incomes between 100 and 400 percent of FPL.[76]

Options for new ACA Exchange Enrollees. Ten insurers are offering health plans for Florida residents on the national exchange that meet the requirements of the ACA: Aetna, Cigna, Coventry Health Care of Florida, Florida Blue (BCBS of Florida), Florida Health Care Plan Health Options, Humana, Molina Healthcare, Simply Healthcare Plan, and Sunshine State Health.[77] [78] Any Florida resident eligible for coverage in the marketplace can choose from one of the 10 plans offered by these companies.

ACA and Behavioral Health Services. The ACA requires that certain types of health plans cover mental health[79] and substance abuse benefits as part of an Essential Health Benefits (EHB) package.[80] The EHB package is the minimum coverage standard that health plans had to meet beginning in 2014.[81] This EHB package must contain at least 10 categories of benefits, one of which is mental health and substance use disorder services.[82] ACA plans are required to meet the EHB criteria, as well as parity

requirements, which require plans that offer mental health and substance use benefits to provide these benefits at parity with medical benefits.[83]

The ACA expressly identifies mental health and addiction treatment services as essential benefits, along with rehabilitative and habilitative services. However, the extent to which specific behavioral health services are covered depends on which existing insurance plan each state selects as its "benchmark" plan – that is, the plan that provides the minimum level of coverage allowed. All other plans must at least provide the same level of coverage as the benchmark plan.[84]

The benchmark plan in Florida is the Florida Blue plan through Blue Cross and Blue Shield of Florida (BCBS Florida). Florida Blue provides the following behavioral health benefits:

- Mental/Behavioral Health Outpatient Services – limit of 20 visits per year.
- Mental/Behavioral Health Inpatient Services – limit of 30 days per year.
- Substance Abuse Disorder Outpatient Services – No quantitative limit on service.
- Substance Abuse Disorder Inpatient Services – No quantitative limit on service, except exclusion for prolonged care or treatment or inpatient confinement primarily for change of environment.[85]

The ACA plans offered in Florida will, at a minimum, adhere to the EHB requirements and parity law, and also must follow the guidelines set in the Florida benchmark plan. However, the details of the plans will vary beyond these minimum guidelines.

Medicaid: Florida Medicaid Reform – Managed Care. As a result of Medicaid reform in Florida, Medicaid consumers will receive services through a new system, the Statewide Medicaid Managed Care Managed Medical Assistance Program. The rollout schedule varies across the Florida regions, with the program implemented in Broward County by July 1, 2014. With few exceptions, individuals with Medicaid coverage will be required to enroll in one of four managed care organizations (MCOs) contracted by the state of Florida for Broward County residents to choose from: Better Health, Humana, South Florida Community Care Network (SFCCN), and Sunshine Health.[86]

Medicaid and Behavioral Health Services. In Florida, Medicaid Health Plans are required by the Florida Agency for Health Care Administration (AHCA) to include the following contractually required behavioral health services:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Psychiatric Physician Services
- Community Mental Health Services
- Mental Health Targeted Case Management
- Intensive Case Management[87]

Medicaid places medical limits on these contractually required behavioral health services. For example, Medicaid will reimburse up to 344 units (15 minutes equals one unit) of mental health targeted case management services per month, per recipient. Medicaid will reimburse up to 48 units of intensive case management services per recipient, per day.[88]

Detailed information on the benefit coverage provided by the four MCOs operating in Broward County is not readily available and comparative information about plan benefits is not available through AHCA. The following information on the behavioral health services provided by the four MCOs was culled largely from the Member Handbooks provided on the four providers' websites and the level of detail varies considerably. Access to this information is a potential barrier to enrollees' ability to make informed decisions about which plan would best meet their needs.

1. **Better Health** provides counseling and referral services by a Participating Psychiatrist or a community health center. Further information was not available.[89]

2. **Humana** provides treatment for psychiatric and emotional disorders, including the following services:

- Counseling
- Evaluation and testing services
- Therapy and treatment services
- Rehabilitation services
- Day treatment services
- Hospital inpatient behavioral health
- Outpatient mental health.[90]

3. **South Florida Community Care Network (SFCCN)** provides the following behavioral health services:

- Inpatient behavioral health care services.
- Outpatient behavioral.
- Other behavioral health services include:
    - Treatment Plan Development and Modification
    - Assessment and Evaluation Services
    - Medical and Psychiatric Services
    - Behavioral Health Therapy Services
    - Community Support and Rehabilitation Services
    - Therapeutic Behavioral On-Site Services for Children and Adolescents (TBOS)
    - Services for Children Ages 0- 5 Years (Behavioral Health Day Services and TBOS)
    - Crisis Intervention Mental Health Services and Post-Stabilization Care Services
    - Substance Abuse Services by Referral (available through fee-for-service only for day treatment services, in the case of adults)
    - Intensive Case Management[91]

4. **Sunshine Health** behavioral health services include inpatient and outpatient hospital services and psychiatric services. Other services include:

- Individual, family, and group therapy
- Social rehabilitation
- Day treatment for adults and children
- Individual and family assessments
- Evaluations
- Treatment planning
- Help with substance abuse problems[92]

Findings – ACA and Medicaid Reform

Because the state of Florida did not expand Medicaid, the impact of the ACA in Broward County is based primarily on the number of people who have enrolled in a health care plan through the federal exchange. There may be, however, significant challenges for FQHCs. Other ACA changes and their impact on Broward County are described below.

F6.3-1: The estimated enrollment of approximately 98,378 Broward County residents in ACA health plans during the first open enrollment period is not likely to have a significant impact on the services provided by safety net providers,

including the services funded and provided by HSD. These relatively small numbers do not change the insurance status of residents who live under 100 percent of the poverty level and who account for a significant portion of the clients seen by the safety net providers in Broward County. Many of the clients served by safety net providers fall into the lowest income brackets and are not eligible for a subsidized ACA health plan.

More than 70 percent of health center patients nationally have family incomes below the federal poverty level.[93] This is also true for BARC: of the 2,810 unique individuals who received services through BARC in FY 2013, 2,160 (77 percent) fall below 133 percent of FPL, making them ineligible for subsidies for ACA marketplace plans. A potentially positive scenario is that newly insured residents may be able to access previously inaccessible behavioral health services as a paying client. These new enrollees have the potential to increase the patient revenue for safety net providers of mental health and substance use disorders services. The actual behavior of new enrollees, however, is not yet known.

F6.3-2: FQHCs are facing significant funding challenges. The ACA and the Health Care and Education Affordability Reconciliation Act provided $11 billion for the expansion of health centers (including FQHCs) nationally over five years. Of these funds, $9.5 billion went into a Health Center Fund for operational expansions, including the opening of new sites as well as expansions of medical and other services. This capacity expansion was designed to allow health centers to meet the needs of the newly insured beginning in 2014. That expansion has been slowed due to a significant reduction in health center funding in FY2011, but growth has resumed in the last two fiscal years. This Health Center Fund will expire after FY2015, resulting in a 70 percent reduction in health center grant funding in FY2016. [94]

Community health centers, including FQHCs, provide health care that equals and "often surpasses that provided by other primary care providers."[95] In addition, they are cost efficient, providing "comprehensive primary care while holding down health care cost growth."[96] The experience with health care reform in Massachusetts suggests that the newly insured may stay with the safety net providers from whom they have been receiving services.[97] The FQHCs in Massachusetts served 10 percent more patients after health reform was implemented, but the proportion of uninsured patients increased by 14 percent,[98] with health centers caring for 60 percent of the remaining uninsured individuals in the state.[99]

FQHCs receive higher Medicaid and Medicare reimbursements than most primary care providers because they are less able to shift the costs of care to private paying patients.[100] Private insurers offering health plans on the exchange must contract with "essential community providers" such as FQHCs and must pay FQHCs their prospective payment rate. However, even with this provision, if health centers do not see an influx of paying patients, especially in Florida where Medicaid was not expanded, their ability to increase their capacity and add services will be hampered.[101]

F6.3-3. Safety net providers may face a number of capacity issues and smaller safety net providers will face challenges in collaborating with other safety net providers and contracting with private insurers. Private insurers offering health plans through the exchanges are required to contract with safety net providers. While most researchers and policy analysts expect safety net providers to continue to be the "providers of choice for the uninsured," these providers will face a number of challenges.[102] In this changing environment, safety net providers have to consider "how to continue to be welcoming to the most vulnerable patients who have come to rely on them, but also to change their image from a place of last resort in order to attract a new group of patients."[103] Access to specialty services and even primary care personnel will be hardest for safety net providers.[104] And the new quality requirements under ACA may strain resources for data collection and reporting.

The ACA allows and encourages safety net providers to coordinate and integrate health care services for low-income populations through Accountable Care Organizations, patient-centered medical homes, and community-based collaborative care networks. Many safety net providers are operating in geographic proximity, however, they are not providing a fully integrated model of care and are not working together in a systematic way. The ACA encouragement of integrated models of care could exacerbate inequalities if profitable providers band together and exclude the safety net. "Safety net providers that are already part of integrated systems are more likely to succeed."[105]

In addition, there is a growing disparity between "economically viable safety net providers and smaller, less successful ones." Many safety net providers are at a disadvantage in participating in the integrated delivery systems because "they have very limited access to capital and few resources to devote to planning for new opportunities or developing new business strategies."[106]

F.6.3-4: Some changes in the ACA, such as the reduction in hospital disproportionate share funding and the employer mandate, are not expected to

have a significant impact, particularly in Florida, in the short-term. Both Medicaid and Medicare provide funding through the Disproportionate Share Hospital (DSH) program to hospitals to reimburse them for the otherwise uncompensated care they provide. While there has been significant concern about the impact of these reductions, particularly on states that did not expand Medicaid, the impact in Florida for 2014 does not appear to be significant.

The Medicaid DSH program is being phased out beginning this year and the Medicare DSH program is reduced by 75 percent, although a new Uncompensated Care payment offsets much of the reduction.[107] The net impact of the changes to the Medicare DSH program is projected to be a reduction of 4.3 percent nationally, although hospitals in the South Atlantic Region, in which Florida is located, are expected to see a very slight (less than 1 percent) net gain overall.[108]

The net reduction in Medicaid DSH payments in 2014 is expected to be just under 5 percent for hospitals in Florida.[109] While the Medicaid DSH payments will continue to decrease until phased out in 2020, current federal rules regarding the reductions cover only 2014 and 2015; new rules specifying the reductions for 2016 and beyond will be developed based on experiences with the actual reductions in the uninsured as a result of the implementation of the ACA.[110]

Beginning in 2015, employers with 50 or more employees are required to provide health insurance or face a penalty. This is not expected to have a significant impact on reducing the number of uninsured nationally. According to the RAND Corporation:

> Less than 5 percent of firms nationally have more than 50 employees, although more than 70 percent of workers work for firms with more than 50 employees. Furthermore, more than 95 percent of firms with 50 or more workers already offer health insurance (although not necessarily affordable insurance as defined by the ACA) to their employees. In other words, most firms will be unaffected by the mandate, and although most people are employed by firms that could be affected, they themselves would not be because their firm offers insurance that is affordable (under the ACA) to them.[111]

F6.3-5: The most significant challenge for HSD related to ACA is how to support individuals who are insured but are unable to pay their premiums, copays, or deductibles. Copays and deductibles are concepts that are new to people who have

been uninsured for significant periods of time. During interviews with providers and stakeholders throughout the community, we heard anecdotes about surprises for the newly insured, including copays for insulin that exceeded sliding scale payments at clinics in Broward County, premiums that clients would not be able to pay, and limits on benefits that were more stringent than those available from safety net providers. In the insulin example, the medication a client had been receiving for a deeply discounted rate from a safety net provider cost significantly more through the ACA plan. As a result, residents who are newly insured may lose access to services and medications they previously had received when qualifying for indigent care.

The inability to pay co-pays and other expenses may result in residents being unable to remain insured once qualified and enrolled in an ACA health plan. Once they have been qualified for a health plan, they are no longer eligible for indigent services with providers they have previously used to access health care services. And some providers, including Broward Health, will not provide services unless a resident has applied for ACA and received a notice that they do not qualify for a subsidized plan. Residents who qualify for an ACA plan but lose coverage because they do not make their premium payments will be considered “insured” and will not be eligible for indigent services. More providers may enact similar requirements in order to remain the “funder of last resort”.

HSD contracts for services through the Community Partnerships Division restrict contracted agencies from providing services to clients who are eligible for or enrolled in Medicaid or are covered by any third-party insurance. This restriction applies even if the insurance benefits do not cover a service deemed necessary for the client. BARC is not subject to these restrictions and funds services for individuals who are insured but have either exhausted their insurance benefits or their insurance does not cover some or all of the services provided by BARC. It should be noted that BBHC, as a safety net provider, pays for clients whose services are not reimbursed by their insurance company

F6.3-6: The transition to Medicaid managed care in Florida presents an immediate challenge to safety net providers, particularly direct services provided by HSD; contracts are required with the Managed Care Organizations in order to become a network provider and continue to serve Medicaid patients and receive Medicaid revenue. Some safety net providers in the community may face challenges securing contracts with the four MCOs in Broward County, and may lose Medicaid clients and revenue as the MCOs choose to provide services in-house or choose to include other providers in their network. The extent to which these providers may request additional

funding from the County due to the loss of Medicaid revenue, or may be unable to stay in operation, is not yet known.

Once a resident is enrolled in a Medicaid managed care plan, they may find that the safety net provider or service they have been using may not be part of their plan's network.

Recommendations – ACA and Medicaid Reform

R6.3-1: Consider a policy similar to that of the BBHC (and currently in use by BARC) that allows County funds to be used to meet copays and deductibles for covered services when insurance benefits have been exhausted.

By filling in the gaps in insurance, this policy allows insurance coverage to be more accessible to everyone. Given the gaps in insurance coverage and the difficulties residents already have in covering copays and deductibles, the best role for the County is to fund insurance gaps, either instead of or in addition to serving individuals who have no insurance. This will require renegotiation of the current HSD contacts with providers.

R6.3-2: Monitor contracted providers, as an integral component of each monitoring visit (at least quarterly), for the impact of ACA and Medicaid managed care on their operations, including changes in the number of Medicaid and ACA clients and revenue.

HSD should maintain information on contractors about their status as a Medicaid provider and the MCOs with which they have contracts. A short, standardized questionnaire can be completed by contractors to provide this information. This information is critical to anticipating what changes might be needed to contracts as a result of the implementation of ACA and Medicaid managed care.

R6.3-3: Facilitate collaboration among safety net providers to include them in existing and developing integrated networks.

R6.3-4: Ensure the new HSD billing unit (see also Recommendation 6.4-1) pursues contracts with the 4 MCOs and the 10 ACA exchange health plans for BARC, EVSD, and NJCC.

R6.3-5: Engage in a marketing campaign to attract Medicaid and ACA enrollees to choose HSD services provided through BARC, EVSD and NJCC.

This will be a new effort by HSD, unlike anything the department has done before. HSD will need to address cost and quality issues (including the condition of the BARC facility) if they want to pursue Medicaid reimbursement.

6.4 Review Direct Services for Efficiencies and Increased Revenue

A. Payer of Last Resort

Background – Direct Services

HSD provides direct services through programs provided by the Broward Addiction Recovery Center (BARC), the Nancy J. Cotterman Center (NJCC), and Elderly and Veteran's Services Division (EVSD) programs. These services are funded by a combination of state funds and County general funds.

Very little income from Medicaid and private insurance is received by BARC and none is pursued by NJCC. BARC can only bill Medicaid for the outpatient treatment that is provided; Medicaid will not reimburse inpatient treatment provided at substance abuse treatment facilities that have more than 16 beds (BARC has an 82-bed residential facility). BARC verifies enrollment in the Medicaid program when a client enters treatment, but does not re-check enrollment status after intake and has limited resources devoted to pursuing Medicaid enrollment. BARC did not assist clients with enrollment in ACA during the most recent enrollment period.

EVSD provides a variety of behavioral health services to older adults (55+) with diagnosed mental health disorders who are at risk of requiring more intensive and restrictive institutional placements. A number of the older adults served have co-occurring substance abuse disorders, many of whom have been incarcerated or committed to mental health facilities. Among the direct behavioral health services provided are: assessment, case management, individual recovery support, outpatient-individual, outreach, intervention-individual, and aftercare.[112] Funding is used to manage the assessment and delivery of community based services designed to direct consumers away from inappropriate and premature institutional placement, allowing them to achieve independence, stability, self-sufficiency, and responsible community living that benefits not only the consumer but the community at large. In FY 2013, 300 clients were served.[113] The EVSD receives state grants to provide these behavioral health and case management services.[114]

Findings – Direct Services

F6.4-1: It is unusual for a county government to operate direct services to the extent that Broward County does, particularly facilities like BARC and NJCC. According to the National Children's Alliance, the governing body that sets national accreditation standards for Children's Advocacy Centers (CACs), approximately 60 percent of CACs are independent, non-profit programs, 20 percent are government-based programs, and 20 percent are part of an umbrella organization (usually a hospital). These numbers have remained fairly constant over the last 15 years.[115]

It is even less common for a county government to operate substance abuse treatment facilities. About 5 percent of treatment facilities in the United States were owned by a local government in 2012, a decrease from 6 percent in 2008. Private non-profit organizations operated 56 percent of all facilities in 2012 and private for-profit organizations operated 31 percent of facilities in 2012. The remainder includes ownership by state governments (3 percent), the federal government (3 percent), and tribal governments (2 percent).[116]

F6.4-2: Participating as a provider for new ACA enrollees and Medicaid managed care will be challenging for entities embedded in County government. Both BARC and EVSD are enrolled Medicaid providers and both have staff responsible for verifying Medicaid eligibility and billing for services and receive varied amounts of patient revenue through Medicaid or private insurance. However, in the transition to Medicaid managed care in Florida, BARC and EVSD will be required to have contracts with the four MCOs in Broward County in order to provide services to Medicaid clients. And even with a contract, receiving referrals from the MCOs is not a certainty.

BARC and EVSD are negotiating with MCOs independently. BARC is currently in discussions with three MCOs, but does not yet have a contract in place. EVSD has a contract in place with one MCO for case management services for elderly Medicaid clients, but has not yet received a referral. EVSD also has one contract with an MCO for behavioral health services for elderly clients, but has received very few referrals and only $78,000 in revenue for the services provided.

The transition to Medicaid managed care has had a severe impact on EVSD; an MCO is now serving as the provider of services that has resulted in a reduction of $850,000 in Medicaid revenue to HSD and a reduction of 9 EVSD staff.

Being a provider for new ACA enrollees will also not be easy nor will developing the collaborations and coordination with other providers that will be essential for participation. The provisions that encourage collaboration among safety net providers may be difficult for local health departments because they will be "competing with providers who have more experience or established relationships" with integrated delivery systems. In addition, "safety net providers imbedded in city or county governments may have limited flexibility to make the types of changes encouraged by the ACA." [117]

F6.4-3: HSD does not require BARC or NJCC to use taxpayer funds as the "payer of last resort." In contracts for providers through the CPD, contractors are required to use County funds as the "payer of last resort" and must aggressively pursue other forms of payment for services. County contracts prohibit the use of County funds for individuals who are enrolled in an insurance plan, even if the insurance benefits have been exhausted or the plan does not cover needed services.

This same standard does not apply to the services provided directly by the County through BARC and NJCC. General funds are spent to provide services without any expectation of pursuing Medicaid or third-party insurance reimbursement.

There are two challenges for NJCC: overcoming the reluctance to bill for services and developing the capacity to bill. NJCC currently does not pursue Medicaid and private insurance reimbursement for the services they provide, reportedly so that a child does not have to be labeled with a diagnosis (which is required for billing). This same expectation of privacy does not extend to the providers funded by HSD, BBHC, or the CSC, all of whom are required by their contracts with HSD to pursue additional source of funding, even for children, before using tax payer funds.

According to the National Association of Counties (NACo), the ability of a Children's Advocacy Centers to bill Medicaid and other insurers is based on whether or not the CAC has the capacity to bill. CACs that are part of an umbrella organization typically bill Medicaid and other insurers for qualifying services because they are part of a hospital with a billing department. Larger independent and government-owned CACs must develop the internal capacity to bill for services.[118]

Recommendations – Direct Services

R6.4-1: Create a centralized billing unit within HSD to contract with and more aggressively bill Medicaid and private insurers for the direct services provided by the Department, including BARC, EVSD and NJCC.

A centralized insurance billing unit should be created within HSD to leverage the expertise of individuals within BARC and EVSD and to have a cohesive and consistent approach to verifying insurance coverage, determining what insurance individuals might be eligible for, assisting with enrollment, and expanding on the billing expertise that is scattered throughout the department.

As the administrator of these programs and stewards of tax payer funds, HSD should be the payer of last resort and ensure that every attempt is made to identify other funding for clients, just as the County requires of its contractors.

Of the 2,810 unique individuals who received services in FY 2013, BARC staff verified Medicaid enrollment for 249 (9 percent). At least another 300 individuals are shown to have incomes at 250 percent of FPL and above, suggesting that these individuals might already have private insurance that could pay for some or all of their treatment, or these individuals may be eligible for ACA plans, with or without subsidies. Assuming 250 consumers already are insured through Medicaid or other health plan, billing $1,000 per individual could mean about $250,000 in revenue to the County annually.

The billing unit should be responsible for the following for all direct services provided by HSD:

- Verifying client enrollment in Medicaid and other insurance plans, both at entry into the program and every 6 months that the client continues to receive services.
- Billing Medicaid for eligible services.
- Assisting clients with enrollment in Medicaid and ACA.
- Coordinating negotiations with the four Medicaid managed care providers in Broward County to establish provider contracts.

B. Broward Addiction Recovery Center (BARC)

Background – BARC

The Broward Addiction Recovery Center (BARC) has been operated by Broward County since 1973 and serves County residents over the age of 18 who are in need of treatment for substance abuse. BARC services include a 34-bed medically supervised detoxification unit, a 92-bed residential treatment program, a non-residential day treatment program, and outpatient treatment programs. In fiscal year (FY) 2013, 73 percent of BARC clients had incomes at 100 percent of poverty and below.

BARC receives about half of its $8 million budget from the State of Florida through the Broward Behavioral Health Coalition (BBHC). BBHC is a non-profit agency established in 2011 for the purpose of serving as the contracted agency in Broward County to coordinate state funding for behavioral health (BH) services. BBHC contracts with the Florida Department of Children and Families (DCF) to receive the state BH funds and manage the distribution of the funding to providers in Broward County. Prior to the creation of BBHC (also known as the "managing entity" or ME), DCF contracted directly with each BH provider individually. Now, BBHC determines the allocation of $43 million in DCF funding through competitive contracts with BH providers throughout the County.

The transition from direct contracts with DCF to contracting with the ME has resulted in significant changes for providers. First, when the DCF funding was turned over to BBHC, the state did not provide administrative funding to operate the ME, so administration of the BBHC is funded by reducing direct services funding to providers by approximately 5 percent. This reduction in funding to providers did not result in a concomitant decrease in performance expectations. Second, the ME has increased focus on accountability and expectations for performance resulting in standardization and enforcement of reporting requirements and the achievement of outcomes, which has increased the administrative burden for providers.

Findings – BARC

F6.4-4: BARC undisputedly plays an important role in the continuum of services for substance abuse treatment in Broward County. In operation for more than 40 years, BARC is a beloved institution and has maintained broad community support for its mission and services.

F6.4-5: BARC has weathered a series of reviews that raised a number of concerns about the administrative operations of the program. A consultant report in 2008[119]

and an audit by the County Auditor[120] the same year both identified a number of concerns about BARC operations. The current BARC director was hired soon after these reports were issued and while many of the issues have been addressed, several concerns remain, such as: low bed utilization rates in the residential treatment program, data collection and reporting, and client fee collection and reimbursement from Medicaid and other payer sources.

In addition, BARC has had a challenging transition to operating under the new Managing Entity and meeting the many new requirements of BBHC. A Contract Accountability Review by BBHC in late 2013 found issues about reporting, record keeping, and data management that resulted in corrective action plans. In their 2014 Business Plan, BARC acknowledges the following challenges:

- Electronic health records and billing systems are not operating at full capacity.
- Low residential services utilization.
- Low staff morale.
- Long-term staff vacancies due to a shortage of qualified health professionals.
- Negligible patient revenue.
- Competition with other providers.

F6.4-6: As a government entity, BARC has more administrative challenges than non-profit providers of behavioral health services. As noted in the 2013 BBHC corrective action plan, the length of time needed to obtain County Commissioners' approval for contracts and contract amendments has had a significant impact on BARC's ability to flexibly meet BBHC requirements, maintain compliance, and receive reimbursement from BBHC.

F6.4-7: While BARC has implemented administrative changes to keep detox beds filled (94 percent occupancy in FY 2012), residential treatment beds often go unused. BARC had a utilization rate of 76 percent for residential beds in FY 2012. According to a federal Substance Abuse and Mental Health Administration 2013 report, utilization rates for residential (non-hospital) beds in substance abuse treatment facilities operated by local governments is lower than the average across all facilities (86 and 96 percent, respectively).[121] BBHC has recently increased the number of residential beds they purchase from BARC that may increase the occupancy rate.

F6.4-8: BARC has begun very limited billing of Medicaid, but less than one percent of revenue comes from patients, Medicaid reimbursements, or third party

billing. BARC is funded by the BBHC and County general funds in roughly equal amounts. In contrast, Henderson Behavioral Health, another BH provider in the County funded through BBHC, has a more diversified funding stream, receiving 40 percent of their funding from BBHC, 20 percent from Broward County, 18 percent from Medicaid, and 8 percent from clients fees and third party insurance. As stated in an earlier section of this report, BARC's ability to bill Medicaid will become more challenging with the transition to managed care for all Medicaid services in Broward County in July 2014. The ACA is not anticipated to have a significant impact on BARC for several reasons, including:

- Of the 2,810 unique individuals who received services in FY 2013, 2,160 (77 percent) fall below 133 percent of FPL, making them ineligible for subsidized ACA marketplace plans.

- BARC is currently serving individuals regardless of their insurance status, so even clients newly insured through ACA could be served through BARC general revenue funds if they have exhausted their ACA plan benefits.

- While ACA plans are required to cover BH services, the actual services provided vary considerably among the plans.

- As noted in an earlier section of this report, an analysis indicates that approximately 98,378 Broward County residents may have enrolled in an ACA plan; it is unknown what percentage of the enrollees might be potential BARC clients.

- ACA enrollees who are in need of substance abuse treatment services will have a choice of facilities to choose from and the extent to which they will choose BARC is unknown.

F6.4-9: Previous reports as well as some of the stakeholders interviewed expressed concern about the risk to the County associated with operating a medical detoxification facility at BARC. Full-time supervision by a licensed physician is required to monitor medical withdrawal from a variety of substances. Concerns include the cost to the County for physicians (one full-time and two part-time) as well as the risk of complications associated with medical withdrawal, which can include seizures. About 29 percent of the BARC budget is for the detox program, which served just over 1,800 individuals in FY 2012.

F6.4-10: The condition of the facility in which BARC is operating is extremely deficient. The BARC facility pre-dates the creation of the BARC program more than 40 years ago and has been retrofitted to accommodate BARC services. The poor condition of the facility has been well documented in numerous reports in recent years. The current facility is a significant impediment to providing efficient and cost-effective services. The condition of the BARC facility will be a major barrier to contracting with the MCOs under Medicaid managed care. Although BARC is fully accredited by the Joint Commission, the MCOs have the ability to choose among several providers for contracts and ultimately, referrals for services for Medicaid clients. Given the choice of newer, more modern facilities for Medicaid patients, MCOs may be more likely to choose other providers over BARC for their enrolled members. In addition, any newly insured individuals through ACA will have a choice of facilities if they are seeking substance abuse treatment and may choose a newer facility.

Recommendations – BARC

There is no question among many of the individuals we interviewed that BARC's services are needed. However, while BARC is an integral component of the continuum of care in the community, and its reputation as a long-time, well-respected provider of services is undisputed, several changes are needed if BARC is going to continue as an efficient and effective provider of services and a good steward of the public funds that support it.

R6.4-2: Increase the operating efficiencies within BARC to manage County resources better.

This includes developing capacity for continuous quality improvement, meeting BBHC administrative requirements, and increasing patient revenue. HSD also should explore options for re-purposing unused residential beds.

R6.4-3: Expedite plans and resolution of issues to move BARC into a new facility.

The current building inhibits the ability of BARC to operate efficiently, recruit clinical staff, and attract insured individuals who have choices about where to get services. The County needs to increase efforts to move BARC into a more functional and modern facility.

C. Child Care Licensing and Enforcement

Background – Child Care Licensing and Enforcement

The Child Care Licensing and Enforcement Section (CCLE) in CPD is a regulatory function that inspects and provides permits to all child care facilities and day care homes in the County. The Florida Department of Children and Families (DCF) has this responsibility in most counties in the state (62 of 67), but allows counties the option of having a local ordinance that is more stringent and administered under local control. Broward County is one of only five Florida counties that exercised this option.

Findings – Child Care Licensing and Enforcement

F6.4-11: Broward County's child care regulations are not more stringent than the state's on significant measures, such as the quality of care, as determined by national child care oversight organizations. One of the benefits of the County maintaining its own child care ordinances is the ability to have higher minimum standards for providers seeking licensure relative to state requirements. The primary difference between the Broward County CCLE program and the state program is that Broward County licenses home-based child care and inspects child care facilities that receive a religious exemption, which the state does not. Another difference between the state-provided services and the County's service is that Broward's CCLE conducts its own criminal background checks, which in some cases returns results faster than those found in other counties that rely on the state. The County also has a popular on-line search feature, but the state program maintains a similar website for the counties for which it provides services.

In April 2008, the County Auditor's Office *Program Performance Review of the Children's Services Administration Division of the Human Services Department* included an assessment of CCLE performance and alternatives.[122] The report found that CCLE appears to be effective in the timely issuance of child care licenses, effective in investigating reports of suspected unlicensed child care, and clients are generally satisfied with services.

A recent study completed by the National Association of Child Care Resource and Referral Agencies (NACCRRA) ranked each state's child care center minimum standards and oversight systems. NACCRRA ranked the state of Florida 2nd in oversight and 28th in regulation.[123] However, the items for which Florida falls short in the NACCRRA regulatory review (requiring center directors to have a bachelor's degree or higher in early childhood education or a related field; requiring center staff to complete

only 10 hours of annual training; and failure to require group sizes necessary for National Association for the Education of Young Children accreditation), are not addressed in Broward County's childcare standards.[124, 125]

Broward County funds CCLE with a mix of 74 percent local General Fund ($1.0 million) and 26 percent state funds ($400,000). A portion of the General Fund ($363,000) is offset by fees from clients. Fees are collected for background screening services, licensure applications, renewals, or name changes. Revenue from these sources is not retained by the CPD but is returned to the General Fund.

Recommendation – Child Care Licensing and Enforcement

R6.4-4: Return responsibility for Child Care Licensing and Enforcement to the state of Florida and redirect the County general funds to the priorities for funding identified in this report.

If responsibility for CCLE remains with HSD, this program should focus on the outcome measures that will increase their standings on the quality and performance measures tracked by NACCRRA.

6.5 Address Competency Determination Policy and Procedures

Background – Competency Decisions

Felony defendants with mental health disorders may be ordered by a judge to undergo an assessment by a qualified professional (such as a psychologist or psychiatrist) to determine if they are competent to proceed in the judicial process. If the defendant is deemed incompetent to proceed (ITP), they may be committed involuntarily to a Florida state hospital for treatment to restore them to competency or they may be released under a conditional release plan (CRP) to receive services in the community to restore them to competency.

Individuals who are found not guilty by reason of insanity or incompetent to proceed and are not committed to a state hospital must receive competency restoration training (CRT) in jail or in the community. According to the Department of Children and Families (DCF), CRT is "education provided to the individual by a mental health provider to gain understanding and comprehension of the charges, legal process, possible court dispositions and the individual's rights under the law. This education may be provided over a period of time until the clinician is confident that the individual has demonstrated understanding and comprehension of the information or it has been determined that the

individual will not regain competency in the foreseeable future." CRT is provided in addition to the outpatient care and treatment that defendants receive as part of their CRP.

Findings – Competency Decisions

We heard from many stakeholders that the number of ITP determinations is very high in Broward County. BBHC provided the information in **Exhibit 6-3** below verifying that claim.

Exhibit 6-3: Comparative Competency Data for Broward, Palm Beach, and Miami-Dade Counties (2013)

	Broward	Palm Beach	Miami-Dade
2013 Population	1.8 M	1.4 M	2.6 M
Competent	116	85	6
Incompetent to Proceed (ITP) on Conditional Release Plan (CRP)	822	20	198
Incompetent to Proceed (ITP) Commitments to DCF	213	106	139
Competency Restoration Training (CRT) in Community	721	Not available	40
Competency Restoration Training (CRT) in Jail	309	Not available	0

Source: U.S. Census Bureau population data; Broward Behavioral Health Coalition

F6.5-1: The number of incompetent to proceed (ITP) determinations ordered through the felony mental health court is very high compared to other counties in Florida (four times more individuals determined ITP are released into the community than in Miami-Dade County) and has a significant negative impact on providers of mental health services.

Broward County releases more than ***four times*** as many ITP defendants into the community on conditional release plans (CRPs) as Miami-Dade County, which has about 50 percent more residents than Broward County. Broward County courts commit nearly ***twice as many*** ITP defendants to a state hospital operated by DCF as Miami-Dade and Palm Beach counties.

The more than 800 forensic clients ordered to receive treatment through community providers significantly reduce the number of placements available for non-forensic clients. Forensic patients present several issues for community providers because many

are violent offenders and they may not meet criteria for mental health treatment. Stakeholders reported that some individuals with developmental and/or intellectual disabilities ordered to receive services in the community through a conditional release plan (CRP) may not meet the criteria for treatment for mental health disorders and may not be "restorable."

Anecdotally, we heard that 78 percent of defendants committed to a state mental hospital are restored to competency, while less than 25 percent of defendants treated in the community are restored to competency. One of the major reasons for the difference is the difficulty of ensuring that individuals treated in the community adhere to their medication regime.

Providing CRT for defendants in Broward County is costly: $1 million is expended annually from the BBHC budget for CRT, which does not include the cost of mental health care and treatment provided as part of the CRP.

F6.5-2: The quality of the assessments completed for determination of competency has been questioned and the assessments are not considered reliable. Many stakeholders expressed concerns about the quality of the assessments for determining whether or not defendants are competent for trial. A peer review process has been initiated to review competency determinations. This review is funded by behavioral health providers hoping to standardize the process, but has not been accepted by all of the parties involved and is currently undergoing a judicial review.

The professionals conducting competency assessments are paid $300 per assessment, which creates challenges in ensuring that the reviews are thorough and complete.

Recommendation

R6.5-1: Lead a collaborative effort to develop an effective diversion program in the felony mental health court.

More coordination is needed in the community to address competency determinations by the felony mental health courts and the significant adverse impact on mental health providers in the community. HSD should take the lead in bringing together BBHC, community mental health providers (including those funded by HSD), judges, public defenders, and others in the legal system to review the competency determination process and to develop an effective diversion program for the felony mental health court.

6.6 Lead Collaboration among Providers and Funders

The Broward County health and human service system is extraordinary. The wide range of services, the mix of public and private service options, the policy of the County to use resources to fill gaps in services, the commitment of providers to collaborate – are aspects of a county system not found in many places around the country. However, changes in state and federal policies that have taken place over the last decade have not been fully embraced and used to the maximum benefit to improve systems operations. There are currently two areas of planning and collaboration that should be revamped to streamline and focus planning and collaboration.

Broward County has a history and solid base of collaborative efforts for over two decades. The changes in structures to support collaboration have grown in response to changes in the system or to address collaborative efforts around specific populations. With the introduction of new structures for major funders such as ChildNet, Early Learning Coalition, Broward Behavioral Health Coalition, and Children's Services Council, the question remains: Beyond funding, what is the role of the County and who should be responsible for how these organizations work together? We believe the County Human Services Department is the sole entity that is concerned for *every* resident in the County, regardless of what "population" someone falls into for funding purposes, and should be the focal point of efforts to bring these major funders together. The recommendations in this section identify changes the HSD can make to organize for this type of role.

A. Coordinating Council of Broward and Funders Forum

Background – Collaboration

There are two groups meeting to coordinate funding, address overlap and duplication, and plan for improved systems operations in Broward County – the Coordinating Council of Broward County (CCB) and the Funders Forum.

The Coordinating Council of Broward County (CCB), formed in the mid-1990's and supported by the South Florida Regional Planning Council, has as its mission:

> "To create and support collaborative systems that more efficiently and effectively meet community needs."[126]

According to the South Florida Regional Planning Council's web site, members include:

Broward Regional Health Planning Council
Children's Services Council
County government
ChildNet
Florida Department of Children and Families
Early Learning Coalition
United Way
Broward County Health Department
Broward Behavioral Health Coalition
Broward College
Nova Southeastern
Broward County Sheriff's Office
Workforce One
Aging and Disability Resource Center
Broward Health
Henderson Behavioral Health
Broward County Public Schools
Memorial Healthcare System

About five years ago, the County was awarded a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to design and implement the concept of systems of care. One outcome of this grant was the creation of a Funders Forum that brought together key mental health and substance abuse stakeholders to collaborate on issues, target coordinated funding opportunities and cooperate on a range of issues that affect the entire system. While the SAMSHA grant has ended, the Funders Forum continues to meet and is chaired by the Children's Services Council. The Funders Forum focuses primarily, though not entirely, on children's services. Membership includes many of the same individuals and organizations as the CCB.

Findings – Collaboration

Through our County stakeholder and provider interviews, from the Provider Town Hall meeting, and through the Provider E-Survey, we heard the following:

"We go to a lot of meetings but I'm not sure that we really collaborate."

Provider comment at Town Hall Meeting

F6.6-1: There is no clear understanding about the roles of the Coordinating Council of Broward County

and the Funders Forum. While providers knew how each organization came into being, no one could articulate why the two forums continue to exist since there is considerable overlap in membership and purpose. It was also reported that attendance for each group is sporadic although the Funders Forum seems to have more consistent attendance than the CCB.

F6.6-2: Members of these groups characterized HSD's involvement as minimal. In fact, providers also seemed to discount the role of the County in these and other strategic planning groups. The County was not seen as playing a leadership role and/or being the catalyst for bringing key stakeholders across systems to the table for strategic planning purposes.

F6.6-3: There is a need for a new paradigm that puts HSD at the forefront of strategic planning and collaboration across the public and non-profit systems. Currently, advisory boards, planning councils, coordinating groups and other groups meet to plan the best approaches for continuously improving the system to deliver services. Many excellent initiatives are being implemented throughout the community, however plans are not clear on what are the priority initiatives and how those priorities can be implemented. Without more consistent leadership and administrative support, these groups will be limited in their ability to have a significant impact on the system.

Recommendations – Collaboration

HSD and other funders should take this opportunity to revise and reorganize the structure of these groups for county-wide collaboration. While it is understood HSD does not have authority over these groups, it can take the lead to negotiate a solution with members that will establish a more effective mechanism for planning.

R6.6-1: Facilitate restructuring of the Coordinating Council of Broward County (CCB) and the Funders Forum to establish one group to focus on county-wide strategic planning and funding decisions.

HSD should take the lead to negotiate a solution with members of these groups to establish the best structure for ongoing work. Service providers should not be part of the revised group except for instances such as Broward County Public Schools (BCPS), Broward Sheriff's Office, or higher education representatives that provide services and also fund services. The County Commission should work to encourage BCPS and Broward Sheriff's Office to become active participants in this revitalized group. HSD should be responsible for leading and staffing the new effort.

The new Funders Group should be charged with:

- Identifying gaps in services and emerging needs that must be addressed.
- Developing cross-system plans that align funding with strategic priorities.
- Developing shared definitions, performance measures, data collection, and monitoring.
- Developing cost analyses for all services (operated by the County or through the non-profit network) to assess costs for similar services by provider that will lead to consistent funding levels based on service definitions.
- Identifying and finding resources to support training across the system to ensure the successful implementation of evidence-based programs.
- Developing pilot initiatives to highlight collaborative efforts, including blending and braiding funding sources.
- Developing common forms and procedures for procurement of services.

These responsibilities are similar to what the CCB and Funders Forum describe as their missions now. As currently structured, however neither group is fulfilling these responsibilities sufficiently and neither group has the full and substantive support of the funders' community. Combining the groups and revitalizing the collaborative effort will serve to re-energize and re-focus efforts that are now diluted and sporadic. HSD should devote staff resources to support the new group.

R6.6-2: Establish a Community Engagement Office that gives HSD the needed resources to take on the leadership role to implement collaborative strategic planning and funding efforts.

To be effective, the newly formed Funders Group will require administrative support to collect and analyze strategic plans and needs assessments, develop agendas, meeting schedules, record decisions, and perform other duties that will help the group maintain meaningful participation.

B. Children's Services Strategic Planning

Background – Collaboration

The Children's Services Board (CSB) has a long and distinguished history advising HSD on children's issues. Created in 1986, the CSB has as its "purpose and sole interest the improvement of life for the children of Broward County."[127]

In 2000, the Children's Service Act of Broward County created the Children's Services Council (CSC) as a "special taxing district….to fund programs and services that improve the lives of children and their families."[128]

Exhibit 6-2 compares the Membership of Children's Services Board and Children's Services Council; **Exhibit 6-3** compares the responsibilities of the two entities.

Exhibit 6-4: CSB and CSC Membership

Children's Services Board	Children's Services Council
School Board member	School Board member
Florida Department of Children and Families	Florida Department of Children and Families
County Commission	County Commission
Florida Department of Juvenile Justice	Juvenile Court Judge
Superintendent of Schools	Superintendent of Schools
Nine members appointed by County Commission To the extent possible, represent the demographic diversity of the community	Five Governor Appointed Members from list recommended by County Commission To the extent reasonably possible, represent the geographic and demographic diversity of the population of the county
Representative of One Community Partnership	
Past or current consumer	
	Broward County Health Department

Source: Broward Ordinances, Article XXVII, Section 1-483 through 1-490 and Florida Statute 125.901.

Exhibit 6-5: Comparison of Duties of Children's Services Board and Children's Services Council

Children's Services Board	Children's Services Council
Advise and recommend on the care of children and on such other matters as the Board considers pertinent to the welfare of the children of Broward County	Provide and maintain in the county such preventive, developmental, treatment, and rehabilitative services for children as the council determines are needed for the general welfare of the County.
Recommend services to improve the delivery of services to children	Provide such other services for all children as the council determines are needed for the general welfare of the County.
Provide a recommended budget and funding levels for children's services	Allocate and provide funds for other agencies in the County which are operated for the benefit of children.
Collect information and data on children's needs and services in Broward County	Collect information and statistical data which will be helpful to the council in deciding the needs of children in the County.
Annual plan shall describe current children's services and include an assessment of how current services are fulfilling the needs of children	Collect information on the effectiveness of activities, services, and programs offered by the council, including cost-effectiveness.
Assist agencies in Broward County government in assessing children's needs and evaluating children's services	Develop detailed anticipated budget for continuation of activities, services, and programs offered by the council, and a list of all sources of requested funding, both public and private.
Prepare and submit a plan of services on behalf of children in Broward County	Provide information on programs, services, and activities that should be eliminated; programs, services, and activities that should be continued; and programs, services, and activities that should be added to the basic format of the Children's Services Council.
	Consult with other agencies dedicated to the welfare of children to the end that the overlapping of services will be prevented.
	Develop procedures used for early identification of at-risk children who need additional or continued services and methods for ensuring that the additional or continued services are received.
	Provide detailed information on the various programs, services, and activities available to participants and the degree to which the programs, services, and activities have been successfully used by children.

Source: Broward Ordinances, Article XXVII, Section 1-483 through 1-490 and Florida Statute 125.901.

Findings – Collaboration

F6.6-4: Since its inception in 1986, ordinances governing the Children's Services Board have modified its membership to recognize changes in the planning and delivery of children's services in the county. County leadership recognized the possible duplication in planning for children's services when the Children's Services Council was formed and took initial steps in 2001 to sunset the Children's Services Board.[129] By 2003 when the board was to sunset, an ordinance was passed to recreate the CSB[130].

The CSB advises the Human Services Department on the spending of approximately $14.9 million for children's services; the Children's Services Council directs the spending of $54.6 million.

The CSB conducted a five-month strategic planning process that involved board members and staff from HSD to develop its most recent strategic plan for FY2014-2016. The board also developed an Emerging Needs plan to ensure it addresses any service whose absence is evident, critical and immediate. This is defined as:

> A gap in the available system of children's services, which it is necessary to address to help Broward County children function effectively. The need falls within one or more of the six focus areas in the current Strategic Plan, but has not previously been addressed or prioritized.[131]

F6.6-5: The Children's Services Council, with similar but not identical membership, has a charge identical to the CSB – improving the lives of children in the County. The CSC, however, has the added responsibility of being a taxing district and must plan for and distribute funds according to its strategic plan.

The CSC planning process is conducted by a very broad coalition of over 1,200 participants and 195 providers. CSC has an on-going system of 26 committees organized around its Leadership Coalition, addressing a wide range of children's needs and services.

F6.6-6: In an attempt to reduce duplication, the CSB and CSC separate planning and funding priorities – CSC focuses on prevention; CSB focuses on intervention and treatment. It is noted, however, that providers expressed confusion in understanding what this really means and how it works. Exhibit 6-4 compares the strategic goals of the two entities.

Exhibit 6- 6: Comparison of Strategic Plan Goals of Children's Services Board and Children's Services Council

Children's Services Board Strategic Plan	Children's Services Council Strategic Plan
Develop a process to support the achievement of recovery from behavioral health/traumatic issues to insure that youth and families have the ability to live and function successfully in our community.	Children live in stable and nurturing families. Children live in safe and supportive communities.
To provide high quality, cost-effective services to children in Broward County with developmental disabilities and other special health needs reach their highest level of functioning	Children are mentally and physically healthy.
To provide high-quality, cost-effective services to support transition to independent adult life for low-income, homeless older adolescents and youth aging out of foster care	Young people successfully transition to adulthood.
To ensure children's success in school and life.	Children are ready to succeed in school.
Identify and engage youth who exhibit violence or other antisocial behavior and their families to effectuate a more functional and healthy lifestyle.	
To ensure that low-income children, adolescents and their families in Broward County have access to an array of high-quality services that are: • Child-focused and family-centered • Individualized and appropriate to their needs • Strength-based • Collaborative and integrated • Culturally competent • Outcome driven	

Source: Children's Services Board Strategic Plan, November 28, 21012 and Broward Children's Strategic Plan 2012, Success for All Broward's Children.

The review and comparison of the roles and responsibilities of the CSB and CSC highlights several issues that need to be addressed.

Recommendations – Collaboration

R6.6-3: Refocus the Children's Services Board to address the range of services needed for children and youth involved in the juvenile justice system.

Providers identified the need to develop services at each end of the spectrum of services for children associated with the juvenile justice system – those at risk or initially in detention and those "deep-end" youth who need intensive services, especially after release from a juvenile facility. The CSB should focus its planning and resource

recommendations to this defined group, thus reducing the confusion, overlap and possible duplication of efforts.

R6.6-4: Redefine CSB membership, as needed, to address this new focus, and establish term limits on membership.

A new focus requires a new look at membership of the CSB. While many members currently on the board may be appropriate for this new focus, some may not and some may need to be added. Membership should include service providers, advocates, thought-leaders, and other key stakeholders with background in juvenile justice issues, services, best practices and evidenced-based service models.

While considering membership, the County Commission should also consider term limits for the revised CSB. According to the Association of Governing Boards, 41 percent of public boards have term limits; an increase of 25 percent since 2004.[132] The large increase in recent years is attributed to findings that indicate term limits can be a way to infuse new ideas and new energy into a long-standing board. Term limits also can provide an opportunity to ensure the board has members with the range of skills and experience needed.

R6.6-5: Expand the CSB planning process to include key stakeholders and providers.

The CSB strategic planning process should be as expansive as possible to include a wider range of providers, advocates, and others. Currently the board conducts its strategic planning using board members. It is recommended that once a year, a more expansive strategic planning process should be implemented to allow other key stakeholders in the community to have input into the needs, gaps and resource allocation recommendations that the board eventually makes to HSD. This could include committees assigned to address different aspects of services – initial detention alternatives to intensive community services needed by children and youth exiting the juvenile justice system. This mechanism also serves to engage a wider array of community stakeholders in finding solutions and supporting recommendations made by the board.

6.7 Better Connect Strategic Planning and Budgeting

Strategic plans are often compared to roadmaps used to guide organizations and track their progress toward goals. To ensure an organization is funding its priorities and using

its funding effectively, budgeting decisions – both *how* money is spent and *where* money is spent – should be based on strategic plans. This review found that HSD's current strategic plan falls short of being a useful planning and assessment tool, and that budgeting decisions are based primarily on historic funding levels rather than strategic priorities. As a result, funding allocation decisions are not clearly justified when compared to needs.

This section first addresses strategic planning on a department-wide scale and looks at generalities across sections. It then looks at budgeting issues in the Health Care Services Section in more detail as an example of the disconnect between strategic planning and budget decisions.

A. Engage in Department-wide Strategic Planning and Link to Budgeting

Background – Strategic Planning and Budgeting

Strategic Planning. The HSD Office of Evaluation and Planning (OEP) coordinates the HSD Strategic Business Plan. This plan ties HSD's goals to two of the County Commission's seven vision statements related to developing a social safety net and having a fiscally sustainable and transparent government. For this initiative we examined only those elements of the Strategic Business Plan that pertain to the social safety net.

The HSD Strategic Business Plan includes a hierarchy of Key Focus Areas (KFAs), goals, objectives, and "actions and initiatives." KFAs were developed in 2008 as part of a SWOTT analysis (Strengths, Weaknesses, Opportunities, Threats and Trends). Five KFAs were developed to connect the County's vision to departmental goals and functions, two of which relate directly to services and service delivery:

- **KFA 1. Promote individual and family self-sufficiency** - highlights the need to target resources to help individuals and families achieve economic stability.

- **KFA 2. Support individual and family health and well-being** - focuses on access to quality primary health care and behavioral health care in order to minimize barriers to economic stability and maximize participation in the community.

Of the six HSD goals developed to address these KFAs, two focus on service delivery:

- Goal 1: Support a service delivery system that promotes self-sufficiency and well-being.

- Goal 3: Support the implementation of quality, creative, cost-effective methods to solving societal challenges especially housing for persons experiencing, or at risk of, homelessness.

For each goal, quantitative objectives are established, along with associated actions and initiatives. The actions and initiatives include a baseline level and target, start and end dates, and the programs responsible for implementation. Staff often refer to these targets as performance measures.

Budgeting. The Broward County Office of Management and Budget establishes HSD's core budget based on the previous year's budget. The core budget includes any changes in salaries and increases in operating expenses due to trends or cost of living changes that are approved by the County. Changes in the budget given to HSD are allocated pro rata across divisions. In the recent past, funding was moved between divisions only in cases of departmental reorganizations; such changes require approval from the County Budget Office and County Administrator.

Division directors may not move funding between sections or programs without approval from departmental administration, although there is some flexibility in the movement of operating funds over the course of the year. The divisions develop budgets and submit them, along with programmatic data, to HSD budget staff.

For the annual budget process, OEP meets with division directors to determine whether performance measures are still relevant. OEP coordinates any changes in performance measures with the divisions and the HSD budget office. OEP also meets with the HSD Director before final budget approval to review the performance measures.

Contracts for services encompass 51 percent of HSD's budget; 89 percent of the $46.6 million in General Fund contracts are the responsibility of the Community Partnerships Division (CPD). Contracts were centralized in this division during the FY 2010 budget process to consolidate oversight and standardize the contracting process. Prior to this time, each program within HSD that contracted for services would procure services and administer contracts on their own, each with its own processes and procedures. Within CPD, the Health Care Services Section (HCS), the Children's Services Administration Section (CSA), and the Homeless Initiative Partnership (HIP) hold $21.4 million, $14.5

million, and $9.8 million in General Fund contracts, respectively. Staff from each of these programs decide what to include in contracts – those in CSA and HIP seek guidance from their advisory boards.

Findings – Strategic Planning and Budgeting

F6.7-1: The HSD Strategic Plan is not a useful planning or assessment tool.

For organizational strategic plans to be useful there should be clear connections between goals and objectives (*what* the organization hopes to achieve) and performance measures (*how* progress toward goals and objectives is measured). Well-designed performance measures look at many components of performance including output, outcome, quality, and efficiency.[133]

The HSD Strategic Plan has a complicated and confusing hierarchy, and some of the performance measures are not clearly quantified either in terms of what is being measured or how it is being measured. For example, the Plan fuses objectives and actions/initiatives (i.e., performance measures):

> Goal 1, Objective 1: Increase the percentage of consumers receiving economic stability and/or self-sufficiency services who achieve service outcomes by 5 percent by 09/30/2016.

This objective is followed by several performance measures pertaining to self-sufficiency services that also have quantified targets. It is not clear what the five percent goal in the objective actually refers to or what it measures.

This is true for several performance measures that are not clearly quantified either in terms of what is being measured or how it is being measured. Without these details, performance measures are ineffective tools for measuring progress and informing decision-making.

Strategic planning is a challenging task for any organization. However, there are many tools available to facilitate the process:

- The National State Auditors Association's *Practices in Performance Measurement in Government*[134] outlines the various components of a strategic plan, including the differentiation between mission statements, agency and program goals, objectives, action plans, and performance measures. It explains

how performance measures relate to such plans, how they should be developed, and the different types of performance measures (input, output, outcome, and efficiency).

- The Fairfax County *Manual for Performance Measures*[135] was first developed in 1999 as a tool for budget development. It is now in its 11th edition. The manual is a toolkit for Fairfax County Administrators that both explains performance measures and provides guidance on communicating goals, determining service areas, focusing objectives on outcomes, and developing indicators that provide useful feedback.

- The IBM Center for the Business of Government guidance document on performance measures provides useful insights on the design and alignment of performance indicators, and the use and communication of the performance information they generate. This document is particularly helpful as it reviews the complaints, criticisms, and obstacles frequently cited by staff during a performance measurement process and provides strategies for addressing them.[136]

Effective strategic plans not only establish clear goals, objectives, and performance measures, but they also align with organizational budgets. In contrast, the priorities identified in the HSD Strategic Business Plan do not seem to be reflected in the division's funding allocations. For example, the Health Care Services (HCS) section receives 34 percent of HSD's General Funds and the Children's Services Administration (CSA) receives 23 percent, even though the Strategic Business Plan contains no objectives or performance measures addressing health care, and only one addressing services provided by CSA (using performance-based practices in children's behavioral health).

There are, however, other service-related objectives and actions/initiatives that focus on housing and homelessness, adult behavioral health, addiction services, independent living, and employment. Either HCS and CSA are overfunded relative to their importance in meeting HSD's goals, or the Strategic Business Plan does not meaningfully capture and measure progress toward all of HSD's priorities. In either case, the Plan is not a useful tool for HSD decision-making, nor is it a useful source of information to inform the public about what HSD is attempting to achieve.

F6.7-2: Funding decisions within HSD are inconsistently tied to community needs and/or strategic plans.

HSD allocates the same amount of funding to each division and each program every year (with the exception of the reorganization in recent years). There is no mechanism in place to evaluate department-level funding decisions based on community needs. Rather, funding decisions are typically historically based. For example, the two largest contracts – those with the two hospital districts – are renewed each year with little negotiation.

As the Department's goals and objectives change, funding allocations should be reconsidered in light of the new goals and objectives.

Recommendations – Strategic Planning and Budgeting

R6.7-1: Develop a new HSD Strategic Plan that addresses all categories of service and includes relevant and clear performance measures.

Traditionally, strategic planning was undertaken only by top leaders in an organization. However, that thinking has changed. Increased participation not only helps include knowledge and insight from all levels and areas of the organization, but also helps build "buy in" or support for the plan. Additionally, as a government entity, HSD's strategic planning process needs to include input from outside the organization. Various advisory groups and boards should have input into goals and objectives that will be used to inform funding decisions.

R6.7-2: Base funding decisions on the new Strategic Plan.

HSD has a responsibility to ensure that its funding rationale is sound and its decision-making process is transparent. The current connection between funding and community needs varies within HSD. By using this needs assessment to inform the development of a new strategic plan – and then using that plan to inform resource allocations - HSD can take a more thoughtful approach to resource allocation and performance measurement.

Initially, and then at periodic intervals, the department should review overall resource allocations and determine which areas should be prioritized. Each program should have a coherent and reasoned methodology for making funding decisions during each budget cycle. Some – such as HIP and CSA – already have sound methodologies in place and simply need to ensure that consideration of the department's new Strategic Plan become

a part of that methodology. Other programs, particularly HCS, need to develop a methodology. With no advisory board to help guide decision-making, HCS' budgeting policies should rely heavily on the HSD's new Strategic Plan.

B. Evaluate Primary Care Allocation and Spending

Background – Primary Care

Chapter 154 of the Florida statutes requires counties to "offer primary care services through contracts" (Section 154.011), which may be through county health departments or other organizations and providers in the community. As indicated in numerous legal opinions over the last several years, no specific amount of funding is required for this purpose, nor is any relationship prescribed between the counties and hospital districts, which are organized through separate statutes.

Primary care services funded through HCS are provided primarily to five organizations in Broward County as shown in **Exhibit 6-7** below.

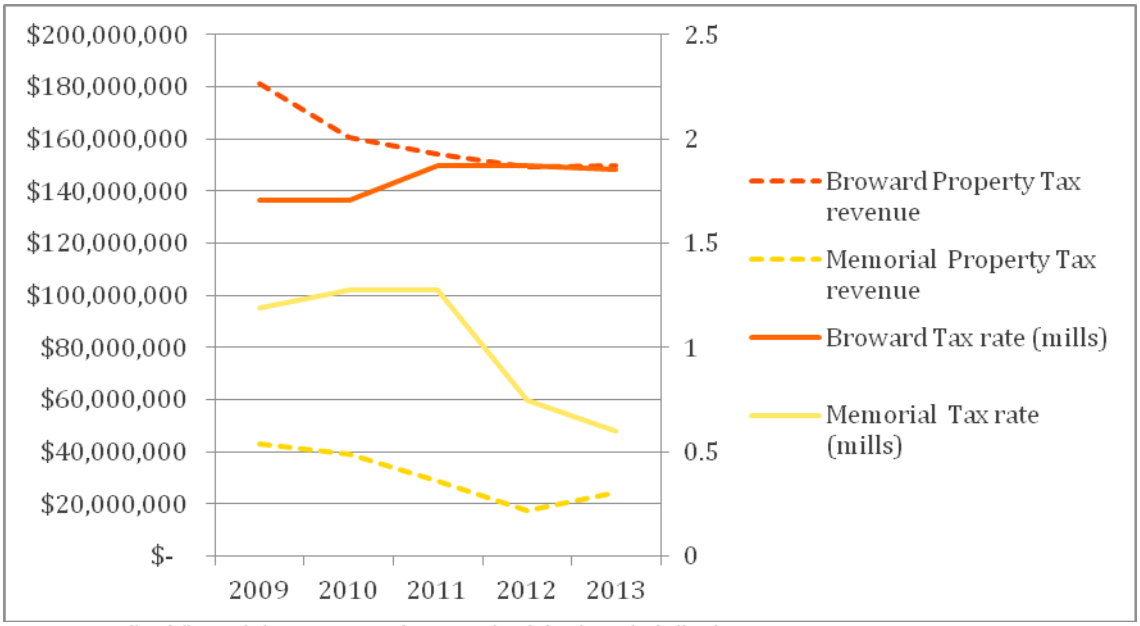
Exhibit 6-7: Organizations Receiving Funds for Primary Care

Entity	Description	HSD GF Funding FY 2013
North Broward Hospital District - Broward Health	Hospital district serving north part of the County. Operates six community clinics (excluding school-based clinics).	$8,495,420
South Broward Hospital District - Memorial	Hospital district serving part of the County. Operates five community clinics.	$7,128,803
FQHC - Broward Community and Family Health Centers, Inc.	FQHC with four community primary health care clinics.	$97,220 Provided by contract to the Florida Agency for Healthcare Administration (AHCA) on behalf of the FQHCs.
FQHC – Care Resources	FQHC with one community primary health care clinic.	
Broward County Health Department	Entity of Florida state government	$1.8 million (FY 2014)

HSD provided $15,624,223 in General Funds (GF) to the two hospital districts in FY 2013, representing 34 percent of the GF funding for contracts.

Both hospital districts are taxing districts and by state law may levy a property tax on residents of their district that may not exceed 2.5 mills. **Chart 6-2** below shows the millage rate and tax revenue generated by the hospital districts from 2009 to 2013.

Chart 6-2: Changes in Hospital District Taxing Rates



Source: Audited financial statements from each of the hospital districts.

HSD supports the two Federally Qualified Health Centers (FQHCs) in Broward County through a transfer of $97,220 in General Fund dollars to the Florida Agency for Healthcare Administration (AHCA). This funding is used to leverage additional federal funds through a Medicaid demonstration project (the Low Income Pool) approved by the federal government in 2006. In 2011, the federal government granted an extension of the program through 2013. The two FQHCs in Broward County received a combined payment from AHCA of $221,722 in FY 2013. The future of the program is uncertain.

FQHCs qualify for several financial benefits and incentives from the federal government, including enhanced reimbursement from Medicare and Medicaid and eligibility to purchase prescription and non-prescription medications at a reduced cost through the 340B Drug Pricing Program. In exchange, FQHCs are required to offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. Health centers must be open to all, regardless of their ability to pay.

FQHCs must provide primary care services to all age groups and preventive health services on-site or by arrangement with another provider. FQHCs must also provide directly or by arrangement with another provider:

- Dental services
- Mental health and substance abuse services
- Transportation services necessary for adequate patient care
- Hospital and specialty care citation[137]

There is a growing body of research that identifies the integration of primary care and behavioral care services as essential to achieving the goal of long-term stabilization and support. The mission of the FQHCs is to integrate these services. Few initiatives elsewhere in Broward County attempt to integrate physical and behavioral health care. Both hospital districts have begun to provide behavioral health services on-site in limited circumstances and Henderson Behavioral Health received a four-year federal grant to bring physical health services into their behavioral health services site. These initiatives co-locate services to allow consumers to receive both behavioral health and physical health services at the same location.

In addition to funding the two hospital districts and the two FQHCs, HSD funds the Broward County Health Department (a state entity); the funding allocation for FY 2014 is $1.8 million

Findings – Primary Care

The proportion of funding for primary care by HSD is out of sync with the needs identified in this assessment and with the HSD Strategic Business Plan. In addition, primary care services in Broward County are delivered by numerous providers with very different eligibility policies and various levels of services.

F6.7-3: One-third of the General Fund contracts in HSD are used to support two hospital taxing districts whose mission is to provide health care to indigent residents of the County. It is unclear why Broward County is providing General Fund revenue to two hospital districts each with the ability to generate tax revenue and with a stated mission to meet the needs of the indigent residents of their districts.

F6.7-4: Contracts with the hospital districts are not based on performance or outcomes and contract amounts have changed very little over the years. The current level of funding for the hospital districts was established in the 1990s and

adjusted only somewhat over time, most recently with a planned three percent increase for FY 2014.

F6.7-5: Support for the FQHCs results in a higher return on investment and is a more urgent need. As discussed above, there are several benefits available to FQHCs, such as enhanced reimbursement for Medicaid and Medicare revenue that provide a higher return for the County's investment. Also, FQHCs are not taxing entities and must rely on patient revenue and grants for their operation. Because the FQHCs in Broward County are not part of a larger health care organization, they have a greater challenge leveraging comprehensive services, such as specialty care for their clients. The uncertain future of the Medicaid Low Income Pool program may mean additional funding issues for the Broward County FQHCs in the near future.

F6.7-6: The amount of support provided to the local health department is also based on historic spending and the amount is not specified in statute. Support is not tied to particular public health services or programs.

F6.7-7. Very little integration of behavioral health care and primary care has been achieved in Broward County. Research shows that individuals with either mental health or substance abuse issues die decades earlier than those without these complicating conditions – primarily from preventable chronic diseases such as hypertension, diabetes, or cardiovascular disease.[138] Behavioral health conditions, such as depression or anxiety, have an impact on an individual's ability to cope with poor health conditions, especially chronic conditions. Conversely, poor physical health can lead to or exacerbate mental health conditions. Health outcomes are improved and treatment costs are reduced when both behavioral health and physical health needs are met.[139]

Models for the integration of primary care and behavioral health fall into three categories: financial, structural or clinical.[140] Financial integration consolidates payments for behavioral and primary care services, emphasizing the provision of both services on the same visit. Structural integration co-locates services and supports patients receiving both services in the same location. Clinical integration integrates services at the actual point of care.[141] Ultimately, the goal is to integrate care at the clinical level where consumers can access the full range of care needed to address both the physical and behavioral health conditions they face.[142] Not only do these models address the treatment of current conditions, they are able to focus on prevention to reduce the

possible escalation of problems regardless of the setting the consumer seeks out first.[143144]

Recommendations – Primary Care

R6.7-3: Reconsider the support to the hospital taxing districts and divert funds to the priorities identified in this report.

If the County chooses to continue to subsidize the two hospital taxing districts at any level, it should use the contract to leverage and standardize outcomes, such as reduced appointment wait times, clinic wait times, increases in services, and collaboration or coordination with other entities.

For example, both hospital districts track wait times for new appointments. At Memorial, new patients are seen within 1 to 110 days, with an average wait time of 56 days. At Broward Health, new patients are seen within 30 to 120 days, with an average wait time of 60 days. HSD could provide incentives and/or penalties to the hospital districts to improve wait times by tying funding to this performance measure.

R6.7-4: Prioritize funding for the FQHCs over the hospital districts since FQHCs are expected to see increased demand, are a good investment to draw additional federal funds, and have no ability to generate tax revenue.

FQHCs are eligible for enhanced reimbursement for the Medicaid services they provide, thus allowing greater leveraging of County funds. Additionally, FQHCs do not have the ability to generate tax revenue to support their operations. The County should also consider helping FQHCs expand their access to specialty providers.

R6.7-5: Use primary care funding to support the integration of primary health care and behavioral health care.

Some funding provided to the South Broward Hospital District and one of the FQHCs is targeted for behavioral health services provided on-site at primary care clinics. However, the efforts to integrate primary health and behavioral health care in Broward County are very limited in scope and constrained by logistical issues – simply having the space available to conduct the mental health interventions is a challenge. None of the current HSD initiatives address the financial integration that would allow a more flexible funding stream to provide the range of services needed.

6.8 Simplify the RFP Process and Make It More Strategic

Contract services are a significant portion of what HSD does; in fact, 51 percent of its total budget supports contracted services. As a major human services funder, HSD's Request for Proposal (RFP) process must be clear, encourage competition, and strategically leverage public funding. We found a consistent and fair RFP solicitation process that has evolved over time to be very thorough and methodical. However, the resulting RFP format and evaluation process is one that is burdensome for both staff and providers. This discourages some providers from seeking funding and restricts department flexibility in decision-making.

The following section examines the current RFP structure while the second section discusses proposal evaluation policies and methodology.

A. RFP Structure and Content

Background – RFP Structure and Content

During the HSD reorganization in 2009/2010, most contracting functions were consolidated into the newly created Community Partnerships Division (CPD). CPD now houses the majority of contracts for HSD (89 percent of the total dollar value) and has developed a standardized procurement process. When other divisions need to procure services, CPD often incorporates the procurement into a larger CPD RFP. While proposals for similar services are often consolidated, the contracts for the services are not.

The process to create a new contract takes approximately 7 to 8 months from start to finish. The RFP is very prescriptive in terms of the services being sought, often referencing the national human services taxonomy to define the types of services that may qualify.[145] Additionally, RFPs for children's behavioral health services require evidence-based practices be used and list which practices qualify. Applicants may propose evidence-based services other than those listed in the RFP (if submitted with supporting literature); however, staff reported no instances when this has happened.

The Special Projects Coordinator in CPD is responsible for contract solicitations and for assisting program staff in drafting RFPs. RFPs are issued for the total amount of funds available for each service sought. CPD attempts to issue one RFP per year, however, in 2013, CPD issued four RFPs for 12 categories of services.

The final RFP must be approved by a subject matter expert in the division, the Special Projects Coordinator, and the CPD Division Director before going to the HSD Department Director for final approval. When the RFP is published, it is posted on the HSD website and sent to 211 Broward which distributes it to a list of over 800 community providers.

For each RFP, CPD holds an applicant workshop to review the description of services, other contract requirements and bidder expectations. Potential applicants can ask questions at the workshop or submit questions in writing. Answers to any questions submitted on-line, or technical questions asked at the workshop, are posted on-line.

The four RFPs issued by CPD in 2013 ranged from 111 to 175 pages. The first three chapters of the RFPs provide information that is common to all HSD RFPs and average 25 pages in total length:

- Chapter 1 includes information about HSD, the applicable division(s), and the funding process.

- Chapter 2 includes information on the terms and type of agreement, required match policy, contact information, timeline, inquiry and submission guidelines, and an overview of the selection process.

- Chapter 3 provides information on policies related to proposals and agreements, including explanations of all the county-required attachments, the use of the AIRS taxonomy, the appeals process, and HSD policy encouraging provider collaboration.

The remaining chapters are used to describe the services for which the department is seeking bidders, typically with one chapter dedicated to each program or service type sought. Recent service chapters ranged from three to 25 pages each, although most were under ten pages.

The bulk of the RFP is made up of four or five appendices depending on the RFP:

- Appendix 1 contains requirements pertaining to the organizational capacity of the applicant. This appendix contains a multi-page application form with several text boxes and tables to be completed and multiple-choice questions to answer.

Appendix 1 also has 13 attachments, all required by the County (though not all attachments are required for every type of applicant).

- Appendix 2 contains requirements pertaining to the programmatic portion of the proposal. This appendix is longer, with another application form with more text boxes, tables, and multiple-choice questions to be completed. An additional four-page budget section and 5 to 11 pages of attachments require additional information on proposed program, staffing, and other requirements.

- Appendix 3 is made up of 24 pages of instructions on how to fill out the information required in Appendices 1 and 2.

- Appendix 4 includes the Proposal Rating Sheets (18 pages) that are used by raters to score the proposal (included as a reference for applicants).

- Appendix 5 contains the Request for Binding Arbitration (only required from applicants seeking funding from the Ryan White program).

Findings – RFP Structure and Content

F6.8-1: The current RFP process within HSD is centralized and thorough.

By consolidating most of the contracting functions into one division, HSD has established an efficient structure and one that enables the department to control RFP consistency and quality. The programmatic staff adds expertise in the types of services being sought in each RFP. Additionally, the standardized RFP template ensures the RFP process is uniform and consistent across program areas. RFPs contain all of the information an applicant would need to put together a successful proposal.

HSD's RFP solicitation and proposal review processes rightfully focus on several priorities: protecting the County's money; ensuring a clear understanding of the service being sought; garnering detailed information from applicants about their organization, proposals, and planned budget; eliminating loopholes; and preventing claims of bias or unfair treatment.

F6.8-2: HSD's standard RFP format is complex and burdensome for providers and staff. In particular, small providers are discouraged from seeking HSD funding because of the complexity of the RFP requirements.

The downside to HSD's effort to create such a thorough RFP process is that the end result is complex and burdensome for both HSD and prospective providers. The application, attachments, instructions, and scoring sheets are difficult to navigate, time-consuming to evaluate, and limit HSD's decision-making flexibility. The process does not focus enough on what should be the department's most basic priorities: funding services that provide clients with good outcomes at a good price.

One of the confusing features of the application is that the application form and attachments are split between two appendices – one addressing organizational capacity and the other addressing program and services detail and budget information. Even more complicating are the related instructions in a third appendix. The CPD divides the RFP this way so that organizational capacity materials can be evaluated first by administrative staff, with only those applications passing this step advancing to the second part of the evaluation. However, this distinction is not made clear in the RFP itself.

The instructions appendix is quite detailed. Unfortunately, these instructions often generate additional confusion as applicants navigate between the two applications they must complete, the attachments for those applications, and the third section with the instructions. And, if the confusing instructions are not followed precisely, applicants can be severely penalized. For example, each page submitted over the page limit results in a penalty even though page length limitations are only found in the instructions, not on the applications. Staff described a case where a qualified small applicant was effectively disqualified due to penalties incurred from exceeding the maximum page length.

Additionally, although the instructions are themselves lengthy, important information such as the County's required responsiveness criteria are not found in the instructions or the applications, but rather in an introductory chapter. Also, there is an assumption that in addition to reading the instructions and filling out the proposals and attachments, providers will read the scoring sheets to glean additional insight that will help them complete a good proposal. The result is cumbersome at best and certainly easily confusing.

The RFP document could easily overwhelm applicants given the detailed requirements, numerous attachments, extensive instructions, and organizational choices that are neither self-explanatory nor clearly explained. Providers, particularly new or small providers, could easily be confused by the RFP requirements and/or may not have the

administrative capacity to be responsive – despite an ability to provide good services at a good cost.

We heard from both providers and staff that many smaller providers simply do not have the administrative capacity to respond to an RFP of such complexity, and when smaller providers do respond, they are more likely to have fatal flaws that eliminate them from consideration.

The pool of applicants for HSD funding tends to remain stagnant from year to year. While 211 Broward has documented 800 providers in the community, the department has contracts with 81. Last year, CSA received only two new provider grant applications.

A dynamic community of providers increases client options and fuels competition that can drive improvements in service delivery. This can also help fill different provider niches in the community, expand geographic coverage and client access, and introduce more innovation.

Throughout this review, several providers and HSD staff expressed a desire to see HSD do more to increase participation to include a wider variety of providers. A small provider pool means that clients have fewer service options available, limiting their choices and perhaps preventing them from finding one that meets their particular need. It can also mean that they have to travel farther to access services. Additionally, a lack of competition can mean that contracts are renewed with providers with a poor performance history simply because there are no options.

Recommendations

R6.8-1: Improve RFP documents by simplifying instructions, requiring only the information essential to program evaluation, and automating the RFP process.

First, any requirements that are redundant should be eliminated. HSD should also consider changing the application from a form to a narrative format. Currently, the form requires multiple narrative attachments in addition to a multi-page form with many multiple-choice questions and answers in text boxes. To further simplify the requirements, the RFP could minimize what is required in the forms and ask for the remaining information in narrative sections addressing organizational capacity, budget, and services detail.

The general information section can be significantly streamlined and important instructions moved to an instructions section. The existing instruction section should largely be eliminated since it primarily consists of explanations for filling out the application forms. Such instructions should be simple enough to include on the forms themselves.

New instructions should also include fatal flaw requirements (including responsiveness requirements) and page limitations. Page limitations should also be indicated on the application forms. HSD should eliminate the bifurcation between the organizational capacity and program information; reviewers can easily focus only on the sections they consider and this will eliminate the need for applicants to navigate between multiple applications and attachment sections.

The RFP process now requires tracking numerous pieces of paper since hard copies must be submitted by providers. The hard copies are used by the administrative checker and raters to review and volunteer scores are hand entered into a spreadsheet where they are calculated into rankings (occasionally with computational errors). Reliance on paper copies is both cumbersome and resource intensive. The contracting process should be more automated from start to finish: proposals should be submitted and evaluated electronically, and information from proposals should be part of a database that is then used by contracting staff to administer and monitor contracts.

As part of this system, HSD should create an on-line database that allows providers to enter and update their organizational capacity information. Once the information is entered, providers could update it at any time, verify that it is up-to-date when they submit a proposal, and submit that portion of the application electronically. This type of system would reduce the need for providers to verify these items over and over again.

Another option that can make both proposal submission and review simpler is to create a prequalification process. Providers interested in contracting with the department would submit organizational and financial information as well as a list of the services for which they want to be prequalified. Applications that pass the review would then be put on a list of prequalified vendors that are eligible to apply for future RFPs in those areas. Prequalification lists can remain in effect for a specified amount of time, depending on County requirements.

R6.8-2: Work to expand the number of providers participating in the RFP process and create a streamlined RFP process for applicants seeking less than $100,000.

Two strategies that HSD can use to increase the number of providers participating in the RFP process are:

- **Encourage funding of multiple providers:** HSD funding allocations are inconsistent across programs. For example, last year the Ryan White program provided *some* funding to all qualified providers while HIP chose to fund only the largest program. The department should consider funding multiple, qualified programs or developing small or new business set-asides within RFPs in areas where more providers or more competition are needed.

- **Fund community-based, local programs:** To further build local provider capacity, HSD should allocate funding for local providers that understand the local culture. Many Broward County providers noted that services in certain areas (e.g., zip code 33311) produced few favorable outcomes. The providers attributed this to poor community interaction. A policy to intentionally grow very local programs could help address challenging issues in specific locations or with specific subpopulations.

For applicants seeking $100,000 or less, HSD should develop a streamlined application with fewer requirements to reduce the administrative burden of applying.

Currently, audited financial statements are required on all applications for $25,000 or more (applicants seeking smaller sums may submit specified IRS forms instead). Audited financial statements can cost an organization $5,000 or more, perhaps making this requirement overly burdensome for smaller providers. HSD should request that the County Commission increase the threshold for the audit requirement to $100,000 and allow alternate ways for a provider to establish financial solvency.

B. Proposal Evaluation

Background – Proposal Evaluation

Proposals are evaluated in a three-step process:

1. **Checklist and Organizational Review.** There are three elements in this portion of the review process, all of which are conducted by CPD administrative staff: Fatal Flaw Checklist, Responsiveness Review, and Organizational Review. Applicants are allowed to correct minor submission mistakes for things other than the Fatal Flaw Checklist and Responsiveness Review.

2. **Financial Review.** The financial review is conducted by staff with financial expertise, such as staff from HSD administration, the County Auditor's Office, or the County Accounting Office. Reviewers use a spreadsheet provided by HSD that is scored and added to the proposal's final score.

   Reviewers evaluate the financial statements and IRS Forms based on criteria such as current assets as a percentage of current liabilities, administrative expenses as a percentage of total expenses, and total grant funds as a percent of total revenue. Budget forms are also evaluated for clear, accurate calculations, the inclusion of other funding in the project, clear narratives, and unit costs consistent with the RFP. Proposals must achieve minimum scores on both facets of the financial review to continue in the evaluation process.

3. **Quality Review.** The quality review is conducted by volunteers from the community who are: experienced in the County's solicitation process; knowledgeable in the field of services being solicited; and free from conflict of interest. HSD solicits at least six volunteers for each type of service for which it is seeking proposals. Volunteers score all proposals that have made it through the process to this point. Proposals are evaluated on the following sixteen criteria:

- Program Narrative
- Target Population
- Participant Improvement Assessment Tool
- Participant Discharge Tool
- Participant Outreach
- List of Services
- Applicant Agency Experience
- Accreditation
- Location
- Time and frequency
- Cost Containment
- Staff
- Output Objectives
- Proposed Outcomes and Measures
- Previous Outcome Report
- Collaboration

Once volunteers have conducted preliminary ratings, applicants are brought in for a round of interviews. Upon completion of the interviews, volunteers finalize each proposal's quality score. CPD staff members then calculate a total score for each proposal and rank all of the proposals. The volunteers are given the rankings (not the scores) and asked to make funding recommendations. Although top-ranked proposals are not guaranteed funding, according to staff, funding almost always follows ranking. Depending on the number of qualified proposals and funding available, volunteers may

have the option to provide all the funding to one applicant or to divide it among multiple applicants.

Volunteers are given an orientation by CPD staff that highlights specific areas of interest and concerns for the RFP, such as geographic capacity. Each applicant is then allowed to make a three-minute verbal presentation followed by a ten-minute question and answer session. PowerPoint presentations and handouts related to the proposal are not permitted. Program staff are on hand to answer questions but are otherwise not allowed to participate in the discussion.

CPD staff then meet with the HSD Director to review recommendations. If CPD staff disagree with the volunteer recommendations, they may make a presentation to the HSD Director who can make adjustments to the volunteer recommendations; however, modifications have not been made in recent years. When the Director approves the recommendation, it goes to the appropriate board for approval (if applicable) before being sent to the County Commission for approval.

Findings – Proposal Evaluation

F6.8-3: The volunteer evaluation process is too informal, inefficient, and does not utilize staff expertise.

While it is laudable for HSD to involve the community in various ways, the current use of volunteers in the proposal evaluation process is not the appropriate place for such involvement. HSD would be better served by having its trained professional staff, including program directors, assess proposals and make funding recommendations to the HSD Director.

There are multiple issues with the current use of volunteers. The selection of volunteers is problematic since there is no volunteer list, nor criteria for selection of volunteers for recruitment or application process. Volunteers with subject-matter experience are recruited through staff contacts in the community. Recruitment is sometimes difficult because of the number of RFPs; therefore, HSD relies on the same group of people each year to make the funding recommendations.

The volunteers receive no substantive training to help standardize their evaluations and are provided only a high-level overview of funding and community needs. As a result, it is not clear that volunteers can provide standardized or well-informed proposal evaluations, nor that they have more objectivity than staff. Valuable staff time is

consumed on the process (finding volunteers, and organizing and running the interview process) rather than relying on staff expertise to evaluate proposals.

F6.8-4: The proposal scoring methodology is inflexible and does not sufficiently weigh the most relevant factors in scoring. Currently, there are eleven pages for scoring and three checklists. Some items are scored multiple times with only slight variations. For example, outcomes and outputs are scored in 11 items; services in six; referrals in five; and caseloads in four. The result is a rating system that is overly complex and time consuming; requiring raters to apply subtle nuances among all the ways services are reviewed.

Moreover, the scoring methodology only indirectly leads to a greater weight on services. Since contract oversight staff is not involved in proposal evaluation, they are unable to weigh-in on past performance. Past success in meeting performance measures is a very small part of the proposal evaluation process (worth only three points) when it should be a major factor in decision-making.

While RFPs state that funding will not necessarily go to the top-ranked applicant, it almost always does. Staff reports that the department often gets "locked into the scores" because the volunteers and boards want to focus only on the highest scored applicant. This presents a challenge when the HSD needs flexibility in awarding contracts – such as when providers are needed in a broader geographical area. Staff reported one case when the provider with the highest score was very close to an existing provider, while the second highest rated provider was located farther away and could provide extended geographic coverage. Despite the community need for and the funder's focus on expanded coverage, the volunteers wanted to go with the highest scoring provider, requiring significant work from staff to convince them otherwise.

F6.8-5: HSD does not use the RFP evaluation process to leverage improvements and outcomes in the delivery system.

HSD is a major funder in Broward County's human services community – providing 20 percent of the countywide human services funding identified in this report. However, the department is missing opportunities to use that funding strategically to drive positive changes in the provider community.

Recommendations

R6.8-3: Develop policies to rely on staff expertise, allow more flexibility in the RFP evaluation process and streamline the review by eliminating the use of volunteer evaluators, eliminating mandatory applicant interviews, and reducing the number of fatal flaws in the initial review.

Factors such as prior performance, meeting outcomes, extent of collaboration with other providers, provider's ability to leverage funding, and meeting geographic or other specialized community needs (such as serving underserved populations or providing multilingual services where they are not available) should be considered in the evaluation process. While these items are included in scoring now, they are not given sufficient weight.

In order to increase the weight of past performance in scoring, contract monitoring and oversight staff should assess applicants with past or existing departmental contracts Another way to increase the weight of past performance would be to tie it to eligibility. For example, the HSD could require providers to come within five percent of all past performance measures to be eligible to receive funding in the subsequent funding cycle.

HSD should take advantage of staff expertise in every aspect of the procurement process. While HSD's desire to involve the community is commendable, procurement is not an appropriate venue for that participation. Community volunteers can participate through the advisory boards, but once HSD determines the types of services to purchase and the amount of funding to be spent, professional staff should make the funding decisions.

The interview process is time-consuming for staff and providers and, with only 13 minutes allocated per proposal, it is unclear how much additional information or value is gained from the process. If staff are evaluating proposals and have questions, they could arrange interviews on an as-needed basis, as is standard practice in contracting for many government agencies.

It is in HSD's best interest to have as many qualified applicants as possible from which to choose. Therefore, the administrative Fatal Flaw Checklist should be shortened to contain only the most essential administrative requirements:

- The proposal was received by the due date and time.
- The applicant is eligible for funds.

- Confirmation that the agency does not owe any money to the County and is current with payments.

The other items now on the list – an audited financial statement and original signatures -- should be eliminated from the Fatal Flaw Checklist. These items should still be required, however, if omitted from the original submission, applicants should be allowed a designated time to submit them (as is the current policy for other missing items).

R6.8-4: Focus proposal scoring on outcomes and cost.

Scoring should be focused primarily on whether: 1) an applicant can provide good services; and 2) the cost is reasonable. If scoring is too complicated, these priorities can easily be lost. To focus on these priorities, several things that are now scored should either be made pass/fail or the scoring component should be adjusted. Program staff should examine the program scoring elements to determine which should be kept, modified or eliminated to focus on obtaining good services at a good cost.

R6.8-5: Use the RFP process to encourage interagency collaboration.

During this review, many providers and staff described their desire to see more provider collaboration. However, many noted that County funding mechanisms drive providers away from collaboration when different funders focus on different aspects of the human services community. When the County's human services funders define niches to prevent paying for a duplication of services, they perhaps miss opportunities to foster collaborations to address problems more broadly. HSD might consider partnering arrangements to develop joint funding RFPs with other funders.

Additionally, the current RFP only awards three points for collaboration and includes complicated requirements to demonstrate such collaboration. To better encourage collaboration, the department could develop specific RFPs or have set-asides exclusively for multi-agency applicants. Additionally, RFPs should make it easy to demonstrate collaboration and award more points for the inclusion of collaborators.

Applicants do not receive any feedback on their proposals. HSD should routinely provide feedback as a tool to help providers strengthen future applications. Additionally, examining proposal strengths and weaknesses can help the department assess its RFP process.

6.9 Strengthen Contract Design and Oversight

Contract design and oversight decisions can ensure that taxpayer dollars are being used appropriately and drive improvements in service delivery. This section examines the contract management processes within the Community Partnerships Division (CPD). CPD manages nearly all of HSD's contracts; the other divisions with contracts – BARC, EVSD, and FSAD – have their own policies, procedures, and staff for contract-related responsibilities.

This section first examines contract design and the use of performance measures to drive improvements in service delivery. The second section examines the staffing and technology needed for effective program oversight and recommended approaches for successful contract management.

A. Contract Design

Background – Contracts Design

CPD prepares contracts for approval by the County Commission. Contract Grant Administrators in each CPD section are responsible for developing contracts that are then reviewed by the HSD attorney and the County Attorney. County code allows contracts to span up to five years; HSD primarily writes one-year contracts with two years of possible extensions. The contracts themselves have three sections: Contracts, Work Authorizations, and the Provider Handbook.

The **Contracts Section** references the RFP and contains an abbreviated scope of work, references the relevant taxonomies, outcomes specific to the contract, and performance indicators (with targeted success rates) that track progress toward desired outcomes. The scope of work includes the services the vendor is committing to provide. In children's behavioral health contracts, providers are required to use the evidence-based practices listed in the RFP. In other areas, AIRS taxonomy definitions are used to describe the services provided and practices used.

The **Work Authorizations** and **Provider Handbook** sections were created to reduce the length of the contracts. Information in these sections can be changed by CPD without going through a formal contract revision; notices are sent to the provider list whenever changes are made. The Work Authorization section contains some program-specific information such as standards, definitions of units of service, and unique requirements for the contract. The Provider Handbook includes more general

information, such as overviews of the department, CPD contract administration, program information, and reports and forms.

Measuring and Reporting Performance. Performance indicators are often outlined in the RFP though they may be modified during contract negotiations. CPD reports that it is trying to standardize performance indicators for similar services, such as case management. Performance indicators in contracts are supposed to tie to the performance measures reported to the County budget office.

A great variety of performance measures are found in CSA contracts. HIP and HCS typically either provide measures (many of their contracts are federally-funded and have required indicators) or allow providers to suggest their own. CPD tries to ensure that contracts have some short-term performance measures, and if appropriate, medium- and long-terms measures as well. Due to the nature of some of the services, long-term measures may not be attainable during the life of the contract; CPD continues to investigate how to address this issue. CPD also reports moving away from prescribing performance measures and instead focusing on desired outcomes and allowing providers to decide how they will demonstrate progress.

Outcomes are often structured as a percentage of clients who show measurable improvement over a defined period. Providers are required to report quarterly progress on outcome measures, although some are difficult to measure in the short-term (such as the success of alcohol and drug counseling and social/emotional counseling). Recently, CPD adopted a policy that General Fund contracts will include a performance penalty: programs that fail to come within five percent of the target goal on performance measures will be assessed a three percent financial reduction on the accompanying invoice. Since this language was only added to contracts as of October 2013, the department does not have sufficient information yet to assess the effect of this policy.

Findings – Contract Design

F6.9-1: The contracting process is not used to drive improvements in provider performance. Performance-based contracting attempts to move contracting away from input and process design specifications (telling contractors *what to do*) in favor of output, quality and outcome-based performance specifications (telling contractors *what is expected*, and allowing them to decide how to meet the expectations).

While HSD's contracts contain performance measures, they have not been used to drive performance improvement. Funding is primarily based on outputs: providers are paid based on the number of clients served, hours billed, or tasks completed.

HSD has a federally-funded HIP contract that directly ties funding to performance goals and sets aside a portion of total funding to be paid when vendors meet all outcomes at the end of the year. Staff reports that this is the only contract in which providers consistently meet their performance objectives.

Providers and staff note that vendors who consistently provide poor services continue to get funded. Consumers participating in focus groups reported mixed feelings about the quality of services they obtained. HSD is heading in the right direction in its efforts to put more emphasis on performance in contracts, both through the inclusion of performance measures and now linking them to funding. However, there are aspects of contract development and oversight that should be modified to facilitate greater success in this area.

The current RFP format is very prescriptive in terms of the types of services being sought and the kinds of practices that must be used to qualify for funding. By defining the types of eligible services that contractors may use, HSD allows little opportunity for providers to try new or alternative services that might produce better outcomes or better meet the needs of clients.

Recommendation – Contract Design

R6.9-1: Increase use of performance-based contracting, including using incentives and penalties to improve outcomes and drive innovation.

Reforming HSD's contracting process will require policy and procedure changes as well as technical modifications to the current system. It will require the involvement of stakeholders with a vested interest in the changes, County Commission agreement on contracting modifications, and staff involvement to establish a process that can realistically be implemented.

High-performance contracts should contain both the right outcome measures and the right incentives/penalties to improve provider services. Despite the inclusion of performance measures in HSD contracts, until recently there have been no mechanisms in place to use the performance data to improve the quality of services.

A proven method to encourage providers to meet performance objectives is to link performance to funding. HSD's new policy to reduce General Fund contract payments by three percent if providers miss performance measures by five percent or more is one such proven mechanism. In another contract, the department has set aside five percent of total funding to be awarded to the provider only if *all* performance measures are met at the end of the year.

Reports from state and local human service agencies around the country, including the Colorado Department of Human Services[146] have found that performance-based contracts are successful in improving outcomes primarily because they allow providers to innovate. However, monitoring performance alone may not drive innovation: real innovation occurs when agencies define outcomes and allow contractors to suggest the practices they will use to meet those outcomes. When providers can decide how best to meet outcomes, they can offer a variety of solutions allowing the department to select the preferred solution at the best price. This practice would allow HSD to utilize the skills of providers in crafting good solutions to problems.

In addition to spurring innovation, allowing providers to offer more flexible services can also open the door for more competition as providers work to offer the best services and outcomes. Performance-based contracts may also encourage collaboration as providers with different strengths work together to achieve the department's objectives.

A shift to performance-based contracts does not have to happen all at once. HSD could pilot these strategies in one area to evaluate results and modify the approach as needed. It should be noted that performance-based contracts will require a different type of monitoring as contract managers will need to assess performance and respond appropriately.

B. Contract Oversight

Background – Contract Oversight

Contract oversight can be divided into three functional areas:

- **Financial Monitoring:** Reviews the financial health and practices of an organization. All providers are reviewed at least annually. When a contract is first signed, a risk assessment is conducted based on the agency's audited financial statements. New contracts and those deemed "higher risk" are assessed earlier in the year. Financial monitoring should be conducted by

administrative staff with fiscal training rather than staff with programmatic expertise.

- **Contract Grant Administration:** Involves all administrative oversight, including RFP and contract development; processing monthly invoices; answering questions about client and service eligibility; providing technical assistance to providers in meeting monitoring requirements; reviewing performance reports; tracking correction plans, if necessary; and providing day-to-day oversight. These responsibilities must be performed by staff with programmatic expertise and knowledge of the funding sources and contract details.

- **Field Monitoring:** Entails on-site inspections of each provider at least annually (depending on a risk assessment). Inspections include client file reviews, administrative field work, and a review of the adequacy of the program's physical location.

Prior to the 2010 consolidation of most contracting functions into the newly created CPD, financial monitoring and field monitoring staff were housed in the Program Development, Research and Evaluation Division (PDRED). Contract Grant Administrators resided within the program sections. With the creation of CPD, contracting oversight staff were consolidated into CPD. Now, CPD Contract Grant Administrators provide all aspects of oversight for the contracts in their "portfolio," and act as a liaison between providers and the department.

In recent years, CPD created a new Quality Assurance (QA) position for all General Fund contracts. This staff reviews quarterly reports, compiles performance measures for the County Budget Office, and reviews documentation and outcomes. The primary focus of the QA position is to determine the validity of vendor reports.

As noted earlier, contracts for similar services are not coordinated across HSD sections. For example, if both the Children's Services Administration and the Homeless Initiative Partnership decide to contract for behavioral health services, they may be included in the same RFP, however, each division would develop separate contracts, even if the same provider is selected.

HSD programs do work collaboratively on some aspects of program monitoring. If more than one section contracts with the same provider, one section will take the lead on

financial monitoring. Each section, however, conducts its own administrative and field monitoring (although site visits may be scheduled jointly and one report produced).

Findings – Contract Oversight

F6.9-2: Contracting functions are not fully consolidated within HSD. The department has made significant progress in consolidating its contracting work. CPD houses 89 percent of HSD's $44 million in General Fund contracts. However, there is still some consolidation left to be done. For example, CPD "houses" grants that are administered by other programs (such as a General Fund contract for FSAD to provide emergency food baskets to families waiting to receive food stamps). Additionally, CPD has some non-contracting responsibilities, such as the Childcare Licensing and Enforcement program (CCLE) and the Nancy J. Cotterman Center (NJCC).

F6.9-3: HSD has insufficient staffing and technological infrastructure for effective contract oversight. Contract administration and oversight are labor-intensive endeavors. Due to budget reductions and changes made during the most recent reorganization, HSD is currently unable to effectively perform these responsibilities. As discussed above, the three elements of contract oversight – financial monitoring, contract grant administration, and field monitoring – are currently assigned to a single Contract Grant Administrator (CGA) per contract. This change resulted in two problems: consolidation of responsibilities with one person when different expertise is needed and understaffing.

- CGAs lack the financial expertise to conduct rigorous financial monitoring. They generally are able to verify whether records are being kept, however, they cannot determine the adequacy of the information in the records.

- Financial and Field Monitors must possess a high level of objectivity in order to conduct professional assessments of providers. During this review, staff voiced concerns that CGAs' frequent interaction with providers on every level of operations can impede objectivity.

- CGAs are also responsible for reviewing and processing all provider invoices, corrective action plans, and quarterly reports, all of which must be reviewed within limited timeframes. It is difficult to maintain these responsibilities at a quality level when caseloads are high.

The distribution of CGAs and contract oversight staff is inconsistent among programs. The Ryan White and HIP programs (which are primarily federally funded) have relatively high contract staffing levels compared to CSA and HCS. CSA staff are responsible for twice the contract dollars compared to Ryan White staff, and four times the amount overseen by HCS staff.

HSD has an automated system in place to collect specific reporting and data from providers. However, HSD has not been successful in developing the system's full functionality. As a result, Contract Grant Administrators use a variety of systems to record and track data. The federally-funded programs have more robust systems due to federal requirements and financial support. The General Fund programs rely on Outlook, Excel, handwritten notes, and other systems which are burdensome and do not lend themselves to reliable long-term storage or data analysis. HSD has recently contracted for a major IT system upgrade; however, it is uncertain what level of contract management support will be included in the new system.

Finally, while the creation of the division's new QA position is a step in the right direction, quality assurance remains insufficiently staffed, with minimal time available to actually evaluate and analyze performance measurement data.

F6.9-4: Contract management is inefficient because it is organized by recipient or program, not by type of service.

When contract solicitation is not coordinated among programs or divisions, inefficiencies result in both contracting and service delivery. For example, Henderson Behavioral Health has more than ten separate HSD contracts (with CSA, HCS, and HIP) for over $7.5 million. These contracts provide case management, counseling, crisis intervention, supportive services, and emergency shelter to various categories of clients. Multiple contracts exist with smaller providers as well: The Salvation Army provides temporary and transitional housing through three contracts (totaling $951,000) with BARC and HIP, as well as another contract for $20,000 with FSAD to provide food baskets. Kids in Distress has three contracts with the department (totaling $425,000) to provide counseling, psychosocial evaluation and other supportive services for children with behavioral health issues and to provide parental visitation monitoring. The Poverello Center also has three contracts (totaling $278,000) to provide food assistance via contracts with the Ryan White Program and with Family Success Administration.

At a minimum, these largely redundant contracts represent contract procurement and management duplication. Furthermore, HSD may not have fully leveraged its funding position to negotiate additional services or volume cost efficiencies that could be realized due to economies of scale.

Recommendations – Contract Oversight

R6.9-2: Fully centralize contracting staff and adjust staffing levels and responsibilities to meet contract oversight demands.

Given the vast size and scope of HSD's contracts, administrative oversight and accountability must be a top priority. One important way to ensure such accountability is to maintain sufficient qualified contracting professional staff focused on the department's financial and programmatic goals. A benchmark for HSD contract staffing levels is seen in its Ryan White program. Federal guidelines for this program allow funding recipients to use up to five percent of awards for administration and another five percent for quality assurance. HSD's Ryan White program uses less than 10 percent of its funding on these contract oversight responsibilities and is considered a model for responsible contract management. The program has separate staff for financial monitoring, field monitoring, contract administration, and quality assurance.

HSD should provide sufficient contract oversight to ensure that public tax dollars are well-managed. Further, if HSD adopts performance-based contracting, strong oversight will be crucial to its success. Adequate staff will be required to track performance results, hold providers accountable, assess overall effectiveness, and adjust performance measures or contract structures to improve results.

R6.9-3: Establish a new Contracting Office and organize contract management around services.

A successful Contracting Office includes two distinct functions: contract administration and contract monitoring. Contract administration should consist of planning staff and CGAs for programs that are entirely contract-based (e.g., Children's Services; Health Care Services; HIP; and Ryan White). Contract monitoring should consist of financial and field monitors and quality assurance staff who work in collaboration with contract administration staff and staff in the direct service programs. This new Contracting Office would include staff now in CPD, however, without the direct services programs (CCLE and NJCC). The organizational positioning of this proposed new Contracting Office is shown in the organization chart in Section 6.10 below.

Finally, HSD's contracts (and the staff that oversee them) should be reorganized around services in order to consolidate contracts with providers and streamline contract administration and oversight. **Table 6-2** below illustrates how the FY 2014 contracting budget might be reorganized by service area compared to the existing contract distribution. The left column shows the current system of organization with funding typically aligned by population. On the right, contracts are reorganized to align funding by the type of service (using the seven service categories outlined in Chapter 4).

Table 6-2: HSD Contracting Budget Organized by Service Category

FY 2014 HSD Contracting Budget Organized by Service Category					
Existing Distribution of Contracts			**Distribution by Service Category**		
Health Care Services	$21.4	29%	**Health Care Services**	$29.4	39%
Homeless Initiative Partnership (HIP)	$16.8	22%	**Housing and Homeless**	$17.5	23%
Children's Services	$14.5	19%	**Children and Family Services**	$13.1	17%
Ryan White (HIV/AIDS) Services	$13.7	18%	**Other Ryan White Program Contracts**	$0.5	1%
Elderly and Veterans Services	$6.3	8%	**Elder Services**	$5.2	7%
Broward Addiction Recovery Center (BARC)	$1.8	2%	**Adult Behavioral Health and Addiction Services**	$8.2	11%
Family Success Administration	$0.4	1%	**Basic Needs**	$1.0	1%
Administration (Civil Citation)	$0.04	<1%	(funding included in Children and Family Services)		
Contracting Total	**$74.8**			**$74.8**	

Source: Current FY 2014 data on contracts was provided by HSD and CPD budget staff.

Superficially, the changes do not seem significant. However, as a result, HSD leaders can see that almost three-quarters of existing contracts are grouped in three large service areas – Health Care, Housing and Homeless, and Adult Behavioral Health and Addiction Services.

Some contract areas do not strictly follow the "service-focus" categorization. Two contract areas – Children and Family Services and Elder Services – are more specialized, with each having a unique group of providers. Due to this specialization, they remain organized by population instead of service. Note that we recommend changing the name of "Children's Services" to incorporate "Family Services" as many of the programs include or are provided exclusively to the families of children. Also note that the category "*Other Ryan White Program Contracts*" includes any Ryan White contracts that are not service-based (e.g., new software, support for the Broward County HIV Health Services Council, and a needs assessment).

By realigning contract work by service area, HSD should be able to reduce the total number of contracts it manages since multiple contracts with individual providers can be replaced by a single contract.

R6.9-4: Develop a fully automated database and contract management system.

Given that half of HSD's budget is distributed through contracts, the department should prioritize the development of an automated system that will make contract management more effective and efficient, and provide the department with data that will be useful in decision-making. Such a system should ensure data collection, storage, and analysis across the life of a contract. An automated system could improve the quality of service provided by HSD and reduce clerical work, freeing up personnel resources that could be spent on other priorities, such as analyzing performance data.

Ideally, an automated contract management system would house RFPs and contracts; enable electronic proposal submission and evaluation; use the data from RFPs and contracts to create a database that contract oversight staff can use for contract administration and monitoring; allow providers to submit invoices and performance data electronically; track contract amendments, corrective actions, and utilization; be searchable; and allow the department to run reports on any contract or provider. As discussed earlier, this system could also include a provider data warehouse where providers could maintain up-to-date organizational information needed when submitting RFPs.

This type of data management system is ambitious; however, there are examples of good human services contract management systems. For instance, Los Angeles County, California, recently won a National Association of Counties Achievement Award for its Contract Management System Business Model.[147] The model uses information

technology to manage and administer contracts and has enabled the city to standardize processes, reduce the time and effort required to complete contracts, make contracts virtually paperless, increase efficiency and accuracy, and maximize resources.

6.10 Continue and Expand the Positive Efforts in the HSD Reorganization

In conducting this community needs assessment, **Public Works** was charged with assessing the service delivery system and making recommendations to improve it. The most complex question to address when considering the optimal organizational structure for the delivery of human services is "What is and should be the role of the County Human Services Department in the planning, delivery and oversight of programs to address the wide range of human needs identified in the community?"

We believe the Broward County Human Services Department (HSD) is the sole entity that is concerned for *every* resident in the County, regardless of what "population" someone falls into for funding purposes, and should be the focal point of efforts to bring major funders together.

Discussion of specific services and gaps, contracting policy and procedures, access, and collaboration are detailed in previous sections of this report. Here we summarize the structural changes that will not only allow the department to better meet the current needs, but also position it for the future.

Background – HSD Organization

Recommendations discussed throughout this report that address organizational changes in HSD include:

- Establishing Single Stop Service Centers that expand the responsibilities of staff to assist individuals and families with the full range of benefit application and assistance and adds Veterans' Services to its mix of services.
- Consolidating phone lines to simplify access for individuals and families seeking information on services.
- Positioning HSD as the lead in county-wide collaboration efforts and providing the administrative support to institutionalize coordinating efforts.
- Consolidating contracting.
- Establishing a centralized billing function to ensure HSD is invoicing third-party payers for services wherever possible.

Following we discuss how these recommendations can be put in the context of the entire HSD organization.

Findings – HSD Organization

HSD undertook a significant reorganization in 2010 based on recommendations from a consultant report published in 2008. One of the major changes resulted in the consolidation of several administrative functions, most notably, centralizing evaluation and planning and most (but not all) contracting. The following observations build on the positive changes made in 2010, our analysis of the current HSD structure, and stakeholder and consumer input from the numerous interviews conducted.

F6.10-1: Some direct services currently report directly to the Community Partnerships Division (CPD) Division Director (such as NJCC) while BARC reports directly to the HSD Director; some contracting and monitoring responsibilities are within service divisions rather than CPD. This split in common functions hinders HSD's ability to fully integrate services around services such as: prevention, early intervention, and on-going support services to address complex needs – a comment made by managers, staff and providers. During this study we found areas where some adjustment to the HSD structure could be made to support these concepts.

F6.10-2: Divisions in HSD remain in silos based on target populations. This raises concerns about duplication of services and difficulty in addressing "whole" person or multiple family issues through successful long-term and wrap-around strategies. The mix of direct and contracted services in some divisions requires managers and staff to split their focus between service delivery and contract management.

HSD is organized primarily around populations – children, families, elderly, veterans, homeless, and adults with substance abuse problems. While this provides a structure and forum for advocacy and services for each population, it contributes to a more complex system to address the full range of consumer needs and is prone to overlap and duplication.

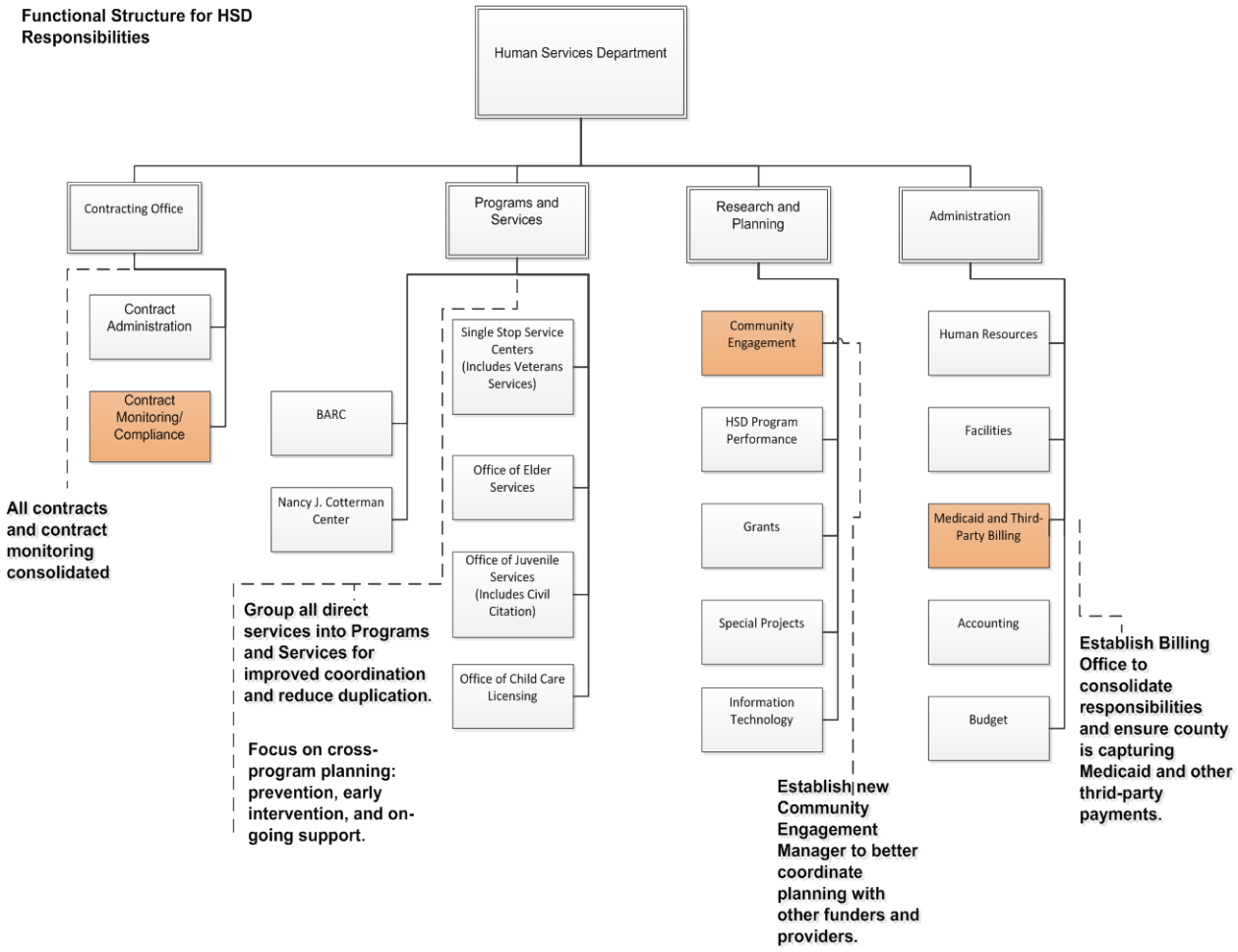
Partly a function of location, but also a result of staff providing similar services based solely on population, we heard of instances where a continuum of services could not be provided without an individual or family having to travel to another location. The silos that now exist will make it difficult for the department to address the recommendations in this report that deal with reducing duplication, increasing collaboration, improving the continuum of care services offered, and improving the quality of services.

Recommendations – HSD Organization

The Broward County Human Services Department needs a structure to support the future direction of the department and that addresses the changes in how human services are delivered in the County. As discussed throughout this report, there is a need for more collaboration, renewed County leadership to coordinate funders, improved access to services, and reduction in the silos that now separate services based on targeted populations rather than service needs. Additionally, changes need to be made to strengthen the administrative structure to ensure HSD has a contracting process that is responsive as well as protective of public funds. The department also must be organized to ensure the County is the payer of last resort.

Exhibit 6-8 depicts the recommended functional groupings for HSD responsibilities.

Exhibit 6-8: HSD Functional Responsibilities Grouped Together



7. NEXT STEPS

As a comprehensive needs assessment, this report provides the foundation to begin an organized strategic planning process – one that is inclusive and wide-ranging – and that will provide the detail required for the Human Services Department (HSD) to make decisions on services, organizational structure and delivery system changes that will position it for the future.

This report discusses eight categories of need that are identified as priority areas that should be addressed so that the Broward County human services system better meets the needs of the community. This report also includes multiple recommendations for both short- and long-term improvement in services and the delivery system.

To take full advantage of this initial effort, it will be important for HSD to develop a detailed strategic plan with specific objectives, tasks, responsibilities, and timeline for completion. As in any successful strategic plan, the process for developing it must be inclusive – involving those who must implement the plan. It also must be done at a level of detail that considers all aspects of the changes needed: moving funds to services of higher need, taking an honest look at duplication and overlap of services that may result in changes in funding, reorganizing staff and responsibilities in a way that is respectful of their dedication and builds on their strengths, improving the RFP and contracting procedures that ensure HSD is getting the best thinking and services at the most reasonable price, and engaging key stakeholders and the community to change some processes that have been in place for many years in exchange for a new approach that meets today's requirements.

This type of comprehensive strategic planning process will take a commitment of resources in order to position HSD for the changes that are taking place now, as well as for the future.

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APPENDIX A

Stakeholder Meetings Master List

COUNTY GOVERNMENT

Human Services Department (meeting plus follow-up site visits)
- Family Success Administration
- Community Partnerships
- Elderly & Veterans Services
- Broward Addiction Recovery Center (BARC)
- Office of Evaluation and Planning
- Civil Citation Program

Community Action Agency
- Advisory Board Meeting

Children's Services Advisory Board
- Advisory Board Meeting
- Strategic Planning Committee

BARC Advisory Board

Homeless Initiative Partnership Board

County Commissioner
- Commissioner Wexler

County Administration
- Rob Hernandez
- Gretchen Hirt

Adult and Juvenile Justice
- Judge Elijah Williams
- Judge Michael Orlando
- State's Attorney
- Gordon Weekes, Public Defender
- Judge Ginger Lerner-Wren

Drug Court
- Judge Giselle Pollack

Mental Health Court
- Judge Mark Speiser

Broward Sheriff's Office
- Bob Pusins
- David Scharff and managers
- Scott Russell and managers

COMMUNITY STAKEHOLDERS

Broward Behavioral Health Coalition
Silvia Quintana
Norma Wagner
Board Retreat

Children's Services Council
Sue Gallagher and chairs of Strategic Plan Committees

Henderson Behavioral Health
Shari Thomas
Pam Galan
Steven Ronik

ChildNet
Monica King
Joel Smith

211 Broward
Sheila Smith

Aging & Disability Resource Center
Edith Lederberg

Early Learning Coalition
Chuck Hood

Broward Planning Council
Barbara Blake Boy

United Way
Howard Bakalar

Broward County School District
Rosemary Russo
Joaquin Eljuaua

Hispanic Unity
Josie Bacallao
Felipe Pinzon

HEALTH CARE PROVIDERS

Hospital District (South)
Melida Akiti, including approximately 8 managers/staff

Hospital District (North)
Jasmin Shirley
Scott DiMarzo, Clinic Operation

Care Resources (FQHC)
Rick Siclari

Broward Community & Family Health Center (FQHC)
Rosalyn Frazier

Broward Regional Health Planning Council, Inc.
Mike De Lucca

STATE AGENCIES

South Florida State Hospital
Larry Davis

Workforce One
Mason Jackson

DOH
Dr. Paula Thaqi

Department of Children & Families
Patricia Kramer
Kim Gorsuch

CITIES

Meeting with City Representatives
Roslynne Powell, Pompano Beach Housing
Vickki Placide, Coral Springs Housing
Yvonne Berrios, Coral Springs Police Department
Mario DeSantis, HOPWA, Ft. Lauderdale

Broward County Human Services Provider Survey

The Broward County Human Services Department and its contractor, Public Works, are conducting a comprehensive needs assessment. As part of the needs assessment, we are surveying Broward County service providers. The survey addresses populations served, services provided, financial resources, collaborations/ partnerships with other organizations, and the impact of the Affordable Care Act.

The survey is confidential. The information you provide will be analyzed and reported in aggregate format only. If you are not a service provider, please answer questions that apply; if you think someone in your organization should be completing the survey, but they did not receive this invitation, please forward it to them so that they can respond. If you completed the survey at the Providers' Town Meeting held on January 15, 2014, there is no need to complete it again.

We encourage you to complete the questionnaire. The more service providers that respond to the survey, the more complete a picture we will have about the services available in Broward County, the populations served, gaps in services, duplication of services, and unmet needs.

Please respond by February 21, 2014.

Broward County Human Services Provider Survey

***1. What is the name of your organization or program?**

***2. What is your position or title?**

3. In what year was your organization or program established?

Year established:

Broward County Human Services Provider Survey

4. What population(s) does your organization/program serve? (choose all that apply)

- [ ] Infants and children
- [ ] Adolescents and youth
- [ ] Adult men
- [ ] Adult women
- [ ] Elderly
- [ ] Veterans
- [ ] Homeless

Other (please specify)

5. Who determines client eligibility for services? (choose all that apply)

- [ ] We determine eligibility for all our clients
- [ ] We determine eligibility for some of our clients (specify category of clients below)
- [ ] Another organization/agency determines eligibility for all our clients (specify organization or agency below)
- [ ] Another organization/agency determines eligibility for some of our clients (specify organization or agency below)

Additional information:

Broward County Human Services Provider Survey

6. What type of service(s) does your organization/program provide? (Please choose all that apply)

- [ ] Addiction recovery
- [ ] Alcohol and drug abuse prevention
- [ ] Assisted living services
- [ ] Childcare/subsidized childcare
- [ ] Childhood shots and immunizations
- [ ] Criminal justice
- [ ] Healthcare
- [ ] Mental health services
- [ ] Integrated behavioral health services
- [ ] Dental care
- [ ] Housing
- [ ] Service planning and case management
- [ ] Homeless assistance
- [ ] Services for the elderly
- [ ] Veterans' assistance
- [ ] Domestic violence prevention
- [ ] Mortgage, rent assistance
- [ ] Energy assistance
- [ ] Cash assistance
- [ ] Nutrition programs
- [ ] STD prevention and treatment

Other (please specify)

7. How many clients does your organization/program currently serve per year?

- ◯ 50 or fewer
- ◯ 51 to 100
- ◯ 101 to 200
- ◯ 201 to 300
- ◯ 301 to 400
- ◯ 401 to 500
- ◯ More than 500
- ◯ Don't know/Not sure

Additional information:

8. In the past three years, has the number of clients you serve:

- ◯ Increased
- ◯ Stayed the same
- ◯ Decreased

Additional information:

9. Did you have wait lists for services for the last fiscal/calendar year?

- ◯ Yes
- ◯ No

10. How many people total did you have on wait lists for services for the last fiscal/calendar year? (Please do not use commas in your answer)

People on wait lists:

11. How many people did you have on wait lists for the last fiscal/calendar year for each service your organization/program provides? (Please enter a number for each service you provide; do not use commas)

Addiction recovery	
Alcohol and drug abuse prevention	
Assisted living services	
Childcare/subsidized childcare	
Childhood shots and immunizations	
Criminal justice	
Healthcare	
Mental health services	
Integrated behavioral health services	
Dental care	
Housing	
Service planning and case management	
Homeless assistance	
Services for the elderly	
Veterans' assistance	
Domestic violence prevention	
Mortgage/rent assistance	
Energy assistance	
Cash assistance	
Nutrition programs	
STD prevention and treatment	
Other	

12. If you filled in a value for "Other" in the question above, please provide a description below; otherwise, please skip to the next question.

13. Have the types of services your organization/program provides changed in the past three years?

- ◯ Yes
- ◯ No

14. How have your services changed? (Please choose all that apply and describe)

Expanded services to new categories of clients (please identify new categories of clients):

Added services such as (please describe briefly):

Stopped providing services such as (please specify services):

Changed services (please explain reason):

Other (please specify):

15. Think of the population(s) you serve, are there any gaps in services they need?

- ◯ Yes
- ◯ No

16. Briefly describe the services they need that are not available.

17. What barriers or difficulties has your organization/program experienced in providing services to your clients? (Please select all that apply)

- [ ] Reduced funding
- [ ] Eliminated funding
- [ ] Increased competition for services
- [ ] Language barriers
- [ ] Inadequate client commitment
- [ ] Lack of transportation
- [ ] Lack of or low awareness of our program

Other (please specify)

18. How many employees does your organization/program have currently? (please do not use commas in your answer)

Number of employees:

19. How many of the following categories of professional staff does your organization/program have? (Please choose all that apply)

Social workers

Therapists (physical, occupational, speech, etc.)

Psychologists

Nurses

Psychiatrists

Physicians

Home health workers

Other

20. If you filled in a value for "Other" in the question above, please describe below; otherwise, please skip to the next question.

21. What is your organization's annual budget in 2013-14? Please enter the figure without using commas.

2013-2014 Budget:

22. About what percentage of your budget comes from each of these sources? Please specify the percentage for each source but do not enter the percentage sign ("%").

Federal

State

Broward County Human Services Department

Private Foundation(s)

Donations

Client fees or co-pays

Other

23. If you filled in a value for "Other" in the question above, please describe below; otherwise, please skip to the next question.

24. In the past three years did your organization's/program's budget: (please select one only)

- ◯ Increase
- ◯ Stay the same
- ◯ Decrease

25. Does your organization/program collaborate or have any formal partnerships with other organizations or programs?

- ◯ Yes
- ◯ No

26. With how many and what other organizations do you collaborate or partner? (please select all that apply and specify number)

Hospital(s)	
Clinic(s)	
HMO(s)	
Nursing home(s)	
Residential facility/facilities	
School(s)	
Childcare center(s)	
Sheriff's office	
Other	

27. If you filled in a value for "Other" in the question above, please describe below; otherwise, please skip to the next question.

Broward County Human Services Provider Survey

Think of the top 3 organizations with which you are collaborating. Please answer the following questions about your top collaborating organization; you will be able to provide the same information about your other top collaborators (if applicable) on the next two pages. If you have fewer than three collaborators, you will be able to move to the next section after answering questions about the first and/or second collaborators.

28. What is the name of the organization with which you collaborate or partner?

29. For how many years have you been collaborating or partnering?

Years:

30. Will you continue collaborating / partnering in 2014-15?

- ◯ Yes
- ◯ No

31. What is the primary reason you collaborate with this organization?

- ◯ It allows my organization to serve more clients
- ◯ It allows my organization to give our clients access to a wider range of services
- ◯ The services the other organization provides extend or add to the services we provide
- ◯ It gives my organization/program another funding source / increased funds
- ◯ To impact public policy
- ◯ To pursue funding jointly

Other (please specify)

32. What is the biggest challenge with this collaboration?

- ◯ Definitions of service are not compatible
- ◯ Level of commitment for services is not adequate
- ◯ Intake requirements are cumbersome
- ◯ Requirements to receive services are too restrictive
- ◯ Clients are required to pay for services
- ◯ Inability to share information to refer and/or track progress

Other (please specify)

33. Are there other organizations / programs with which you collaborate?

- ◯ Yes
- ◯ No

34. What is the name of organization with which you collaborate or partner?

35. For how many years have you been collaborating or partnering?

36. Will you continue collaborating / partnering in 2014-15?

- ◯ Yes
- ◯ No

37. What is the primary reason you collaborate with this organization?

- ◯ It allows my organization to serve more clients
- ◯ It allows my organization to give our clients access to a wider range of services
- ◯ The services the other organization provides extend or add to the services we provide
- ◯ It gives my organization/program another funding source / increased funds
- ◯ To impact public policy
- ◯ To pursue funding jointly

Other (please specify)

38. What is the biggest challenge with this collaboration?

- ◯ Definitions of service are not compatible
- ◯ Level of commitment for services is not adequate
- ◯ Intake requirements are cumbersome
- ◯ Requirements to receive services are too restrictive
- ◯ Clients are required to pay for services
- ◯ Inability to share information to refer and/or track progress

Other (please specify)

39. Are there other organizations with which you collaborate?

- ◯ Yes
- ◯ No

40. What is the name of organization with which you collaborate or partner?

41. For how many years have you been collaborating or partnering?

42. Will you continue collaborating / partnering in 2014-15?

- ◯ Yes
- ◯ No

43. What is the primary reason you collaborate with this organization?

- ◯ It allows my organization to serve more clients
- ◯ It allows my organization to give our clients access to a wider range of services
- ◯ The services the other organization provides extend or add to the services we provide
- ◯ It gives my organization/program another funding source / increased funds
- ◯ To impact public policy
- ◯ To pursue funding jointly

Other (please specify)

44. What is the biggest challenge with this collaboration?

- ◯ Definitions of service are not compatible
- ◯ Level of commitment for services is not adequate
- ◯ Intake requirements are cumbersome
- ◯ Requirements to receive services are too restrictive
- ◯ Clients are required to pay for services
- ◯ Inability to share information to refer and/or track progress

Other (please specify)

45. Is there other information we should know about the types of collaboration in which your organization/program is engaged, or obstacles to collaboration that exist in the human services community?

46. Is there any duplication of health and human services in Broward County? (please choose one only)

- ◯ Yes, to a great extent
- ◯ Yes, to some extent
- ◯ Very little
- ◯ Not at all

47. Briefly describe the areas where there is great or some service duplication.

48. What are the greatest challenges that your organization/program is facing currently? (please describe briefly)

49. What impact do you expect the Affordable Care Act (ACA) to have on the following aspects of your organization/program: (please respond for each)

	Increase Significantly	Increase Moderately	Stay the Same	Decrease Moderately	Decrease Significantly
Number of clients	◯	◯	◯	◯	◯
Funding sources	◯	◯	◯	◯	◯
Amount of funds	◯	◯	◯	◯	◯
Services offered	◯	◯	◯	◯	◯
Collaboration/Partnership with other organizations	◯	◯	◯	◯	◯

50. In the areas where you expect the Affordable Care Act to have a significant impact, briefly describe the impact it may have.

51. What changes do you expect in the population you serve in the next five years? (please describe briefly)

52. How do you expect your services to change in the next five year? (please describe briefly)

53. Is there anything else you would like us to know about the current environment in which you provide services?

Broward County Human Services Provider Survey

Thank you for completing this questionnaire. The Broward County Human Services Department values your input which will contribute to the success of the comprehensive needs assessment. Questions about this survey can be directed to Ester Smith of Public Works, at egs@prismnet.com.

Appendix C

BROWARD COUNTY PROVIDER SURVEY REPORT

1. Executive Summary

This report presents the results of an Internet-based survey (e-survey) of Broward County providers conducted by **Public Works** as part of the comprehensive health and human services needs assessment for the Broward County Human Services Department (HSD).

The 133 service providers who responded to the survey represent the range and diversity of services available to Broward County residents. Providers vary greatly in number of employees, financial resources, range and type of services, and number of clients they serve. Providers rely on multiple funding sources. About 37 percent of providers get funds from the Broward County Human Services Department. Providers have experienced changes in their financial resources in the past three years with 19.5 percent having their budget decrease and 31.6 percent having budget increases. However, 63.2 percent saw an increase in the number and categories of clients they serve. Nearly 60 percent of providers either added services or expanded services to new categories of clients, while about 30 percent stopped services and about one-quarter changed the services they offer. About two-thirds of providers collaborate or partner with a variety of organizations in order to serve more clients and give their clients access to a wider range of services.

Nearly 40 percent of providers have wait lists. Providers with wait lists tend to provide more services than providers with no wait lists, more of them had an increase or no change in the number of clients they serve, and more faced reduced budgets in the past three years. Indeed, in light of increased demand and community needs, the primary challenge providers face is lack of or inadequate funding.

Nearly three-quarters of the providers see gaps in the services their clients need. The most common service gaps are in the area of affordable housing and access to transportation. Nearly one-quarter of the providers find duplication of services.

Providers vary in their expectations of the impact that the Affordable Care Act will have on their organizations. Between 6.1 and 16.5 percent expect significant or moderate

increases and between 2.3 and 11.3 percent expect moderate or significant decreases in the number of clients, funding levels, services, and collaboration with other organizations.

2. Methodology

Public Works developed a list of Broward County service provider organizations/agencies from the resource list used by Broward 211 and supplemented with key stakeholders and community partners identified by each division of the HSD. The list consisted of publicly and privately funded organizations, as well as those that operate with a combination of funds. It included: community providers; Advisory Board members related to various functions within HSD; major funding sources such as the Broward Behavioral Health Coalition, the Children's Services Council, ChildNet, United Way; foundations and associations that may provide funding for health or human services directly to non-profit agencies; hospital districts and other health care centers; county organizations such as the Broward Sheriff's Office, the School Board, adult and juvenile court systems; and state offices, such as the Florida Department of Health, Florida Department of Juvenile Justice, Florida Department of Children and Family Services, and any other state office that provides services directly or funds services in the community. The resulting list had 363 e-mail addresses.

The questionnaire used in the e-survey was designed to solicit information on provider organizations, the services they provide, and the populations they serve, provider staffing and financial resources and source of funds, insights into and opinions about gaps in services, duplication of services, the changing environment, and challenges facing funders and providers of services. The questionnaire was distributed to providers who participated in a January 15, 2014 meeting and completed by 15 service providers who attended the meeting. The e-survey was conducted during February 2014. A total of 133 Broward County providers completed the survey representing 36.7 percent of the providers included in the survey.

3. Service Provider Organizations' Background

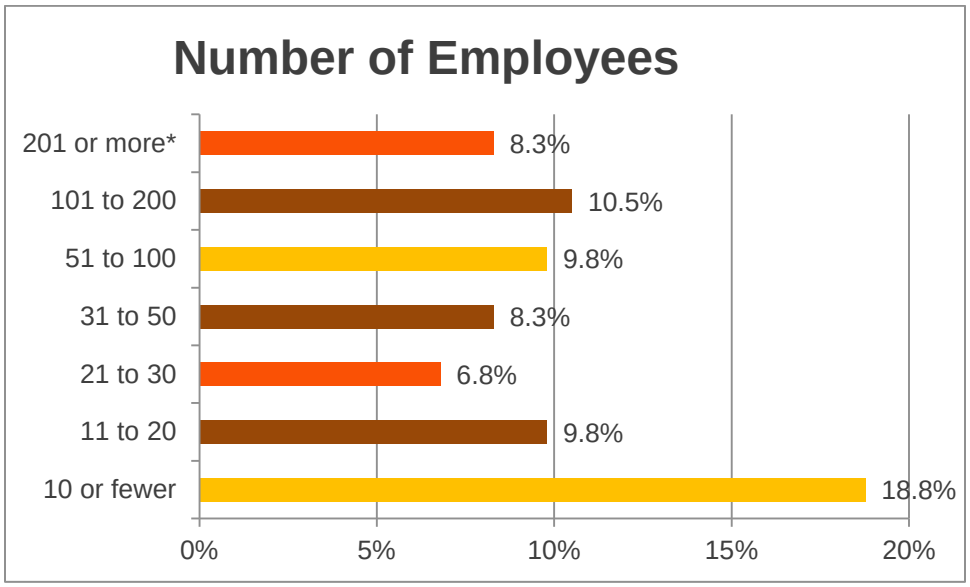
The longevity of service provider organizations that responded to the survey varies greatly. Of the 126 providers that identified the year their organization was established, more than 35 percent were established in 2000 or later; 30.8 percent were established in the 1990s; 8.3 percent were established in the 1980s; 12.0 percent were established in the 1970s; and 9.0 percent were established in 1950 or earlier.

Service providers also range widely in the number of employees (Exhibit 1). Data on number of employees was provided by 98 (73.7 percent) of the responding organizations. The median number of employees providers have is 30.

Exhibit 1: Number of Employees

	Number (N=133)	Percent
10 or fewer	25	18.8%
11 to 20	13	9.8%
21 to 30	9	6.8%
31 to 50	11	8.3%
51 to 100	13	9.8%
101 to 200	14	10.5%
201 or more*	11	8.3%
No answer	37	27.8%

**Some of the providers are statewide organizations and provided data on their total number of employees in the state rather than on the employees they have in Broward County.*



Service providers employ different categories of professionals, as shown in Exhibit 2. Most frequently, 41.4 percent of service providers employ social workers.

Exhibit 2: Median Number of Employees by Category

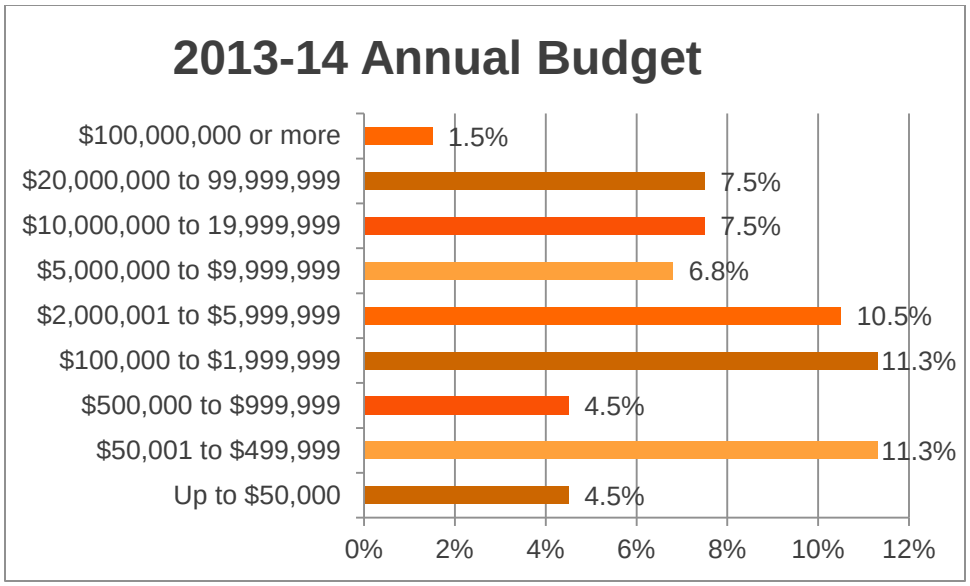
	Number	Median Number of Employees
Social workers	55	5
Therapists (physical, occupational, speech)	27	4
Psychologists	15	2
Nurses	29	2.5
Psychiatrists	19	1
Physicians	17	5
Home health workers	8	2
Other	61	10

4. Budget and Funding Sources

Providers' annual budget for 2013-14 varies greatly (Exhibit 3). The 2013-14 annual budgets that 87 (65.4 percent) of the providers specified ranged from less than $50,000 to more than $100 million.

Exhibit 3: 2013-14 Annual Budget

	Number (N=133)	Percent
Up to $50,000	6	4.5%
$50,001 to $499,999	15	11.3%
$500,000 to $999,999	6	4.5%
$100,000 to $1,999,999	15	11.3%
$2,000,001 to $5,999,999	14	10.5%
$5,000,000 to $9,999,999	9	6.8%
$10,000,000 to 19,999,999	10	7.5%
$20,000,000 to 99,999,999	10	7.5%
$100,000,000 or more	2	1.5%
No answer	46	34.6%



Between 46 (34.6 percent) and 57 (42.9 percent) providers use multiple funding sources (Exhibit 4). The largest source of funds is the state; 48.9 percent of providers receive state funds, accounting for an average of 36 percent of these providers' funds. About 37 percent of the providers receive funds from the Broward County Human Services Department. On average, these funds account for 12 percent of their budgets.

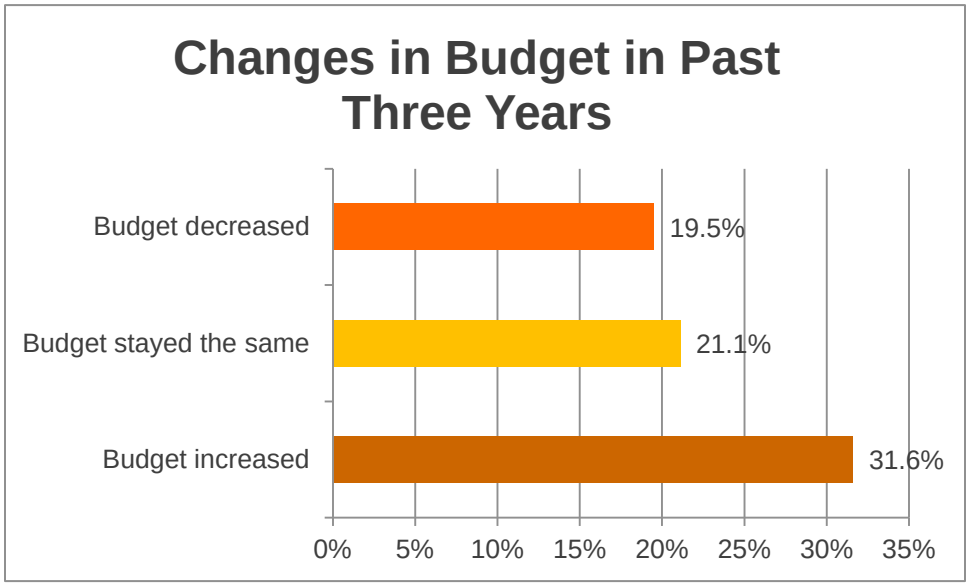
Exhibit 4: Budget Sources

	Number of Provider Organizations	Range	Average Percentage
Federal	55	0 to 90%	22%
State	65	0 to 100%	36%
Broward County Human Services Department	49	0 to 100%	12%
Private foundation(s)	50	0 to 100%	14%
Donations	57	0 to 95%	20%
Client fees or co-pays	46	0 to 99%	12%
Other	54	0 to 100%	35%

Nearly one-third of the providers experienced budget increases over the past three years, 21.1 percent of the organizations did not experience any budget changes, and 19.5 percent had their budget decrease (Exhibit 5).

Exhibit 5: Changes in Budget in Past Three Years

	Number (N=133)	Percent
Budget increased	42	31.6%
Budget stayed the same	28	21.1%
Budget decreased	26	19.5%
No answer	37	27.8%

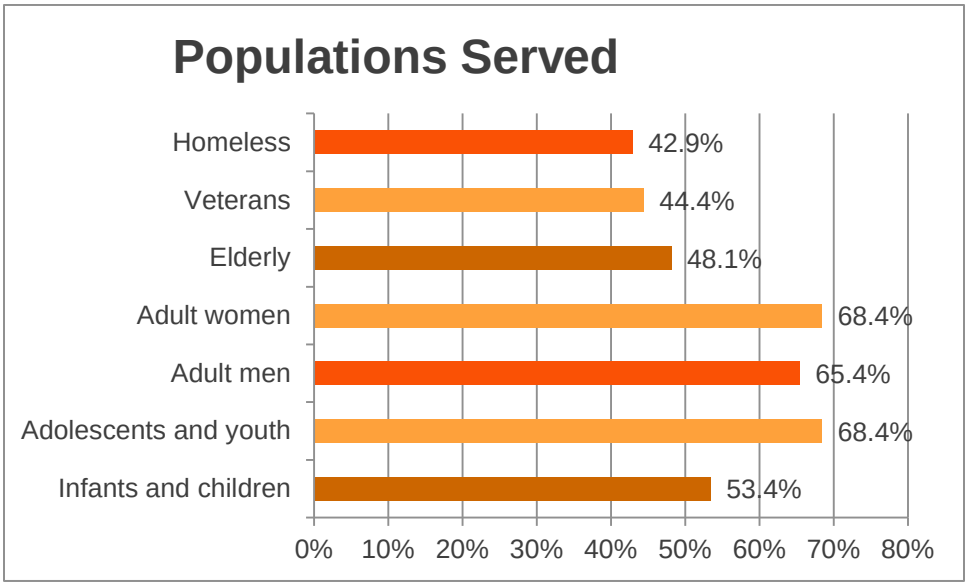


5. Populations Served

Providers serve a wide range of populations, as shown in Exhibit 6. Most frequently, they serve adolescents and youth, adult women, and adult men.

Exhibit 6: Populations Served

	Number (N=133)	Percent
Infants and children	71	53.4%
Adolescents and youth	91	68.4%
Adult men	87	65.4%
Adult women	91	68.4%
Elderly	64	48.1%
Veterans	59	44.4%
Homeless	57	42.9%



Two-thirds of the providers determine their clients' eligibility for services (Exhibit 7).

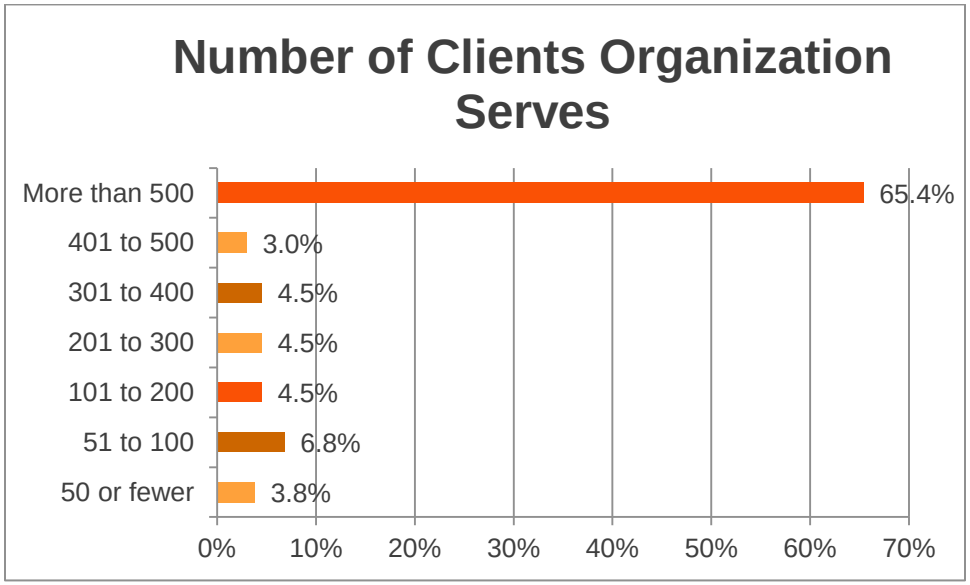
Exhibit 7: Who Determines Eligibility for Services

	Number (N=133)	Percent
Provider determines eligibility for services	90	67.7%
Provider determines eligibility for some of the clients	23	17.3%
Another organization/agency determines eligibility for all clients	19	14.3%
Another organization/agency determines eligibility for some of the clients	22	16.5%

The number of clients these providers have ranges widely. More than 65 percent of providers have more than 500 clients (**Exhibit 8**).

Exhibit 8: Number of Clients Organization Serves

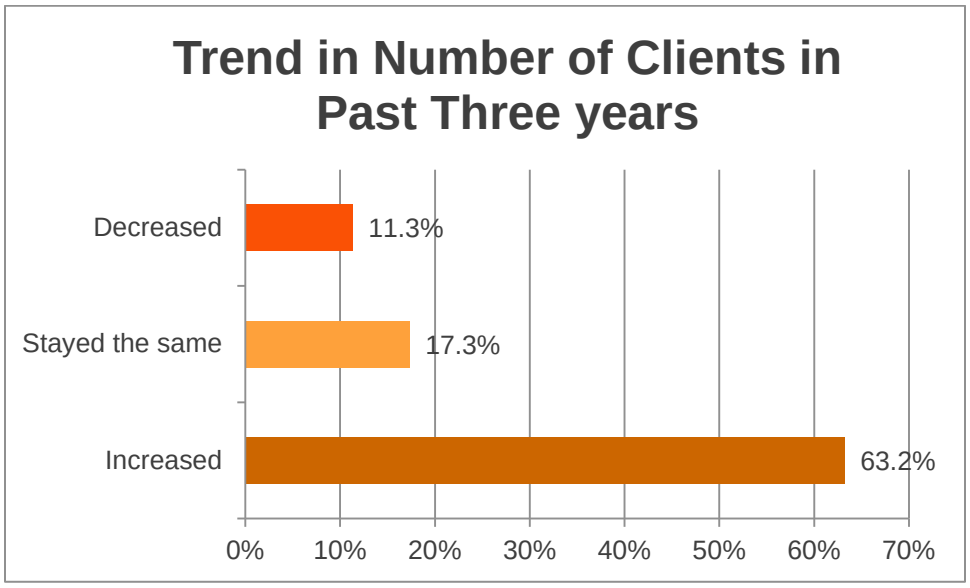
	Number (N=133)	Percent
50 or fewer	5	3.8%
51 to 100	9	6.8%
101 to 200	6	4.5%
201 to 300	6	4.5%
301 to 400	6	4.5%
401 to 500	4	3.0%
More than 500	87	65.4%
Don't know/Not sure	4	3.0%
No answer	6	4.5%



The number of clients of 63.2 percent of the providers increased in the past three years, 17.3 percent of the providers did not see any change in the number of their clients, and 11.3 percent saw a decrease (Exhibit 9).

Exhibit 9: Trend in Number of Clients in Past Three years

	Number (N=133)	Percent
Increased	84	63.2%
Stayed the same	23	17.3%
Decreased	15	11.3%
No answer	11	8.3%



6. Wait Lists

More than 39 percent of the providers (N=52) had wait lists for services in the past fiscal/calendar year (Exhibit 10). The number of people on wait lists ranged widely: 36.5 percent of these providers had up to 100 people on wait lists; 13.4 percent had between 101 and 999 people on the wait list, and 13.5 percent had 1,000 or more people on the wait lists.

Exhibit 10: Number of People Wait Listed in Last Fiscal/Calendar Year

	Number (N=52)	Percent
1 to 100	19	36.5%
101 to 300	5	9.6%
310 to 999	2	3.8%
1,000 or More	7	13.5%
No answer	19	36.5%

A comparison of providers with and without wait lists shows little difference in terms of populations served. A larger percentage of providers with wait lists (55.8 percent) served the homeless than providers without wait lists (48.5 percent) (Exhibit 11).

Exhibit 11: Populations Served by Providers With and Without Wait Lists

	Have Wait Lists		No Wait Lists	
	Number (N=52)	Percent	Number (N=68)	Percent
Infants and children	35	67.3%	44	64.7%
Adolescents and youth	44	84.6%	55	80.9%
Adult men	40	76.9%	52	76.5%
Adult women	40	76.9%	56	82.4%
Elderly	30	57.7%	38	55.9%
Veterans	27	51.9%	36	52.9%
Homeless	29	55.8%	33	48.5%

The two groups of providers did not differ in the number of clients they serve.

Exhibit 12: Agency Size With and Without Wait Lists for Services

Number of Clients Served	Have Wait Lists		No Wait Lists	
	Number (N=52)	Percent	Number (N=68)	Percent
50 or fewer	1	1.9%	2	2.9%
51 to 100	4	7.7%	5	7.4%
101 to 200	1	1.9%	5	7.4%
201 to 300	4	7.7%	2	2.9%
301 to 400	4	7.7%	2	2.9%
401 to 500	-	-	4	5.9%
More than 500	36	69.2%	46	67.6%
Don't know/Not sure	2	3.8%	2	2.9%

More providers with wait lists (88.5 percent) than those with no wait lists (79.4 percent) had an increase or no change in the number of clients they served in the last three years. Of providers with wait lists, 67.3 percent saw increases and 21.2 percent saw no change in their number of clients compared with 61.8 percent and 17.6 percent, respectively of those without wait lists. A larger percentage of providers without wait lists (14.7 percent) saw the number of their clients decrease compared with providers with wait lists (9.6 percent).

Exhibit 13: Trend in Number of Clients Over Past Three Years by Providers With and Without Wait Lists

	Have Wait Lists		No Wait Lists	
	Number (N=52)	Percent	Number (N=68)	Percent
Increased	35	67.3%	42	61.8%
Stayed the same	11	21.2%	12	17.6%
Decreased	5	9.6%	10	14.7%
No answer	1	1.9%	4	5.9%

Providers with wait lists offer a larger variety of services than providers with no wait lists. Of 21 services listed, a larger percentage of providers with wait lists than providers without wait lists offered services in 18 areas. A larger percentage of providers with no wait lists than providers with wait lists offered childhood shots and immunizations, health care, and dental care.

Exhibit 14: Type of Services by Providers With and Without Wait Lists

	Have Wait Lists		No Wait Lists	
	Number (N=52)	Percent	Number (N=68)	Percent
Addiction recovery	18	34.6%	17	25.0%
Alcohol and drug abuse prevention	18	34.6%	14	20.6%
Assisted living services	6	11.5%	1	1.5%
Childcare/Subsidized childcare	12	23.1%	4	5.9%
Childhood shots and immunizations	2	3.8%	10	14.7%
Criminal justice	14	26.9%	8	11.8%
Health care	13	25.0%	21	30.9%
Mental health services	30	57.7%	27	39.7%
Integrated behavioral health services	22	42.3%	13	19.1%
Dental care	2	3.8%	9	13.2%
Housing	27	51.9%	8	11.8%
Service planning and case management	36	69.2%	22	32.4%
Homeless assistance	18	34.6%	10	14.7%
Services for the elderly	15	28.8%	7	10.3%
Veterans' assistance	10	19.2%	7	10.3%
Domestic violence prevention	12	23.1%	7	10.3%
Mortgage, rent assistance	12	23.1%	4	5.9%
Energy assistance	11	21.2%	2	2.9%
Cash assistance	4	7.7%	-	-
Nutrition programs	10	19.2%	5	7.4%
STD prevention and treatment	9	17.3%	7	10.3%

The main difference between the two types of providers with regard to difficulties they have experienced involves reduced funding: 84.6 percent of providers with wait lists compared to 70.6 percent of providers with no wait lists had their funding reduced.

Exhibit 15: Barriers and Difficulties in Providing Services Experienced by Providers With and Without Wait Lists

	Have Wait Lists		No Wait Lists	
	Number (N=52)	Percent	Number (N=68)	Percent
Reduced funding	44	84.6%	48	70.6%
Eliminated funding	16	30.8%	20	29.4%
Increased competition for services	10	19.2%	15	22.1%
Language barriers	5	9.6%	6	8.8%
Inadequate client commitment	13	25.0%	17	25.0%
Lack of transportation	24	46.2%	34	50.0%
Lack of or low awareness of program	13	25.0%	19	27.9%

Indeed, a larger percentage of providers with wait lists (25.0 percent) than those with no wait lists (20.6 percent) saw their budget decrease in the past three years.

Exhibit 16: Changes in Budget in Past Three Years by Providers With and Without Wait Lists

	Have Wait Lists		No Wait Lists	
	Number (N=52)	Percent	Number (N=68)	Percent
Budget increased	20	38.5%	25	36.8%
Budget stayed the same	10	19.2%	19	27.9%
Budget decreased	13	25.0%	14	20.6%
No answer	9	17.3%	10	14.7%

7. Services Provided

Providers offer a wide range of services. Service planning and case management (41.4 percent) and mental health services (39.1 percent) are the most commonly provided services. Other services provided by 20 percent or more of the organizations included: addiction recovery (24.8 percent), integrated behavioral health (24.8 percent), housing (24.8 percent), health care (24.1 percent), and alcohol and drug abuse prevention (22.6 percent) (**Exhibit 17**).

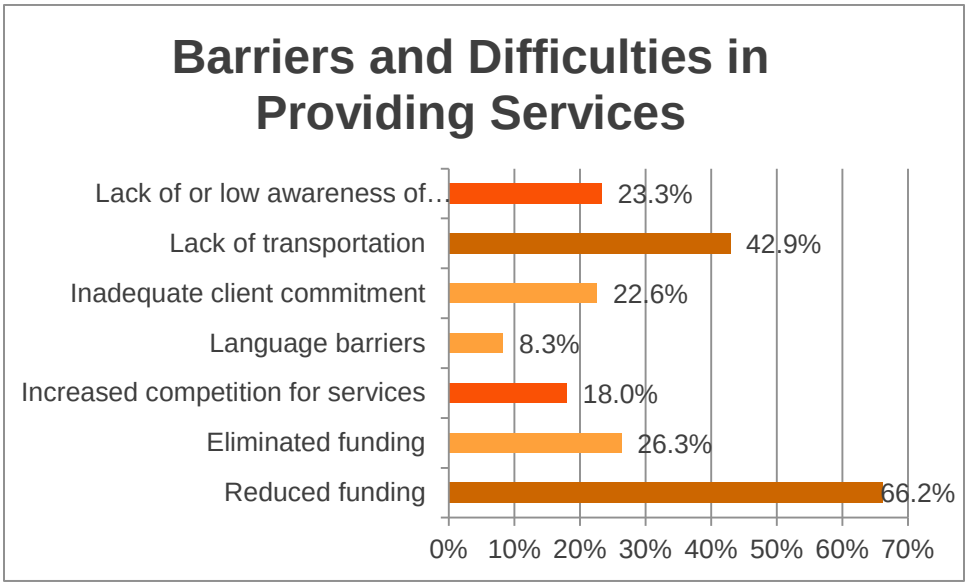
Exhibit 17: Type of Services Organization Provides

	Number (N=133)	Percent
Addiction recovery	33	24.8%
Alcohol and drug abuse prevention	30	22.6%
Assisted living services	6	4.5%
Childcare/Subsidized childcare	16	12.0%
Childhood shots and immunizations	11	8.3%
Criminal justice	21	15.8%
Healthcare	32	24.1%
Mental health services	52	39.1%
Integrated behavioral health services	33	24.8%
Dental care	11	8.3%
Housing	33	24.8%
Service planning and case management	55	41.4%
Homeless assistance	26	19.5%
Services for the elderly	20	15.0%
Veterans' assistance	16	12.0%
Domestic violence prevention	18	13.5%
Mortgage, rent assistance	15	11.3%
Energy assistance	12	9.0%
Cash assistance	4	3.0%
Nutrition programs	15	11.3%
STD prevention and treatment	15	11.3%

Providers face different barriers to services. As shown in **Exhibit 18**, providers considered reduced (66.2 percent) or eliminated funding (26.3 percent) the prime barrier to service provision followed by lack of transportation (42.9 percent).

Exhibit 18: Barriers and Difficulties in Providing Services

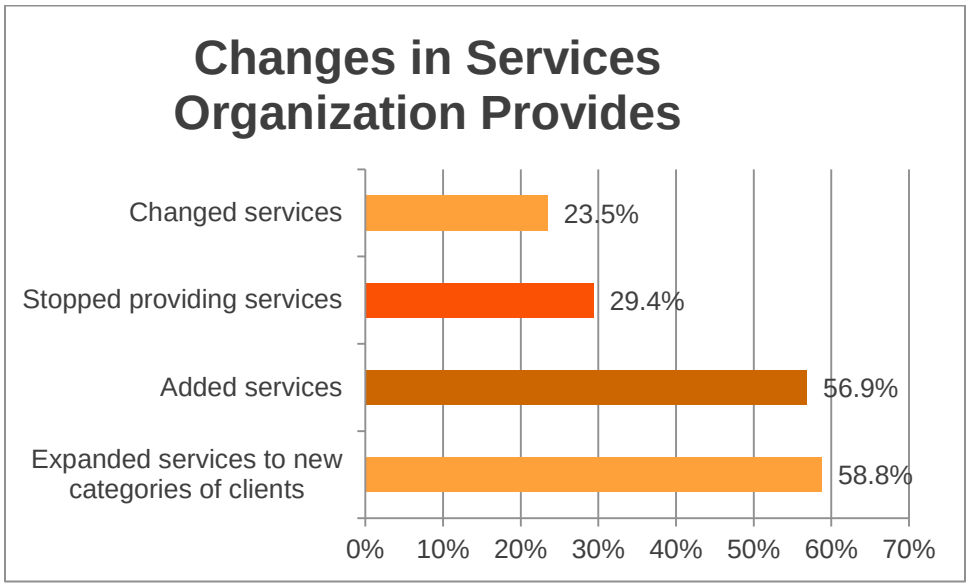
	Number (N=133)	Percent
Reduced funding	88	66.2%
Eliminated funding	35	26.3%
Increased competition for services	24	18.0%
Language barriers	11	8.3%
Inadequate client commitment	30	22.6%
Lack of transportation	57	42.9%
Lack of or low awareness of program	31	23.3%



Nearly 40 percent of the providers (38.3 percent, N=51) reported that the type of services they offered has changed in the past three years (**Exhibit 19**). Nearly 60 percent of those who changed the type of services they offered expanded their services to new categories of clients, 56.9 percent added new services, 29.4 percent stopped providing certain services, and 34.5 percent changed the services they provide.

Exhibit 19: Changes in Services Organization Provides

	Number (N=51)	Percent
Expanded services to new categories of clients	30	58.8%
Added services	29	56.9%
Stopped providing services	15	29.4%
Changed services	12	23.5%
Other	6	11.8%



8. Service Gaps

Nearly three-quarters of the providers (73.7 percent; N=98) indicated that there are service gaps in the services their clients need. Providers identified many service gaps. The most common service gaps providers identified included:

- Affordable housing (N=25);
- Access to transportation, including senior transportation (N=20)
- Services to homeless youth, adults, and families (N=11)
- Access to specialty care, including therapy (N=11)
- Access to substance abuse treatment, in- and out-patient, for youth, adults, and pregnant women (N=8)
- Employment training and job search assistance (N=8)
- More dental care services (N=7)
- More mental health services (N=5)

- Mentoring and tutoring for youth (N=5)
- Services for children with disabilities (N=4)
- Subsidized daycare (N=3)
- Respite care (N=3)
- Easier access to medication (N=3)
- Access to health care (N=3)

Other gaps identified by one or two of the providers included:

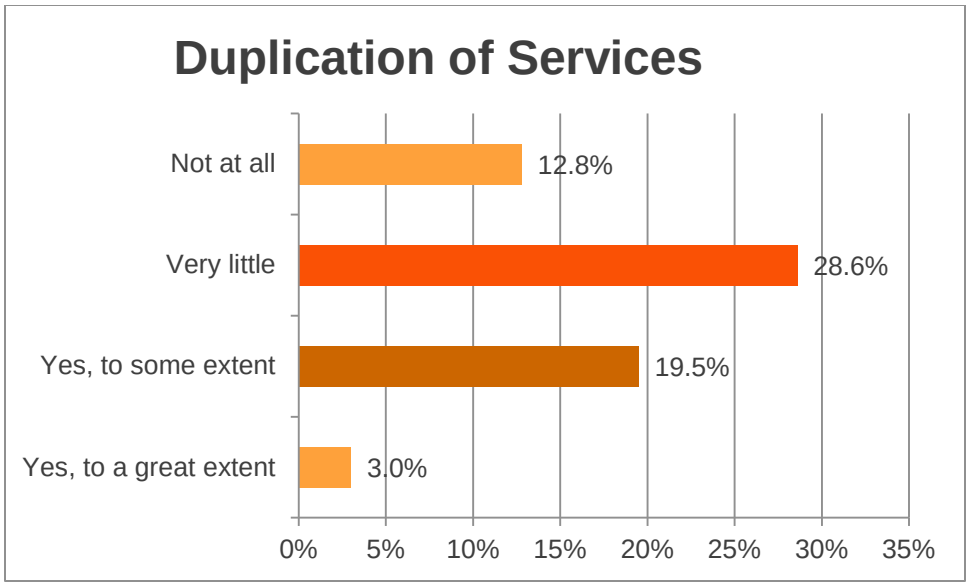
- More HIV/AIDS services
- Services for people 55 to 65 years old
- More intermediate care facilities (ICFs)
- More assisted living facilities
- Residential treatment options for children and adults
- In-home support
- Pre-schools for children up to two years old
- After school services
- Income assistance
- Food services
- Access to healthcare

9. Duplication of Services

Nearly one-quarter of the providers (22.5 percent, N=30) indicated that there is duplication of services in Broward County; 41.4 percent (N=55) of providers saw very little or no duplication of services (Exhibit 20).

Exhibit 20: Duplication of Services

	Number (N=133)	Percent
Yes, to a great extent	4	3.0%
Yes, to some extent	26	19.5%
Very little	38	28.6%
Not at all	17	12.8%
No answer	48	36.1%



Twenty-two of the providers specified areas of duplication of services. Providers listed duplication of services in the following areas:

- Case management
- Community mental health programs
- CSC services
- Food for the poor and homeless
- Prevention and outreach services that the Department of Health offers
- Primary care
- Social and health care services
- Substance abuse
- School-based services
- Early childhood
- HIV/AIDS services
- Services for the elderly

Several providers indicated that duplication of services may be necessary.

- I believe there should be multiple options for service delivery. The focus should be on the quality of the services and the outcomes achieved.

- Only duplication to the extent that several organizations perform the same service, but this is good since the need is usually greater than the total the organizations can provide for.

- Although there is some service duplication, e.g., there are many organizations providing shelter and services, client demand continues to exceed supply.

- There is duplication of services in various systems, and this is ok because no one entity can handle the need in our community.

10. Collaboration and Partnerships

Nearly two-thirds (66.2 percent, N=88) of the providers reported that they collaborate or have formal partnerships with other organizations **(Exhibit 21)**. The largest number of providers (N=38, 28.6 percent) collaborate with hospitals, schools, and the Sheriff's office.

Exhibit 21: Type and Number of Other Organizations Providers Collaborate or Partner

	Number of Providers Reporting Collaborating/Partnering with…	Range of Organizations with whom Providers Collaborate/Partner	Average Number of Organizations with whom Providers Collaborate/Partner
Hospitals	38	1 to 18	4
Clinics	23	1 to 12	4
HMOs	18	1 to 15	6
Nursing homes	10	1 to 20	5
Residential facilities	23	1 to 30	7
Schools	38	1 to 200	15
Childcare centers	15	1 to 700	80
Sheriff's office	38	1 to 25	2

11. Greatest Challenges for Providers

Seventy-five providers identified multiple challenges facing their organizations. The most common challenge, specified by 36 providers, involves lack of or inadequate funding for different programs and services especially in light of increased demand and community needs. Other challenges mentioned included:

- Increased demand for services. (N=13)
- Ability to find qualified professional staff (e.g. therapists). (N=4)
- Not enough shelters or assistance with housing and rental. (N=3)
- Changes in access to healthcare due to the changing law. (N=3)

One or two providers also identified:

- Making the community aware of specific resources.
- Ability to recruit volunteers.
- Ability to find mentors for students.
- Difficulty to qualify for services because of increased restrictions.
- Lack of transportation.
- Influx of undocumented families who need services.
- Lack of specialty services.

12. Expected Impact of The Affordable Care Act

As shown in **Exhibit 22**, between 1.5 and 5.3 percent of the providers expect that the Affordable Care Act (ACA) will affect their organization by increasing significantly different aspects of their organization. Between 3.8 and 13.5 percent expect to experience a moderate increase. The significant or moderate increases are expected mostly with regard to providers' collaboration with other organizations (16.5 percent) and number of clients (13.6 percent) followed by amount of funds (9.0 percent), services they offer (6.8 percent), and their funding sources (6.1 percent).

Between 35.3 and 42.1 percent of providers expect to see no effect of the ACA on their organization. Between 2.3 and 10.5 percent expect moderate decreases, especially in the amount of funds (10.5 percent) and funding sources (9.8 percent). Significant decreases are expected by a minute number of providers (1.5 percent) in funding sources, amount of funds, and services offered.

Exhibit 22: Expected Impact of the ACA on Providers

	Increase Significantly	Increase Moderately	Stay the Same	Decrease Moderately	Decrease Significantly	No Answer	Mean
Number of clients	7 5.3%	11 8.3%	54 40.6%	4 3.0%	-	57 42.9%	2.72
Funding sources	3 2.3%	5 3.8%	51 38.3%	13 9.8%	2 1.5%	59 44.4%	3.08
Amount of funds	2 1.5%	10 7.5%	47 35.3%	14 10.5%	2 1.5%	58 43.6%	3.16
Services offered	4 3.0%	5 3.8%	56 42.1%	6 4.5%	2 1.5%	59 44.4%	2.92
Collaboration/ Partnership with other organizations	4 3.0%	18 13.5%	49 36.8%	3 2.3%	-	59 44.4%	2.69

**Mean was calculated on a 5-point scale: 1-increase significantly, 2-increase moderately, 3-stay the same, 4-decrease moderately, 5-decrease significantly.*

Twenty-seven providers specified expected effects of the ACA. However, some providers cautioned that the conflicting information in the ACA makes its impact unclear at this time, especially on areas such as behavioral health. Consumers do not have a good understanding of the law.

Providers' comments can be divided into two groups: those who anticipate a reduction or loss of services as a result of ACA and those who expect a positive impact.

Decrease or loss of services:

- Lack of coverage for individuals between 101 and 139% of the Federal Poverty Guidelines.
- People with very low income will not be able to receive mental health services at various agencies.
  People who need a mental health case manager may not be able to have one because agencies do not fund this position.
  ACA's required co-pay and deductibles will prevent the poor from accessing care on a regular basis. This will increase the load on emergency rooms.
- Companies will not offer health insurance to spouses of employees.
- The coverage provided may not be sufficient, leading to services from less ~~expert~~ competent providers.
- Some providers will have an increase in staffing costs.
- Low Medicaid reimbursement will affect quality and availability of services.
- Some people will become ineligible for services.

Positive effects of the ACA:

- Funding sources will diversify.
- Funding for services will increase.
- Access to healthcare services will increase.
- There will be an increase in patient volume.
- There will be an increase in the call volume to the Helpline.
  The ACA will provide increased resources for homeless and low income persons to pay for health care, thus freeing up more of their budgets to pay for housing.
- More homeless will have access to health care services.
- Providers will need to collaborate more because of the increased volume of patients.
- There will be a greater coordination of services.

13. Expected Changes in Service Population and in Services

Sixty-six providers elaborated on expected changes in the populations they serve. Only eight of the 55 providers do not expect any or very little changes in the population they serve. Most commonly (N=26) providers are expecting an increase in the population they serve and consequently an increase in the need for respective services (N=19). Providers expect the population to be more diverse (N=2) and poorer (N=3) although they expect that a large number of people will have insurance (N=2) and access to health care services (N=2). Some providers foresee demand exceeding available services (N=3). Some providers see a decrease in need for services if the economy keeps improving, and because they expect seniors to be healthier and more active (N=2).

Five of the 62 providers who described changes in services in the next five years, expect no or very little change in services. Seven providers expect to see more services offered as a result of increased demand. More services will be offered for people with developmental disabilities, mental health issues, the elderly, the homeless, students, and young children. There will be a greater focus on primary care, prevention, and a greater emphasis on health education. Services will be of higher quality (N=2) and a greater variety of services will be offered to generate more revenue (N=4). Providers will become more efficient in service delivery in order to make better use of their funding: more services will be provided by nurses instead of physicians and providers will make greater use of case management, collaboration and partnering. Most providers expect to see no change or a decrease in funding at the same time as demand increases.

Appendix D

LRP Survey of Broward County Residents
N=400 Adults in Select ZIP Codes

DRAFT QUESTIONNAIRE

Hello. My name is _____. I'm calling from Florida Opinion Research. We are conducting a public opinion survey on behalf of Broward County Human Services to determine service needs in the county. Your telephone number has been chosen randomly, and we value your input. I would like to ask you some questions about services you may have received or may need in Broward County. This survey is part of a project to study ways to improve those services.

1. First, to confirm, have I reached you on your cell phone?

   Yes 1
   No 2
   (Don't know/refused) 3

2. Would you please confirm for me which ZIP code you live in?

   _____
   RECORD 5-DIGIT CODE
   [IF NOT ON FOLLOWING LIST, PLEASE DOUBLE-CHECK, THEN TERMINATE.]

[33004, 33009, 33019, 33020, 33021, 33023, 33027, 33060, 33062, 33063, 33064, 33066, 33068, 33069, 33304, 33308, 33309, 33311, 33312, 33313, 33314, 33316, 33319, 33321, 33322, 33441, 33442]

1. How would you rate the overall quality of the services that are available to Broward County residents: excellent, good, just fair, or poor?

   Excellent 1
   Good 2
   Just fair 3
   Poor 4
   (Don't know/refused) 5

Next, I'm going to read you a list of services that are available to residents of Broward County. For each, please tell me whether you have a very favorable, somewhat favorable, somewhat unfavorable, or very unfavorable impression. If you have heard of the service, but do not know enough to have an impression **[5],** or if you haven't heard of the service **[6]**, just say so, and we will move on.

[READ NAME] Do you have a very favorable, somewhat favorable, somewhat unfavorable, or very unfavorable impression of **[NAME]**?

RANDOMIZE LIST

		very fav	some fav	some unfav	very unfav	no opin	never heard
2.	_Mental health services	1	2	3	4	5	6
3.	_Alcohol and drug abuse prevention and treatment services	1	2	3	4	5	6
4.	_Health care	1	2	3	4	5	6
5.	_Dental care	1	2	3	4	5	6
6.	_Services for the elderly	1	2	3	4	5	6
7.	_Services for children and adolescents	1	2	3	4	5	6
8.	_Domestic violence	1	2	3	4	5	6
9.	_Homeless services	1	2	3	4	5	6
10.	_Infant, toddler, and child care	1	2	3	4	5	6
11.	_Mortgage and rent assistance	1	2	3	4	5	6

12. _Veterans' assistance 1 2 3 4 5 6
13. _STD or HIV prevention and treatment 1 2 3 4 5 6

14. Regardless of whether you have used any of these services, if you or your family needed them, how easy or difficult would it be to obtain these services?

Very easy to obtain 1
Somewhat easy to obtain 2
Somewhat difficult to obtain 3
Very difficult to obtain 4
(Don't know/refused) 5

Next, I'm going to read you a list of services that are available to Broward County residents. This time, for each one, please tell me how satisfied you are with the quality of that particular service for county residents: very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied. If you're not sure how you feel about a particular service [5], please say so and we'll move on.

[READ NAME] How satisfied you are with the provision of that particular service?

RANDOMIZE	**Very Satisfied**	**Smwht**	**Smwht Dissatisfied**	**Very**	**Unsure/DK**
15. _Mental health services	1	2	3	4	5
16. _Alcohol and drug abuse prevention and treatment services	1	2	3	4	
17. _Affordable health care	1	2	3	4	5
18. _ Affordable dental care	1	2	3	4	5
19. _Services for the elderly	1	2	3	4	5
20. _Services for children and adolescents	1	2	3	4	5
21. _Afterschool programs	1	2	3	4	5
22. _Juvenile delinquency intervention services	1	2	3	4	5
23. _Domestic violence services	1	2	3	4	5
24. _Homeless services	1	2	3	4	5
25. _Infant, toddler, and child care	1	2	3	4	5
26. _Mortgage and rent assistance	1	2	3	4	5
27. _Veteran assistance services	1	2	3	4	5
28. _Public Transportation	1	2	3	4	5
29. _Nutrition programs	1	2	3	4	5
30. _STD and HIV prevention and treatment	1	2	3	4	5

31. In the past 12 months, have you or a member of your immediate family received any of the services we have been discussing during this survey or any other services?

Yes – me ..... 1 TRACK FOR BLOCK 1(p.2-4)
Yes – family member ..... 2 TRACK FOR BLOCK 1(p.2-4)

No ..... 3 TRACK FOR BLOCK 2 (p.4-5)
(Don't know/refused) ..... 4 TRACK FOR BLOCK 2 (p.4-5)

BLOCK 1 [ASK QXX-XX ONLY IF "YES" ON QXX, IF NO OR DON'T KNOW, SKIP TO QXX]

32. And what service or services have you or your family member received: **[READ. RANDOMIZE. ACCEPT MUTIPLE RESPONSES.]**

Mental health services 1
Alcohol and drug abuse prevention and treatment programs..... 2
Affordable health care 3
Affordable dental care 4
Services for the elderly 5
Services for children and adolescents 6
Afterschool programs 7
Juvenile delinquency intervention programs..... 8
Domestic violence 9
Homeless services 10
Infant, toddler, and child care..... 11
Mortgage and rent assistance..... 12
Veterans' assistance 13
Public transportation 14
Nutrition programs..... 15
STD and HIV prevention and treatment..... 16
(Other - RECORD) ..... 17 _____ (RECORD)
(Don't know) 18

33. In the past 12 months have you or a member of your family tried to obtain any of those services but could not? **[IF YES]** Was that you or a family member?

Yes – me 1
Yes – family member 2
No..... 3
(Don't know/refused)..... 4

IF YES TO THE PREVIOUS QUESTION

34. What is the reason you could not obtain the service **[RANDOMIZE]**

It is not located close enough to you..... 1
It is not affordable..... 2
You did not know where to go or how to obtain it 3
The office was closed or the hours were not convenient for you. 4
You were not eligible 5
[READ LAST:] Another reason **(RECORD)** 6
(Don't know/refused) 7

35. Which of the following services do you or your family member need most? **[READ. RANDOMIZE. ACCEPT MULTIPLE ANSWERS]**

Mental health services 1
Alcohol and drug abuse prevention and treatment programs..... 2
Affordable health care 3
Affordable dental care 4
Services for the elderly 5
Services for children and adolescents 6
Afterschool programs 7
Juvenile delinquency intervention programs..... 8
Domestic violence 9
Homeless services 10
Infant, toddler, and child care..... 11
Mortgage and rent assistance..... 12
Veterans' assistance 13
Public transportation 14

Nutrition programs.....15
STD and HIV prevention and treatment.....16
(Other - RECORD) .....17 _____
(Don't know) 18

36. What is the primary reason you use services in Broward County? **[RANDOMIZE]** _They offer the lowest cost, _they are the most convenient, _the services are effective/meet my needs, _they are the only resources I know of for the services I need, OR is there another reason?

Lowest cost/no cost.....1
Most convenient.....2
Effective 3
Only resources for services I need 4
Other – **RECORD** .....5 _____
(Don't know/refused) 6

37. How likely are you to continue using services provided in Broward County?

Extremely likely 1
Very likely.....2
Somewhat likely 3
Not too likely.....4
Not at all likely.....5
(Don't know/refused).....6

END BLOCK 1—PROCEED TO QXX

BLOCK 2 [ASK QXX-XX ONLY IF "NO" OR "DON'T KNOW" ON QXX]

38. What is the primary reason you don't use services in Broward County? **[RANDOMIZE]** _you can find cheaper services elsewhere, _you can find better services elsewhere, _it is too difficult to obtain these services, _you weren't aware of these services, _you are not in need of any of these services, OR is there another reason?

Cheaper services elsewhere.....1
Better services elsewhere.....2
It is too difficult to obtain these services 3
Weren't aware 4
Not in need of any services.....5
(Other – **RECORD)** .....6 _____
(Don't know/refused) 7

39. How likely would you be to seek out services in Broward County if you needed them in the future?

Extremely likely 1
Very likely.....2
Somewhat likely 3
Not too likely.....4
Not at all likely.....5
(Don't know/refused).....6

40. And out of the following services, which would you or your family be most likely to seek out? **[READ. RANDOMIZE. ACCEPT MULTIPLE ANSWERS]**

Mental health services 1
Alcohol and drug abuse prevention and treatment programs.....2

Affordable health care 3
Affordable dental care 4
Services for the elderly 5
Services for children and adolescents 6
Afterschool programs 7
Juvenile delinquency intervention programs 8
Domestic violence 9
Homeless services 10
Infant, toddler, and child care 11
Mortgage and rent assistance 12
Veterans' assistance 13
Public transportation 14
Nutrition programs 15
STD and HIV prevention and treatment 16
(Other - RECORD) ..... 17 _____
(Don't know) 18

41. In the past 12 months have you or a member of your family tried to obtain any of those services but could not? **[IF YES]** Was that you or a family member?

Yes – me 1
Yes – family member 2
No 3
(Don't know/refused) 4

END BLOCK 2—PROCEED TO QXX

RESUME ASKING ALL

Next, I'm going to read you a list of services. For each one, please tell me how interested you would be in that service: very interested, somewhat interested, a little interested, or not interested at all. If you're not sure how you feel about a particular service [5], please say so and we'll move on.

[READ ITEM] Would you be very interested, somewhat interested, a little interested, or not interested at all in that service?

RANDOMIZE	**Very Intrstd**	**Smwt Intrstd**	**A Little Intrstd**	**No interest**	**Not Sure**
42. _ Financial planning education programs for individuals and families	1	2	3	4	5
43. _ Programs to support immigrants and their families	1	2	3	4	5
44. _More financial assistance for child care	1	2	3	4	5
45. _Nutrition and healthy living programs	1	2	3	4	5
46. _Low-interest cash and lending programs	1	2	3	4	5
47. _Juvenile detention and rehabilitation	1	2	3	4	5
48. _In-patient mental health evaluation and rehabilitation services	1	2	3	4	5
49. _Stronger HIV and AIDS outreach and prevention programs for youth	1	2	3	4	5
50. _Bullying education programs	1	2	3	4	5
51. _Suicide prevention, especially for youth	1	2	3	4	5
52. _Programs to offer low-cost health care to individuals and families in need	1	2	3	4	5

53. _More after-school programs for children and young adults 1 2 3 4 5
54. _Alcohol and drug abuse treatment and prevention programs 1 2 3 4 5
55. _More public transportation options 1 2 3 4 5
56. _More services for children and adolescents with disabilities 1 2 3 4 5
57. _More services for adolescents who are homeless or have other special needs 1 2 3 4 5

ASK LAST

58. Is there a service you have an interest in but did not hear in the list I just read? **[IF YES]** What is it? **[RECORD ANSWER]**

Yes – **RECORD ANSWER** 1
No 2
(Don't know) 3

59. In the past year, have you needed any services and had to be put on a wait list? **[IF YES]** Which service or services? **[RECORD ANSWER]**

Yes – **RECORD ANSWER** 1
No 2
(Don't know) 3
(Other/refused) 4

Now I will ask you some questions about health care.

60. Since October, because of the Affordable Care Act, more commonly known as Obamacare, there has been a new way for people to buy health insurance called health insurance marketplaces. Have you seen, read, or heard anything about these new marketplaces?

Yes 1
No 2
(Don't know) 3
(Other/refused) 4

61. If you need to find health insurance, how interested would you be in using a health insurance marketplace to find a health insurance plan - extremely interested, very interested, somewhat interested, a little interested, or not at all interested?

Extremely interested 1
Very interested 2
Somewhat interested 3
A little interested 4
Not at all interested 5
(Don't know) 6

62. What type of health insurance do you have now **[READ LIST]**

Insurance paid for by employer 1
Insurance paid for by self 2
Covered under partner or spouse's insurance 3
Medicare 4

Medicaid 5
(Other - RECORD) 6
(Don't know/refused) 7

63. Do you have a doctor or health care provider for routine visits or physicals or when you are ill?

Yes 1
No 2
(Don't know) 3
(refused) 4

64. About how long has it been since you saw a doctor for a routine visit/physical/check-up, not a specific illness?

Within the past year 1
1 year but less than 2 years ago 2
2 years but less than 5 years ago 3
Can't remember 4
Never been to a doctor 5
(Don't know/refused) 6

Finally, I would like to ask you a few questions for statistical purposes only.

65. What is your age? **[RECORD, IF REFUSE CODE AS 999]**

IF REFUSED IN PREVIOUS QUESTION

66. I am going to read you some categories. Please stop me when we get to your category.

18-24 1
25-29 2
30-34 3
35-39 4
40-44 5
45-49 6
50-54 7
55-59 8
60-64 9
65-69 10
70-74 11
Over 74 years 12
(Refused) 99

67. Are you married, unmarried with a partner, single, separated, widowed, or divorced?

Married 1
Unmarried with partner 2
Single 3
Separated 4
Divorced 5
Widowed 6
(Don't know/refused) 7

68. What is your current work status: [RANDOMIZE]:

Employed for wages 1
Self-employed 2

Unemployed for more than a year 3
Unemployed for less than a year 4
A homemaker.....5
A student 6
Disabled or unable to work 7
Retired.....8
(Other – RECORD) 9

IF EMPLOYED FROM PREVIOUS QUESTION (Q XX = 1, 2)

69. How many hours per week do you work?

20 hours or less.....1
21-30 hours 2
31-39 hours 3
40 hours or more.....4

70. What is the last year of schooling that you have completed? **[DO NOT READ]**

1 – 8th grade 1
9 -11th grade 2
High school graduate/GED 3
No college, technical training/licensing).....4
Some college (incl. jr. college or associate degree) 5
College graduate.....6
Post-graduate school 7
(Don't know) 8

71. Including yourself, how many people are in your household? **[RECORD ANSWER, DON'T KNOW = 999]**

72. Do you have a child under 18 living in your household?

Yes 1
No.....2
(Don't know) 3

73. How long have you lived in Broward County?

Less than two years 1
Between two and five years 2
Between six and ten years.....3
Between eleven and twenty years 4
More than twenty years.....5
(Don't know) 6

74. Rounding to the nearest thousand, what was your household income in 2013 before taxes? **[DO NOT READ.]**

Less than 10 thousand.....1
10 thousand to 14 thousand 2
15 thousand to 24 thousand 3
25 thousand to 34 thousand 4
35 thousand to 49 thousand 5
50 thousand to 74 thousand 6
75 thousand to 99 thousand 7

100 thousand to 149 thousand 8
150 thousand or more 9
(don't know) 10
(refused) 11

[**IF REFUSED IN PREVIOUS QUESTION]**

75. This information is collected for research purposes only. Would you mind telling me if your household income is **[READ OPTIONS]**:

Less than $50,000 1
Between $50,000 and $100,000 2
More than $100,000 3

76. Do you or anyone in your household receive any of the following assistance? [Record all that apply]

TANF (welfare) 1
SNAP (food stamps) 2
SSI (Supplemental Security Income) 3
SSDI (Social Security Disability Insurance) 4
Unemployment benefits 5
Other 6
No 7
Don't know/refused 8

[IF YES IN PREVIOUS QUESTION]

77. For the assistance you have had the longest, how long have you been receiving this assistance? [Record all that apply]

Less than 6 months 1
6 months to 1 year 2
More than 1 year 3
More than 5 years 4

78. Just to make sure we have a representative sample, could you please tell me whether you are from a Hispanic, Latino, or Spanish-speaking background?

[IF YES] Would that be Cuban, South American, Central American, or somewhere else?
[IF NO] What is your race - white, black, Asian, or something else?

White 1
Black/African American 2
Cuban 3
Puerto Rican 4
Mexican 5
Central American 6
South American 7
Other Latino/Hispanic 8
Asian 9
Native American 10
Haitian/Creole 11
(other) 12
(don't know/refused) 13

79. Finally, for verification, may I have just your first name? ..... _____

THIS COMPLETES OUR SURVEY. THANK YOU FOR YOUR TIME, HAVE A PLEASANT EVENING!

Appendix E

Broward County Human Services Assessment

Findings from a Survey of 415 Adults in Selected Zip Codes in Broward County

March 2014

Methodology

- Lake Research Partners designed and administered this survey, which was conducted by phone using professional interviewers. The survey reached a total of 415 adults in selected zip codes in Broward County. The zip codes targeted high density populations of the elderly and low-income residents in the county. The survey was conducted February 10th – February 15th 2014.

- Telephone numbers for the survey were drawn from a file of county residents within targeted zip codes, and included an oversample of respondents reached on cell phones (extra cases of cell respondents to ensure statistical validity). In total, 34% of respondents were reached on a cell phone. Data were weighted slightly by gender, age, education, region, and race in order to closely match the demographic characteristics of the population at large. The margin of error for the survey is +/-4.8%.

- In interpreting survey results, all sample surveys are subject to possible sampling error; that is, the results of a survey may differ from those that would be obtained if the entire population were interviewed. The size of the sampling error depends upon both the total number of respondents in the survey and the percentage distribution of responses to a particular question. For example, if 50% of respondents in the total sample answered "yes" to a particular question, we can be 95% confident that the true percentage will fall within +/-4.8 percentage points of this percentage or between 45.2% and 54.8%.

Executive Summary

- **A solid majority (59%) of respondents express satisfaction with the quality of services available to Broward County residents.**

- **Importantly, respondents register high levels of awareness of many of the services offered throughout Broward County.**

  - Sizeable majorities are both aware of, and hold favorable opinions of, Broward County's public transportation services (65% favorable), childhood shots and immunizations (62% favorable), affordable health care (59% favorable), and services for the elderly (58% favorable).

  - **This trend does not extend across the board, however.** Respondents express less favorable opinions of—and also tend to be slightly less familiar with—cash assistance programs (31% favorable), mortgage and rent assistance (37% favorable), and juvenile delinquency intervention services (38% favorable).

- The most favorably regarded services also tend to receive the highest overall marks for satisfaction among county residents, **marks that are consistently higher among those who have received county services over the past year** (by an average of 12 points, but by as much as 20-25 points higher in some cases).

  - The biggest discrepancies in the satisfaction ratings between recent "customers" of the county's services and non-customers is apparent with regard to HIV prevention and treatment (63% satisfied vs. 38% satisfied, respectively), after-school programs (69% satisfied vs. 48% satisfied, respectively), nutrition programs (59% satisfied vs. 43% satisfied, respectively), and infant, toddler, and child care services (62% satisfied vs. 46% satisfied, respectively).

Executive Summary (continued)

- **For those who have received county services in the past year, public transportation is the most common service cited (20%), followed by affordable health care (16%), services for the elderly (15%), child care services (14%), and after-school programs (14%).** The remaining services are used by smaller portions of adults.

- **Affordable health care (27%) and dental care (25%) are the services adults indicate they need most**, followed by public transportation (13%), cash assistance (13%), and mortgage and rent assistance (13%).

- **The reason these respondents use County services is primarily because they are effective in meeting their needs (28%) and are convenient (24%).** Fully three-quarters (75%) of those who receive services are likely to continue using services.

- **It is important to note that there is room to expand public awareness of, and satisfaction with, even the most popular and recognized services**, as roughly one-third of respondents has either no opinion of, or is completely unfamiliar with, all of the services described.

  - Moreover, while majorities of respondents are satisfied with many of the services discussed in this survey, none registers overwhelmingly intense satisfaction ratings, even among those who have received county services over the past year.

Executive Summary (continued)

- **A majority of those who have not taken advantage of County services in the past 12 months expresses real interest in doing so**, saying they would be either extremely or very likely to seek out those services if they needed them in the future**.**

- **Nearly half (48%) show high interest in programs that offer low-cost health care to individuals and families in need.** This is followed by piqued interest in after-school programs, nutrition and healthy living programs, public transportation services, financial planning, services for children and adults with disabilities, and services for the elderly.

  - The resident who currently does not receive services but expresses a strong interest in seeking them out in the future tends to be a lower-income white woman without children, living in northern Broward County.

  - By contrast, the resident who currently does receive services tends to be a younger, non-college educated, lower-income African American or Latino.

- While overall perceptions about the quality of County services are largely positive, **addressing concerns over accessibility will be key in retaining (and growing) the Human Service Department's consumer base**. Those who have not recently obtained services, in particular, are uncertain about ease of access.

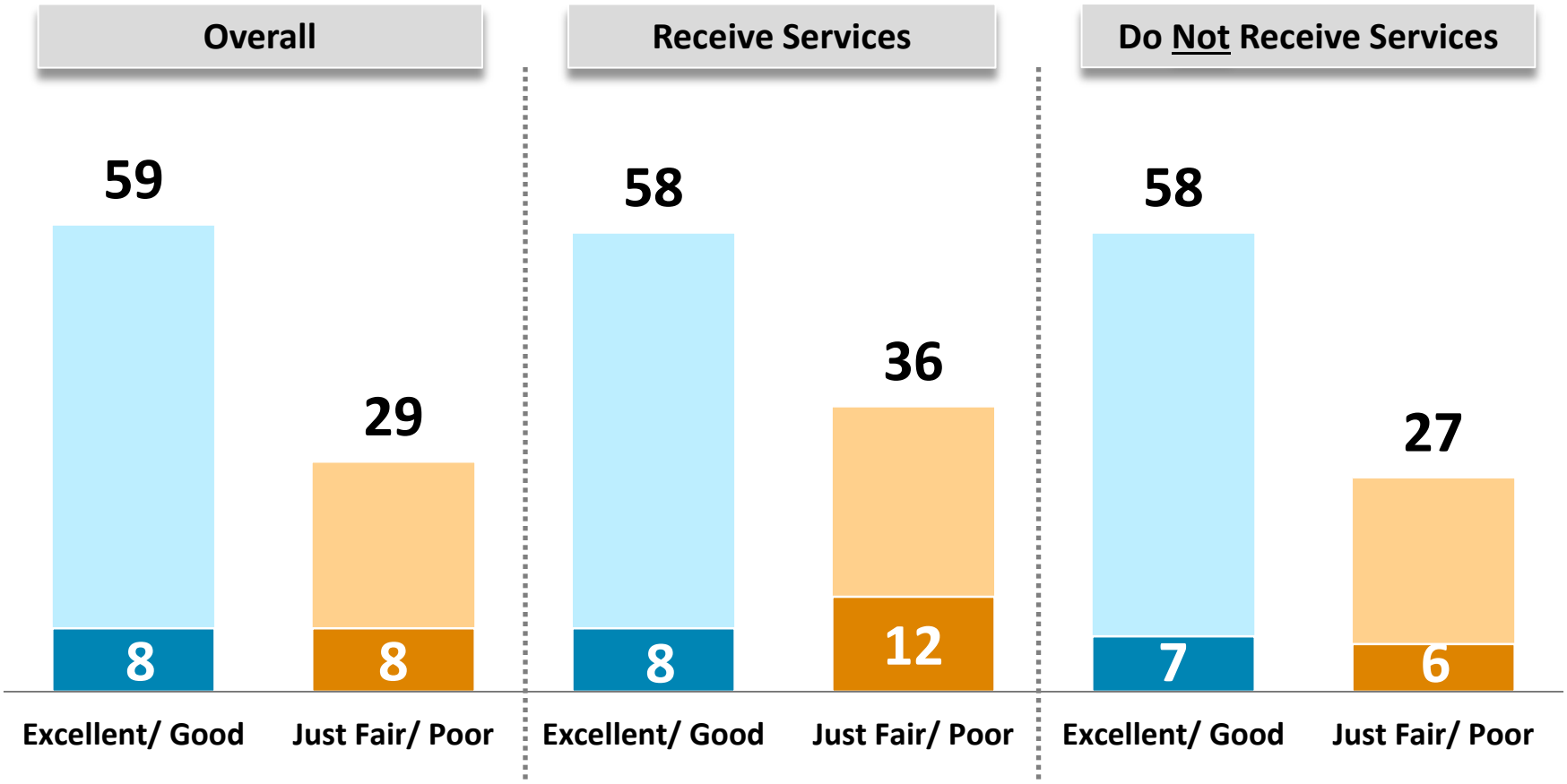
Overall Perceptions of Broward County Human Services Programs

Sizeable majorities of respondents rate the quality of services available in Broward County as either excellent or good. There is, however, room both to expand and deepen these sentiments. Further, respondents are divided on whether the services they need are accessible to them. Soliciting direct customer service feedback may reveal new ways to address concerns over accessibility, particularly for residents in southern Broward County, as well as for younger and non-college-educated women. An ongoing emphasis on quality will be important, but the real challenge will be convincing residents that there are fewer barriers than ever when it comes to accessing County services.

Lake Research Partners

By and large, Broward County residents assess the quality of County services available to them in positive terms, though there is a noticeable lack of intensity underpinning their feelings (i.e. few rate service quality as either "excellent" or "poor"). This is true by and large even among those who have received County services in the past year.

Quality of Broward County Services



Darker colors indicate intensity.

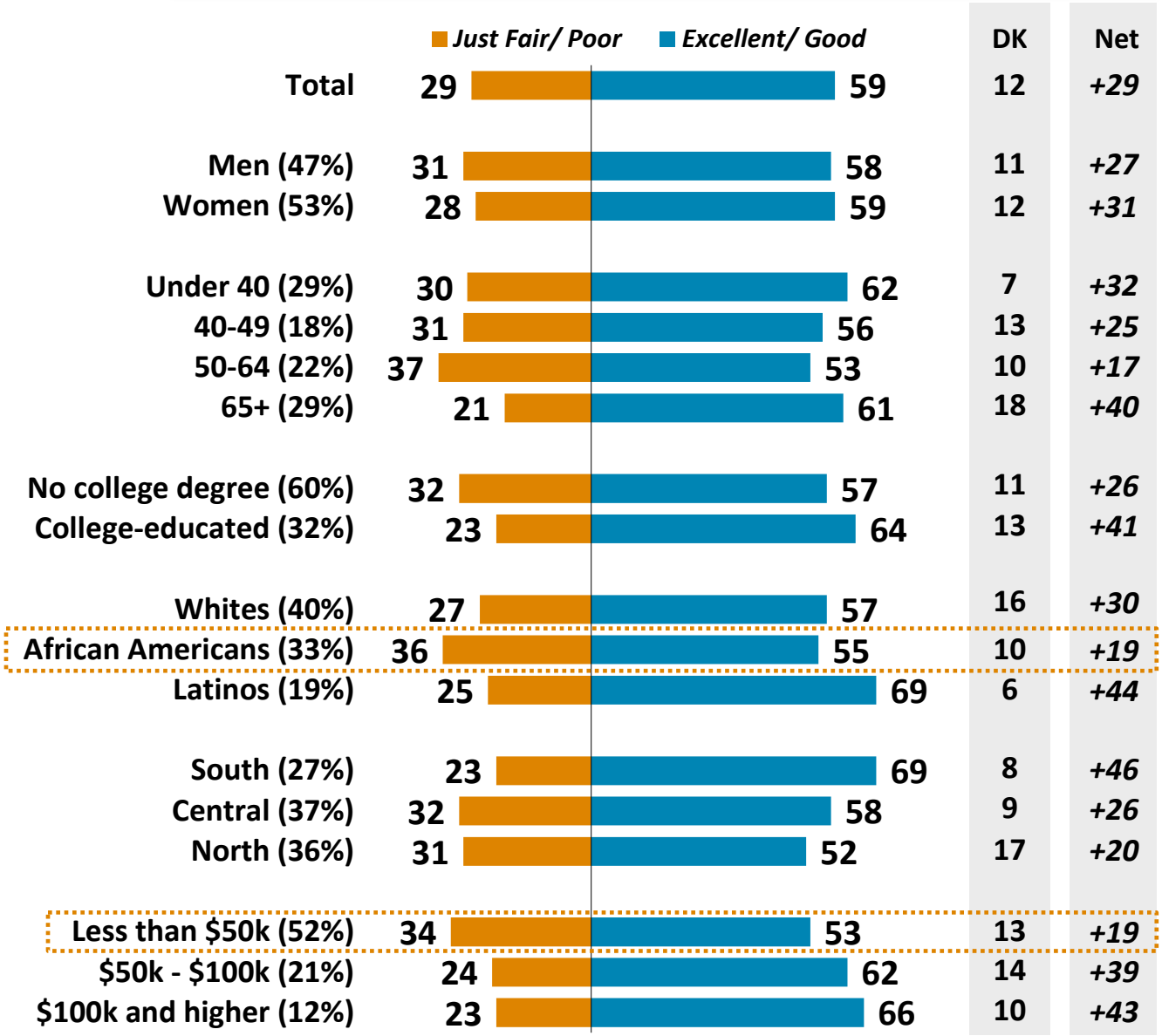
Q3: How would you rate the overall quality of the services that are available to Broward County residents: excellent, good, just fair, or poor?

Lake Research Partners

Quality of Services by Subgroup

While every subgroup rates the quality of services positively (and by wide, double-digit margins), African American residents and low-income residents tend to be more critical in their assessments.

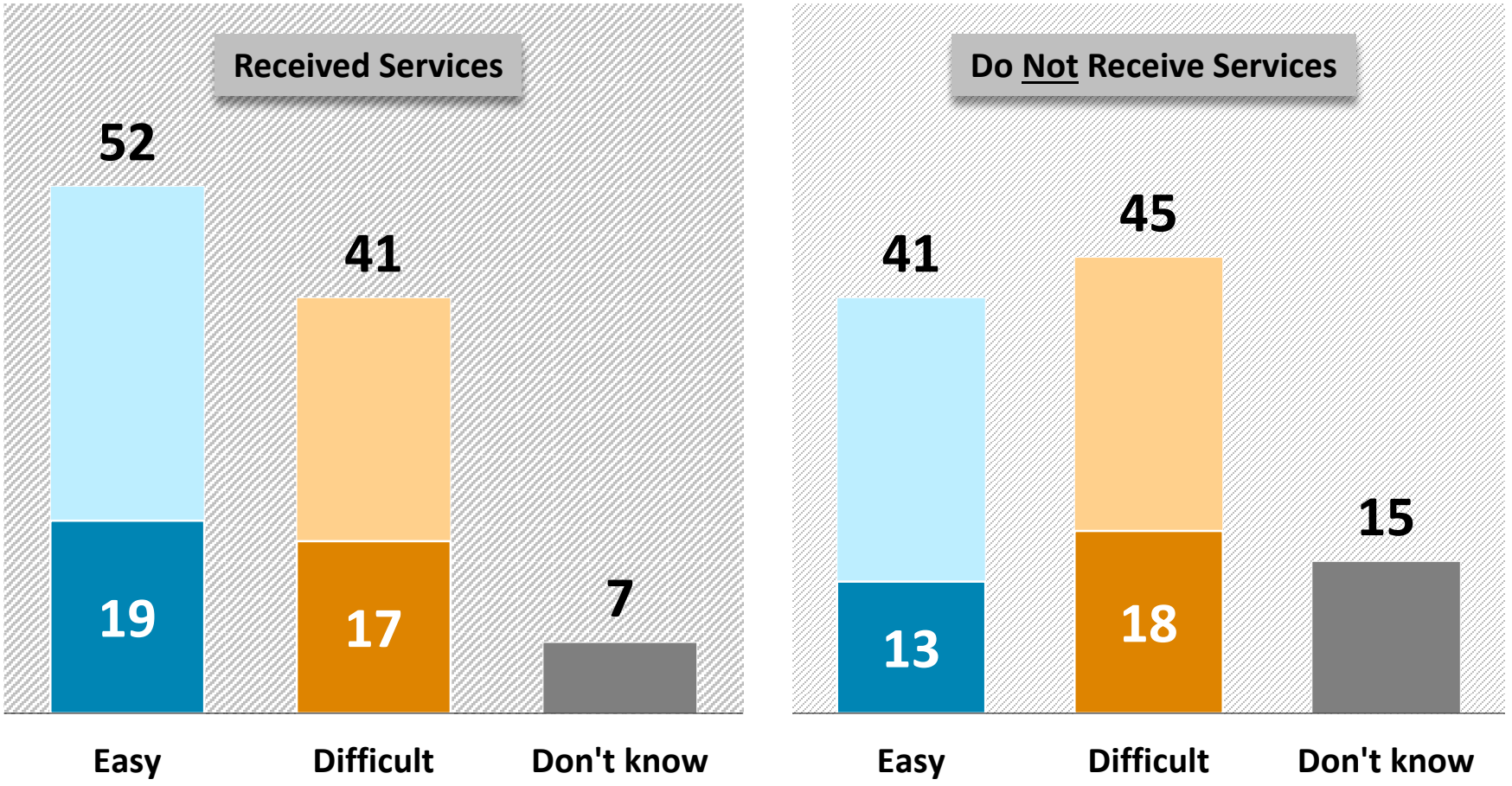
On the other hand, seniors, Latinos, and residents of southern Broward rate county services even more positively than the average resident.



Lake Research Partners

Enhancing accessibility (and perceptions of accessibility) should be a top focus in any public education efforts. Overall, residents are equally divided on ease of access for these services. Those who have received services recently are more positive on this front, though four-in-ten say that services are difficult to obtain. Among non-consumers, a plurality imagines that trying to obtain county services would be difficult.

How Easy or Difficult Would It Be to Obtain These Services?



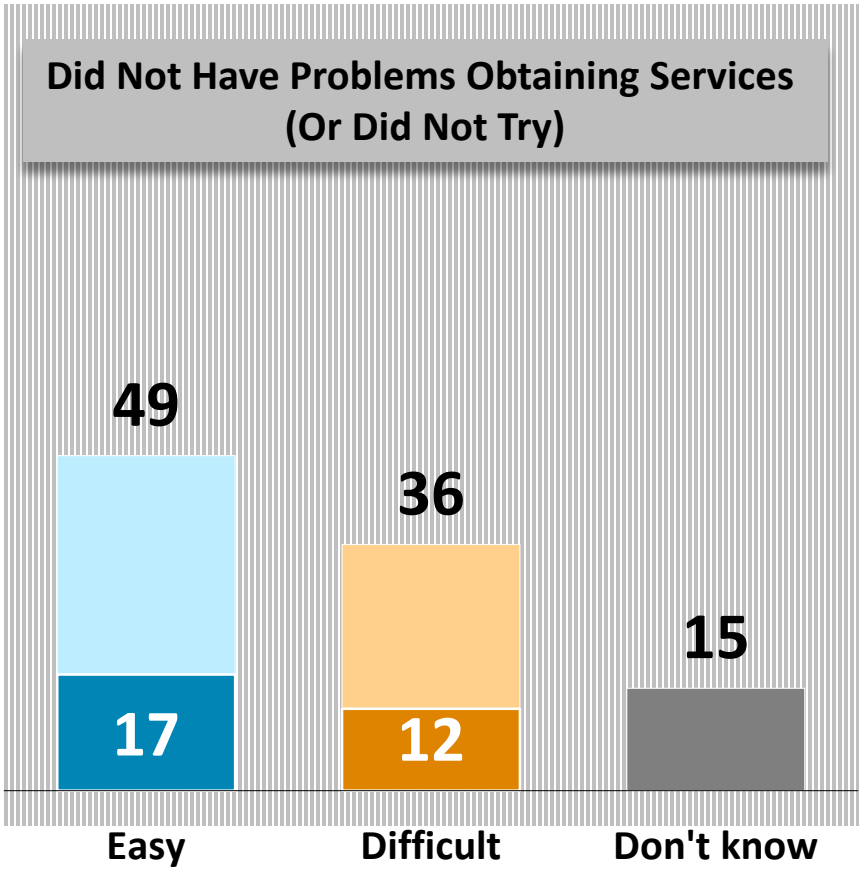
Darker colors indicate intensity.

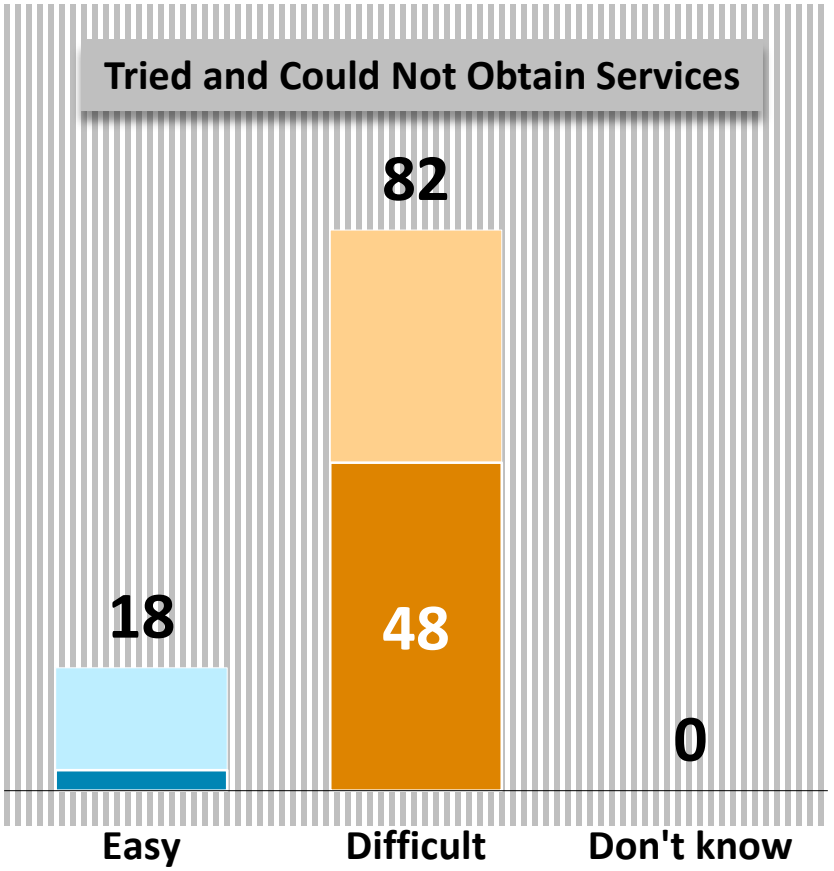
Regardless of whether you have used any of these services, if you or your family needed them, overall, how easy or difficult would it be to obtain these services?

Lake Research Partners

Those who report having had difficulties receiving ~~e~~County services are, not surprisingly, quite negative in their ratings of overall accessibility. However, even among those who do not indicate having experienced any serious obstacles in obtaining services, more than one-third characterize the process as difficult.

Ease of Obtaining Services (Based on History of Trying to Obtain Services*)





*Respondents qualified as "having tried to obtain services" if they or a member of their family tried to obtain them but could not in the last 12 months.

Regardless of whether you have used any of these services, if you or your family needed them, overall, how easy or difficult would it be to obtain these services?

Lake Research Partners

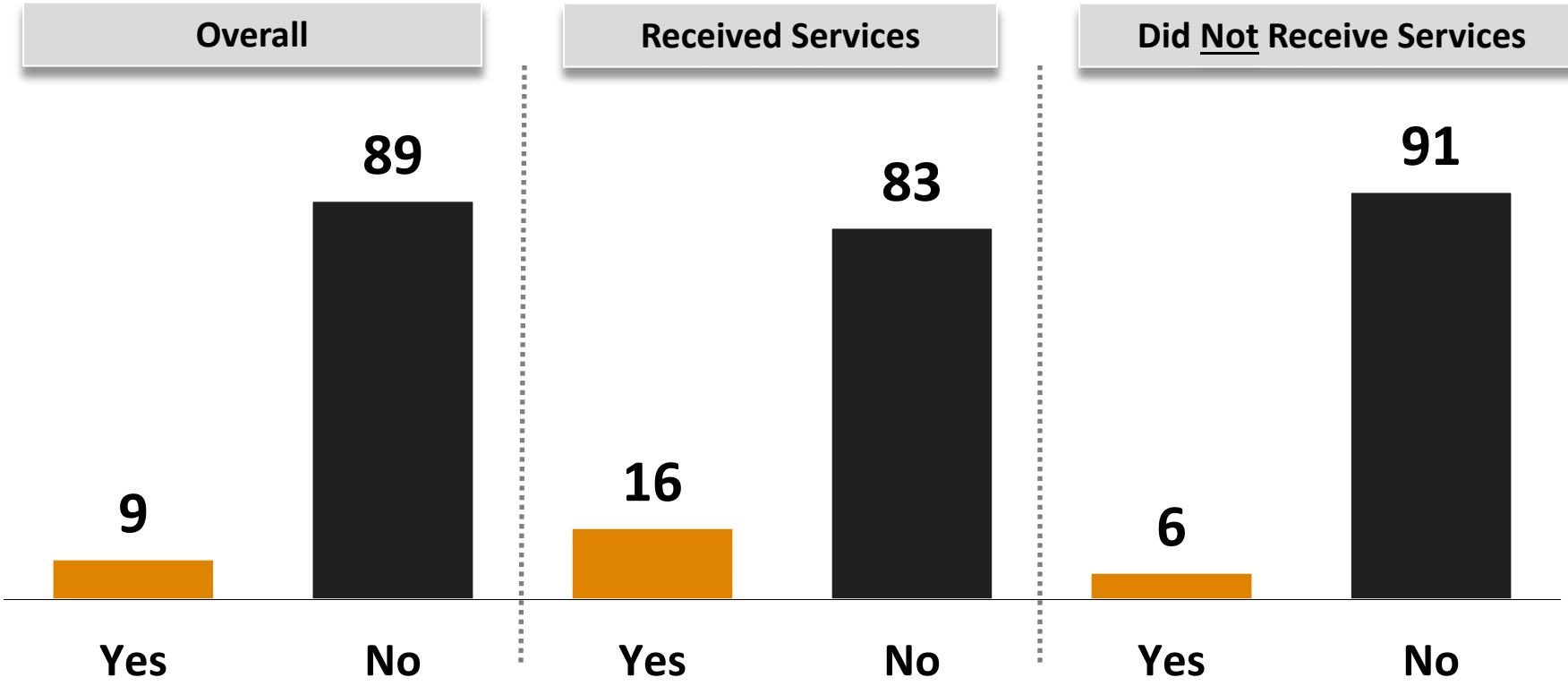
The groups who find obtaining Broward County services easiest tend to be women in northern Broward, younger residents (especially those in northern Broward), and Latinos. Those in their forties, non-college-educated women, and residents of southern Broward County are most likely to characterize access to County services as difficult.

Easiest to Obtain Services	*% Very Easy*	*% Net (Easy – Difficult)*
North under 60	**29**	*+23*
Latinos	**24**	*0*
Single	**22**	*+3*
Black women	**22**	*+5*
North women	**21**	*+8*
Under 40	**21**	*+28*
Non-college women	**20**	*+1*
Total	***15***	*--*

Hardest to Obtain Services	*% Very Difficult*	*% Net (Easy – Difficult)*
Ages 40-49	**26**	*-14*
Non-college women	**26**	*+1*
South women	**25**	*-18*
Women under 60	**24**	*0*
South under 60	**24**	*-9*
Women who have received services in last 12 months	**23**	*-1*
Total	***18***	*--*

The number of respondents who have been put on a wait list is very low, and only slightly higher for those who have received services (and have therefore been more active in pursuing them). Essential services like general health and mental health care, veterans' and elderly support, and financial assistance are the most likely to be mentioned as leading to a wait list.

Have You Needed Any Services for Which You Were Put on A Wait List?



Most common wait list services: *health care, veterans assistance, elderly assistance, financial assistance, mental health programs*

Q71: In the past year, have you needed any services and had to be put on a wait list? **[IF YES]** Which service or services?

Lake Research Partners

Available Services: Image and Satisfaction

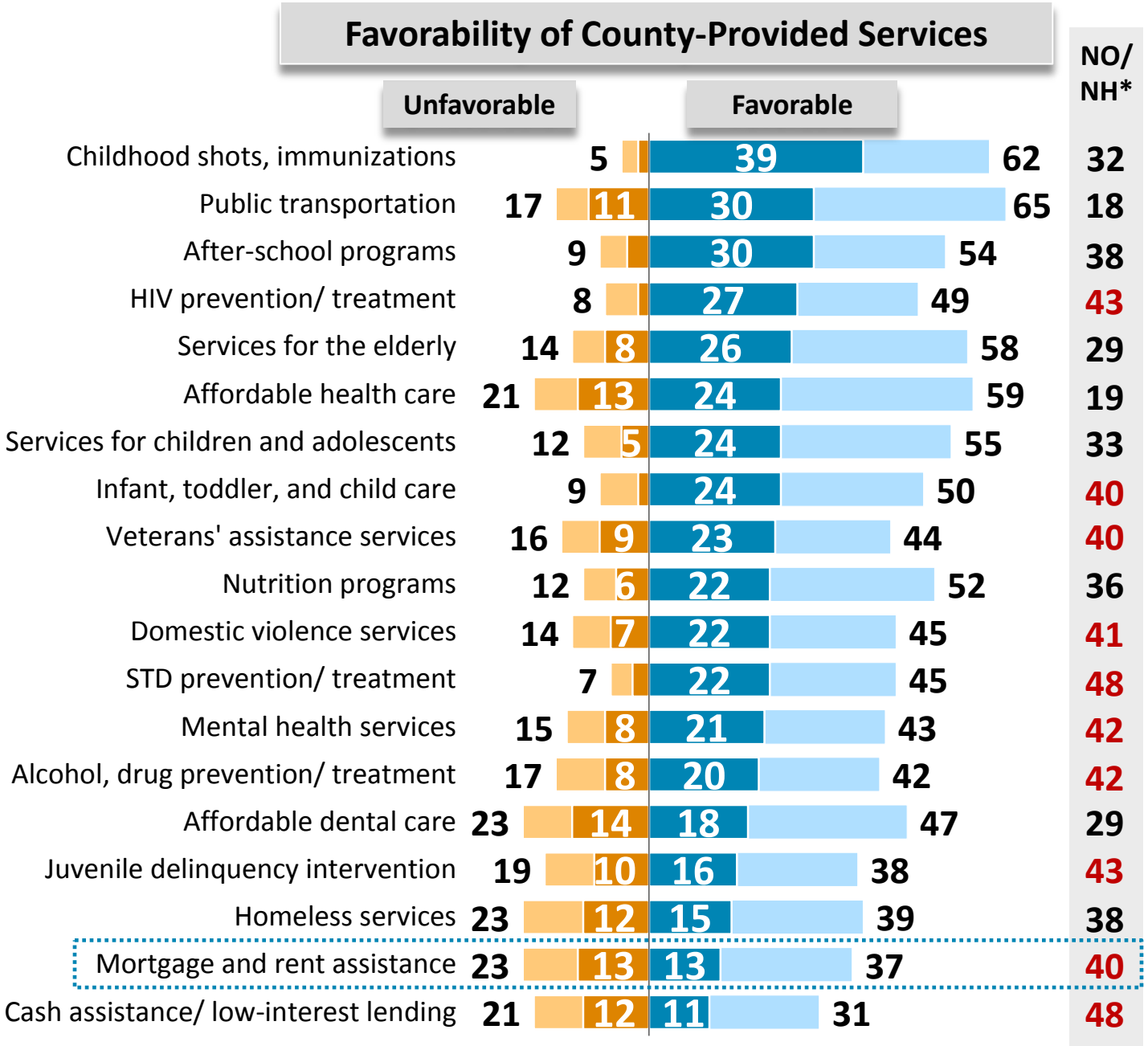
Most respondents are aware of, hold favorable opinions of, and report high levels of satisfaction with the broad array of services available in Broward County. While gaps between overall favorability and satisfaction do appear for some services, none approaches a level that would suggest real problems in program execution. Instead, basic support services like childhood immunizations, public transit, after-school programs, affordable health care, and elderly services tend to earn the highest ratings, while programs geared toward financial and homeless assistance, juvenile delinquency, alcohol/drug prevention, and mental health services elicit more mixed responses. In terms of new County offerings, more low-cost health care services generate the most interest, though that interest varies greatly by subgroup.

Lake Research Partners

Favorability of County-Provided Services

Some County services are better known than others. Childhood shots and immunizations, public transit, and after-school programs receive the highest marks, both in terms of net appeal and positive intensity.

Other services—such as HIV/STD prevention, low-interest lending, juvenile delinquency intervention, mortgage and rent assistance and mental health services—suffer from a combination of lack of familiarity and public skepticism. Education and branding efforts will be important to increasing public confidence in the wide gamut of services offered by the County. To this end, regression analysis indicates that having a favorable impression of the County's mortgage and rent assistance programs predicts to a higher overall rating of Broward County services.



*NO/ NH = no opinion/ never heard.
Darker colors indicate intensity.

Next, I'm going to read you a list of services that are available to residents of Broward County. For each, please tell me whether you have a very favorable, somewhat favorable, somewhat unfavorable, or very unfavorable impression. If you have heard of the service, but do not know enough to have an impression, or if you haven't heard of the service, just say so, and we will move on.

Lake Research Partners

Across all key subgroups, childhood shots and immunization programs are consistently viewed the most favorably, with especially positive perceptions among high-need groups like the uninsured, residents relying on government assistance, and households with children at home. A sizeable gap exists between African Americans and other residents on HIV treatment, as well as on public transit, after-school programs, elderly services, and affordable health care.

Favorability of County-Provided Services Among Subgroups

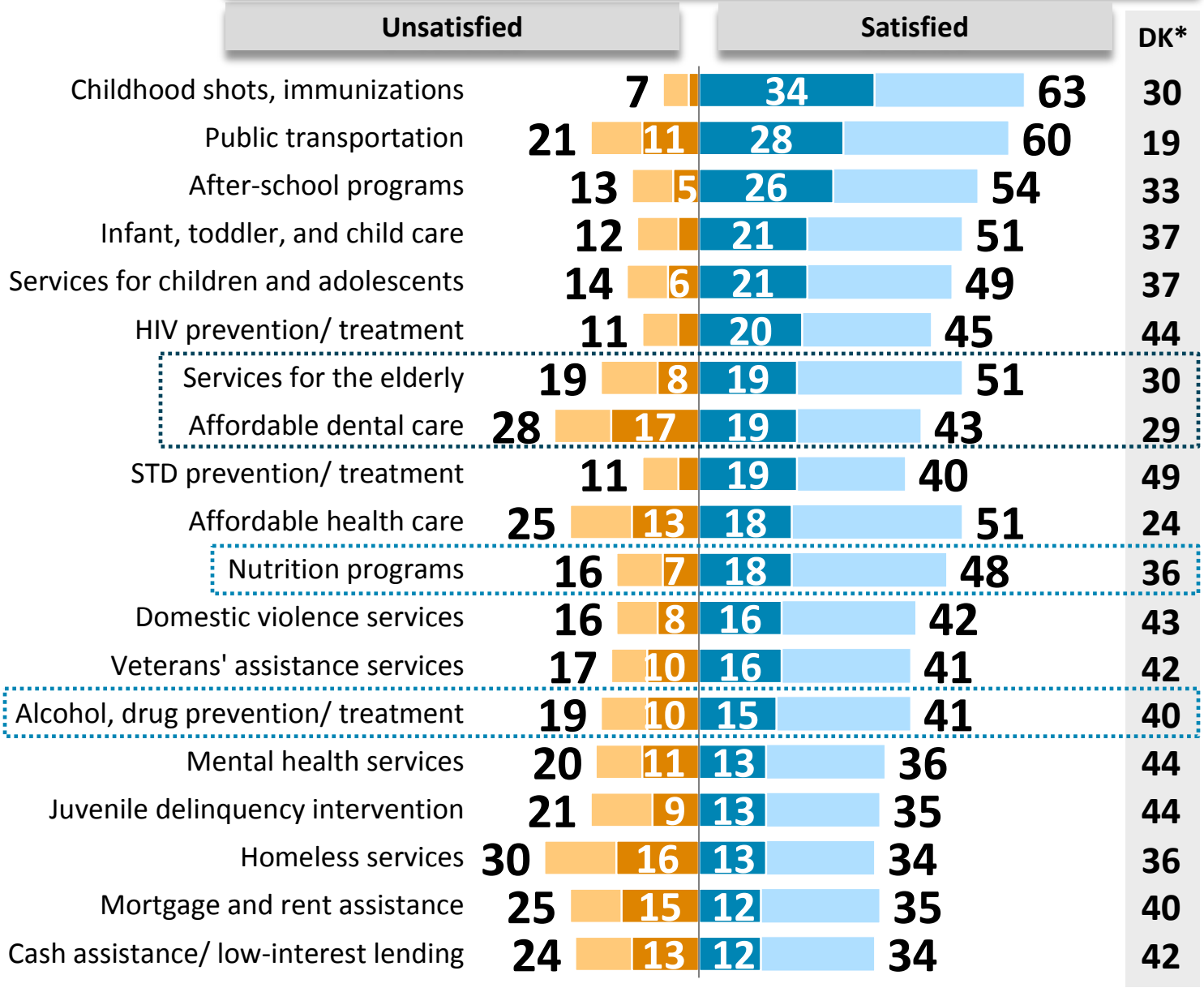
	All	Received Services	Did Not	White	AA	Latino	Uninsured	Children in HH	Receives Gov. Assist.
Childhood Shots, Immunizations	**39**	**44**	**37**	**33**	**47**	**44**	**54**	**50**	**49**
Public Transportation	30	31	30	24	42	24	40	35	37
After-school programs	30	38	28	20	46	31	46	43	32
HIV Prevention and Treatment	27	31	26	21	**41**	23	26	29	30
Services for the elderly	26	22	27	22	33	23	25	23	27
Affordable Health Care	24	19	25	20	32	20	23	21	26
Services for children and adolescents	24	26	22	16	32	28	29	32	24
Infant, toddler, and child care	24	30	22	17	32	26	31	36	27
Veterans' assistance services	23	22	23	20	27	23	25	18	25

Next, I'm going to read you a list of services that are available to residents of Broward County. For each, please tell me whether you have a very favorable, somewhat favorable, somewhat unfavorable, or very unfavorable impression. If you have heard of the service, but do not know enough to have an impression, or if you haven't heard of the service, just say so, and we will move on.

Satisfaction With County-Provided Services

Satisfaction with County services tracks closely with overall favorability, though a satisfaction gap emerges with regard to some services, most notably affordable health care and mental health services.

Regression analysis indicates that satisfaction with nutrition and drug and alcohol prevention/ treatment programs predicts to a positive rating for overall service quality, while positive ratings for elderly services and dental care predict to perceptions of overall accessibility.



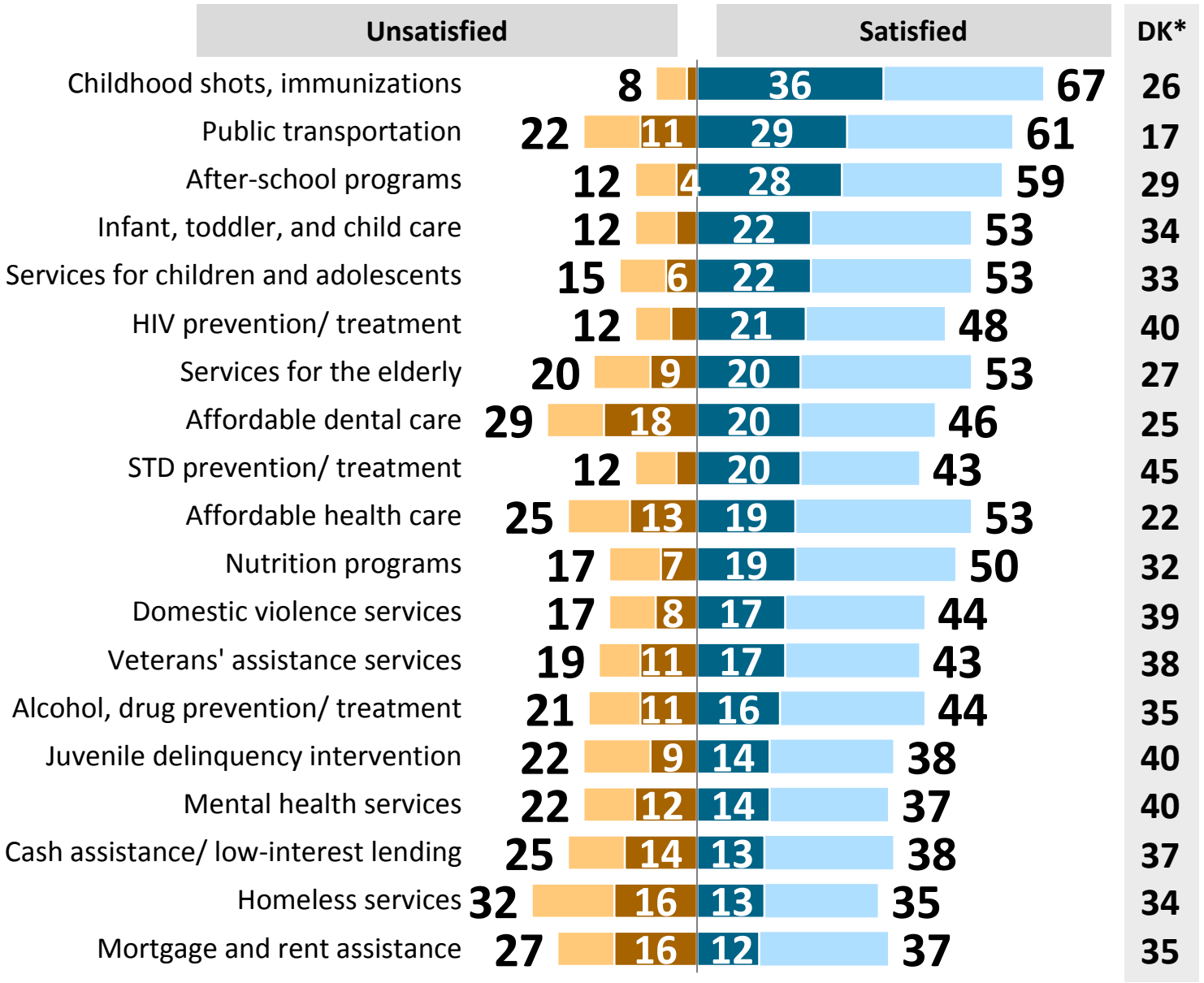
*DK = unsure/don't know.
Darker colors indicate intensity.

Next, I'm going to read you a list of services that are available to Broward County residents. This time, for each one, please tell me how satisfied you are with the quality of that particular service for county residents: very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied. If you're not sure how you feel about a particular service, please say so and we'll move on.

Lake Research Partners

Satisfaction (Among Those Who Are Familiar With Services)

Looking only at those who have heard of the services in question (the vast majority of respondents), satisfaction changes very little.



*DK = unsure/don't know.
Darker colors indicate intensity.

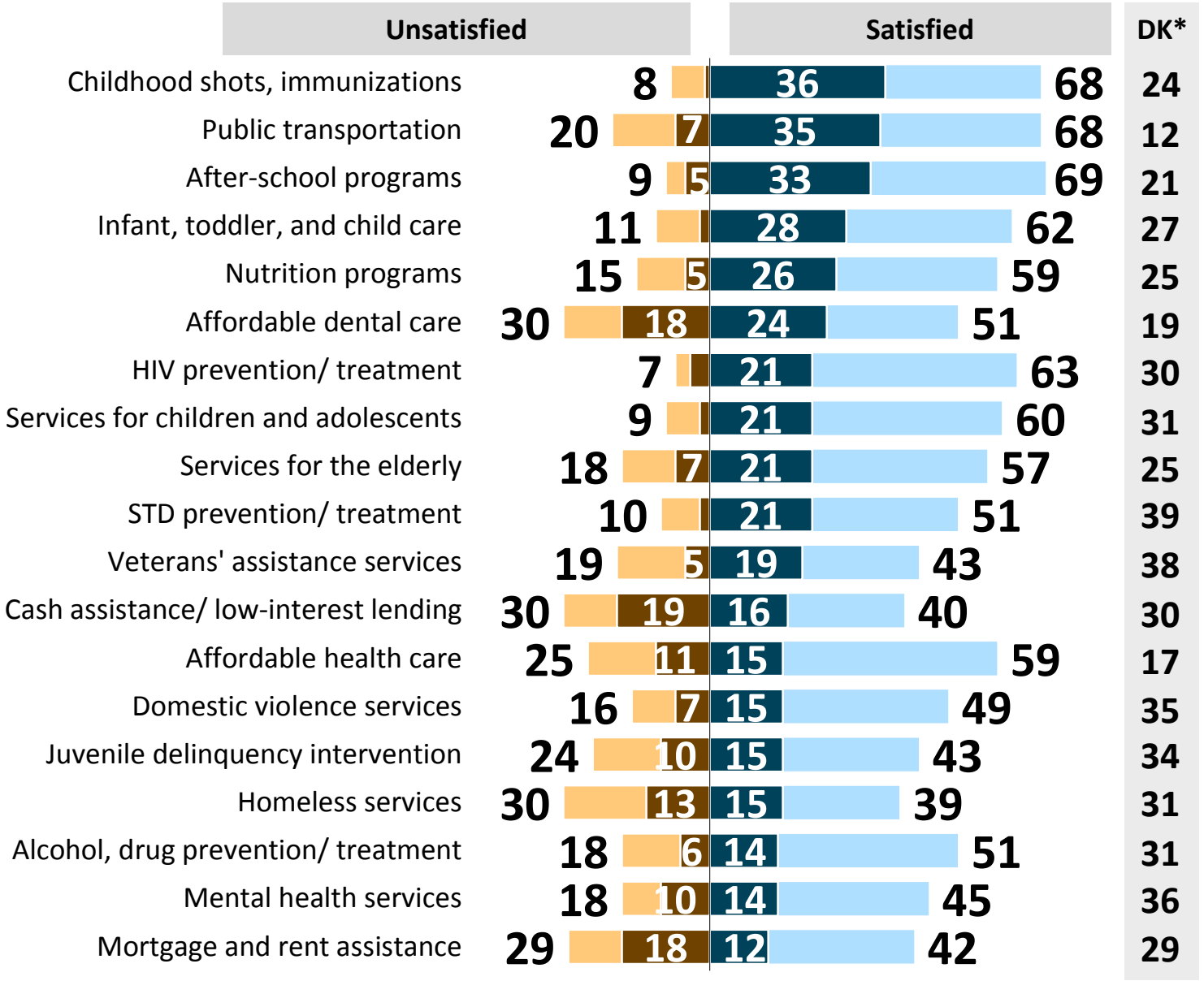
Next, I'm going to read you a list of services that are available to Broward County residents. This time, for each one, please tell me how satisfied you are with the quality of that particular service for county residents: very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied. If you're not sure how you feel about a particular service, please say so and we'll move on.

Lake Research Partners

Satisfaction (Among Those Who Have Received Services)

Those who have received services in the past year give especially high ratings to services that benefit children and families (including immunizations, after-school programs, and child care). Public transportation is also very popular (and the most familiar service), with nearly nine-in-ten expressing a positive opinion.

Programs involving financial help, like cash or rent assistance, receive more mixed ratings among these residents as well.



*DK = unsure/don't know.
Darker colors indicate intensity.

Next, I'm going to read you a list of services that are available to Broward County residents. This time, for each one, please tell me how satisfied you are with the quality of that particular service for county residents: very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied. If you're not sure how you feel about a particular service, please say so and we'll move on.

Lake Research Partners

The programs that register the biggest gaps between favorability and satisfaction tend to be some of the programs that are less favorably regarded, relatively speaking: mental health and homeless services, dental care, and juvenile delinquency. However, more favorably regarded services draw lower satisfaction scores, namely elderly services, public transportation, nutrition programs, STD and HIV prevention/treatment, and services for children.

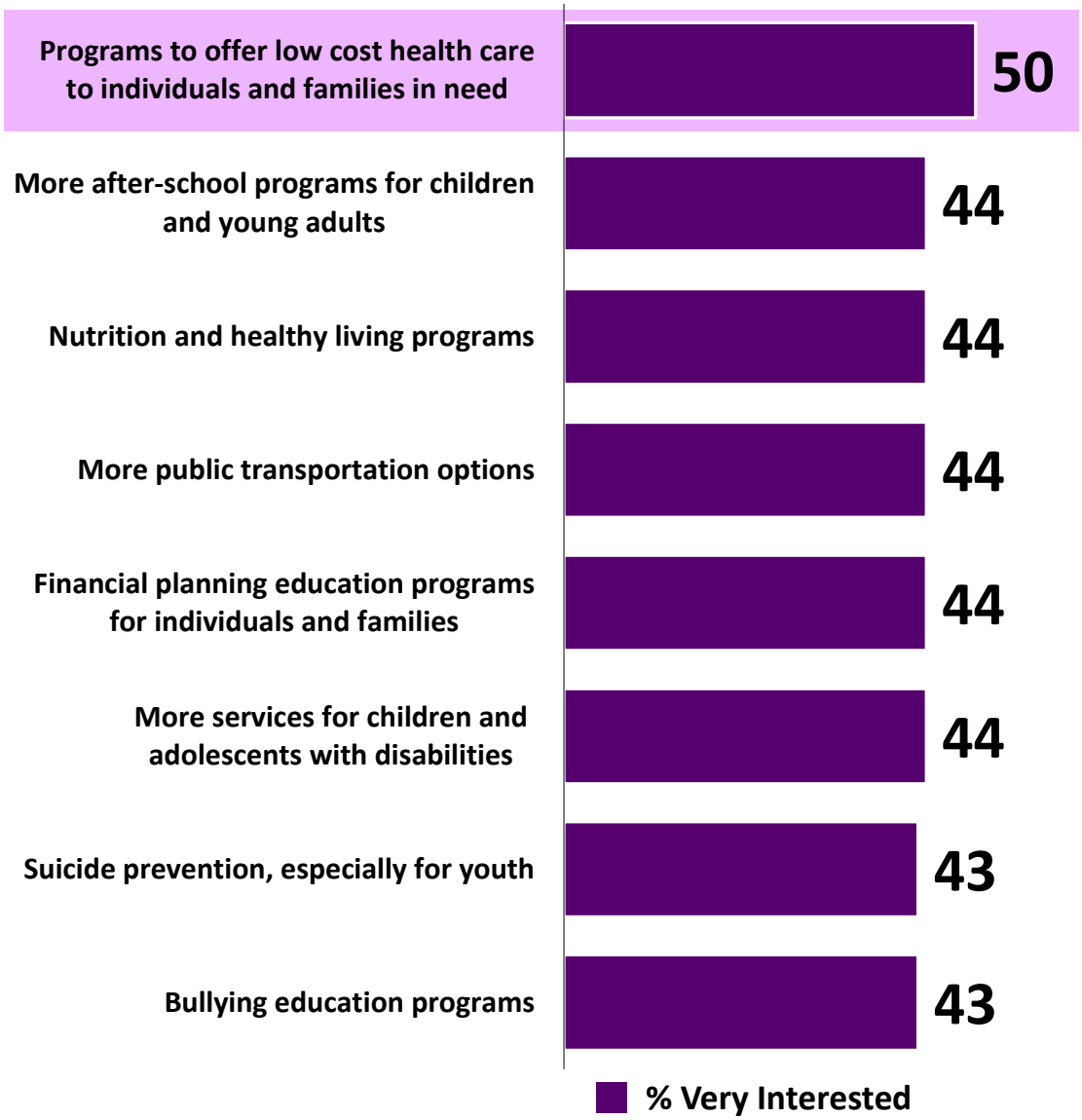
Service Ratings: Favorability vs. Satisfaction

	Net Favorability	Net Satisfaction	*% Net Diff.*
Mental health services	+28	+15	*-13*
Affordable health care	+38	+26	*-12*
Elderly services	+44	+33	*-11*
Homeless services	+16	+5	*-11*
Affordable dental care	+24	+14	*-10*
STD prevention/treatment	+37	+28	*-9*
Public transit	+48	+39	*-9*
Nutrition programs	+40	+32	*-8*
Services for children	+43	+35	*-8*
HIV prevention/treatment	+41	+34	*-7*
Juvenile delinquency	+19	+14	*-5*
Veterans' assistance	+28	+23	*-5*
Domestic violence services	+31	+26	*-5*
After-school programs	+46	+41	*-5*

When it comes to identifying additional needs, low-cost health care programs top the list of desired services—both for those who have received services recently and those who have not– followed by more after-school programs, public transportation options, financial planning services, and services for youth, such as suicide prevention and bullying education.

We find large gaps in interest between consumers and non-consumers when it comes to nutrition programs and public transportation, a point that underscores the larger socioeconomic differences between the two subpopulations. Nonetheless, these programs still attract the interest of 40% of residents who do not currently use Broward County services.

How Interested Would You Be in Each Service? (Top Tier)



Received Services?	
Yes	No
55	48
51	42
54	41
55	40
49	42
49	42
50	41
46	41

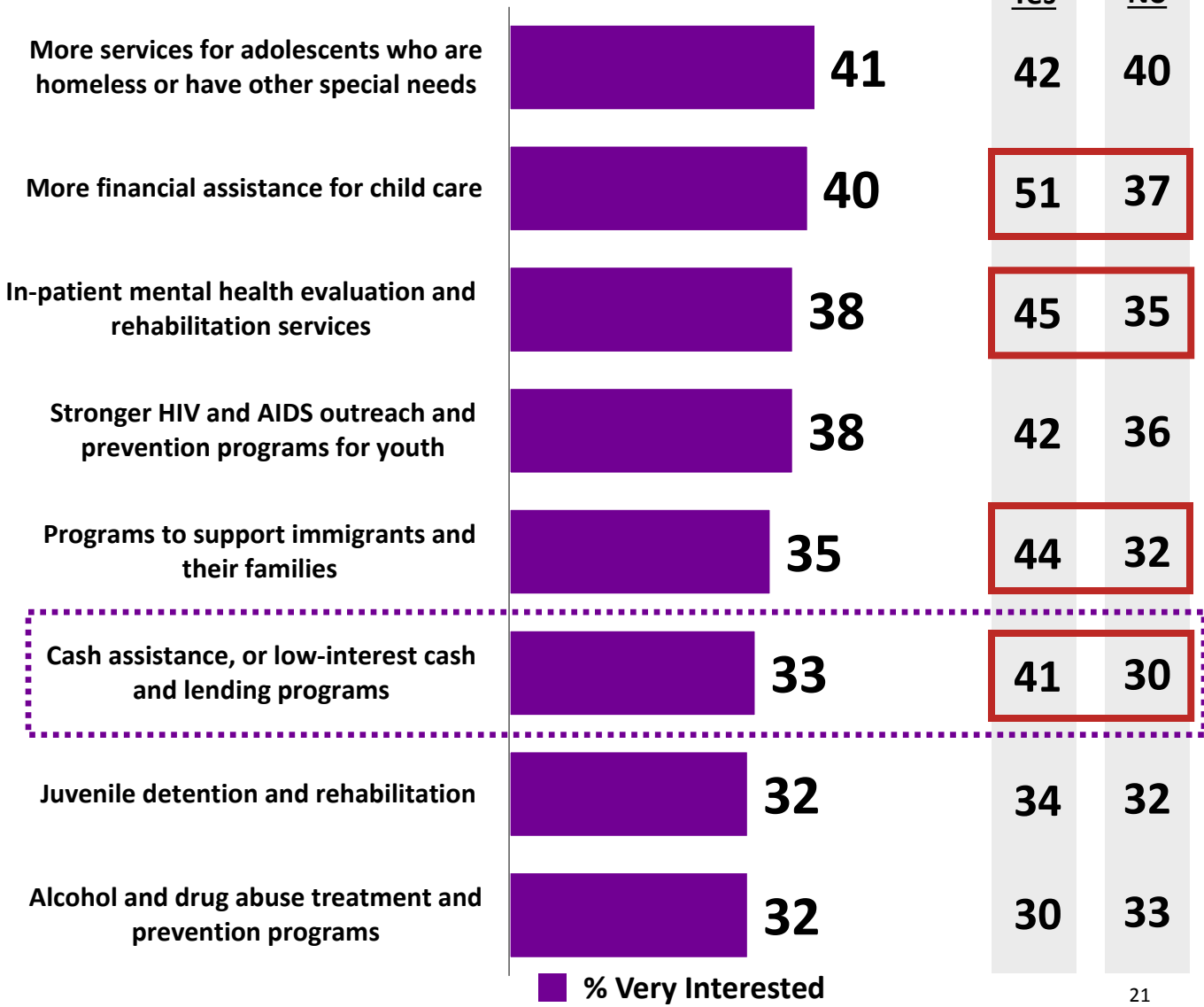
Next, I'm going to read you a list of services. For each one, please tell me how interested you would be in that service: very interested, somewhat interested, a little interested, or not interested at all. If you're not sure how you feel about a particular service, please say so and we'll move on.

Lake Research Partners

Other gaps in service interest include financial assistance for child care, an especially pertinent topic for the younger women and large families that make up a large share of those currently receiving services. The same holds true of mental health services, immigrant support programs, and cash assistance—divides that are also characterized by the demographic differences between consumers and non-consumers.

Although there is little overall interest in additional cash assistance programs, they are a major driver in increasing residents' likelihood to seek out County services in the future.

How Interested Would You Be in Each Service? (Second Tier)



Next, I'm going to read you a list of services. For each one, please tell me how interested you would be in that service: very interested, somewhat interested, a little interested, or not interested at all. If you're not sure how you feel about a particular service, please say so and we'll move on.

Lake Research Partners

Low-cost health care boasts strong appeal across all major subgroups. Meanwhile, after-school programs stand out for those with children under 18 and residents currently receiving government assistance. Nutrition and healthy living programs appeal most to Latinos and existing consumers, and those currently receiving services are also partial to more public transit options.

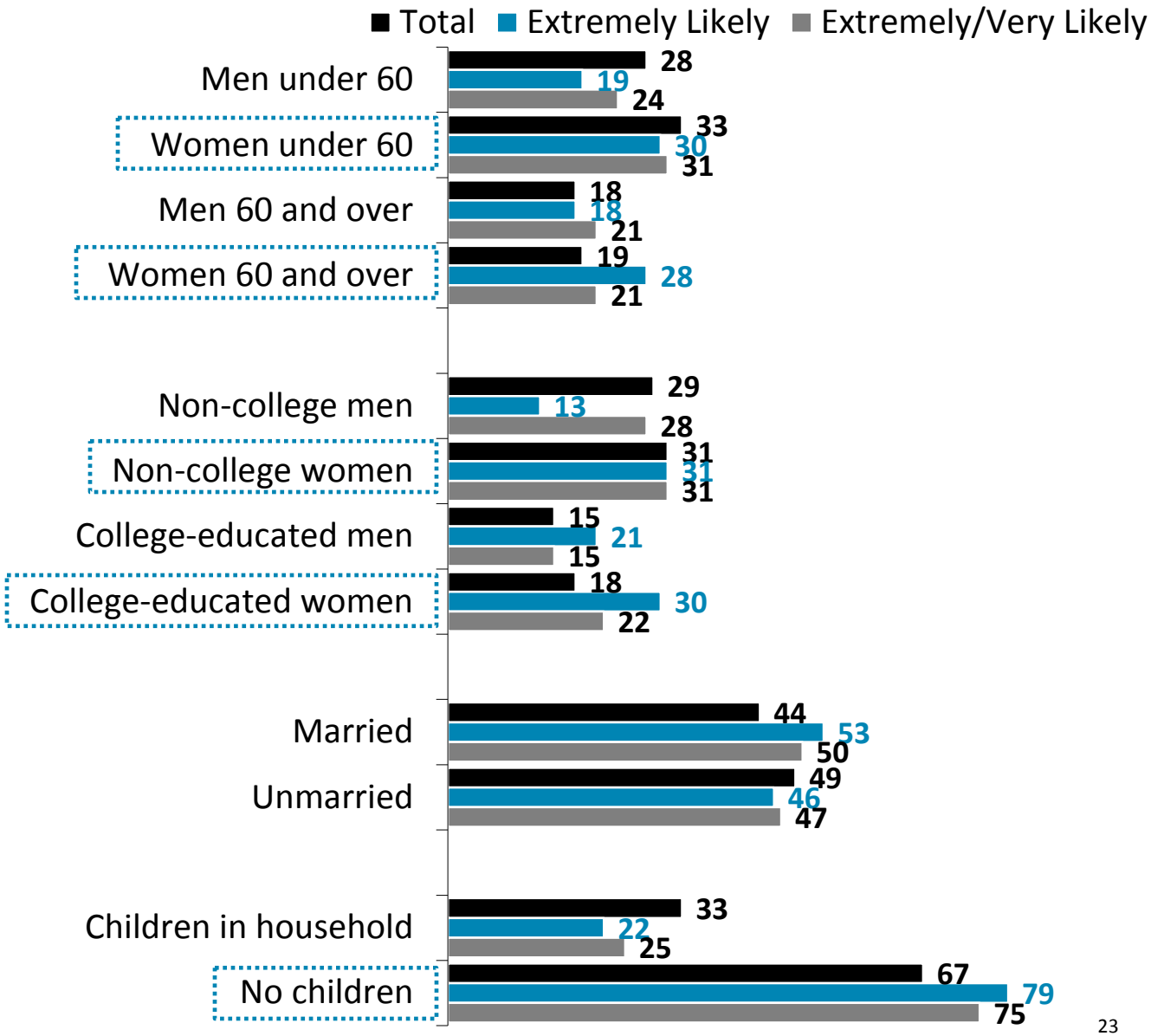
Interest in Each Service Among Subgroups									
	All	Received Services	Did Not	White	AA	Latino	Uninsured	Children in HH	Receives Gov. Assist.
Low-cost health care	***50***	**55**	**48**	**41**	**62**	52	**65**	**60**	**58**
More after-school programs	*44*	51	42	35	52	53	43	57	**57**
Nutrition/ healthy living	*44*	54	41	31	55	**59**	54	52	**57**
More public transit options	*44*	**55**	40	39	50	47	50	48	45
Financial planning education	*44*	49	42	35	57	46	54	53	53
More disability programs	*44*	49	42	36	53	46	42	51	50
Suicide prevention	*43*	50	41	35	50	52	52	52	44
Bullying education programs	*43*	46	41	32	53	47	46	51	48

Next, I'm going to read you a list of services that are available to residents of Broward County. For each, please tell me whether you have a very favorable, somewhat favorable, somewhat unfavorable, or very unfavorable impression. If you have heard of the service, but do not know enough to have an impression, or if you haven't heard of the service, just say so, and we will move on.

Target Profile: Non-Recipient Who Is Likely to Seek Out Services

The County resident who is not currently receiving services but reports an "extremely" high likelihood of seeking them out in the future is a childless woman, and more likely to be educated and older when compared to the overall demographic composition of Broward County.

When revising the criteria to those who are "extremely" or "very likely" to use services, our target becomes more male and educated.

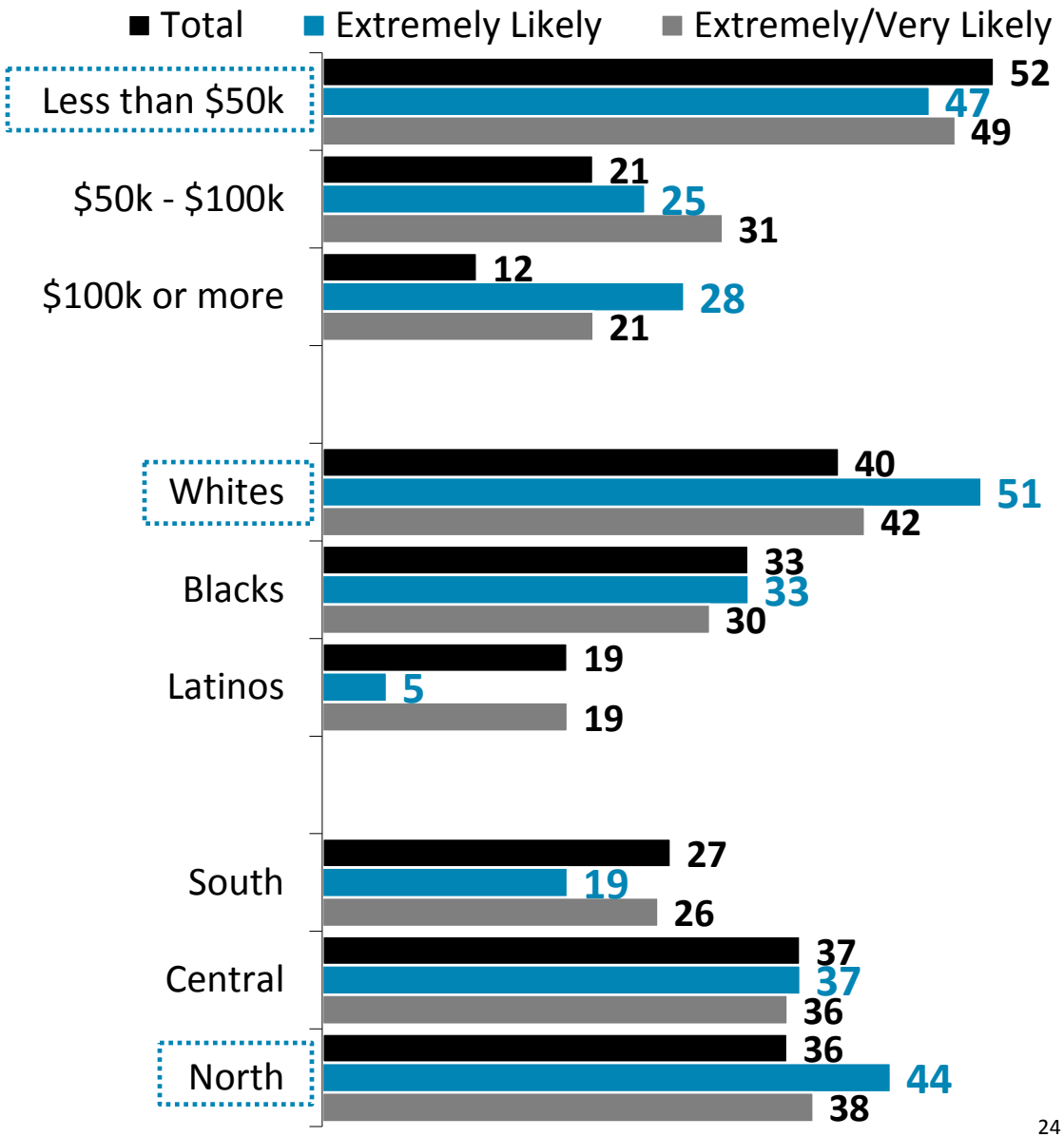


Lake Research Partners

Target Profile: Non-Recipient Who Is Likely to Seek Out Services

The non-consumer who describes herself as extremely amenable to participating in County services also tends to be in a lower income bracket but tends to be a white woman living in Northern Broward County, a significant departure from current service users. Very few Latinos are in this group.

Again, those who are either extremely or very likely to seek out services differ slightly in that they match the overall racial and regional profile of the County.



Lake Research Partners

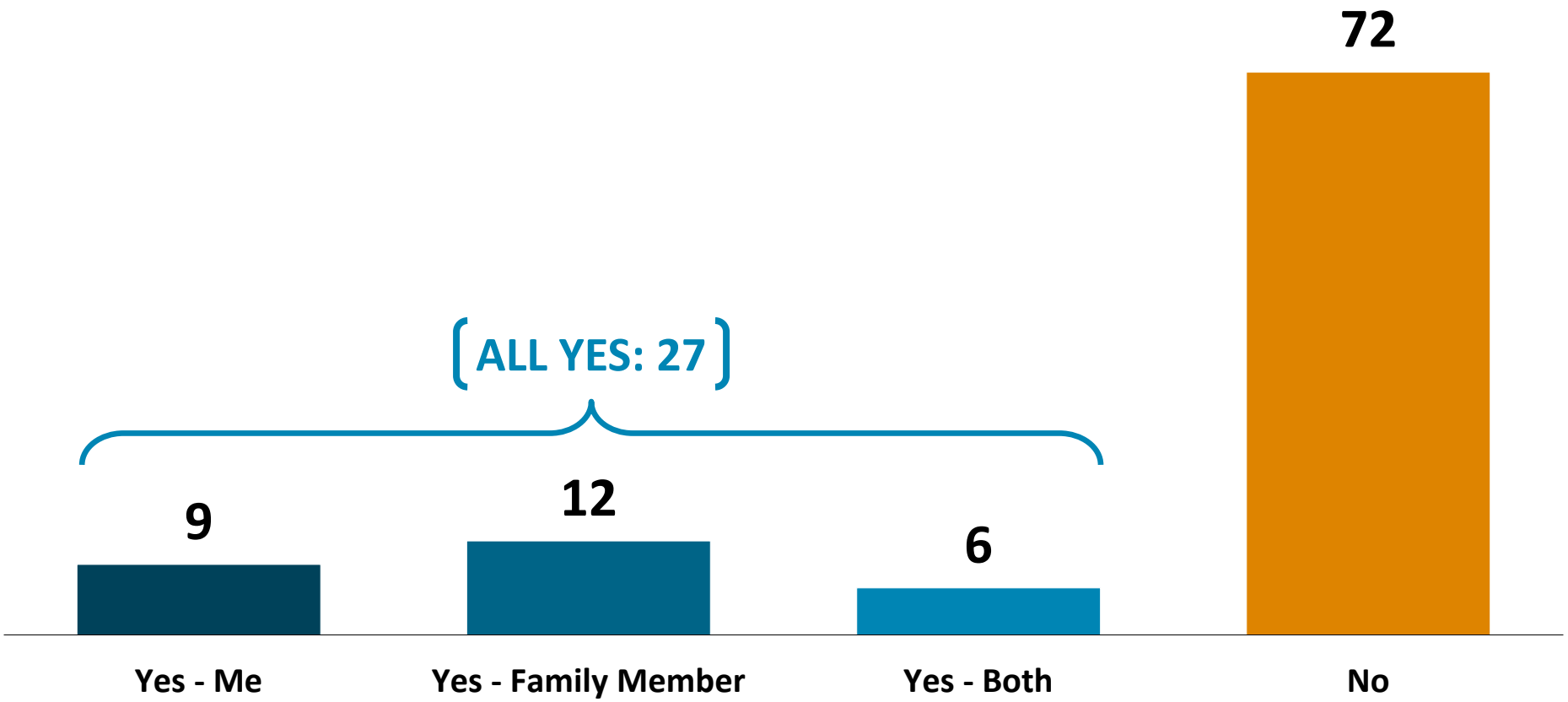
Recipients of County Services: a Closer Look at Existing Consumers

Those who report having received County services in the past year tend to be younger, lower income, more likely to be African American and Latino, and more likely to have children living at home. Public transit and health care services are the most frequently consumed offerings from the County. While most indicate they will continue using County programs on account of their efficiency and convenience, some report shortcomings in accessibility as an obstacle to obtaining the services they need.

Lake Research Partners

More than one in four Broward County residents have received County services themselves in the past year, or report that an immediate family member has.

Have You or Your Immediate Family Received Services?



Q44: In the past 12 months, have you or a member of your immediate family received any of the services we have been discussing during this survey or any other services?

Lake Research Partners

Residents in large households and those without health insurance are the most likely to have received County services, as well as certain subgroups of women, Latinos, African Americans, and younger residents. Those least likely to report having received services are seniors and those on Medicare, respondents with private insurance, whites, and married, college educated women.

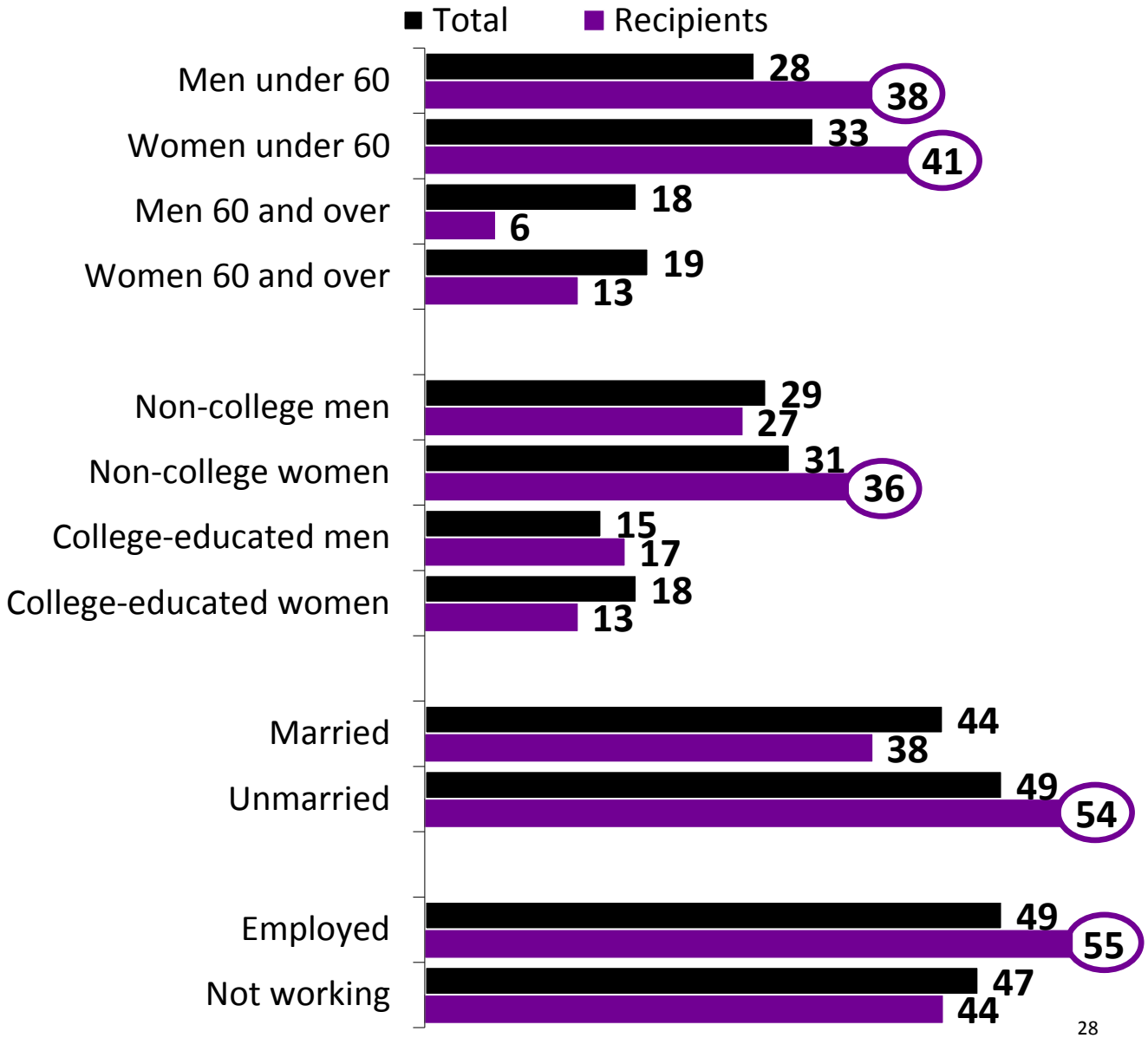
Those Most Likely to Receive Services		
Disproportionately Yes	% Yes	% of Population
Live in a household with 5 or more people	**46**	*16*
Do not have health insurance	**42**	*22*
Southern region women	**41**	*15*
Latinos	**40**	*19*
African American women	**39**	*19*
Under age 40	**39**	*29*
Have children at home	**37**	*33*
Under age 60	**34**	*61*
Some college experience	**32**	*23*
Age 40-49	**32**	*18*
Total	*27*	*--*

Those Most Likely to NOT Receive Services		
Disproportionately No	% No	% of Population
Age 65+	**86**	*29*
Have Medicare	**86**	*21*
Retired	**85**	*27*
Pay for health insurance themselves	**85**	*12*
White	**83**	*40*
Live in household of one	**83**	*17*
Live in a household of three	**79**	*13*
Have no children at home	**78**	*67*
Married women	**78**	*21*
College educated women	**78**	*18*
Total	*72*	*--*

Profile of the Broward Resident Who Receives Services

The typical consumer of Broward County Human Services offerings is a younger (i.e. under 60) resident, more likely to be unmarried, employed, and without a college degree.

Fully 43 percent of recipients are under the age of 40 and nearly two-thirds (65%) are under the age of 50.

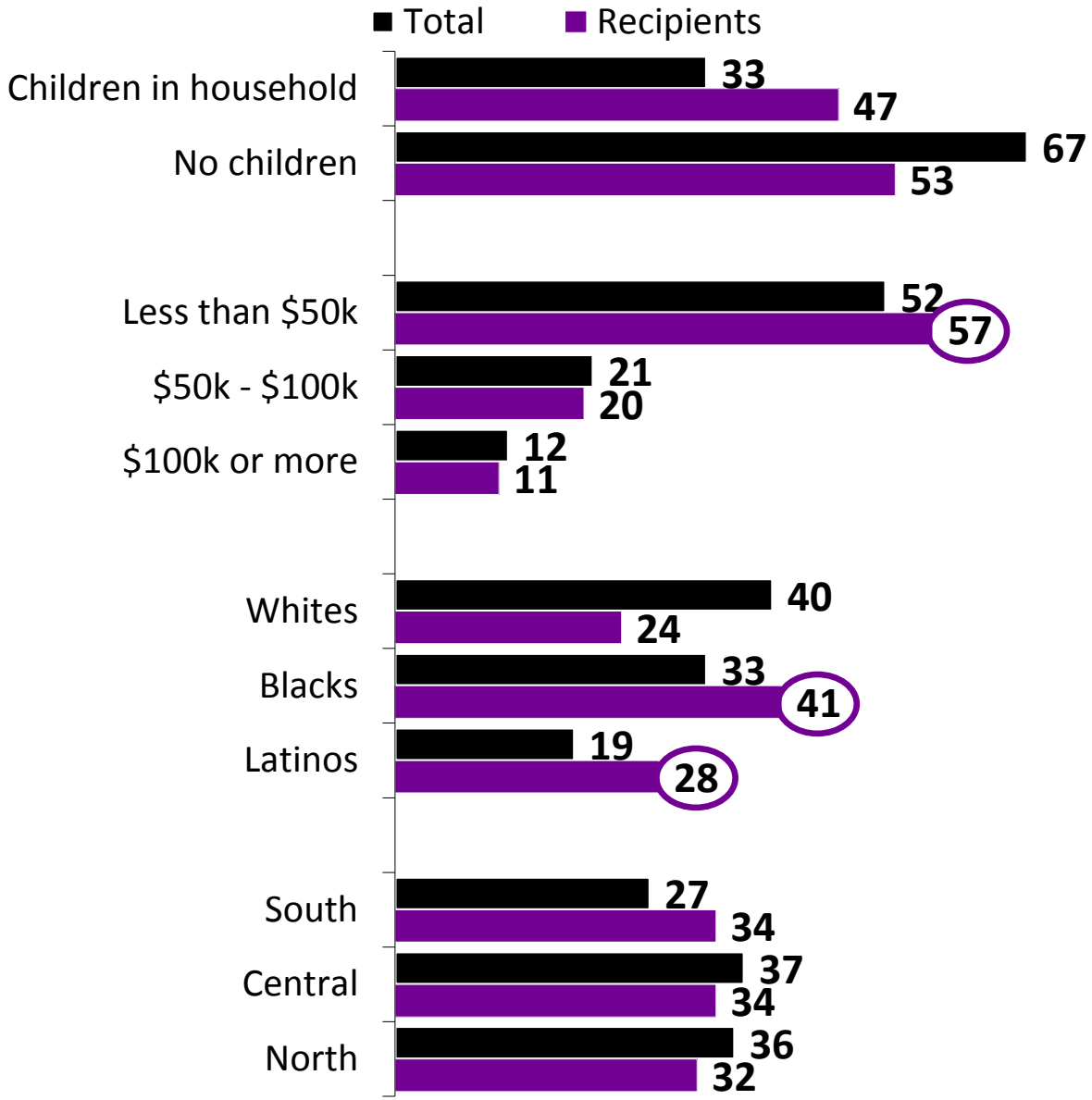


Lake Research Partners

Profile of the Broward Resident Who Receives Services

African Americans and Latinos are disproportionately represented among the population of consumers of County services, as are residents with household incomes under $50,000. Recipients are more likely to have children at home than the average resident.

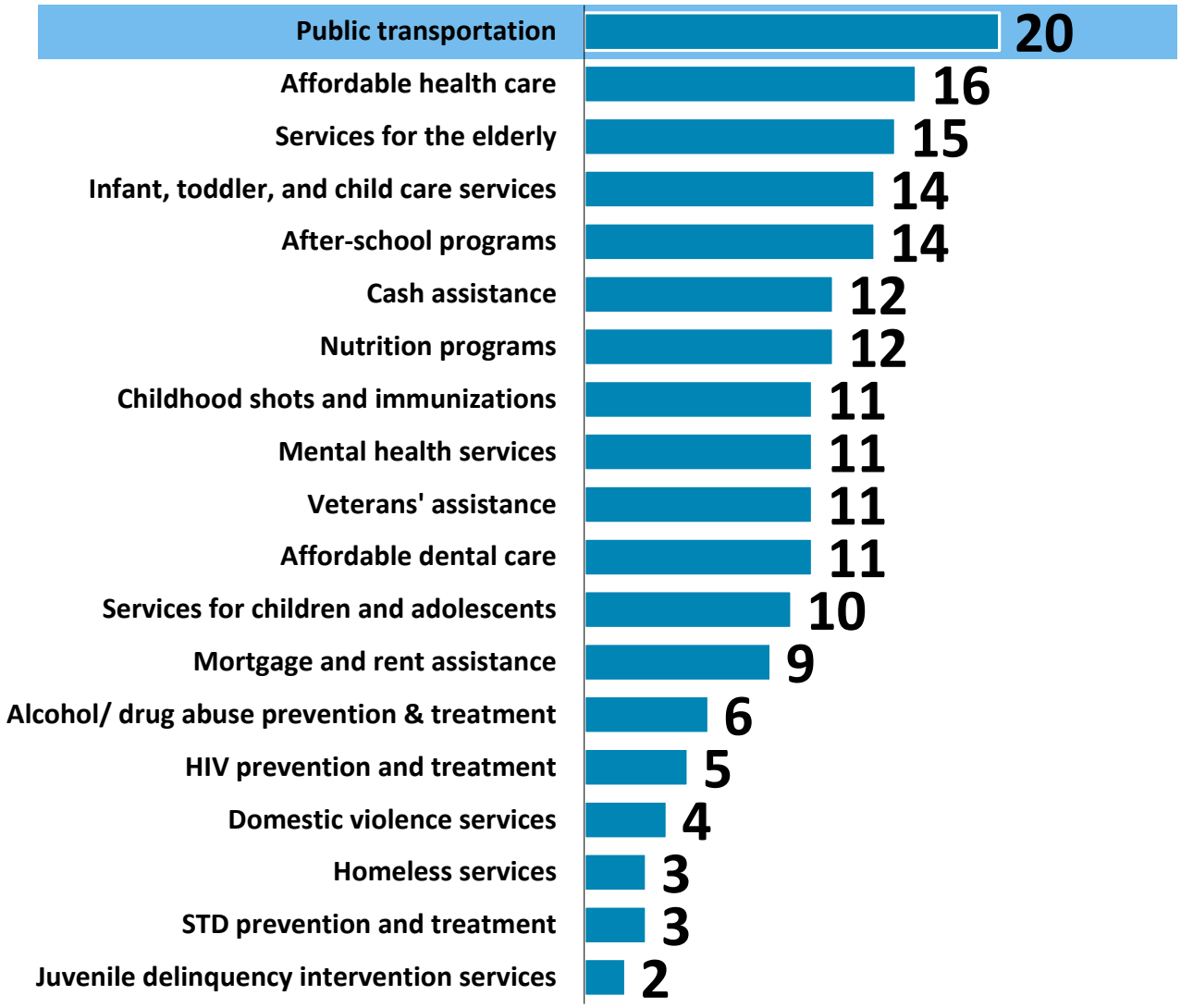
Consumers are evenly distributed throughout the county but are more concentrated in southern Broward compared to the population as a whole.



Lake Research Partners

Which Services Have You Received?*

Among those who have used County programs in the last year, public transportation is the most commonly cited service, followed by affordable health care programs and services for the elderly. While slightly less prevalent overall, child care services and nutrition programs are more heavily used by women (19% and 16%, respectively).



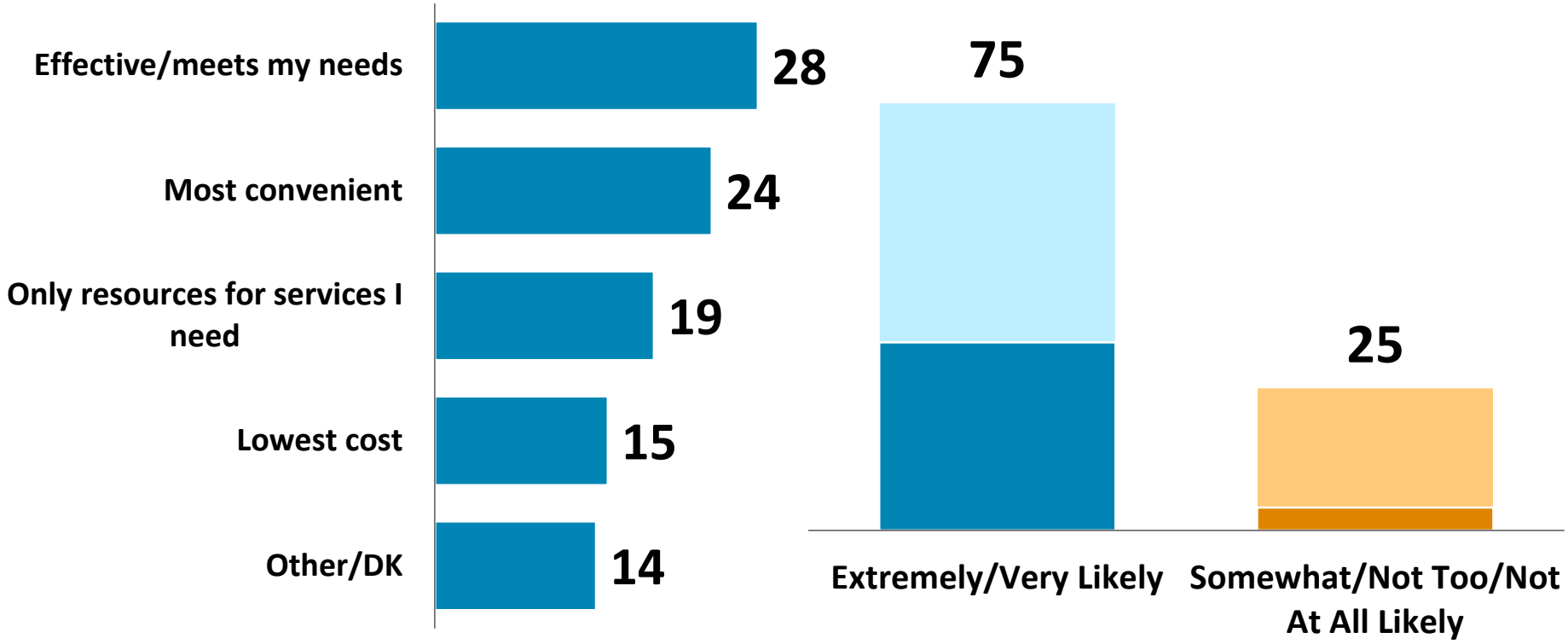
*Asked only of the 110 respondents who reported that they or a family member have received services in the past 12 months.

And what service or services have you or your family member received? (Multiple responses recorded.)

Lake Research Partners

Three-quarters of recent consumers of County services report a high likelihood of continuing to use those services, though the remaining one-quarter indicates some uncertainty or diminished likelihood to continue seeking services through the Broward County Human Services Department. Effectiveness and convenience top the list of reasons why residents turn to County services.

What is the primary reason you use services in Broward County?* And how likely are you to continue using services provided in Broward County?



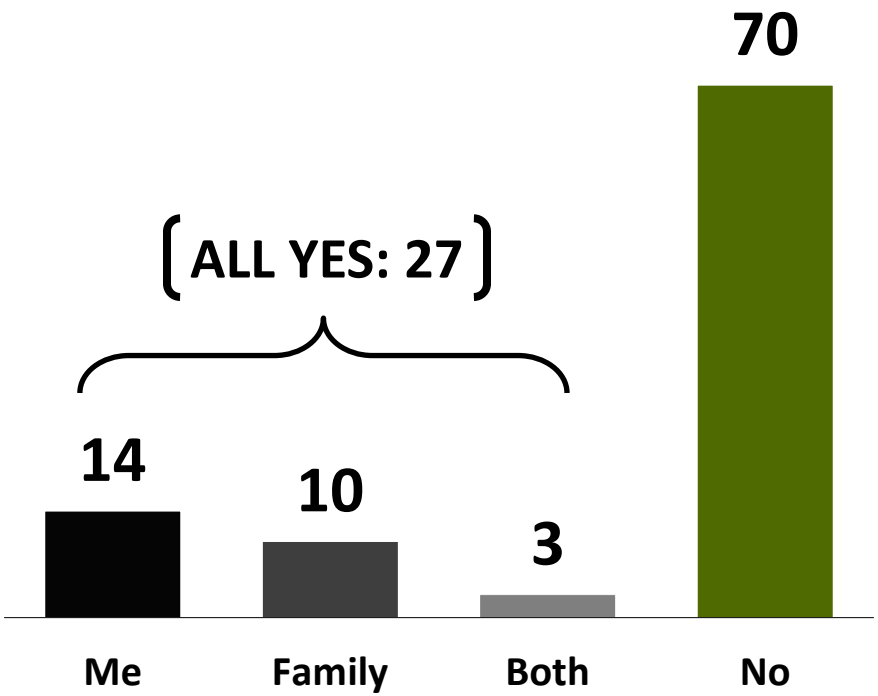
*Asked only of the 110 respondents who reported that they or a family member have received services in the past 12 months.

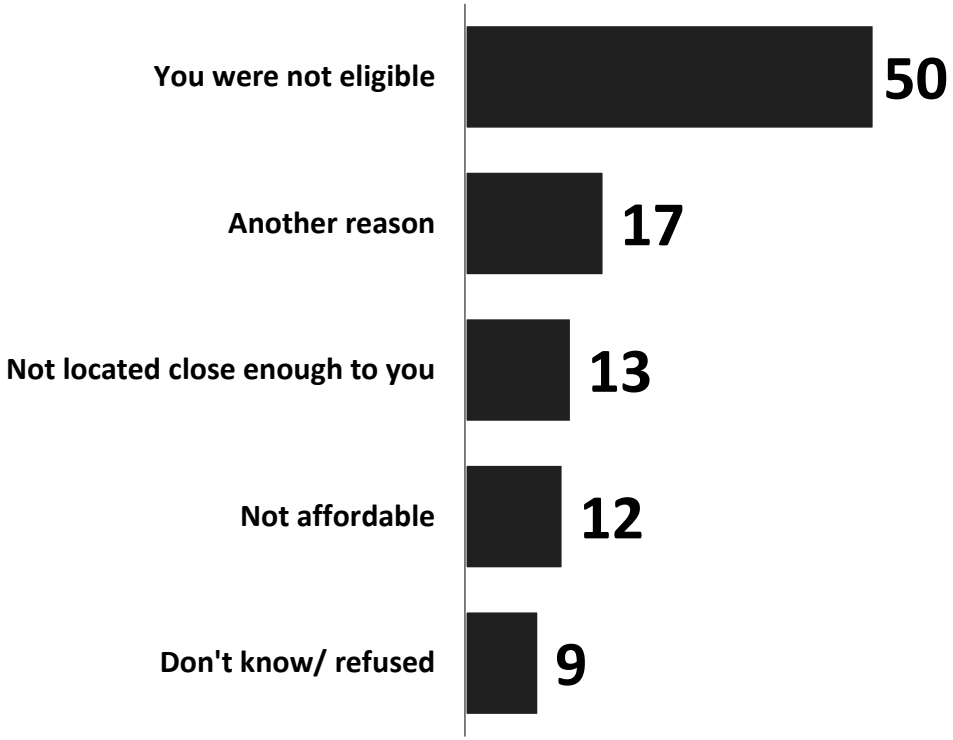
What is the primary reason you use services in Broward County? How likely are you to continue using services provided in Broward County?

Lake Research Partners

Though most consumers do not report any problems obtaining services, nearly three in ten say they or a family member have encountered some obstacle. Of this latter group, fully half cite ineligibility as the dominant reason for denial of services, though one-in-four point to inconvenience and a lack of affordability as the chief culprits.

Have You or Family Tried to Obtain Any Services But Could Not?* What Was the Reason?





*Asked only of the 110 respondents who reported that they or a family member have received services in the past 12 months.

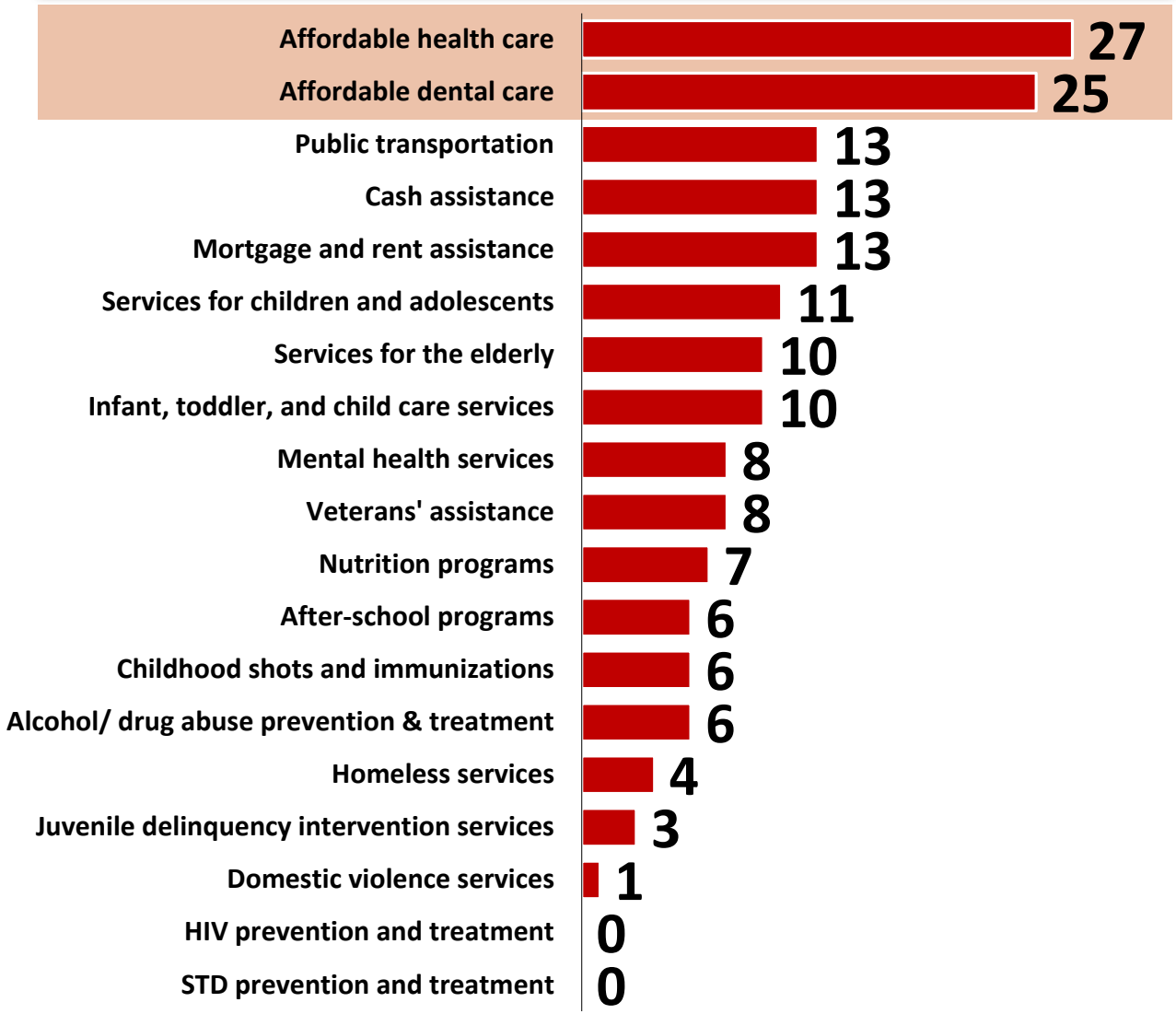
In the past 12 months have you or a member of your family tried to obtain any of those services but could not? [IF YES] Was that you or a family member? What is the reason you or your family could not obtain the service?

Lake Research Partners

Among existing consumers, affordable health and dental services are the most commonly reported needs. Affordable health care is also among the services most often obtained, but the need for affordable dental care measurably outpaces the rate at which it is being obtained.

While there is little *reported* demand for programs that address homelessness, juvenile delinquency, domestic violence, and HIV/STD, these needs are also some of the most likely to be underreported in a telephone survey due to social desirability bias (and in the case of homelessness, logistical barriers to participating in this study).

Which Services Do You Need Most?*



*Asked only of the 110 respondents who reported that they or a family member have received services in the past 12 months.

Which of the following services do you or your family member need most? (Multiple responses recorded.)

Lake Research Partners

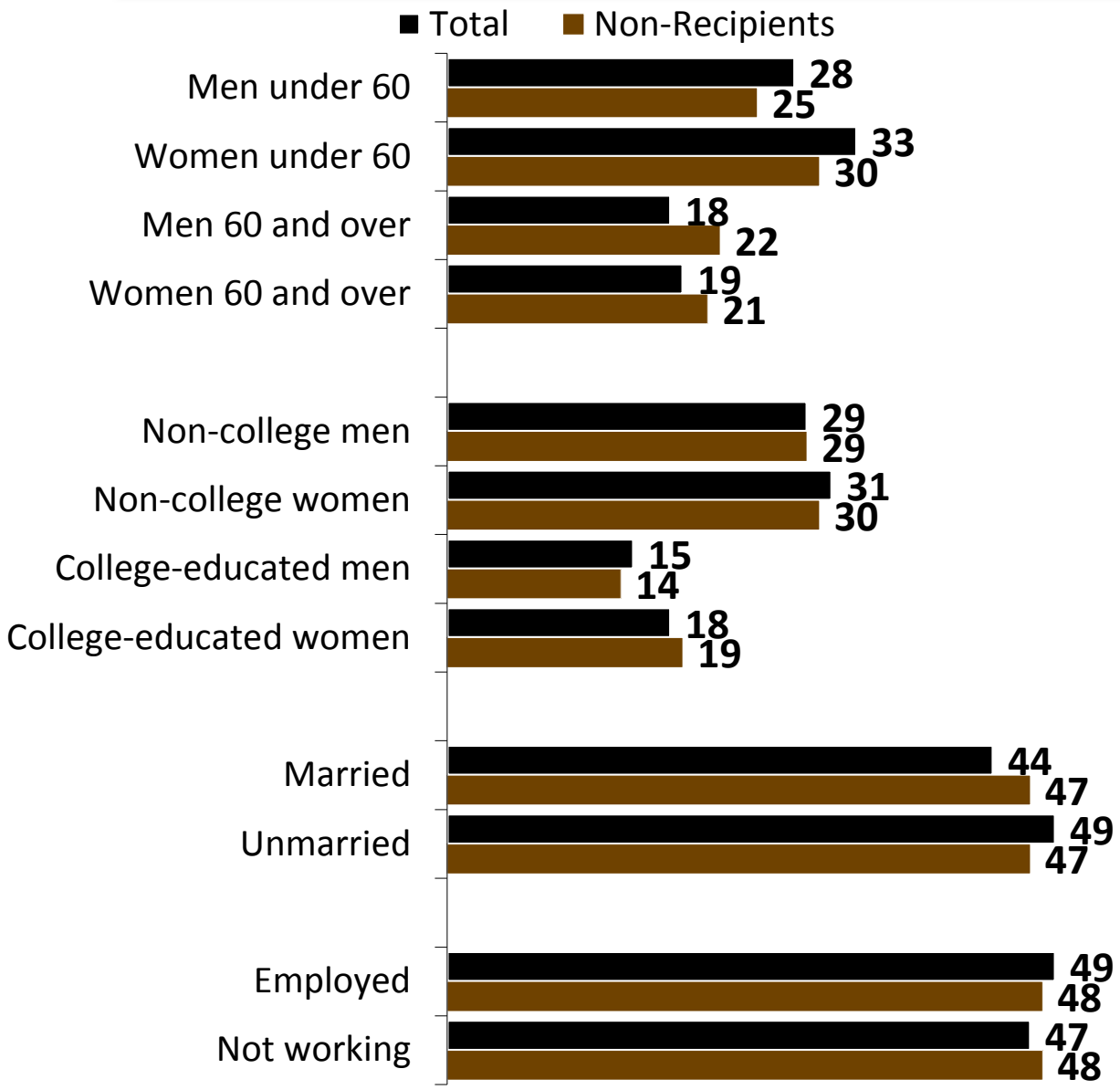
Understanding Those Who Do Not Receive County Services: a Closer Look at Potential Consumers

Those who have not recently participated in Broward County programs tend to be older, white, slightly more affluent, and considerably less likely to have children living at home. While many of these residents profess no need of the County's offerings, there may be real opportunities to engage certain subgroups by raising awareness. In fact, more than half of non-consumers express a willingness to use County services in the future, and very few raise quality concerns.

Lake Research Partners

Profile of the Resident Who Does Not Receive Services

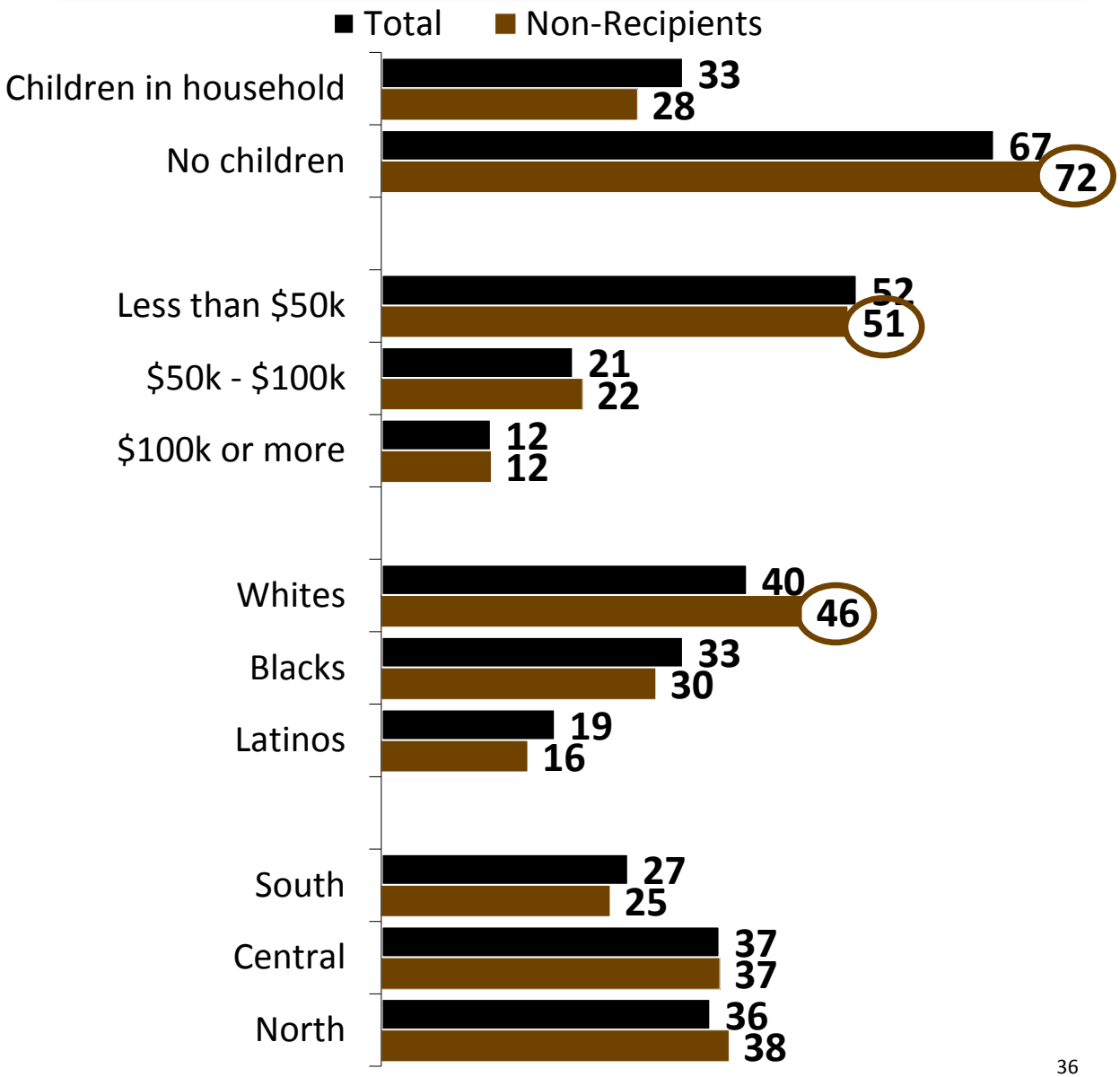
Among the principal differences between consumers of County services and non-consumers: the latter population is older (34% are seniors) and more likely to be married and unemployed/ retired than their counterparts who have received County services in the past twelve months.



Lake Research Partners

Profile of the Resident Who Does Not Receive Services

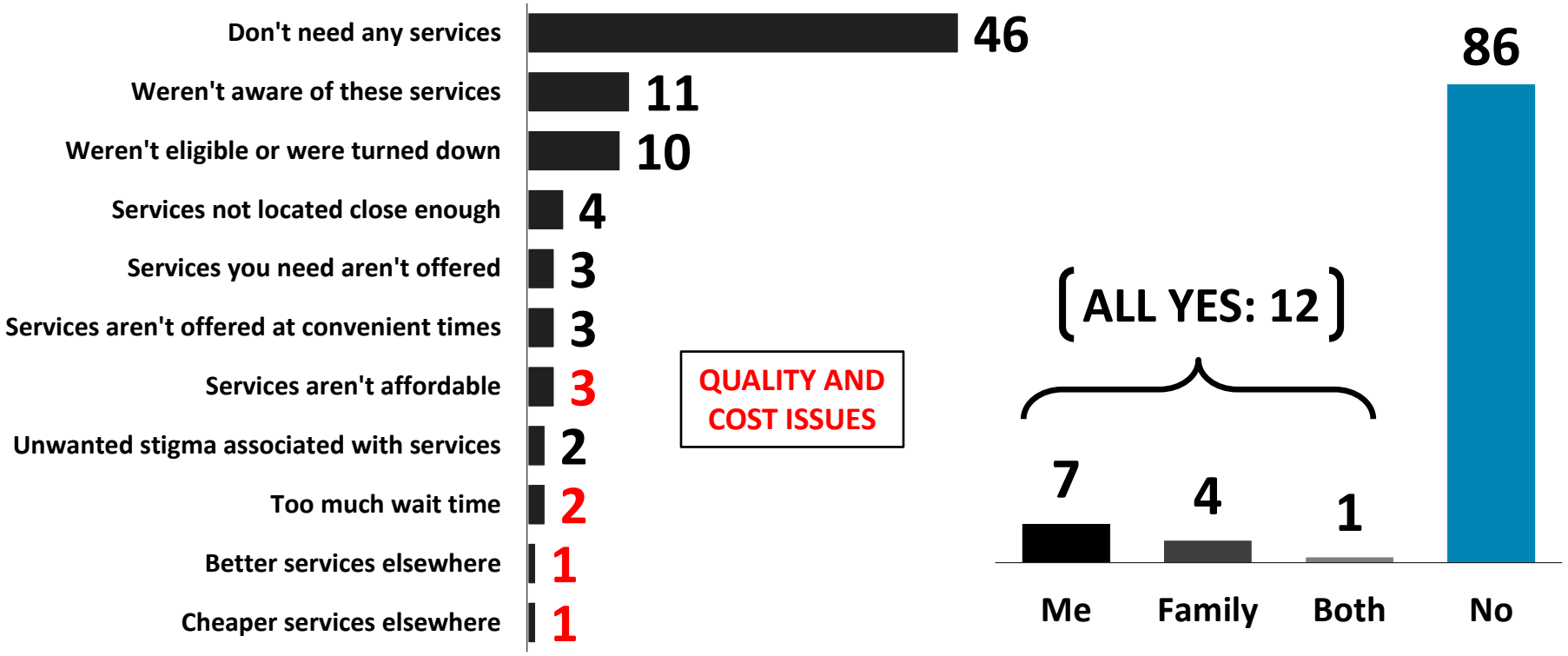
While the income and regional profiles of non-consumers tend to track the demographics of the County as a whole, the average non-consumer is much less likely to have children in the household and much more likely to be white.



Lake Research Partners

Nearly half of those who say they have not received County services recently point to a lack of need for those services, rather than any institutional barriers. Much smaller numbers cite a lack of awareness, lack of accessibility, and ineligibility. Notably, very few of these respondents take issue with quality or cost. Just 12% of Broward residents who have not recently used services actually sought them and could not obtain what they needed.

What Is the Primary Reason You Don't Use Services in Broward County?* Have Your or Family Tried to Obtain Any Services But Could Not?



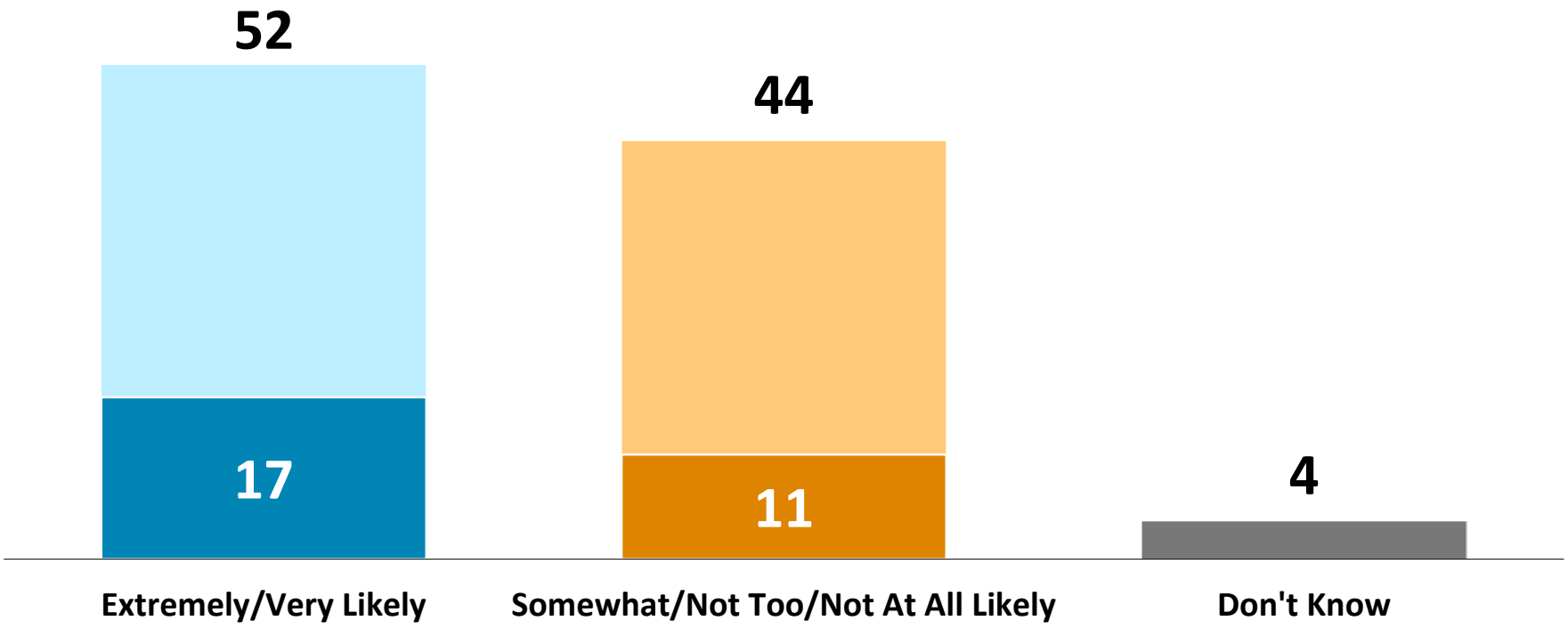
*Asked only of the 300 respondents who reported that they or a family member have not received services in the past 12 months.

In the past 12 months have you or a member of your family tried to obtain any of those services but could not? [IF YES] Was that you or a family member? What is the reason you or your family could not obtain the service?

Lake Research Partners

Fully half of those who have not received County services recently say they would be likely to seek out services in the future if they needed them. Only 11% of non-consumers reject the idea outright. Expanding awareness of available services and addressing accessibility concerns could help capitalize on this existing interest.

How Likely Would You Be to Seek Out Services in Broward County?



*Asked only of the 300 respondents who reported that they or a family member have not received services in the past 12 months. *Darker colors indicate intensity.*

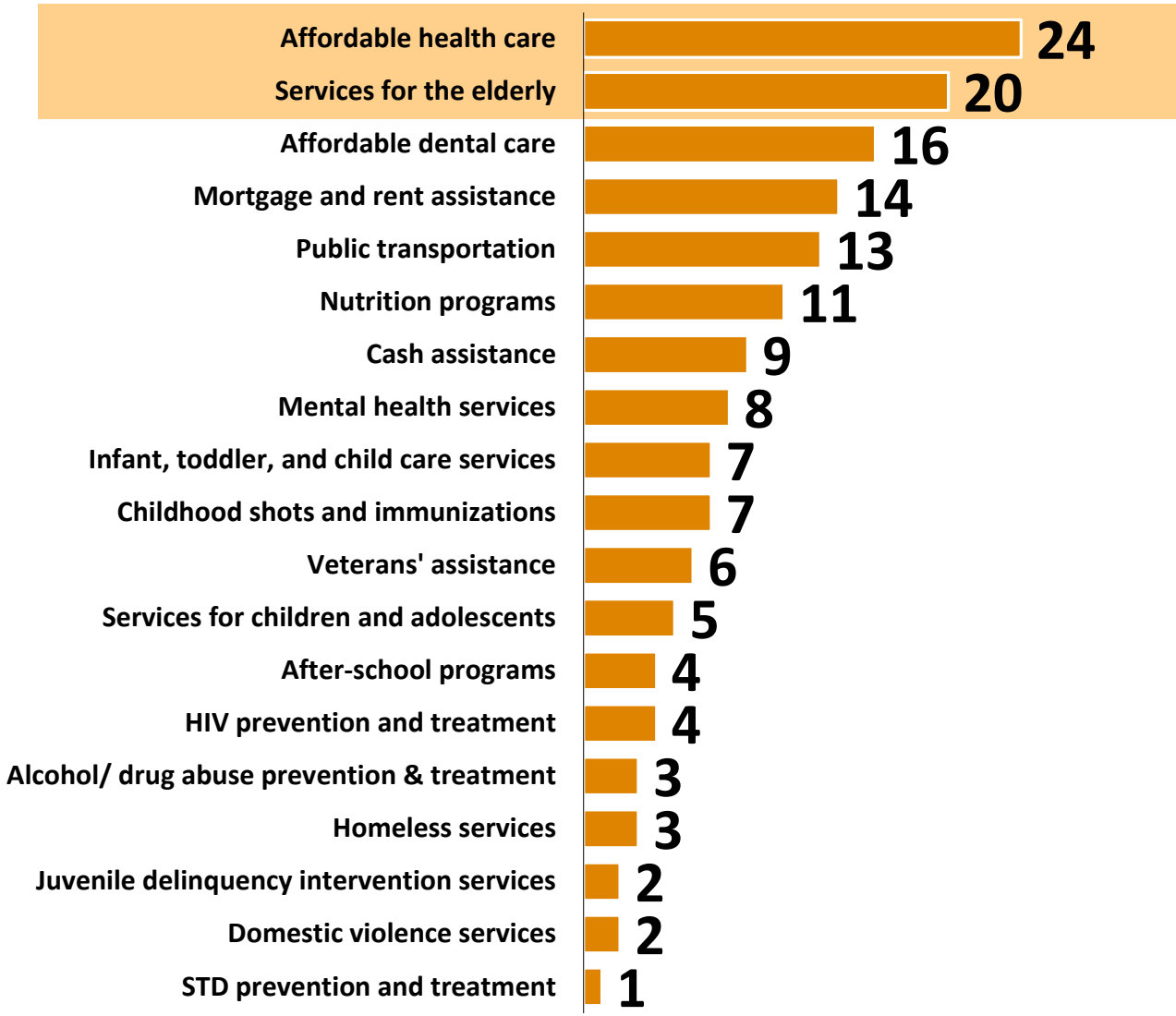
How likely would you be to seek out services in Broward County if you needed them in the future?

Lake Research Partners

Which Services Would You Be Most Likely to Seek Out?*

Residents who have not received County services recently show similar interest in affordable health care programs and double the interest in senior services when compared to existing consumers.

While affordable dental care ranks slightly lower on their priority list, it remains a top-tier concern, alongside financial assistance programs, public transit, and nutrition programs.



*Asked only of the 300 respondents who reported that they or a family member have not received services in the past 12 months.

And out of the following services, which would you or your family be most likely to seek out? (Multiple responses recorded.)

Lake Research Partners

Women and African American residents are most prone to seek out County-sponsored affordable health care programs. African Americans and men express disproportionate interest in mortgage and rent assistance. Whites tend to gravitate toward elderly services, then affordable health care.

Services to Seek Out*	*Total*	Men	Women	Whites	Blacks
Affordable health care	***24***	**18**	**30**	**17**	**33**
Elderly services	***20***	**19**	**22**	**23**	16
Affordable dental care	***16***	15	18	14	20
Mortgage/rent assistance	***14***	**18**	11	11	**23**
Public transportation	***13***	15	10	14	12
Nutrition programs	***11***	10	13	8	15
Cash assistance	***9***	10	9	8	8
Mental health services	***8***	9	7	6	8
Child care services	***7***	5	8	4	11
Childhood shots	***7***	6	7	4	6
Veterans' assistance	***6***	8	4	5	8
Services for children	***5***	4	5	4	6

*Asked only of the 300 respondents who reported that they or a family member have not received services in the past 12 months.

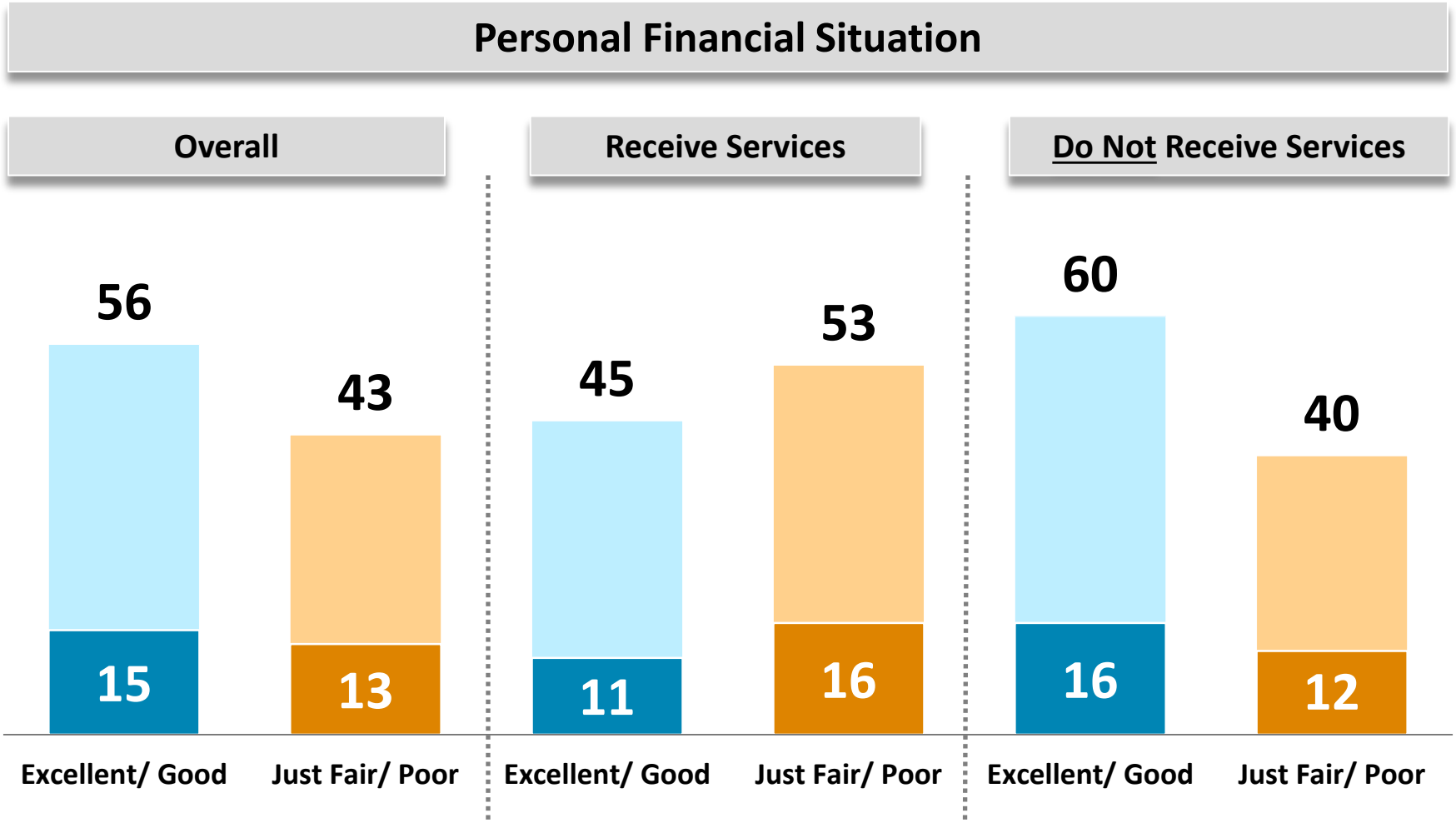
And what service or services have you or your family member received? (Multiple responses recorded.)

The Economic Context that Informs Public Opinion in Broward County

Many Broward residents feel a poignant sense of economic insecurity, in particular regarding their financial future—a perception that is undoubtedly heightened among the 22% who lack any health coverage. This anxiety frames their approach to County services and influences their understanding of the Department's purpose. Just over one-quarter (27%) of all respondents reports having received County services in the past year (themselves or an immediate family member), though interest in using those services is far higher, suggesting ample opportunity to bring a greater share of County residents into the fold. When it comes to the health insurance marketplaces, most residents have heard of them but interest in using them is limited.

Lake Research Partners

In assessing their personal financial situations and their ability to afford basic needs, respondents are roughly divided between optimism and concern. Those who have received County services report far less financial security than those who have not.



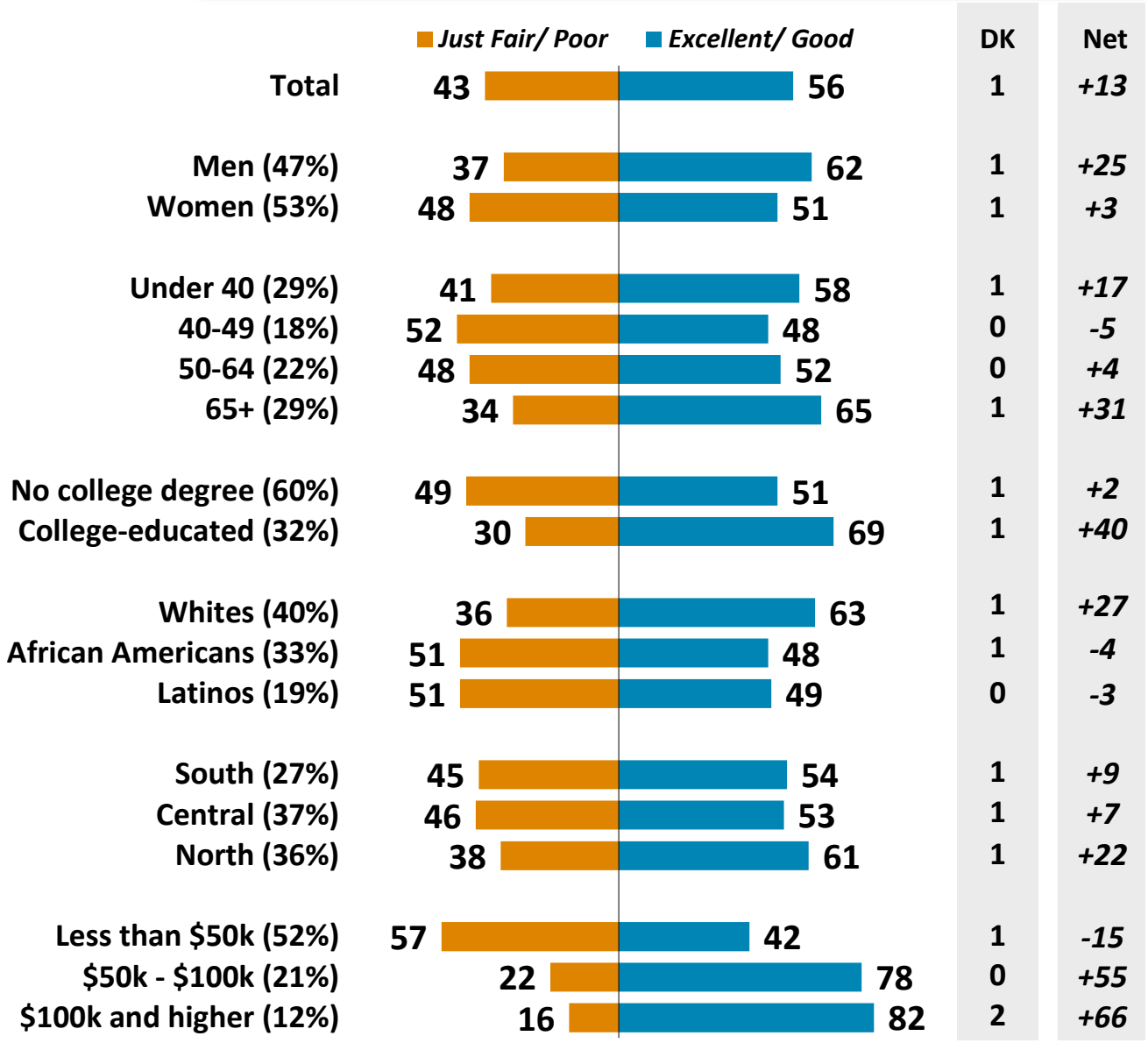
Darker colors indicate intensity.

Q4: Overall, how would you rate your personal or your family's financial situation, in terms of being able to afford adequate food, housing, and pay the bills you currently have?

Lake Research Partners

Personal/Family Financial Situation by Subgroup

Seniors, college-educated residents, whites, and those in northern Broward County are the most sanguine about their personal financial situation. However, the majority (52%) of respondents that put their household income below $50,000 are much less secure in their ability to afford basic necessities—and represents a clear audience for County services.

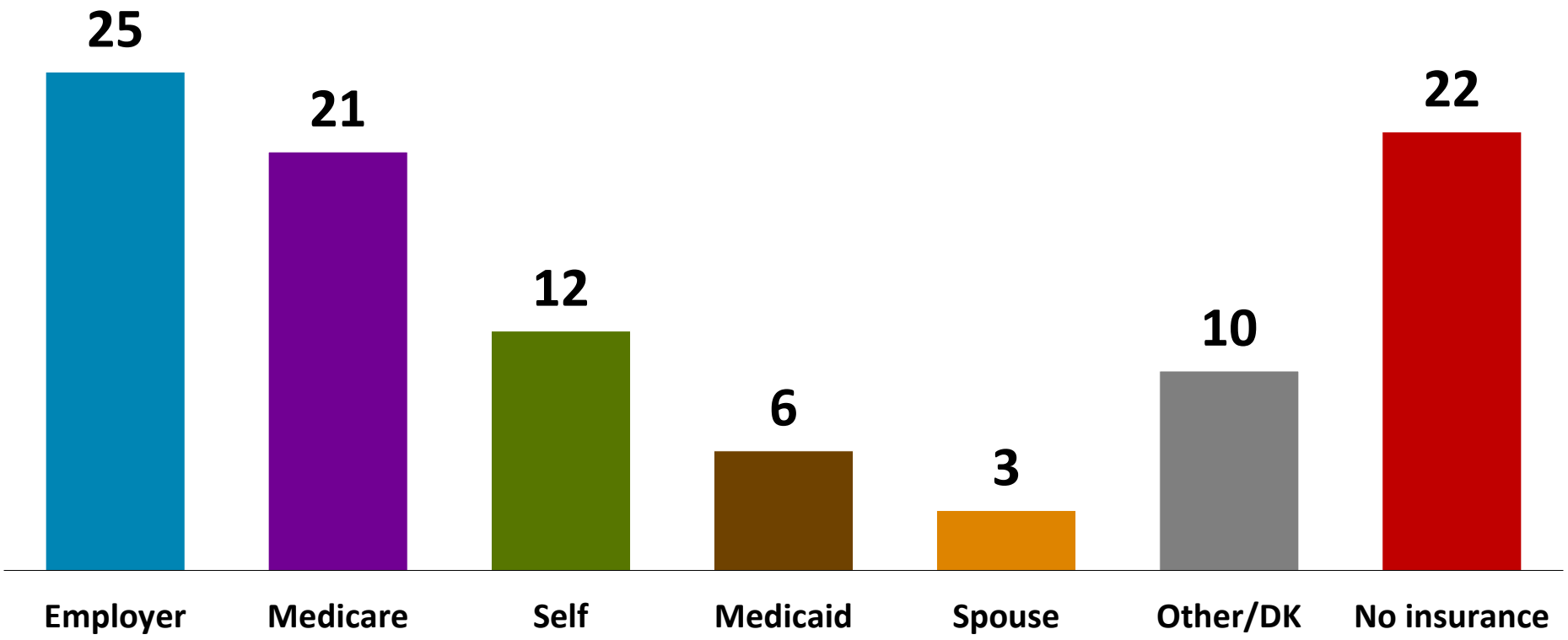


Q4: Overall, how would you rate your personal or your family's financial situation, in terms of being able to afford adequate food, housing, and pay the bills you currently have?

Lake Research Partners

One-quarter of Broward County residents within the targeted zip codes have employer-sponsored health insurance, and roughly the same number rely on Medicare or Medicaid. One-in-five is uninsured, a number that climbs to one-in-three among respondents under the age of 60.

Type of Health Insurance



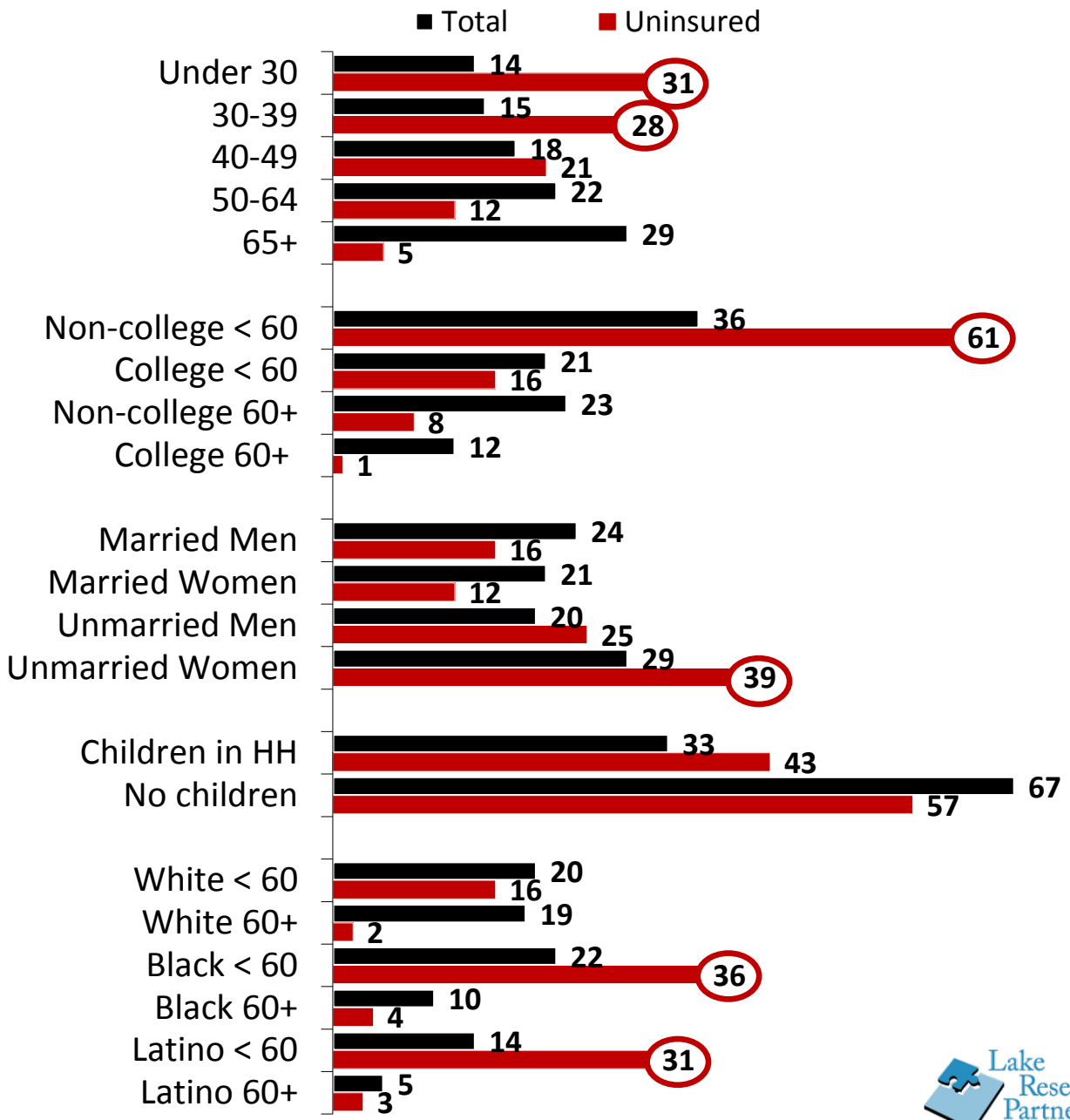
Q74: What type of health insurance do you have now, or do you not have insurance?

Lake Research Partners

Profile of the Uninsured

The profile of the uninsured resident in Broward County is a younger, unmarried, non-college educated, African American or Latina woman.

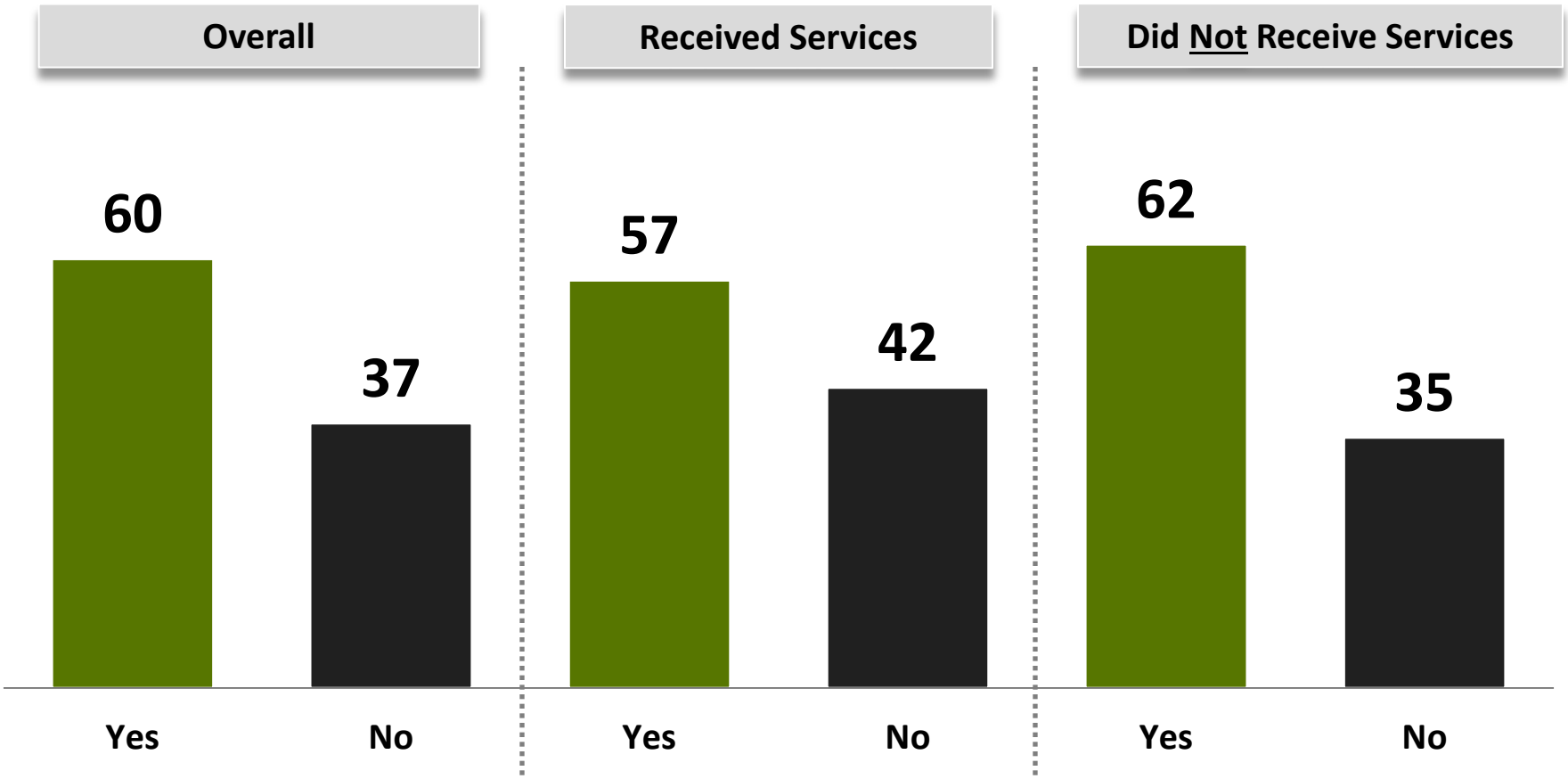
While most respondents live in households without children, those with children in their household account for a larger percentage of the uninsured.



Lake Research Partners

Six in ten Broward residents report having heard something about the health insurance marketplaces, with little difference in levels of awareness between those who have received County services in the past year and those who have not.

Seen, Read, or Heard Anything About Marketplaces?



Q72: Since October, because of the Affordable Care Act, more commonly known as Obamacare, there has been a new way for people to buy health insurance called health insurance marketplaces. Have you seen, read, or heard anything about these new marketplaces?

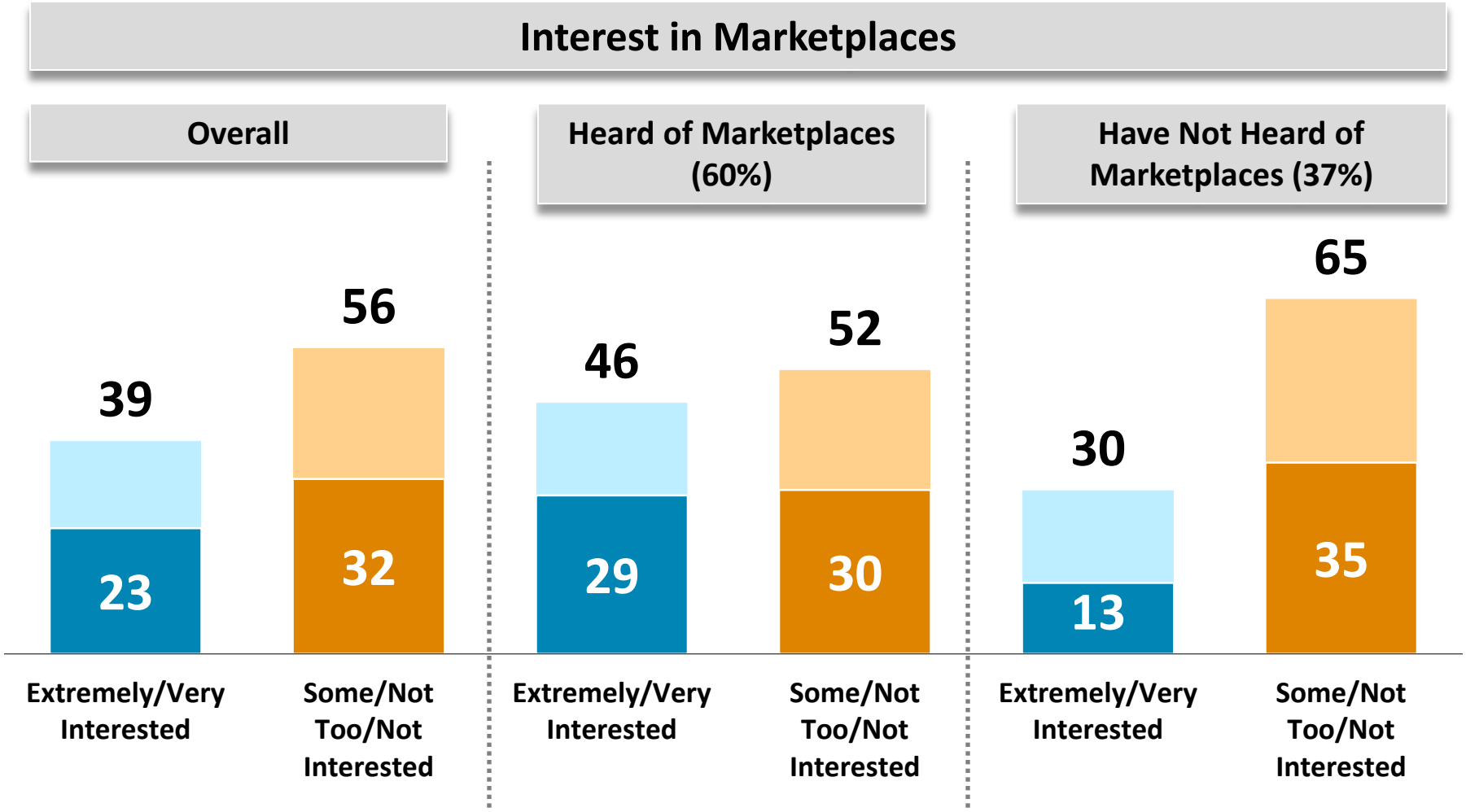
Lake Research Partners

Those who could disproportionately benefit from the marketplaces are often the groups least likely to be aware of them. A majority of residents without health insurance have not heard of the marketplaces. The same is true for roughly half of those with a high school degree or less, younger residents, and African Americans. Highlighting the benefits and accessibility of the marketplaces could yield real results among these segments of the population.

Most Likely to Hear About Marketplaces		
Disproportionately Yes	% Yes	% of Sample
South Men	**75**	*13*
College graduates	**73**	*32*
North under 60	**72**	*19*
Income $100k+	**72**	*12*
Post H.S.	**71**	*23*
Age 50-64	**71**	*22*
White	**68**	*40*
Latino	**68**	*19*
Income $50k-$100k	**67**	*21*
Married	**66**	*44*
North	**66**	*36*
Total	*60*	

Most Likely to NOT Hear About Marketplaces		
Disproportionately No	% No	% of Sample
Do not have health insurance	**52**	*22*
Central Men	**52**	*18*
H.S./Less	**49**	*37*
African American	**48**	*33*
Central under 60	**47**	*24*
Under age 40	**47**	*29*
Have children at home	**44**	*33*
Non-college Men	**44**	*29*
Non-college over 60	**43**	*23*
Receive Government Assistance	**42**	*23*
Receive Broward Health Services	**42**	*27*
Total	*37*	

Those who have heard something about the marketplaces express a notably higher level of interest than those who have not. Providing even a superficial understanding of the marketplaces could be a critical next step in galvanizing new interest throughout the County.



Darker colors indicate intensity.

Q73: If you need to find health insurance, how interested would you be in using a health insurance marketplace to find a health insurance plan - extremely interested, very interested, somewhat interested, a little interested, or not at all interested?

Lake Research Partners

Those who express an interest in the marketplaces today tend to be a mix of younger college-educated residents, those with household incomes under $50,000, African Americans, Latinos, and those currently without health insurance. Those least interested tend to be seniors, whites, and higher-income households.

Most Likely to Be Interested in Marketplaces		
Disproportionately Interested	%	% of Population
College under 60	57	*21*
Age 40-49	53	*18*
Do not have health insurance	51	*22*
African American under 60	51	*22*
College graduates	48	*32*
Central under 60	48	*24*
Have children at home	47	*33*
African American	46	*33*
Latino	45	*19*
Income < $50k	45	*52*
Receive Broward Health Services	44	*27*
Total	*39*	*--*

Most Likely to NOT Be Interested in Marketplaces		
Disproportionately Uninterested	%	% of Population
White over 60	77	*19*
Central over 60	73	*13*
65 and older	71	*29*
Live in household of one	69	*17*
Widowed	68	*10*
Retired	68	*27*
White	65	*40*
Post H.S.	65	*23*
North Men	64	*17*
Income $100k+	63	*12*
Insurance paid by self	63	*12*
Total	*56*	*--*

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Appendix F

Consumer Focus Group Moderator Guide

Welcome and thank you for coming. My name is ____ and I will be the moderator of our discussion today.

Has everyone signed the consent/release form that recognizes you understand this session is being recorded? The recording is for our use only and will not be shared with anyone. We use it to review today's session for our analysis only.

We have invited you here as consumers of services provided by the Human Services Department in Broward County.

HSD hired us, **Public Works**, an independent consulting company, to do a comprehensive assessment of its services. That is, to look at the services it provides and to determine whether the services are effective, are of high quality, and whether these services meet your needs.

As part of this assessment:

- We conducted many interviews with people in the department who are responsible for services.
- We met with representatives of other community organizations that provide services.
- We conducted a survey of all service providers in the county.
- We also just finished a telephone survey of Broward County residents and asked them how much they know about the services the county is providing, what they think of these services, and for residents who received services, we asked about their experiences and satisfaction with those services.
- By the way, did any of you participate in the telephone survey?
- Finally, we are also talking face-to-face with Broward County residents like you who actually received services. It is very important for us to hear about your experiences, if the services are meeting your needs, how they meet your needs, and what suggestions you may have on how to make these services better, and what services you need that are not being provided. So, thank you again for coming to talk to us.

Before I start asking you some questions, I would like each of you to introduce yourself. Tell me your name, how long you have lived in Broward County, how long you have been receiving services, and the name of the organization from which you receive services.

[Following the introductions]

Before we start our discussion, I would like tell you about how things will go today.

1. I will ask a series of questions and invite you to respond. Please be open and honest in your response. I want everyone to participate in the discussion. That is why we invited all of you here.

2. What is said in this room is confidential and will not be reported out except in general themes or anonymous comments. What you tell us will be summarized into a report. However, no names will be attached to any of the experiences, opinions or suggestions.

3. The questions I will ask do not have right or wrong answers, they are about your experiences and opinions, so do not hesitate to speak.

4. So that I can hear each of you clearly, please talk one person at a time. Do not interrupt others when they speak.

5. As the moderator, I may ask while you are speaking to give me more details or examples. I may also tell you that we need to move on to the next topic so that we can cover everything in the time that is allowed.

6. We are scheduled to meet for 1.5 hours, that will be until XX o'clock.

Any questions before we start?

The first question I want to ask is about the process you had to go through to get the services you have been receiving.

What circumstances made you seek assistance?

When you realized that you needed help, did you know where to go to get help?

If you knew where to go for help, how did you know?

If you did not know where to go for help, did you ask anyone what to do about finding or getting help? Who did you ask or contact for information? How did you decide whom to contact for information?

If you contacted more than one person or source, who was most helpful?

How long did it take you to identify where to get help?

What happened when you contacted the agency for help?

How long did it take you to qualify for services?

How difficult was it for you to qualify for services? What was the most difficult thing in this process? How helpful were the staff at the agency during this time?

How could the process of applying for services and determining eligibility be made easier for consumers? What would you change about the eligibility process?

What, in your opinion, is the most important thing to change in this process to make it easier and faster?

Were you on a waiting list? For how long? Did they tell you how long you were likely to be on a waiting list?

How did being on a waiting list affect you? What did you do while you were on the waiting list?

What do you think the agency can do (should do) about people who need services and are on a waiting list?

Tell me about the services you are receiving. If you are here representing a family member who is receiving services, please answer based on your knowledge of their experience.

What service are you receiving?

When did you start receiving this service (these services)?

Do you pay for the service? If so, do you consider it affordable?

What is the name of your service provider organization?

How helpful is the staff?

How well are you treated by the staff? Is the staff polite? Do they treat you with respect? Do they listen to what you tell them? Do they answer your questions?

How do you feel as a consumer of these services?

How good is the service (are the services) you are/have been receiving?

If you were to rate the quality of the service you have been receiving, would you rate it excellent, very good, good, fair, or poor?

Those of you who gave an “excellent” rating to the service you are receiving, explain what makes it excellent.

Those of you who gave a “poor” rating to the service you are receiving, explain what makes it poor?

How can the service(s) you are receiving be made better for you?

How helpful is the service (are the services) you have been receiving?

If you were to rate the helpfulness of the service you are receiving, would you consider it very helpful, helpful, somewhat helpful, of little help, or not at all helpful?

Give me some examples of how the service has helped you.

Give me some examples of how the service has not been helpful.

How much longer do you/your family expect to need the service(s) you/they are receiving currently?

What would you change about the service(s) you are receiving?

If you were to rate how satisfied you are with the service(s) you are receiving, how many of you would say that you are very satisfied, satisfied, somewhat satisfied, dissatisfied or very dissatisfied?

What is most satisfying to you? Give me some examples.

What is the least satisfying? Give me some examples.

How have the service(s) you are receiving affected your life, family, work? Give me some examples.

Do other members of your family receive services?

Who (spouse, child, parent, grandparent)?

What services do they receive?

Is the experience of this family member (Are the experiences of these family members) similar to your experience?

If not, how does their experience differ?

Are there other services that you need but do not get at present?

What are those services?

Did you apply for those services?

Why have you/they not received them?

How likely are you to get them?

What service do you/your family need most but are unable to obtain?

If you have been receiving services for three years, has the quality of the services and the way in which they are provided changed in the past three years?

How has it changed?

What impact has the change had on you?

As you know the Affordable Care Act or Obamacare is being implemented:

Have you heard about it?

How much do you know about it?

Have you applied?

Do you plan to apply?

Is it likely to have an impact on you?

How is it likely to affect the service(s) you are receiving?

How is it likely to affect where you receive services?

Are you currently insured?

Have your health care costs increased?

How has Obamacare changed your access to health care services?

These are all my questions. Do you have any comments you want to make before we conclude?

Thank you again for coming and sharing your experiences, opinions, and suggestions with us. As you go out, we will give each of you a $20 gift card as a token of appreciation for your attendance.

Appendix G

Public Works conducted three 90-minute focus groups on March 12, 2014 with 26 Broward County consumers. Focus group participants were recruited by HSD. To recruit participants, HSD distributed a flyer designed by staff, in collaboration with the County Office of Public Communications that contained information about the focus groups. **Public Works** provided a brief screening questionnaire asking consumers interested in participating about their age, gender, ethnic/racial background, length of residence in the County, the categories of services they receive, and length of time receiving services.

Public Works first developed a Moderator Guide that addressed the following issues:

- Need for services
- How consumers found out where to seek services
- The process they went through to access services and their experiences throughout the different stages of the process, including any difficulties or barriers they encountered
- Services consumers are receiving
- Assessment of the helpfulness and quality of the services they are receiving and whether the services are meeting their needs
- Satisfaction with the services they are receiving
- Impact of the services on the consumer's life, work and family
- Need for any other services
- Whether family ~~services~~ receives services
- Changes in the services over the past three years
- Awareness and knowledge of the Affordable Care Act: whether consumer has applied or plans to apply, and expected impact of the ACA

A summary of each of the focus groups follows.

Group	Highlights
Social Services Consumer Focus Group **7 participants receiving services through the Family Success Center**	The focus group was convened on March 12, 2014 and consisted of seven participants. All participants received services from Family Success Center. Participants included two men and five women. Six of the participants are African American and one is White. Participants represented a wide age range from 25 or younger to 60 or older. Participants have been residents of Broward County from four to 50 years. Participants have been receiving services from the Family Success program from less than one year (three participants) to more than five years (two participants). The Family Success Administration Division (FSAD) of the Human Services Department and on-site provider agencies bring services to the community through Family Success centers in multiple locations throughout the county. Family Success centers constitute a one-stop source of social services information, referrals and services to assist individuals and families in setting goals, learning skills, and accessing the services they need. Working with on-site community partners, the centers provide integrated intake, assessment and case management and rent/mortgage and utility assistance. The centers also provide information and referral services for job training and employment, housing counseling, legal aid services, budget counseling, family support services, subsidized child care, children's services, health services, and elderly and veterans services. The center also helps Broward County residents who may have faced in the past three months loss of employment; reduced household income or unexpected expenses; eviction notice or mortgage default letter; or water or electricity shut-off notice. **Need for Assistance.** Focus group participants most commonly sought assistance due to job loss and subsequent income loss. Assistance sought ranged from help with paying rent/mortgage and utility bills to help with finding housing. For example, one of the participants who lost his job and exhausted his food stamps needed help with paying his utility bill. The Low Income Home Energy Assistance Program (LIHEAP) provided him with $300 to pay his electric bill. Similarly, another participant lost two jobs and received rent assistance through the Family Success program. Several participants lost their housing and could not find a place to live. They are either in a shelter or in a 2-year housing assistance program that will end in 2015. One participant who left the army when she got pregnant received child care assistance, but it was available only for four months. Once the child care assistance ran out, she had to quit her job and has difficulty pursuing her education. Focus group participants found where to go for help primarily through information they received from family and friends, through referrals from organizations such as 211, through a food kitchen, and through advertising. **Process for obtaining and qualifying for services.** Five of the seven focus group participants considered the application process arduous, frustrating and "a vicious cycle." Participants described the numerous telephone calls they had to make just to find out how to apply for services and the lack of responsiveness on the part of the service provider organization staff. One participant complained that he was put on hold for such long periods that he hung up. Another participant, who was employed all her life until she lost her job indicated that provider staff used an unfriendly tone and treated her as if she wanted "to take advantage of the system." Even when provider staff members responded to her phone call, they typically asked her to call another number at a certain day and time and when she followed these instructions no one responded to her call, called her back or provided her with the information she needed. This participant who looked for assistance in paying her rent never got the rental assistance she sought. "The system doesn't let you be eligible unless things are really bad; you don't qualify if you have a low paying job or are between jobs." One of the participants lost three months in his application process due to miscommunication and wrong information provided to him. Another participant was asked to come back multiple times without consideration to the cost of gas for trips that did not yield any results or the realization on the part of the service provider staff that "some people don't have gas money or a

car…Some people just get fed up." The process for getting assistance, according to some participants took a year or longer, and during that time they moved from place to place, ran out of food stamps, their unemployment insurance ran out, and they became increasingly frustrated and desperate.

The application process was fast and smooth for two applicants. The participant who applied for assistance with paying his heating bill had to call a few times, came in once and filled out the LIHEAP paperwork and then received the help he needed. The applicant who applied for child care was approved within two weeks.

The requirements for eligibility are confusing and inconsistent, according to some participants. For example, to qualify for housing assistance the applicant has to demonstrate that he/she has nowhere to live. They actually have to be residing in a shelter before they can apply. It took one participant six months to get housing assistance due to miscommunication. This participant thought that once he had completed the application and has the needed paperwork he could go and access the program but was then told that he needed to be living in a shelter to qualify for transitional housing. At the time he was living in a room with someone. The Salvation Army called and told him he could have a bed but he turned them down because he was on the waitlist for transitional housing. When the transitional housing called with a spot they told him he had to be in a shelter to qualify for the program. "I had to take a step back before I could move forward."

According to focus group participants, the system is more responsive to adults or families with children than to single adults. "If you have kids, it is easier to get in." The only participant in the group with a small child who needed child care assistance reported that the process for qualifying for assistance was short: two weeks. However, the child care assistance she got was only for a period of four months and could not be extended unless "something bad happened." When the four months were over she had to quit her job to take care of her child.

Suggested improvements and changes. Participants provided several suggestions on how to improve the application process.

- Increase public awareness of the Broward County Human~~s~~ Services Department and of the service centers throughout the community. A participant indicated that he was not aware of the existence of the department and the service centers at the County level. There should be a brochure listing services and telephone contact information for each service, similar to a brochure for homeless people titled "How to Survive." The brochure listed shelters, food pantries, food kitchens, and medical help. Having such a brochure may ease the volume of calls to 211 and reduce the long waits on the phone. In addition to a brochure, the County should advertise on television, radio, have a web page, and distribute flyers at centers, in supermarkets, libraries, health clinics, and soup kitchens. According to a participant, the City of Chicago has Department of Human Services offices in each community that act like one-stop centers. These offices have computers, provide job information, give out food, serve as shelters at night for the homeless, and in the summer the elderly can come in from the heat.

- Services are fragmented. Service providers are not aware of the range of services that are available through other programs or even within their own program. Service providers do not network: "providers here aren't well connected – they don't know what else is out there and what's available." There is a need for an intake form that has a list of all services available in the County, and not just through a specific program, and the applicant can check off what he/she needs. In addition, there is no general database for all services (continuum of care) the County provides or funds. So applicants have to fill out multiple applications depending ~~of~~ on their needs. Having a comprehensive database that can be accessed by all service providers will also allow the system to keep track of what services

	each recipient is receiving. • Service provider staff needs to be more friendly and responsive and return calls in a more timely manner. • The County should have a telephone number for reporting problems. Currently, applicants are not able to reach supervisors to complain. Even when they reach a supervisor and the ~~supervise~~ supervisor promises that someone will call them back this does not happen. • The system is set up for people who need continuous services but not for people who just need "little bits of help" or "one time" short-term assistance. "I need a little help. I don't want to be on assistance for long." **Additional services needed.** Focus group participants identified housing as the key service they needed and had difficulty getting. Participants who are homeless or are in temporary housing need help with finding a longer term solution. One participant has tried to get on the list of Section 8 housing but her calls have not been returned. She heard that there is a 2 to 3-year waiting list to get into the program. Participants who are older also identified the need for help with transportation. The County used to offer some free bus service and reduced rate bus passes but those were discontinued. **The Affordable Care Act.** Focus group participants are aware of the Affordable Care Act but know little about it. Participants find the law confusing, and they do not know whether or not they should sign up. Having to use a computer to sign up poses a barrier: they either do not have a computer or do not know how to use it. Some of the participants have other sources of insurance although they indicated their insurance does not offer good coverage. However, they are afraid that they may lose their existing insurance if they get on Obamacare. Participants are aware that if one does not sign up he/she "will be in trouble." Yet, only one focus group participant actually signed up. The focus group participant who signed up did not have any health insurance: "I am on a fixed income – health insurance is not in my budget." He signed up with help from the 7th Street Clinic. He had to sign up in order to use the clinic. He has not yet heard whether he is enrolled and therefore cannot use the clinic until he is officially enrolled.

Group	Highlights
Mental Health Customer Focus Group **12 participants receiving mental health services directly or a family member (child)**	The focus group was convened on March 12, 2014 and consisted of 12 participants. All participants received mental health services for themselves or their children. Participants included three men and nine women. Eight of the participants were African American, two were White, and two were Hispanic. Participants represented a wide age range from 25 or younger to 60 or older. Five of the participants were in the 51 to 59 age range and three were 60 or older. Participants have been residents of Broward County from five to 40 years. Participants have been receiving mental health services for themselves or their children from less than one year to more than five years: four participants have been receiving services between one and two years, three participants have been receiving services for three to four years, three have been receiving services for five or more years, and one participant has been receiving services for less than a year. **Need for Assistance.** Participants needed assistance for a variety of reasons. For example, a young parent needed daycare for her child so that she could get a GED. Another parent wanted counseling for her child who used marijuana. Several of the participants struggled with homelessness because they are on a fixed income or lost their jobs and were not able to find new jobs. One participant has been staying at shelters for almost two years. Other participants needed medical help after they lost their health insurance or were not insured and needed surgery. Participants used different information sources on where to go for help. Sources included a parent who received services in the past, a church minister, the child's school, a friend, the Florida Power and Light agency, and the Child Protective Services agency. Several of the sources told focus group participants to call 211. Participants who called 211 had mixed experiences with regard to the helpfulness of the organization. Overall, participants considered 211 friendly and helpful: "I have always gotten good information from 211; very professional. They told me where to go, what to do, and how long it would take to enroll me." However, several participants indicated that 211 is not always helpful because "they aren't able to direct you to services. They are limited in the amount of information they have; gave out the wrong number." Several participants indicated that they had to call multiple times and that the 211 staff expertise and knowledge are not consistent. Participants also commented that 211 staff is more helpful to people in extreme situations ("you have to be extreme to get help") than to people whose needs are less urgent. **Services.** Focus group participants received a variety of services in addition to mental health services. Additional services included housing, rental assistance, food stamps, day care and assistance with utility bills. Three of the participants have children who receive mental health/behavioral services. Several participants also indicated that their child or other members of their family also received services. The mother of a participant received mental health services more than a decade ago and thinks that the services available currently are of better quality and can be obtained faster. Another participant who received services in the past observed that a greater range of services is available at present but the wait times to see therapists and physicians are longer and the physicians are less attentive. The length of time it took focus group participants to get the assistance they needed varied considerably from one day to several months. Participants who needed help with housing received it within one day through the Homeless Task Force which provides direct outreach services to homeless people and informs them of the social services available in the community. The participant who needed assistance with paying his utility bill got the assistance in two days. The participants who needed assistance with day care had to wait a couple of months because of the preschool schedule. Getting access to mental health services took longer: from several weeks to

three months because of limited availability of mental health staff.

Process for obtaining and qualifying for services. The most challenging part of the process was proving the need for assistance and meeting the paperwork requirements. It seems easier to qualify for services when one is "about dead or suicidal before things happen." A participant was informed after she completed the paperwork that she does not qualify for the services because she has "not been diagnosed with anything." The service provider staff "tell you what you need but you're on your own; when you bring it in, they may tell you that you need something else and you have to come back."

Three of the participants were put on waiting lists. One participant who needed surgery was put on a waiting list for a month because it took so long for her paperwork to be processed.

Another participant has been on a waiting list for therapy for five years because "they don't have enough people and when they get someone, it's a student therapist which is not a pleasant encounter because it's awkward – it's like you're educating them; if you refuse you don't have anyone."

Quality and responsiveness of services received. Most participants were satisfied with the services they or their children have received. A participant whose child received mental health services considered the service provider her "rock and safety net;" she had been trying to get services for her child and had to fight the school and go to court. Another participant, while thankful for the help with housing, complained that the doctor he sees does not spend any time with him and does not listen to what he says. A third participant is thankful that the County will pay for child care for a full year for her child until he starts school. However, several participants indicated that although they are grateful, the assistance they receive is marginal and their case worker does not seem to help. One participant indicated that the services he gets are enough to keep him above water, but not enough to where he feels "like 100 percent." The medication he receives is not adequate and is old and he cannot get any quality therapy; he feels that he is not getting quality treatment. This participant attributed his situation to the shortage of health care professionals the provider has and the overwhelming caseload these professionals have.

Suggested improvements and changes. Focus group participants made the following suggestions.

- Make the application process and the paperwork easier by developing a list of what information and documentation are required and suggest how to go about getting the information and what will constitute sufficient proof.
- There is a need for more shelters for women; especially shelters where women can stay temporarily until they find work.
- Staff at the homeless shelters needs additional training because they often do not recognize the need for more serious mental health interventions.
- There is a need for inexpensive housing for older adults and seniors.
- There is a gap in services for women who do not have children and who are between the ages of 35 and 65.
- People who get Medicaid are not allowed to get food stamps if they earn a certain amount of money. The amount of money allowed is not sufficient for meeting food needs. Often such people have to choose between food and medicine.

Additional services needed. There is a gap in services for people "who have fallen between the cracks;" that is, people who just want a little help not a handout and are not easily classified. "If you are not an addict or HIV positive, it is hard to get services… you have to be labeled something to get services… If you live right they don't help you at all." The process of applying for assistance de-

	empowers. "As soon as you start getting on your feet, you don't qualify for anything; whenever you go somewhere the responsibility falls on you when all you're trying to do is empower yourself to get back on your feet." Housing for people 55 or older was one of the primary needs participants identified: "there are a lot of people looking for homes but there's nothing out there." The staff in the shelters is not well informed about housing programs and other services. The qualifying requirements are not sensible: "you have to be homeless for a year before you qualify for housing." The level of assistance provided is often not sufficient; "it is only enough to keep your head above water." This creates a sense of dependency. **The Affordable Care Act.** Focus group participants indicated that they know little about the law, have many doubts about its ability to improve their access to health care and are concerned that it might actually limit their options and subsequently the health care services they can get. Participants who do not have any income were most concerned: "they say you have to pay something in order to get it." Only two ~~pf~~ of the participants applied. One participant who applied was turned down when she explained that she does not have any income. A second participant needs to provide additional documentation and is still in the process. Participants who have some health insurance were not able to use it either because of the high deductible or the high co-pay.

Group	Highlights
BARC Focus Group **7 participants receiving services through Broward Addition Recovery Center (BARC)**	The focus group was convened on March 12, 2014 and consisted of seven participants. All participants received services from Broward Addiction Recovery Center (BARC). Participants included two men and five women. Three of the participants were African American, four were White. Participants ranged in age from 26 to 60 or older. Three of the participants were in the 51 to 59 age range; two were 36-40; one 26-35 and one 60 or over. Participants have been residents of Broward County from 15 to 43 years. Five participants have been receiving services through BARC for less than one year; two participants were receiving services for one to two years. **Need for Assistance.** Participants came to BARC from a variety of avenues – four were court-ordered, one came to services after a family intervention, two were self-referrals who sought services on a voluntary basis. Four participants went through detox; one went directly to inpatient treatment (having been detoxed at a hospital and referred from the hospital); two started receiving non-residential/outpatient treatment. The three self-referral participants had some difficulty finding services. All three reported having to research options that took between three days and one week to find BARC services. **Services.** Most participants reported waiting for service from one day to one week. The participants needing detox waited approximately one week – a wait time that was particularly difficult for this group. One participant needing detox reportedly had to wait almost 30 days and had to call on several occasions before finding an open detox bed. **Process for obtaining and qualifying for services.** Since the majority of participants were court-ordered there were no issues concerning referrals for services. The three self-referred participants, once they found where to go for services, did not report difficulty in applying for services. One participant reported problems in producing proof of residency since identification papers were confiscated when arrested and not returned for weeks. One participant felt that she needed inpatient treatment but was advised that she would be able to receive outpatient treatment only. **Quality and responsiveness of services received.** Participants generally rated services and staff at BARC as excellent or good. They commented that staff will work to "figure out what is needed" to help find services that are beyond what is directly provided at BARC. Examples of helpful services included: • Accommodations were made for special meals for a participant with diabetes. • Counselor worked with probation officer to make sure there were no issues related to meeting court requirements. • Staff ~~were~~ was flexible to accommodate work schedules and counseling sessions. • Staff had time for one-on-one sessions that were helpful in supplementing group work. **Suggested improvements and changes.** Focus group participants made the following suggestions. • Self-referred participants thought initial services should be different for them compared to those court-ordered. They expressed initial confusion about services, expectations and the purpose of some activities since they had not "been in the system" before. They were only able to figure out what was expected and the reasons for some of the counseling sessions after weeks of participation. They required strong convictions to stay with the program during this time and thought that more direct and clear information would have helped them through this time. • One self-referral participant knew he needed more structure. After weeks of working with a counselor, they were able to identify specific targets that must be met (like passing drug test weekly) that helped him to be successful.

	• The majority of participants expressed frustration with being able to obtain referrals for services once completing their BARC program. Some were homeless when they entered the program and needed help with housing, when leaving, which proved difficult. **Additional services needed.** The most significant problem facing participants is the need for financial help and assistance in meeting basic needs. Additionally, participants reported: • Obtaining primary care services is often difficult. Participants expressed frustration in having to sometimes wait all day to see a doctor even when they had an appointment. The simple task of picking up medications required hours. Once in to see a doctor, the examination was superficial and the doctor did not spend sufficient time to really understand the physical and mental condition of the participant. • The referral system using the W72 and W80 forms is difficult at best. One participant reported having an ear infection and still not being able to obtain health care services for three months. • Affordable housing was cited as the most significant gap. • One participant shared the difficulty she had in applying for Medicaid even though she had a very ill child at time of application. The delay in being designated eligible required her to seek help for paying for her child's medications from a non-profit agency. **The Affordable Care Act.** Focus group participants know about the Affordable Care Act. Five participants applied for health care (three were denied and two approved); one participant did not apply and one participant was on Medicaid. Concern was raised that having little or no income actually made participating in a health plan impossible. One participant was pleased that her premiums for health insurance are now lower. There was also some skepticism that obtaining insurance would make health care any better. One participant reported being able to go back to her primary care doctor once she became eligible for an insurance subsidy through ACA.

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Appendix H

Countywide Human Services Funding by Funder, by Category (in millions)

	Children & Family Services	Housing & Homeless	Health Care Services	Adult Behavioral Health	Adult Addiction Services	Basic Needs	Senior Services	Funder Total	%
Aging and Disability Resource Center			$ 0.4	$ 0.1		$ 3.1	$ 4.3	**$ 8.0**	**2%**
Broward Behavioral Health Coalition	$ 10.8			$ 21.2	$ 6.4			**$ 38.4**	**7%**
Broward Sheriff's Office	$ 19.2		$ 0.1	$ 3.5	$ 4.4	$ 0.1		**$ 27.3**	**5%**
ChildNet	$ 62.6							**$ 62.6**	**12%**
Children's Services Council	$ 38.5	$ 1.6	$ 3.5			$ 1.1		**$ 44.7**	**9%**
Community Foundation	$ 2.9		$ 0.4					**$ 3.2**	**1%**
Early Learning Coalition	$ 72.3							**$72.3**	**14%**
Florida Department of Children & Families		$ 0.2	$ 0.3					**$ 0.4**	**<1%**
Housing – Federal		$ 13.5						**$ 13.5**	**3%**
Housing – Housing Authorities		$137.2						**$ 137.2**	**27%**
Housing – State		$0.2						**$ 0.2**	**<1%**
Human Services Department	$12.1	$ 18.7	$ 33.2	$ 8.2	$ 10.8	$ 13.0	$ 7.7	**$ 103.6**	**20%**
Jim Moran Foundation		$ 0.2				$ 0.2	$ 0.1	**$ 0.5**	**<1%**
United Way	$1.1	$ 0.3	$ 0.7	$ 0.4		$ 0.9	$ 0.1	**$ 3.5**	**1%**
Totals	**$ 219.4**	**$ 171.9**	**$ 38.5**	**$ 33.4**	**$ 21.6**	**$ 18.2**	**$ 12.2**	**$515.3**	
%	**43%**	**33%**	**7%**	**6%**	**4%**	**4%**	**2%**		

Source: Various sources of budget data provided by funders. Figures and percentages have been rounded.

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Appendix I

HSD FY 2014 Total Budget for Contracted and Direct Services by Service Category (Detail)
(numbers rounded)

Service Category	Contracted Services	Direct Service Provision	Total Spending on Services	Spending as % of Service Category Subtotal	Spending as % of Total Contracted & Direct Services Spending
Health Care Services					
Health Care Services Subtotals	**$29,859,047**	**$3,294,354**	**$33,153,401**		**31%**
Primary Care	$15,854,483		**$15,854,483**	48%	15%
Health Care for Specialized Populations					
STI/HIV/AIDS	$875,000		**$875,000**	3%	1%
Ryan White Health Care Services	$10,882,481		**$5,714,418**	33%	10%
Prenatal Care & Maternal & Infant Health	$200,000		**$200,000**	1%	0.2%
Children's Medical Home	$979,997		**$979,997**	3%	1%
Domestic & Dating Violence and Sexual Assault Prevention or Counseling (NJCC)		$3,294,354	**$3,294,354**	10%	3%
Seniors	$157,755		**$157,755**	0.5%	0.1%
Disabled or Long-term Illness	$388,750		**$388,750**	1%	0.4%
Other Ryan White	$520,581		**$520,581**	2%	0.5%
Housing & Homeless					
Housing & Homelessness Subtotals	**$17,517,491**	**$1,152,635**	**$18,670,126**		**18%**
Mortgage & Rent Assistance	$343,000		**$343,000**	2%	0.3%
Temporary/Transitional Housing	$6,662,490	$877,635	**$7,540,125**	40%	7%
Housing Opportunities for Persons with Substance Abuse	$524,335		**$524,335**	3%	0.5%
Housing Opportunities for Battered Women	$47,500		**$47,500**	0.3%	0.05%
Housing Opportunities for Homeless Families	$270,000		**$270,000**	1%	0.3%
Housing Opportunities for Seniors	$903,371	$275,000	**$1,178,371**	6%	1%
HIP: Outreach, Support Services, Shelters	$7,902,700		**$7,902,700**	42%	7%
Homelessness - Planning & Coordination	$864,095		**$864,095**	5%	1%

Service Category	Contracted Services	Direct Service Provision	Total Spending on Services	Spending as % of Service Category Subtotal	Spending as % of Total Contracted & Direct Services Spending
Children and Family Services					
Children and Family Services Subtotals	**$13,078,103**	**$394,090**	**$13,472,193**		**13%**
Addiction Services					
Residential	$538,844		**$538,844**	4%	1%
Children's Behavioral Health					
Case Management	$1,245,650		**$1,245,650**	9%	1%
Outpatient Counseling & Therapy	$6,787,767		**$6,787,767**	50%	6%
Respite Care (Children's BH)	$1,039,280		**$1,039,280**	8%	1%
Supportive Services	$1,043,767		**$1,043,767**	8%	1%
Family Support Services					
Parental Visitation	$40,000		**$40,000**	0.3%	0.04%
Childcare & Education					
Child Care Subsidy	$2,342,795		**$2,342,795**	17%	2%
Juvenile Justice					
Juvenile Diversion Programs	$40,000	$394,090	**$434,090**	3%	0.4%
Basic Needs					
Other Basic Needs Subtotals	**$555,037**	**$11,970,282**	**$12,525,319**		**12%**
Family Success Centers		$4,175,245	**$4,175,245**	33%	4%
Wealth Building & Employment	$60,741	$1,103,206	**$1,163,947**	9%	1%
Emergency Support					
Ryan White Food & Nutrition	$158,890		**$158,890**	1%	0.2%
Food/Hunger	$41,000		**$41,000**	0.3%	0.04%
Energy Assistance		$6,691,831	**$6,691,831**	53%	6%
Legal Support					
Legal Aid	$162,980		**$162,980**	1%	0.2%
Ryan White Legal Services	$131,426		**$131,426**	1%	0.1%
Adult Behavioral Health					
Adult Behavioral Health Subtotals	**$8,180,731**	**$0**	**$8,180,731**		**8%**
Outpatient Counseling & Therapy	$4,455,016		$4,455,016	54%	4%
Ryan White Counseling & Therapy	$1,175,345		$1,175,345	14%	1%
Crisis Stabilization	$350,000		$350,000	4%	0.3%
Specialized Court	$1,803,157		$1,803,157	22%	2%
Supportive Services	$397,213		$397,213	5%	0.4%

Service Category	Contracted Services	Direct Service Provision	Total Spending on Services	Spending as % of Service Category Subtotal	Spending as % of Total Contracted & Direct Services Spending
Elder Services					
Elder Services Subtotals	**$5,185,587**	**$2,973,936**	**$8,159,523**		**8%**
Adult Day Care	$402,571		**$402,571**	5%	0.4%
Independent Living for Seniors					
Emergency Alert Devices	$51,705		**$51,705**	1%	0.05%
Homemaker & Other General Support Services	$1,976,631	$2,973,936	**$4,950,567**	61%	5%
Personal Care	$1,763,157		**$1,763,157**	22%	2%
Not yet allocated	$227,408		**$227,408**	3%	0.2%
Respite Care	$764,115		**$764,115**	9%	1%
Adult Addiction Services					
Adult Addiction Services Subtotals	**$0**	**$10,785,075**			**10%**
Residential		$5,094,190	**$5,094,190**	47%	5%
Outpatient Counseling & Therapy		$1,941,250	**$1,941,250**	18%	2%
Detox		$3,397,581	**$3,397,581**	32%	3%
Other Services		$352,054	**$352,054**	3%	0.3%
Referrals					
Referrals Subtotals	**$433,609**		**$433,609**		**0.4%**
Referrals	$433,609		**$433,609**	100%	0%
GRAND TOTAL SERVICES SPENDING	**$74,809,605**	**$30,570,372**	**$105,379,977**		

Appendix J

HSD FY 2014 Funding by Service Category – All Fund Sources

Service Areas	Contracted Services	Direct Service Provision	Total Spending on Services	Spending as % of Service Area Subtotal	Spending as % of Grand Total
	Health Care Services				
Health Care Services Subtotals	**33,275,673**	**3,294,354**	**36,570,027**		**32%**
Primary Care	15,854,483		**15,854,483**	42%	
STI/HIV/AIDS (including Ryan White funding)	12,278,062		**12,278,062**	32%	
Domestic Violence/Sexual Assault		3,294,354	**3,294,354**	10%	
Children's Medical Home	979,997		**979,997**	3%	
Disabled or Long-term Illness	388,750		**388,750**	1%	
Prenatal Care & Maternal & Infant Health	200,000		**200,000**	1%	
Seniors	157,755		**157,755**	0.5%	
	Housing & Homeless				
Housing & Homelessness Subtotals	**17,517,491**	**1,152,635**	**18,670,126**		**18%**
Housing Initiative Partnership	8,766,795		**8,766,795**	47%	
Temporary/Transitional Housing	6,662,490	877,635	**7,540,125**	40%	
Housing Opportunities for Special Populations					
Senior Housing	903,371	275,000	**1,178,371**	6%	
Housing for Persons with Addictions	524,335		**524,335**	3%	
Housing for Transitioning or At-Risk Youth	343,000		**343,000**	2%	
Housing for Homeless Families	270,000		**270,000**	1%	
Housing for Battered Women	47,500		**47,500**	0.3%	

Does not include administration or pass through

Service Areas	Contracted Services	Direct Service Provision	Total Spending on Services	Spending as % of Service Area Subtotal	Spending as % of Grand Total
	Children & Family Services				
Children & Family Services Subtotals	**13,078,103**	**394,090**	**13,472,193**		**13%**
Children's Behavioral Health					
Outpatient Counseling and Therapy	6,787,767		6,787,767	50%	
Case Management	1,245,650		1,245,650	9%	
Supportive Services	1,043,767		1,043,767	8%	
Respite Care	1,039,280		1,039,280	8%	
Child Care Subsidies	2,342,795		2,342,795	7%	
Residential Addiction Recovery	538,844		538,844	4%	
Juvenile Diversion Programs	40,000	394,090	434,090	3%	
Parental Visitation	40,000		40,000	0.3%	
	Basic Needs				
Basic Needs Subtotals	**988,646**	**11,970,282**	**12,958,928**		**12%**
Energy Assistance		6,691,831	6,691,831	52%	
Family Success Centers		4,175,245	4,4175,245	32%	
Wealth Building/Savings	60,741	1,103,206	1,163,947	9%	
Referrals	433,609		433,609	3%	
Legal Support					
General Legal Aid	162,980		162,980	1%	
Ryan White Legal Aid	131,426		131,426	1%	
Food & Nutrition					
Ryan White Food & Nutrition	158,890		158,890	1%	
General Food & Nutrition	41,000		41,000	0.3%	

Service Areas	Contracted Services	Direct Service Provision	Total Spending on Services	Spending as % of Service Area Subtotal	Spending as % of Grand Total
	Adult Addiction Services				
Adult Addiction Services Subtotals		**10,785,075**	**10,785,075**		**10%**
Residential		5,094,190	5,094,190	47%	
Detox		3,397,581	3,397,581	32%	
Outpatient Counseling and Therapy		1,941,250	1,941,250	18%	
Special Grants		352,054	352,054	3%	
	Adult Behavioral Health				
Adult Behavioral Health Subtotals	**8,180,731**		**8,180,731**		**8%**
Outpatient Counseling and Therapy	4,445,016		4,445,016	54%	
Specialized Courts	1,803,157		1,803,157	22%	
Ryan White Counseling & Therapy	1,175,345		1,175,345	14%	
Supportive Services	397,213		397,213	5%	
Crisis Stabilization	350,000		350,000	4%	
	Senior Services				
Senior Services Subtotals	**5,185,587**	**2,513,954**	**7,699,541**		**7%**
Independent Living Services					
Homemaker and Other General Support Services	1,976,631	2,513,954	4,490,585	58%	
Personal Care	1,990,565		1,990,565	26%	
Emergency Alert Devices	51,705		51,705	1%	
Respite Care	764,115		764,115	10%	
Adult Day Care	402,571		402,571	5%	
GRAND TOTAL SERVICES SPENDING	**74,809,605**	**30,110,390**	**104,919,995**		

Source: Current FY 2014 budget data provided by HSD budget staff.

Appendix K

As shown in **Table 5-1** for calls in which a zip code could be determined, just over 90 percent of all calls and unmet needs originate in 30 zip codes.

Table 5-1: Top 30 Zip Codes – Total Calls and Unmet Needs from 211 Broward

Caller Zip Code	Number of Calls	Caller Zip Code	Calls with Unmet Needs
33311	18,852	**33311**	2,637
33313	5,201	**33313**	1,062
33020	4,702	**33020**	693
33023	3,447	**33023**	560
33060	3,283	**33060**	516
33312	3,207	**33312**	504
33065	2,385	**33065**	397
33068	2,185	**33068**	381
33321	1,942	**33319**	337
33319	1,872	**33024**	330
33024	1,843	**33064**	323
33064	1,808	**33321**	299
33309	1,695	**33309**	286
33442	1,615	**33025**	281
33063	1,483	**33063**	238
33009	1,458	**33009**	232
33025	1,448	**33351**	217
33441	1,231	**33069**	214
33334	1,114	**33004**	209
33317	1,080	**33441**	183
33069	1,037	**33317**	178
33021	1,033	**33334**	168
33004	1,022	**33021**	166
33314	1,017	**33314**	153
33304	983	**33304**	147
33351	982	**33324**	112
33324	931	**33322**	103
33322	867	**33027**	96
33308	774	**33442**	92
33315	631	**33308**	87

Table 5-2: Age Group of Caller

Age Group	Call Count	Percent of Calls
55 and Over	12,043	12.2
21-54	85,786	86.8
0-20	999	1.0
Total	98,828	

As shown in **Table 5-3**, 211 Broward received 133,075 calls in 2013. Of these calls, requests included:

- 64,821 (48.7 percent) for basic needs.
- 28,112 (21.1 percent) for behavioral health services.
- 12,277 (9.2 percent) for health.

Table 5-3: Reason for Call to 211 Broward

Major Need Group Code	Count	Percent of Calls
Basic Needs	64,821	48.7%
Government/Community Services	15,874	11.9%
Health	12,277	9.2%
Emotional/Mental Health	10,691	8.0%
Chronic Mentally Ill	5,916	4.4%
Legal	4,749	3.6%
Special Needs	4,458	3.3%
Addictions	3,740	2.8%
Jobs/Education	2,784	2.1%
Family Issues	2,103	1.6%
Children's Mental Health	2,012	1.5%
Abuse & Neglect	1,825	1.4%
Teen Issues	1,111	0.8%
Suicide/Homicide	714	0.5%
Total	**133,075**	

Table 5-4 below identifies 16,845 calls coded as an unmet need for one of eight reasons: Caller declined referral, Caller lacks transportation, Caller not eligible, Caller terminated call, Provider funds exhausted, Provider language barrier, Provider No such

service available, and Provider waiting list for services. Of these, the primary reasons callers could not be referred include:

- 5,489 calls for basic needs, the vast majority of calls (87 percent), were not referred because of wait lists or exhausted funding.
- 6,310 (36.9 percent) because wait lists existed or provider exhausted funds.
- 4,648 callers (27.6 percent) were not eligible for services requested.
- Of those callers, 93.8 percent (4,361) were requests for basic needs.
- 956 calls (5.7 percent) requested help with behavioral health services that could not be met.
- Of the behavioral health calls, 630 (65.9 percent) were for mental health services; 136 (14.2 percent) were for substance abuse services.

Table 5-4: Reason for Unmet Need

Major Need Group	Caller declined referral	Caller lacks transportation	Caller not eligible	Caller terminated call	Provider funds exhausted	Provider language barrier	Provider No such service available	Provider waiting list for services	Grand Total
Basic Needs	1,588	70	4,361	762	71	16	930	5,418	13,216
Government/Community Services	155	10	85	175	28		322	413	1,188
Health	127	4	86	101			139	112	569
Emotional/Mental Health	110	6	5	175		1	30	11	338
Legal	89		19	44			25	28	205
Jobs/Education	48		33	21		2	42	47	193
Family Issues	20	1	10	26	1		13	119	190
Addictions	55	3	5	45			13	15	136
Children's Mental Health	61	1	7	29		2	20	10	130
Special Needs	32	2	4	17			8	29	92
Abuse & Neglect	16		11	25			4	3	59
Chronic Mentally Ill	1		1	41					43
Suicide/Homicide	5		2	23			1		31
Teen Issues	4			20			4	1	29
Touchline Services	4			2		1			7
FEMA Client Check				1					1
Need Exception (Call did not permit a need assessment)	6	2	19	350			37	4	418
Grand Total	**2,321**	**99**	**4,648**	**1,857**	**100**	**22**	**1,588**	**6,210**	**16,845**