



Branch County  
County Collaborative



## Action Plan 2008-2010

A working plan created on January 1, 2008 to provide leadership to enhance and achieve optimum quality of life for all people in Branch County by supporting: economic sufficiency, healthy lifestyles, healthy family and social relationships and overall community well being.



## **Mission**

The Family Services Network is a community collaborative working to achieve optimum quality of life for all people in Branch County by supporting: economic sufficiency, healthy lifestyles, healthy family and social relationships and overall community well being.

## **Vision**

The vision of Family Services Network is that every resident of Branch County will have the resources and support necessary to reach full economic, social, health, learning, community and civic potential.

## **Family Services Network Values**

Family Services Network believes in and strives to uphold the following values:

- Accountability
- Communication
- Community Involvement
- Community Well Being
- Inclusion
- Innovation
- Leadership
- Teamwork
- Trust

Family Services Network has adopted the following as standards for programs, projects and workgroup efforts:

- Best Practices
- Community Driven
- Culturally Sensitive
- Prevention
- Results-Oriented
- Respect and Dignity

## **Who are the members of Family Services Network?**

Membership may include:

- Agencies
- Businesses
- Community Members
- Educators
- Elected Officials



- Faith based organizations
- Law Enforcement Officials
- Private agency and community representatives

### Current membership list (as of February 2008)

ADAPT	Michelle Aerts
Beginnings Care for Life	Jane Ford
Branch County Administration	Bud Norman
Branch County Area Chamber of Commerce	Hillary Eley
Branch County Commissioners	Ted Gordon
Branch County Community Foundation	Colleen Knight
Branch County Commission on Aging	Nancy Davis
BHSJ Community Health Agency	Steve Todd and John Robertson
Branch Interfaith Hospitality Network	Martha Bartlett
Branch Intermediate School District	Mike Beckwith
City of Coldwater	Chris Hilton
Community Action Agency	Nancy Macfarlane and Teresa Yohe
Community Health Center	Randy DeGroot and Julie Stratos
Coldwater Housing Authority	Cathy Gordon
Department of Human Services	Kim Willis and Shawn Culp
Michigan Works! HRDI	Missy Lafferty
Phase One	Kathy Pendergrass
Pines Behavioral Health	John Bolton
United Way	Judy Krzeminski
Workforce Development Board	Colleen Knight

We always encourage and strive to have new members join the collaborative to help in making our workgroups and projects more successful.

#### Other:

Community Representatives  
Midwest Radio Group  
Q-1 Video Network  
The Daily Reporter

#### Suggestions on additional invites:

Area Agency on Aging  
Baker College  
Branch Area Transit Authority  
Bronson Community Schools  
Coldwater Community Schools  
Economic Development



Great Start Collaborative  
Michigan Prisoner Reentry Initiative  
Quincy Community Schools  
STARS  
Substance Abuse Task Force  
Union City Community Schools



## Family Services Network Goals

**Goal 1: Take a leadership role in evaluating and identifying the needs and strengths of the community.**

Objective: Use data to determine strengths of the community and assist in filling the gaps and guidance for FSN in the creation of new workgroups or projects to work on these needs.

Timeline: Continuous

**Goal 2: Serve as the conduit that facilitates collaboration amongst agencies and throughout the community.**

Objective: Coordination and approval of community grant applications.

Objective: Allocation and monitoring of grant applications as needed.

**Goal 3: Promote, revise and coordinate activities of the 10 Year Plan to End Homelessness.**

Objective: Support the Continuum of Care system.

Objective: Annual Review of the Ten Year Plan

Objective: Oversee the access and distribution of funds to implement programs that meet all requirements.

Timeline: Continuous

**Goal 4: Increase community awareness of FSN and its member agencies.**

Objective: Implement and annually evaluate Communications Work Plan to increase awareness throughout the community.

Timeline: Continuous

Objective: Continually educate community agencies and community members on FSN and our role in the community.

Timeline: Continuous



## Workgroups

Workgroups will be created and disbanded as the need increases or decreases in the community. This can be a long-term or short-term collaborative project or a series of projects targeted at a specific outcome or community barrier. An example of a workgroup disbanding is Access to Healthcare disbanded in 2007 once the goals they set in 2005 were met.

To be successful, workgroups will require the support of the Community Collaborative and will make specific recommendations for action to the Executive Committee and Family Services Network at bi-monthly meetings. Workgroups will complete work plan of action and share the progress, outcomes and needs of the workgroup at bi-monthly meetings.

Below are the greatest community needs identified by FSN members during the December 10, 2007 Strategic Planning Session. During the next two years, we will focus our attention and efforts on the topics of Community Development, Health, Housing, and Seniors.

## Community Development

**Charge:** Collect and analyze data; identify priorities from data; prepare annual report card to distribute to the community on data and gaps analysis.

**Workplan:** Create a two year work plan.

**Goal:** Continually collect and organize new data from the national, state and local level important to our community and its' citizens.

**Goal:** Distribute data pertinent to the well being of Branch County and its' citizens.

**Objective:** Share relevant data with FSN and member agencies.

**Objective:** Work with the Communications Committee to create and publish annual Branch County Report Card.

**Goal:** Monitor community issues; for example: Education, Economics and Family Strength, Stability and Development.

**Objective:** Be prepared to act on issues affecting the community and react and make recommendations to FSN based on these issues.

**Goal:** Implement a 211 system for all Branch County residents.



## Health

Charge: A healthier Branch County and healthier residents

Workplan: Investigate health needs and concerns in Branch County and create a two year plan for FSN to adopt.

Items discussed at FSN Strategic Planning included:

**Goal:** Monitor health issues affecting the community and be prepared to act.

Objective: Reduce teen pregnancy.

## Housing

Charge: Build partnerships that will lead to the prevention and ending of homelessness in Branch County. Work should support the coordinated delivery of critical services and the development of permanent housing and housing options that promote housing stability.

Workplan: 10 Year Plan to End Homelessness

**Goal:** Eliminate homelessness in Branch County

Objective: Invest in prevention.

Objective: Coordinate efforts to educate the community about homeless issues.

Objective: Reach out, provide housing first, and ensure services with housing.

Objective: "Harm reduction" and treatment access.

**Goal:** Work on establishing more permanent housing in Branch County.

## Seniors

Charge: Improving Lives of Seniors in Branch County

Workplan: Create a two year workplan.

**Goal:** Seniors will actively seek and access community services.

Objective: Maintain a process for updating accurate senior resource and referral information.



Objective: Initiate and promote a senior advocate program utilizing volunteers.

Objective: Improve marketing and outreach to seniors

Objective: Look into and apply to become an Elder Friendly Community.



## Committees

FSN Standing Committees will continue to meet and work toward the completion of goals. The FSN standing committees have ongoing goals that will be needed to lead and guide the collaborative as they work to meet the goals of the ever changing workgroups.

### Executive Committee

The  
Exec

utive Committee will lead the implementation of a comprehensive, data driven process to define and prioritize needs, determine gaps and design strategies to enhance the quality of life for all Branch County residents.

#### Current Executive Committee Members

-Branch County Commissioners	Ted Gordon
-Branch, Hillsdale, St. Joseph Health Department	John Robertson
-Branch Interfaith Hospitality Network	Martha Bartlett
-Branch Intermediate School District	Mike Beckwith
-Chamber of Commerce	Hillary Eley
-City of Coldwater	Chris Hilton
-Coldwater Housing	Cathy Gordon
-Community Health Center of Branch County	Randy DeGroot
-Department of Human Services	Kim Willis or Shawn Culp
-Pines Behavioral Health	John Bolton

The Executive Committee will be responsible for the management of all funds, including dues and the leadership for the annual fundraiser.

### Communications Committee

The Communications Committee will develop and implement a marketing plan that effectively communicates the FSN mission and outcomes; design recruitment strategies for new and prospective FSN members; harness collective power of FSN to impact public policy and be a force for change.

#### Current Communications Committee Members:

-Chamber of Commerce	Hillary Eley
-Community Foundation	Colleen Knight
-Community Health Center of Branch County	Randy DeGroot
-Pines Behavioral Health	John Bolton

**Goal:** Communicate the value of being a member



Membership of FSN provides opportunities for members to:

- Network with other service organizations, businesses and community members ,
- Have a link on our website,
- Create social capital,
- Have your events posted on our website,
- Play an integral role in the creation and development of community wide projects and programs; and
- Participate in discussions and planning on issues that affect our community through the numerous workgroups and committees.

In regard to membership, the Communication Committee serves numerous purposes:

- To continually build a broad and diverse membership within the FSN by building relationships and establishing community partners; and
- To continually enhance the benefits of FSN membership by surveying, reviewing, and responding to membership feedback.

**Goal:** Member recruitment and retention.

**Goal:** Marketing Plan.

**Goal:** Annual fundraiser.

**Goal:** Community Education

### Allocation Committee

The Allocation Committee will meet on a quarterly basis. Quarterly meetings are held to review the use of allocated monies. This committee will be responsible for the allocation of MSHDA, ESG and SFSC monies. This committee will also take a leadership role any other any time funding oversight and distribution is needed.

Current Allocation Committee Members:

- |                               |                  |
|-------------------------------|------------------|
| -Chamber of Commerce          | Hillary Eley     |
| -Coldwater City               | Christine Hilton |
| -Coldwater Housing            | Cathy Gordon     |
| -Community Foundation         | Colleen Knight   |
| -Department of Human Services | Kim Willis       |
| -United Way                   | Judy Krzeminski  |

Recipients of funds are ineligible to sit on the allocation committee, due to conflict of interest.



## Appendix A

### Stages Of Working Together: Networking To Collaboration

	NETWORKING	COOPERATING	COORDINATION	COLLABORATING
<b>PURPOSE</b>	Exchanging information for mutual benefit.	Altering activities for mutual benefit.	Sharing resources for mutual benefit.	Enhancing the capacity of each other for mutual benefit and common purpose.
<b>AGENDA</b>	Better relationships.	Avoid duplication.	Divide up new Resources. Share resources.	Develop integrated service system, community system of care involving <ul style="list-style-type: none"> <li>• Joint decision making</li> <li>• Common forms</li> <li>• Common training across agencies etc.</li> </ul>
<b>FOCUS</b>	<b>Staff</b>	<b>Client</b>	<b>Program</b>	<b>System</b>
<b>SCOPE</b>	Individual agency functioning.	Individual provider/ agency functioning.	Cross-agency functioning Generally limited to one service population/issue.	Cross-agency/systems functioning. Multiple population groups/issues.
<i>Example</i>	<i>Show and tell</i>	<i>Coordinating times for home visits.</i>	<i>Making van, space, staff available to another agency.</i>	<i>Pooling resources, designating a lead agency, joint responsibility.</i>
<b>ORGANIZATION</b>	Informal, limited to periodic meetings.	Informal.	Formal structure.	Formal structure including workgroups.
<b>MEMBERSHIP</b>	Whoever comes; service providers and supervisors.	Service providers. Supervisors.	Agency directors. Supervisors.	Agency directors or surrogates with authority to allocate resources; Community representatives.
<b>LEADERSHIP</b>	Whatever is necessary to maintain meetings.	Facilitative.	Autonomous, facilitative. Lead agency in control.	Shared leadership. Lead agency responsible to collaborative body.
<b>GOVERNANCE</b>		Informal agreements.	Formal interagency agreement on allocation of resources	Formal interagency agreement on allocation of resources, respective responsibilities. Institutionalizing systems change.
<b>LEVEL OF TRUST, MANAGEMENT OF CONFLICT</b>	Low trust /minimal conflict. Protecting turf.	Some trust/conflict Recognize we all can benefit.	More trust. Recognize and manage conflict when it arises.	High trust. Develop strategies for dealing with conflict before it arises.
<b>COMMITMENT of MEMBERS</b>	Just have to show up.	Work together at meetings or informally one on one.	Work on agenda outside of meetings.	Work on agenda (structure and issues) outside of meeting.

*This material is from SECOND REPORT, STATEWIDE EVALUATION OF ASAP-PIE GRANTEES, Michigan State University, Institute for Children, Youth and Families and University Outreach, March 2003.*



Appendix B  
Continuum of Care  
Source: HUD

## Key Characteristics of a Successful Continuum of Care Design

**Long-range:** The problems of homelessness are complicated and will need to involve long-range solutions and planning. It is important to recognize that to better serve homeless people and to create affordable permanent housing and supportive housing, considerable time, energy, and financial resources, as well as linkages to mainstream services and affordable housing, are needed.

**Comprehensive and collaborative:** A Continuum of Care system should address and deal with all major homeless populations and involve the breadth of housing and service options. The plan should be designed to meet the unique needs of subpopulations while also developing capacity to serve people who are homeless with multiple needs, such as people with histories of substance abuse or mental illness.

**Strategic:** A Continuum of Care plan should incorporate realizable strategies to move homeless individuals and families beyond shelter to permanent housing and self-sufficiency. Solutions to complex problems require carefully developed Action Plans to achieve the desired objectives. Further, these strategies should be grounded in community needs and priorities identified through a planning process which includes stakeholder input.

## Why is a Continuum of Care Plan Important?

**Assess capacity and identify gaps:** Continuum of Care planning provides communities with an opportunity to step back, critically assess capacity, and develop solutions to move homeless people toward permanent housing and self-sufficiency.

**Proactive rather than reactive:** Continuum of Care planning helps communities look comprehensively at needs and to anticipate policy or demographic changes and develop the capacity to respond to these changes (e.g., new drug therapies for people living with HIV/AIDS which change the models of supportive housing most appropriate for this population).

**Common goals for which to advocate:** Continuum of Care planning helps communities develop a common vision and a set of common goals.

**Coordination and linkages:** Historically, homeless services have been fragmented at best. Continuum of Care planning helps providers identify ways of coordinating and linking resources to avoid duplication and facilitate movement toward permanent housing and self-sufficiency.

## Key Characteristics in the Design of a Continuum of Care:

- Long range
- Comprehensive and collaborative
- Strategic
- Based on an assessment of community needs and priorities



### **Why Develop a Continuum of Care Plan for Your Community?**

- Assess capacity and identify gaps
- Develop proactive solutions rather than reactive stop-gaps
- Identify common goals for which to advocate
- Increase community "buy-in" and access to mainstream resources
- Increase competitive advantage for receiving HUD McKinney Homeless Assistance funding

**Community "buy-in" and access to mainstream resources:** Continuum of Care planning ideally involves stakeholders outside of the traditional homeless system with the goal of educating these stakeholders and getting them to become part of the solution (e.g., the city housing department could include a set-aside of HOME funds for tenant-based rental assistance to transition homeless women and their children to permanent housing).

**Competitiveness for McKinney Homeless Assistance Funding:** Comprehensive and inclusive Continuum of Care planning makes communities highly competitive for receipt of McKinney Homeless Assistance funding through the Homeless SuperNOFA process. The plan will also be useful in leveraging other, non-McKinney resources needed to build a comprehensive system to address homelessness.

### **Family Services Network and the role as the Continuum of Care**

According to HUD, The Continuum of Care is a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness.

### **Being an effective CoC**

HUD continues to explain, an effective Continuum of Care plan is coordinated. It not only includes the fundamental components identified by HUD, but also the necessary linkages and referral mechanisms among these components to facilitate the movement of individuals and families toward permanent housing and self-sufficiency. It balances available capacity in each of its key components and provides a framework that is both dynamic and responsive to changing needs over time.

In addition, a Continuum of Care plan should include a focus on homelessness prevention strategies and services. Prevention services might include one-time emergency funds to keep families housed, crisis intervention services for people with mental illness living in the community, and peer networks for people in early recovery living in permanent housing.



## Appendix C Operating Guidelines

### Family Services Network Membership

Membership may include:

- Agencies
- Businesses
- Community Members
- Educators
- Elected Officials
- Faith based organizations
- Law Enforcement Officials
- Private agency and community representatives

### Responsibilities of Membership

It is expected that every member of the FSN commit to certain responsibilities. They include the following:

- Payment of dues;
- Attendance at meetings;
- Serve as indicated on the executive committee, standing committees and workgroups;
- Appointments of staff to workgroups;
- Provision of clerical and other support for workgroups;
- Commitment to reading background materials;
- Commitment to understanding issues that do not directly affect one's own organization or constituency;
- Willingness to share information and decisions with staff or constituency;
- Commitment to critically examine how business is conducted within one's own organization at times;
- Willingness to mentor new members.

Family Services Network Membership Financial Participation:

- Dues are required for full membership in order to make the FSN viable it is essential that membership dues.
- The fiscal year will start on October 1 and end on September 30 of each year.
- New members will be charged a pro-rated fee in the first fiscal year that they join the FSN.
- Dues may be paid at any time during the fiscal year but must be paid before the November meeting to retain voting privileges throughout the current fiscal year and until September 30.
- The Executive Committee will be responsible for fiduciary management of the dues.



All members will be expected to contribute to the financial support of the organization.

The following dues structure will apply:

\$2,500 – Major Contributing Members

- Branch County (Board of Commissioners)
- Branch County Department of Human Services
- Branch-Hillsdale-St. Joseph Community Health Agency
- Branch Intermediate School District
- Community Health Center of Branch County
- Pines Behavioral Health Services
- Community Action Agency of South Central Michigan

\$200 - Other Community Members (agencies, businesses, organizations, churches, etc.)

\$25 - Individual Members

## **Voting**

Only members in good standing shall be permitted to vote at any meeting of the members, and each paying organization shall have one vote.

## **Executive Committee**

The Executive Committee at a minimum shall consist of the Chairperson, the Vice Chairperson (or Co-Vice chairs), and the Director. All of the members of the Executive Committee will be responsible for giving support to the Director and will act as the main decision making body for the FSN. All other Executive Committee members will be titled as trustees.

All major funders (listed above) should be invited (not required) to serve as a member of the Executive Committee.

All Executive Committee members will share the responsibility of overseeing workgroup and committee establishment and progress toward goals.

Executive Committee members shall be elected bi-annually at the September meeting. The Vice Chairperson shall succeed to the Chairperson. Executive Committee members will serve in their positions for a period of two years or until their successors are elected, and their term of office shall begin at the October meeting. Two-year terms may be renewed with the consent of the person holding the office and the membership.

The Executive Committee has power to act on behalf of the general membership as necessary and when a special meeting cannot be held due to time constraints.



## **Director**

The Director assists with the operation of the FSN and accomplishment of its purpose. The Director is responsible for facilitating collaborative and comprehensive community planning. He or she will facilitate communication and networking with agencies and organizations throughout the county, and will serve as liaison between the workgroups and committees and the FSN.

The Director will provide technical assistance to the FSN, through the preparation of descriptive materials and reports. He or she will also facilitate the investigation of new collaborative efforts and will assist with the preparation of funding proposals. The job description of the Director will be approved by the Executive Committee. The Executive Committee will evaluate the Director on an annual basis.

## **Responsibilities of Workgroups**

The FSN may assign a project or goal to the necessary workgroup to study a priority issue or a community concern. Workgroups study the population groups or issues that they have been appointed and make recommendations in the form of action plans. The FSN approves the action plans and makes decisions regarding how the plans will be implemented. The FSN may appoint a time-limited implementation committee to monitor and evaluate the results of implementation.

## **Standing Committees**

The FSN has standing committees for the purpose of achievement of collaborative goals and well being. The FSN shall establish the goals of each committee, and will appoint a chairperson and chairperson-elect. The chairperson of the committee will report to the FSN on a regular basis. The standing committees shall include the following committees:

- Allocation Committee
- Executive Committee
- Communications Committee

## **Meetings**

The FSN shall meet on a bi-monthly basis, with regular day, time, and location to be determined as the Third Wednesday of each month. The Executive Committee meets monthly. Other Standing Committees and Workgroups meet as scheduled.



## Appendix D SWOT

Information obtained from pre-strategic planning survey

### Strengths

#### Communications/Networking

- Ability to bring all players/leadership to the table
- Ability to facilitate connections/relationship building between agency reps
- Ability to serve as a clearinghouse for info regarding projects/initiatives in community
- FSN provides the opportunity for collaboration among member agencies
- Networking
- Planning, cooperation, conversation and overall communication between agencies

#### Community Well Being

- Long term planning for the community and its' members
- Working toward a shared community vision

#### Funding/State Requirements

- Assistance in receiving grants
- Meets state requirement for local cooperation
- Support new or ongoing funding applications as required by funding sources

#### Successful Projects

- Fight against homelessness, Project Connect and the Ten Year Plan
- Improving Lives of Seniors Workgroup, Senior Resource Guide & other Senior initiatives
- Printing and distribution of the Community Resource Guide
- Snapshot
- Strategic Planning

#### Working On...

- Exploration of dental clinic
- Fight to end homelessness
- Working on the mentor/advocacy program for Seniors

#### Other – Community Strengths...

- Agencies/Organizations – DHS, Free Clinic, CHC, Senior Center, schools
- Business people (especially locally owned) are very generous in supporting community events
- Caring, giving and helpful leaders and community members
- Family Services Network, Housing and Homeless Coalition
- Heritage Park, recreation
- High social capital



- History of agencies working together and agency reps know each other; not much turn over; willingness to work together
- Location, small community feel, rural – promotes feeling of community,

## Weaknesses

### Collaboration

- More collaborative projects.

### Communications/Networking

- Could use more cross agency and community wide communication of FSN.
- More agency LEADERS at the table.

### Membership

- Decreased membership.
- Would like to see a higher level of participation.

## Opportunities

### Change the world

#### Collaboration

- Be able to take a system level problem or issue to this group for work or resolution.
- Be involved in a continual process of collaborative identification of gaps/overlays in services so that we can work together to resolve those that are priority areas.
- Be part of a coordination of calendars/events - not simply hearing about things after they are scheduled - though this is the first step.
- Continue with shared vision so we're all on the same page and not duplicating services.
- Increase coordination between all health and human service agencies
- More collaborative efforts.

#### Communications/Networking

- Be connected with not only other agencies but also business, faith based organizations that are interested in improving human services and education in our community.
- More info sharing.
- Continue connecting resources.

#### Community Well Being

- Actively identify community needs.
- Actively research, collect, distribute and maintain data

#### Funding/State Requirements



-Agencies cooperate and use public funds in more efficient way if possible.

### **Membership**

- Membership growth
- Membership including community members, local businesses, faith-based, etc.

### **Working On...**

- Greater PR for all members so the community knows the needs
- Have FSN promote our agency in the community
- Continue to connect and develop relationships with others in the human service and education community

### **Threats**

- Apathy
- Lack of jobs/unemployment in the community
- Loss of funding



## Appendix E State Collaborative Information

### TOOLS FOR THE COMMUNITY COLLABORATIVE THE COMMUNITY COLLABORATIVE

#### Background:

Currently all counties, either individually or in cooperation with other counties, have an established collaborative group that addresses issues that impact the lives of children, families, and special populations in their area. These collaboratives provide for:

- Community planning and visioning (establishes workgroups of agency staff, consumers, and community representatives to plan and/or implement services for a target population or coordinate services);
- Sharing of information regarding programs, policies and protocols/procedures;
- Taking responsibility for the local directions and coordination of state-, federal- and foundation-sponsored collaborative enterprises, including reporting the results/activities;
- Managing state-funded collaborative initiatives and workings with the designated fiduciary; and
- Linking with or consolidating other community collaborative groups (Early On Local Interagency Coordinating Councils, Homeless Continuums of Care, Child Abuse/Neglect Councils, Workforce Development, etc.).

#### Role and Expectations of the Community Collaboratives

- Role of the Community Collaboratives  
It is recommended that each Community Collaborative serve as the entity that 1) sets the agenda for collaborative activities, 2) focuses resources on common "outcomes" and 3) acts as the common community interface with State agencies on State "collaborative" efforts in human services.
- Expectations of the Community Collaboratives:  
Each Collaborative will be expected to:
  - Communicate annually their priority goals for the upcoming year and how they are coordinating existing resources and efforts to achieve those goals.
  - Collaborate (share ownership and decision making) in the allocation of new and sustaining resources available to the county to address unmet human service needs
  - Communicate to the State human services directors recommendations for policy changes that could improve the way services are funded and delivered to improve the effectiveness (impact on goals) and efficiency (better use of existing resources) of services.
  - Coordinate community efforts to address State priorities
  - Identify barriers to progress that State agencies create.

#### Operationalizing the Community Collaborative:

To fulfill the role and expectation of the Community Collaborative as an inclusive planning and implementation body of stakeholders at the county or multi-county level, the Collaborative needs to:

- X Articulate a **shared vision and mission to improve outcomes** for children, families and special populations.

Recognizes that improved outcomes for children, families and special populations are the responsibility of all of the human service agencies and the entire community.



Recognizes that human service agencies have a shared interest in risk factors and protective factors that mediate outcomes for children, their families and special populations.

Recognizes that a community needs a balance of prevention, early intervention, and remedial services.

- X Share **risk, responsibility, resources and accountability** in carrying out its vision and mission.
- X Operate on the basis of **mutual trust, respect and consensus**.
- X **Make decisions** (within parameters determined by the funding source) concerning the use of funds which are made available by the state, the federal government or foundations for collaborative efforts to improve outcomes for children, families and special populations.
- X Assign responsibilities to its respective **workgroups and initiatives** for:
  - 1) assessing neighborhood/community needs and strengths
  - 2) developing plans to respond to needs and to utilize strengths
  - 3) implementing plans
  - 4) monitoring results
- X Make **programming and policy decisions** based on an analysis of the best available information and data about: 1) the needs and assets of the community, and 2) approaches and interventions which have been found to be effective in accomplishing desired outcomes.
- X Facilitate the development of comprehensive **cross-systems arrangements** through which agencies and the community working together can better meet the needs of children, families and special populations (Memo of Understanding, Letter of Agreement, Cross System Training Plans, etc.).



## Appendix E State Collaborative Information

### TOOLS FOR THE COMMUNITY COLLABORATIVE PARTICIPATION IN THE COMMUNITY COLLABORATIVE BY CONSUMERS

*Persons who have had experience seeking services from human service agencies bring an important perspective to Collaborative planning and service development, and the Community Collaborative will benefit from facilitating their involvement. As participants in the work of the Community Collaborative, consumers will reflect the impact of systems on children and families and will advocate for serious and prompt attention to improving those systems.*

#### ROLES WITH THE COMMUNITY COLLABORATIVE

1. Full and equal **members of the Community Collaborative**. The November 1, 2004 letter and issue paper from the human services directors included consumers as members of the Community Collaborative.
2. Participants on all **workgroups**.
3. Members of **focus groups** when the Community Collaborative undertakes assessments of community need, perceptions of service, or service planning.
4. **Facilitators and staff in training** parents and interagency staff for family-centered service.
5. Any other role deemed appropriate by the Community Collaborative and consumers.

#### WHO IS A CONSUMER?

In various service systems, consumers of service may be referred to as:

- clients
- consumers
- users of services
- parents
- recipients
- partners
- individuals/family members

#### WHO SHOULD BE RECRUITED?

Persons selected should have experience with publicly funded services provided to themselves or to their family members by one or more of the following:

- \* family independence agency
- \* mental health agency
- \* public health agency
- \* early childhood agencies
- \* schools
- \* courts
- \* substance abuse agencies
- \* senior service agencies

Persons selected will be better able to serve as equal partners with professionals if they:

- \* have used multiple systems and have ideas for their improvement
- \* are able to consider issues in a broader context than their own experience
- \* are involved with others in an advocacy or support group

#### POSSIBLE RECRUITMENT ROUTES - *use multiple strategies*

1. Recruit persons who have been involved in other community collaboratives.
2. Recruit persons who have served on agency boards or committees.
3. Nomination by parent support/advocacy groups.
4. Recruit through a newspaper article inviting inquiries.
5. Develop an advisory group across agencies from which Community Collaborative participants can be drawn.
6. Recruit persons through leadership/advocacy training programs.

#### SUGGESTED SUPPORT FOR PARTICIPATION

1. Appoint at least two consumers to provide mutual support.



2. Assign an experienced member of the Community Collaborative to mentor each new participant.
3. Provide an adequate orientation to the organization and work of the Community Collaborative.
4. Provide for training in advocacy and group process when necessary.
5. Remove barriers to participation by providing reimbursement for travel, meals, and child/dependent care. Keep the paperwork simple.
6. Consider the feasibility of providing financial support for participation for meetings, training and conference attendance.
7. To provide for liability coverage, enroll non-agency participants as volunteers for one of the public agencies.
8. Recognize competing family demands when scheduling time and location of meetings.
9. Define consumers or "consultants."



## Appendix E State Collaborative Information

### TOOLS FOR THE COMMUNITY COLLABORATIVE STAFFING THE COMMUNITY COLLABORATIVE

*Community Collaboratives can function more effectively with a staff person (also referred to as a Coordinator) who takes an active role in facilitating the work of the Collaborative. This summary describes the functions and desirable characteristics of a Community Collaborative staff person.*

The Community Collaborative's staff person assists with the operation of the Community Collaborative and accomplishment of its mission:

to improve outcomes for children, families and special populations by collaboratively planning and delivering human services using a comprehensive, data-based, systemic approach.

The Community Collaborative's staff person thus is responsible for **facilitating collaborative and comprehensive planning for children, families and special populations.**

#### Tasks

The professional staff to the Community Collaborative is expected to carry out such tasks as the following:

- X Provide staff services to the Community Collaborative, e.g.:
  - a. Assist the chair with development of meeting agendas.
  - b. Assist the chair with group process issues.
  - c. Review meeting minutes produced by the secretary with the chairperson.
  - d. Follow-up on tasks assigned during meetings.
  - e. Obtain and provide information to the Community Collaborative, as needed or requested, on existing programs, model interventions, financing strategies, and other matters relevant to the work and effective operation of the Community Collaborative.
  - f. Provide or arrange for training and consultation on emerging state and local collaborative planning process, collaborative leadership, group process, and effective service models (prevention, early intervention, treatment)
  - g. Assist the Community Collaborative to formulate strategies, working tools and reports.
  - h. Facilitate communication among Community Collaborative members.
  - i. Facilitate consumer participation.
  
- X Provide services related to the Community Collaborative's workgroups, e.g.:
  - a. Serve as liaison between workgroups and the Community Collaborative.
  - b. Serve as liaison among workgroups so that their activities are coordinated and their respective action plans put together into a comprehensive and internally consistent community/ system of services and supports plan.
  - c. Provide technical assistance on action plans as they are drafted by workgroups.
  - d. Staff some, but not all, workgroups, e.g.:
    - 1) assist the chair with development of meeting agendas
    - 2) assist the chair with group process issues
    - 3) follow up in tasks assigned during meeting



4) obtain and provide information

X Provide other staff functions, e.g.:

- a. Serve as liaison between Community Collaborative and appropriate community groups that are not part of Community Collaborative.
- b. Assist in development of collaborative funding proposals.
- c. Function as a local clearinghouse for information on prevention, early intervention and treatment models; planning and evaluation models; local and state collaborative initiatives; community resources; federal, state and local trends; funding opportunities, etc.
- d. Keeping informed of developments at the state level and national level.

### Competencies

The staff to the Community Collaborative generally possess (or are willing to gain) the knowledge, skills, and experience which provide, or facilitate the learning of:

- X Working effectively with agency directors, community leaders and consumers.
- X Systems-level planning, strategic planning and needs assessment.
- X Community organization, group process and consultation.
- X Managing complex tasks and multiple time frames.
- X Operating with minimum supervision.
- X Enthusiasm for working with community based, collaborative body
- X Motivating others.
- X Conceptualizing at the systems level, to see interrelationships and the Abig picture@.
- X Understanding of human development and the causes, consequences, avoidance and treatment of human disabilities.
- X Understanding of social science research and ability to find and interpret results relevant to specific problems, issues and interventions.
- X Familiarity with prevention concepts, psychoeducational programming, youth development, family centered services, and evidence based programming for target populations.

Staff to Community Collaborative need to have speaking and writing skills and the ability to assist groups in formulating their thoughts and putting them into concise, understandable written form.

- X Mature judgment.
- X Flexibility, patience, confidence.
- X Organization.



- X Self-starter.
- X Computer skills.
- X Interest in an evolving, challenging assignment.

### **Education**

Staff to Community Collaboratives generally have had a Masters degree in a human services area, with direct experience in service delivery, community organization, service planning and policy analysis. Involvement in systems-level planning, human services program development, group process, training and consultation and grant writing are helpful background. However, nobody has received a formal education to be staff to a Community Collaborative, and on-the-job learning must be expected.

Training and technical assistance is provided to the Staff via statewide technical assistance meetings (3 times per year), regional meetings (2-3 times per year) and individualized assistance (as needed).