Humboldt County, California: A Promising Model for Rural Human Services Integration and Transformation

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RUPRI Rural Human Services Panel

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Overview

In February 2010, the Rural Policy Research Institute (RUPRI) Rural Human Services Panel released its report titled "**Rethinking Rural Human Service Delivery in Challenging Times: *The Case for Service Integration" (RUPRI Rural Human Services Panel 2010)*[1].** This was developed as a response to the current unparalleled need for human services in rural America, with significant long-term unemployment, an increased concern for food insecurity and an increased reliance on food assistance programs, along with increased challenges and decreasing funding for state and local human service providers. These troubling trends have created a significantly greater need for human services and safety net programs for rural families. To further complicate matters, the global recession has had devastating impacts on state and local government budgets, a situation that is unlikely to improve in the foreseeable future. As this Report points out, with dwindling resources, even the most basic essential services may not be accessible or may no longer even exist. Beyond that**,** those facing hardships often cannot access rural human service providers with sufficiently specialized knowledge to align their unique client needs with the limited array of public and non-profit program support for which they may be eligible and would likely find standard in urban settings. In fact, this may result in a disturbingly different expectation of what are minimally accepted levels of services in rural vs. urban communities.

This Report sought to help meet this challenge by describing a different approach for more efficiently aligning resources and fully integrating human services into locally and regionally-based *client-centered* systems. Critical to the success of this model is the creation of readily accessible local hubs for service integration that emphasize local leadership and support. This, coupled with essential services offered in close proximity to clients, can provide improved organizational capacity and oversight, promote greater efficiency of management infrastructure and finite resources, and provide greater opportunity for attracting and better utilizing external philanthropic support and grants for innovative design and testing.

With these key elements of the proposed service integration model in mind, the Rural Human Services Panel conducted a national search to identify rural places where some or all of these elements were operational, and to determine to what extent these factors could lead to more efficient and effective use of resources and improved access to essential human services. This led to Humboldt County, California where many of the desirable attributes described in the Panel Report had been in development for more than fifteen years and were currently operational.

[1] This report was completed with the support from the Federal Office of Rural Health Policy and is available on the RUPRI website: http://www.rupri.org/Forms/ServiceIntegration_Feb2010.pdf

This report provides a summary of an in-depth assessment of the Humboldt County fully integrated health and human services delivery model, which included multiple extended site visits to Humboldt County in 2010 by the Rural Human Services Panel, staff, and RUPRI Director, detailed field interviews with the Humboldt County Department of Health and Human Services (DHHS) management, staff, community partners and stakeholders; focus groups; field observations, on-site visits to remote offices, partners, and family resource centers; and critical review of the strategic plans, reports, data collection forms and other relevant documents. Additionally, the report provides an analysis and summary of the critical structural and operational elements of the model resulting in demonstrated effectiveness in serving its residents in need.

Humboldt County, California

Located in the far northwest corner of California over 200 miles from San Francisco Bay Area, Humboldt is one of the most isolated, as well as diverse counties in California. Humboldt County has a population of 134,623 (US Census, 2010), inhabiting an area in excess of 4,000 sq. miles (about equal in size to the State of Connecticut). It is characterized by a rugged coast, extensive redwood forests, rivers, and interior mountainous terrain. Its primary population is found along the coast in the micropolitan area of Eureka(county seat), and Arcata although much of the county's population is spread throughout its small towns and unincorporated areas, and the eight federally recognized Indian reservations and Rancherias in the county (including Hoopa, the geographically largest Indian reservation in California.)

Evolution of a New Approach to Human Service Delivery

By numerous measures, Humboldt County in the early 1990s was a distressed rural region, with long-standing challenges common to many rural counties in the country. The poverty rate was, and continues to be higher than the state average, median household income was lower than the California state average and usage of public assistance, such as supplemental security income, cash public assistance and food stamps exceeded the state average. As county leaders began conversations about a new system of human service delivery in the early 1990s, structural change in the timber industry led to mounting local unemployment; lumber mills were shutting down and the downtown business infrastructure was diminishing. These factors were compounded by increasing social and economic pressures on its Indian reservations, which faced numerous threats to livelihood and economic well-being, particularly as their fishing heritage became almost impossible to sustain.

Enabling Innovation

State and local foundations recognized opportunities for philanthropic support in the county, but with little or no sustainable success. With 31 competitive service organizations vying for the same funds, Humboldt County had developed an inefficient safety net and a sense of

desperation. As described by key informants, in addition to the economic stresses, the human service delivery system was taxed beyond capacity and services were becoming increasingly inadequate. There was widespread dissatisfaction with the fragmented service delivery system, leading not only to poor morale within the service delivery system, but to court action. In 1988, the local Superior Court Judge, concerned about alarming recidivism rates for juveniles, requested a study to map county service delivery and recommend new approaches.

In the face of this desperation, a group of talented and engaged leaders emerged to respond to the challenge. There were a number of interest groups and committed local residents who cared a great deal for their community, but had no productive outlets with which to participate. These leaders displayed passion and creativity, a willingness to accept ownership of both problems and solutions, and a dedication to learning the new skills necessary for collaboration. During this period, The Humboldt Area Foundation emerged as a key catalyst to nurture leadership and facilitate transformational community change. Instead of "leading with the money" (often the case with private philanthropy), this foundation acted as a convener, and brought credibility and resources to assist the community in facilitating dialogue and skills training to develop a shared central vision and action plan.

Being a county administered health and human services system with limited resources, the local government and its leadership were also motivated to maximize efficiency to better meet needs of residents. Thus, with leadership transitions in the local public administrative staffing, impetus from court action, leadership and resources from the local community foundation, trained and mobilized community leadership, and the emergence of a collaborative community vision, the critical early ingredients for catalyzing service integration had begun to emerge.

Developing the Shared New Vision

The new vision for a fully integrated and responsive delivery system required three critical paradigm shifts to achieve success:

- A shift from the focus on programs and services derived from funding streams to a fresh view of people in their environment--their assets, needs, and services--to help them achieve health and independence;
- A shift from treatment of the most serious problems to prevention and early treatment whenever possible and then the provision of intensive treatment when necessary
- A shift from the exclusive ownership of health and human services from public and non-profit agencies to a shared commitment and ownership with the community.

The earliest reference to this paradigm shift in Humboldt County is in the judicially-requested study completed by Dr. Marianne Pennekamp (1993).[2] After describing the fragmented delivery system in operation, Pennekamp recommended a redesign based not only on needs but community assets, and on a developmental model throughout the lifespan for achieving

[2] The Humboldt County Families, Children and Youth Services and Community Development Study. Marianne Pennekamp, Ph.D. April 1993.

positive outcomes. Specific recommendations included bringing services to people and people to services; integration of information, services, funding; monitoring/evaluation; creating a community approach to delivery; grant seeking, including shared vision, shared language, trust, coalition building; coordinated planning, and reduced isolation; and the creation/utilization of family and community resource centers in small communities for ease of consumer access. Pennekamp's study portrayed an understanding of community development and of the interests of community partners, and was reflective of natural opportunities in the county, which were later operationalized in the community vision and action steps.

Implementing the Shared Vision: The Role of Legislation

One of the early critical factors that permitted Humboldt County to solidify its emerging integration vision was the passage of state legislation allowing the expansion of pilot projects for county health and human service integration. In 1999 the County Integrated Health and Human Services Program (AB 1259, Strom-Martin) was passed providing authority for the funding and delivery of services and benefits through an integrated and comprehensive county health and human services system. The county's integration initiative was well underway by this stage, but this legislation removed state barriers, encouraged a stronger partnership with state agencies and likely enabled the process to proceed more quickly. This legislation launched the first phase of Humboldt County's integration (1999 – 2004), integrating six departments (Social Services, Mental Health, Public Health, Employment Training, Veterans Services and Public Guardian) to form the Department of Health and Human Services. The first phase included integrating and colocating administrative infrastructure, consisting of information services, employee services, and financial services for health, mental health, and social services. When State Proposition 63, The Mental Health Services Act increased funding, personnel, and resources for county mental health (including prevention, early intervention, infrastructure technology and training needs), Humboldt County was in position to make the best use of these resources through their integrated service delivery system.

"Giving counties the flexibility to structure their health and human services programs in a manner that fits the needs of their local communities is a basic hallmark of the state-county relationship and should be preserved."

In 2007 AB 315 (Berg) made the County Integrated Health and Human Services Program permanent. Supporters contend that, "giving counties the flexibility to structure their health and human services programs in a manner that fits the needs of their local communities is a basic hallmark of the state-county relationship and should be preserved."[3] By this time, the county had already entered its second phase of integration, which targeted strengthening the infrastructure for further transformation, specifically targeting cultural diversity, research and evaluation support; training, education and supervision support; and resource development support and enabling the identification and

[3] California State Senate, AB 315 Senate Health Committee Analysis, May 23, 2007

implementation of several evidence-based practices across service delivery.

Implementing the Shared Vision: The Role of County Policy

The flexible use of DHHS funds has been facilitated by a long-standing mutual agreement with the County Board of Supervisors to "de-couple" DHHS funding from the county General Fund to the maximum extent possible. Currently, DHHS only derives 3% of its funding from the General Fund, and operates two programs on behalf of the General Fund that are most effectively operated by DHHS. This arrangement provides opportunities and risks to both DHHS and the County Board of Supervisors and County Administrative Officer. Moving DHHS out of the General Fund has limited the fiscal liability of the County for funding state mandated or federal entitlement cost growth in health and human service budgets, many of which have been the largest driver of increased county funding demands during these fiscally challenging years for public budgets. The DHHS has taken on a new level of fiscal responsibility, as the General Fund has less responsibility to relieve DHHS if it overspends or has massive state reductions.

At the same time, this agreement has provided DHHS with the capacity to retain Certified Public Expenditures and other front loading capacity that generates new revenues for services. For example, with the ability to pool reserves, the DHHS is in a better position now to claim under-utilized state allocations or uncapped entitlements that may have multi-year lag time for payments from the state. This ability to keep reserves within DHHS accounts provides greater opportunities to stabilize program delivery and reinvest in departmental services beyond what is provided by state funding. And for the time being, as state and local budget constraints have necessitated a reduction in public services and the public employee workforce, the DHHS in Humboldt County has largely been shielded from these cuts. This agreement within the County, while long-standing, is not codified into law. It continues as the operating structure because it has been beneficial to both the county General Fund and DHHS. However, with unprecedented changes to the structure of public services still evolving, challenges may yet arise to make this agreement unsustainable.

In this case, the integrated funding model and a shared vision facilitated DHHS to not only distribute funds as appropriate within the agency to best accomplish goals, but also in this case, establish funding arrangements outside the agency, when funds could be better utilized to achieve greater effectiveness through other organizations, such as family resource centers and Area Agencies on Aging. This model offered an engaged community and local foundations an opportunity to support the integrated system with resources, funding and volunteers.

Humboldt County Services Integration 2012

As a relatively mature model for service integration, Humboldt County has achieved important milestones and successes in its redesign of systems and use of scarce resources to efficiently and effectively meet the growing social and health needs of residents. However, there is agreement that this is still a work in progress, particularly as the economic and social challenges deepen in this rural region.

Nevertheless, the critical factors that formed the impetus for this vision appear to be still in place today. Throughout the county, in interviews with residents, volunteers, county staff, nonprofit and county agency leadership, there remains a sense of pride, ownership, passion and commitment to make this model work. Today, with the State of California facing even more difficult budgetary challenges, counties are experiencing the impact of significant reduction in public resources—and increased devolution of responsibility (and corresponding funding) for services from the state to the county. In the current demand for increased services, the county is also experiencing the results of major state policy changes that realign significant responsibilities for health and human service to counties.

The RUPRI Human Services Panel has concluded that the Humboldt County model for services and resource integration provides a valuable blueprint for adaption in other rural counties and states, and has reinforced its belief that this is the right approach for these challenging times for rural America. With this in mind, the Panel has identified six key elements that characterize this model and that should be considered by other rural communities.

Key Elements of a High Performing Integrated Human Services System

In analyzing the Humboldt County case study, the Panel looked for key elements that promoted its effectiveness. As discussed above, the development of an integrated human service delivery system required an extensive reorganization of programs and administrative structures. Transformation was not linear, but the result of many linked initiatives and paradigm shifts implemented sequentially over a period of time. Finally, the goal of transformation was to improve efficiency with scarce resources to achieve the best outcomes for the residents of Humboldt County.

The following are six key elements identified as critical to the success of this model:

- Shared (and public) vision, goals, principles of practice, responsibility and accountability for success
- A culture of service with a focus on the whole person/family
- Integrated funding streams and shared resources
- Reorganization of centralized and decentralized functions
- Community driven transformation through continual step-by-step engagement and partnerships
- Quality leadership and appropriate leadership at each stage

Shared (and Public) Vision, Goals, Principles of Practice, Responsibility and Accountability for Success

The shared vision, goals and operational principles are well understood, embraced and verbalized by staff, providers and the community, and are operationalized by publication and dissemination of progress evaluations and by ongoing dynamic community planning.

Department staff and community collaborators are able to provide numerous examples of integration and successful outcomes in people's lives, offer data that support their perceptions of improvement, and demonstrate how their work fits into the overall program mission.

The shared vision leads to and is supported by continual cross-fertilization of staff, through numerous training opportunities. In addition, non-profit providers have been hired for DHHS staff positions when appropriate, bringing their own perspectives, skills and contacts and further increasing cross-fertilization internally and externally. As noted above, resources are shared with the county, and with local communities.

A Culture of Service with a Focus on the Whole Person/Family

The traditional tendency of local government is to view services as individual programs, largely because of disparate, and at times conflicting funding streams, reporting requirements and government oversight. An essential element for achieving full integration of health and human services delivery is a re-orientation from organizing programs and services/resources according to the categorical or "siloed" funding to the commitment and ability to orient service delivery toward the people the funding is intended to help. In Humboldt County, services were reorganized by ages and life stages instead of programs. One of the outcomes of focusing directly on the person or family is a renewed interest in prevention, both overcoming the problems the family faces at the time of intervention, and preventing new ones from arising. An integrated approach also allows a broader perspective on the family circumstances with new possibilities for preventing future undesirable conditions. Preventing human problems is generally less expensive than treating them after the fact and prevention and early intervention services are those most often suitable for community assistance. But prevention activities are difficult to evaluate and are least often funded by government.

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The Humboldt County Department of Health and Human Services has chosen to operationalize its focus on the person/family by using what it refers to as a "3x5 design". There are three basic service strategies identified: prevention, early intervention services for at risk populations, and focused treatment interventions for high risk populations. Resources have been redirected to help the largest numbers of people in prevention, and then early intervention, with concentrated treatment services provided for the fewest, with improved outcomes over time. This strategy has the double advantage of identifying issues early in order to employ lower-cost interventions and avoid greater future costs for concentrated treatment services, and at the same time keep families on the road to sufficiency and contributing to the county's economic base.

The county also identified five target populations, rather than program purpose, for delivery focus. Those target populations are: a) children, youth and families; b) transition age youth; c) adults; d) older adults; and e) community. Programs are designed in this context. Outcomes and trends are reported through this framework, stakeholders and communities are engaged through this framework, and staff members understand their work in this context.

The 3x5 model (three service strategies for five target population groups) provides an alternate structure that embodies the shared vision and language of the community. The model also creates a culture of service for the agency -- a client-centered orientation makes it easier to recognize the impact on the population served, reshaping siloed services into individual and family recovery, self sufficiency and well being.

Traditional services provided within these divisions are as follows (Nilsen, 2010):

Children, Youth and Families	Transition Age Youth	Older Adults
WIC	Independent Living	In-home Services
TANF	Mental Health Services	Adult Protective Services
CalWORKS	**Adults**	Older Adults
Food Stamps	General Relief	Dependent Adults
Welfare to Work	Transportation	**Community Health**
Medi-Cal and Children's Health	County Medical	Public Health Authority
Child Welfare	Dual Recovery, Alcohol and Drug	Mortality
Children's Mental Health	Adult Mental Health	Behavior Change

Integrated Funding Streams and Shared Resources

Integrated funding streams advance the operation of client-centered comprehensive service delivery. The ability of many human service units to work together on person-based outcomes is greatly facilitated by the flexibility inherent in combined resources. As early as 1993 this community identified the necessity of analyzing all financial resources to determine how they could be better utilized to help clients in a holistic manner. One of the first steps that Humboldt County undertook was a fiscal examination that determined which funds had the most limitations and regulations for use, which were most flexible, and which could be used for matching to leverage other funds. Integrated funds provides DHHS increased flexibility to utilize some funds as matching dollars (often very scarce in rural communities) in order to access public and private funds that require a match that would otherwise not be available to them. In addition, this new configuration made the agency more attractive for investment from private philanthropy interested in supporting the county's innovative approach. The leveraged funds can be used efficiently and effectively for improved family-centered services, and ultimately improved outcomes. This type of system, however, requires continual oversight, accurate documentation and reporting, and determination and collaboration, particularly to meet reporting requirements from diverse sources. Integrating program evaluation,

information technology, research and funding at the county level increases the county's ability to leverage funding and to share its resources and expertise with community partners since specific expertise is often necessary to provide accurate documentation that both depict family successes and specific funding outcomes. For example, DHHS provides ongoing financial support to the Family and Community Resource Centers with training, assistance with grant writing and documentation, guidance, and in return utilizes local meeting space and offices, volunteers, etc. to meet the needs of residents.

Reorganization of Centralized and Decentralized Functions

DHHS examined which elements of service administration and support could be better organized as a centralized function of the agency and which would be better provided in decentralized locations. One of the first steps toward service integration taken in Humboldt County was the integration and co-location of the administrative infrastructure, including information services, employee services, and financial services. In addition, resource development, research and evaluation and DHHS internal training are all critical to quality integrated services and "make sense" centralized.

In rural northern California, DHHS offers many services in outlying communities where people live, instead of forcing access in more centralized centers many miles away. Services can be destigmatized when community support for health and well-being is provided in ways that bring people together and unites communities. Humboldt County has different avenues to deliver services in a decentralized manner, including the rural health clinic network and Family Resources Centers scattered throughout the region and through two kinds of Mobile Engagement Vehicles (MEV's/vans) it uses. The Rural Outreach Services (ROSE) van is equipped to bring behavioral health, public health and social service assessment, counseling and case management to communities, while the Street Outreach Services (SOS) van assists the homeless. The mobile units offer services in the places that people most need them and have provided Well Child Dental Services, housing referrals, car seat safety checks, and veterans' services among their offerings. The "decentralized" Family Resource Centers are community sites for a number of activities that promote healthy people in healthy communities, including parent education, food and clothing, social services, local health and behavioral health, and sites for meetings, including family meetings. These centers provide varied services driven by the needs of the community in an approachable manner. Community-focused resources encourage involvement by all community members in the task of community health and well-being.

Community Engagement and Partnership

Over a period of many years, Humboldt County was transformed from a deeply divided and failing community into an energetic, dynamic, integrated system. However this transformation took time, trust and commitment. Philanthropy provided training expertise, strong facilitators and a safe environment for diverse community members to learn collaborative visioning and problem solving, assuring that strongly held beliefs could be expressed, achieving a united

result. The Pennekamp study also increased community engagement by providing a broad needs assessment that included both the agency and community and suggesting that limited resources be redirected for maximum benefit. County government provided mechanisms to work across agencies and develop strategic plans for centralized leadership. Local rural school systems collaborated in development through the Healthy Start sites. The Family Resources Centers (several originally Healthy Start sites) were engaged as resources for local residents to access services and support. Of particular importance was the recognition that the volunteer sector and active participation by community residents was essential, resulting in a culture shift to collaboration and inclusion. As a result, the engaged communities allow the public agency to "keep the pulse" of all the county's communities so that the entire system is able to react to an issue more quickly and comprehensively. Service providers within the engaged community can implement new programs immediately and effectively through cross training, contracted services, and cooperative agreements and through shared client recruitment and certain kinds of recordkeeping.

Transformation from a program specific, multi-agency system to an integrated community partnering system took several years to accomplish and is maintained by continued collaboration, resource and information sharing. As one site visit participant noted: "real transformation, changing a culture, changing a community, takes time."

Quality Leadership and Appropriate Leadership for Each Stage

Paradigm shifts, particularly those involving multiple actors and large agencies, require effective leadership and particular kinds of leadership for each stage of development. In the early stages of developing a common vision, philanthropy played an essential role of identifying, training, and cultivating local leaders to work together for the community's benefits. Instead of providing direction, philanthropy provided guidance and expertise and an environment for growth. Research, fact finding and program suggestions are also forms of leadership, very necessary in the early stages. The community evidenced collaborative leadership in helping to identify a structure for integration, and the County Board of Supervisors and local judiciary demonstrated leadership in their willingness to identify the agencies that could be integrated, and choosing an appropriate director. The community and county administration identified a method for natural transition to a unified department under one director, by taking advantage of one department director's retirement and other timely occurrences.

The next stages of integration - the actual reorganization of departments and administrative functions - required leadership in creatively analyzing funding streams, developing organizational structures, operationalizing the vision into specific programs, implementing and funding structures for community engagement and partnership, and leadership for ongoing development, evaluation and adaptation. In order to do this, the director of the integrated agency must demonstrate several qualities and capabilities. Inclusionary leadership requires recognition not only of the right of communities to engage in human service delivery through their faith and non-profit informal networks, but the responsibility of communities to care for their members. It requires the ability to follow the lead of others in the community when

appropriate. It requires an understanding of and great respect for the diverse cultures in the community, and a willingness to learn within those cultures. It requires sensitivity to the individuality of rural communities in order to provide flexible place-based delivery. Leadership must include the capacity to translate the expressed vision of the community into practice, to envision how work is reorganized, redistributed, re-reported, evaluated, and then to create the appropriate organizational structure to accomplish this mission. Leadership must have the tenacity to maintain the vision within the organizational structure, particularly when change is difficult, and the ability to communicate the transformation to all: funders, policy makers, legislators, staff and community. In order to accomplish this, leadership requires the ability to take risks, and to risk criticism. Leadership for an integrated adaptable organization requires the willingness and commitment to develop other leaders both within and outside of the organizational structure at all levels of service delivery. Particularly for integration of services, leadership must have or must develop the critical technical skills for blending and managing funding streams, with a clear orientation of organizing resources not by service, but by target population, translating the redesign into programming. Finally, leadership must have the commitment to report successes and failures honestly to all partners, or the partnership dissolves.

Future Opportunities and Considerations

In the next few years, Humboldt County faces the implementation of new Affordable Care Act programs and requirements, major budget reductions and a new arrangement between the state of California and counties for the delivery of health and human service programs. These changes present potential opportunities and challenges for Humboldt County.

The large potential pool of funding in the Prevention title of the Affordable Care Act holds great promise for the county, where many prevention programs are already well-established and successful. The county is now poised for implementing new Affordable Care Act programs. The county, like many rural counties with already high Medicaid enrollment, faces a potentially much larger pool of Medicaid recipients starting in 2014. However, the county already has established a public insurance benefit enrollment program, called Path2Health. This program will transition to Medicaid enrollment when the program expands eligibility. Humboldt County will need to be prepared to meet the program requirements, as California was the first state to pass the necessary legislation to begin implementing the Affordable Care Act and is progressing as scheduled. However, if certain Affordable Care Act programs are not fully implemented, there will be even more pressure on human service systems to incorporate prevention and early intervention efforts that ward off poor health and well-being conditions.

The state of California is undergoing massive budget reductions which triggered a major realignment, with county governments assuming responsibility for numerous state-operated public service programs with less state funding. In the first phase of the realignment, the state is “devolving” program and administration responsibility for 12 health and human service programs and public safety operations from the state to the county governments. This is

forcing California counties to revisit how services are delivered in their counties. The smaller rural counties may not have the infrastructure in place to design a system with more responsibility. For example, there will be a migration of managed care to counties, which is a vastly different way of delivering services for many rural counties in northern California. However, Humboldt County, with its state authorization to deliver services in an integrated manner, has the ability to ask for regulatory waivers to use any new funds flexibly. This presents great opportunity for the county to create an even deeper integrated infrastructure in responding to these momentous reductions, realignments and reforms. As the Director of DHHS stated recently, "Integration is never really done, as you know well."

It is likely that the county's well-designed integrated system will find more opportunities than challenges in the years ahead. The county has achieved notable improved outcomes for different county residents needs' over the last decade.

- The county's In-Home Supportive Service caseload (for elderly services) has decreased by 8.5% from 2001 levels, while the statewide caseload has increased by 70% during the same time period[4]. Through the use of flexible funds in the county's Adult Division, the public health nurses, mental health clinicians and social workers are now integrated into the In-Home Support Services process, increasing the ability of the department's multi-disciplinary teams to appropriately screen and enroll participants and monitor outcomes.
- In instances when children are removed from their home by reasons of abuse and/or neglect, there has been an 82% decrease in group home placements for these youth. Instead youth are placed in local, less restrictive and less expensive settings and total group home expenditures have decreased 72% since July 1997. Child Welfare, mental health and public health resources are now partnered to achieve better outcomes for the youth in need in the county. [5]
- Humboldt County is the only county in California able to leverage state funding to provide youth mental health and substance use disorder treatment in a local, secure treatment facility, the New Horizons Regional Facility. Rates of program completion for participating youths were over 70% in the 2009 reporting period and 78% of program participants did not recidivate after participation, while nationwide, 50 to 80% of youth released from secure retention facilities recidivate. [6]

CONCLUSION

[4] County of Humboldt, Department of Health & Human Services, Integrated Progress and Trends Report, Autumn 2011, page 56, http://www.co.humboldt.ca.us/hhs/administration/documents/autumn%20trends%202011.pdf

[5] County of Humboldt, Department of Health & Human Services, Integrated Progress and Trends Report, Autumn 2011, page 27, http://www.co.humboldt.ca.us/hhs/administration/documents/autumn%20trends%202011.pdf

[6] County of Humboldt, Department of Health & Human Services; Humboldt County's Aggression Replacement Training and New Horizons Outcomes Report, July 2010, page 18.

The timing of the RUPRI Human Services Panel's engagement with Humboldt County is fortunate as it transforms the delivery system to operate within these new realities. Therefore this paper is the first in a series of studies and analysis of Humboldt County to be undertaken by the Panel. Future papers will examine the benefits of delivering services in a client-centered system and the challenges of trying to operate outside of the traditional and established method of service delivery. And the Panel will follow the county as the Affordable Care Act and state realignment take full effect.

The Panel's report entitled, Rethinking Rural Human Service Delivery in Challenging Times: *The Case for Service Integration" (RUPRI Rural Human Services Panel 2010)*[7] was written to develop a response to the current unparalleled need for human services in rural America. When we examined Humboldt County, we found not only an integrated system, but also the necessary elements for such a system to exist and innovate over time. Humboldt County's model has been evolving over the last 15 years and there are many things that other counties implementing or considering an integrated system can learn from the key elements of their system, regardless of their geographic size or location. It is through continuous consideration of these elements that the system can continue to innovate and address emerging problems that face the community today. Humboldt County's client-centered system and focus on prevention has allowed it to become more efficient and effective, and at the same time leverage additional dollars to add value to their efforts to address poverty, long-term unemployment, hunger and family well-being.

[7] This report was completed with the support from the Federal Office of Rural Health Policy and is available on the RUPRI website: http://www.rupri.org/Forms/ServiceIntegration_Feb2010.pdf

RUPRI Rural Human Services Panel

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Colleen Heflin, **PhD** is an Associate Professor, Truman School of Public Affairs, University of Missouri. Ms. Heflin's interdisciplinary research program focuses on understanding the survival strategies employed by low-income households to make ends meet, the implications of using these strategies for individual and household well-being, and how public policies influence well-being.

Mario Gutierrez, *Panel Chair*, is the interim Executive Director of Center for Connected Health Policy in California, a non-profit planning and strategy organization working to remove policy barriers that prevent the integration of telehealth technologies into California's health care system. From 1996 to 2009, he served as a Strategic Programs Director for The California Endowment, working with grant programs that provide health and human services to rural migrant farmworkers.

Bruce Weber, **PhD** is a Professor of Agricultural and Resource Economics and Extension Economist at Oregon State University, Director of the Rural Studies Program and Senior Research Affiliate at the National Poverty Center. His current research projects focus on the causes of poverty and hunger in rural areas, particularly on the interaction of community characteristics, public policy, and household economic outcomes for low-income people.

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