WEEKLY INFORMATION PACKET

MEMORANDUM

TO: Mayor Toor and City Council

FROM: Frank W. Bruno, City Manager
John Pollak, Co-Director, Housing & Human Services
Karen Rahn, Co-Director, Housing & Human Services
Richard D. Johnson, Director, Division of Community Services and Administration, HHS

DATE: April 7, 2004

RE: **Information Item:** Housing & Human Services Master Plan Update

Executive Summary

In 1994 City Council approved the Human Services Master Plan, which serves as a policy guide for the Department of Housing and Human Services (HHS) in allocating approximately $2 million annually to community agencies for the provision of human services. Now, ten years later, HHS is in the process of updating and enhancing the Master Plan to encompass all services provided by the department as well as serve as a coordinated funding guide for each of the Funds allocated through the department. The City Manager appointed an Advisory Committee to assist HHS in updating this master plan. The Committee held its second quarterly meeting on March 29 and heard from various Committee members concerning driving trends and emerging issues in human services. Council will receive periodic progress updates throughout the 18-month development of the plan.

Goals of the Master Plan

In developing the Housing and Human Services Master Plan, HHS will identify and assess:

- Current resources and gaps in housing and human services available to residents of the city of Boulder;
- Demographic, financial and service trends to anticipate future housing and human service needs within the city of Boulder;
- Appropriate roles for the City of Boulder in the provision of various housing programs and human services in partnership with others in the community; and
- Future financial sustainability of appropriate City housing and human services functions, and determine funding and policy mechanisms to meet needs.

Timeframe

The Housing and Human Services Master Plan development process began in December 2003 and is expected to take 18 months. This period will be divided into three major phases: (1) information collection, (2) information analysis, and (3) recommendation development. The project is currently in the first phase, data collection. Updates will be provided to Council quarterly, with public input occurring during the second half of the project period. Final approval of the Master Plan by Council is anticipated by Summer 2005.

Progress To Date

The HHS Master Plan Advisory Committee has held two quarterly meetings, the most recent on March 29. The purpose of both meetings has been to gain a common foundation of data and information concerning Boulder city residents, their housing and human services needs, and the existing structure of housing and human services programs to meet those needs. At its March 29 meeting, staff presented Committee members a demographic profile of the city. Additionally, four Committee members presented their view of the driving trends and emerging issues in charitable giving, health care, public health, and Boulder's Latino community.

The next meeting of the Advisory Committee will take place this summer and will examine the following issue areas: housing, the justice system, mental health, K-12 education and social services. This meeting will conclude the first phase of the project.

Availability of Advisory Committee Materials

Agendas, meeting summaries and staff-developed materials and presentations are available on the HHS Master Plan website: www.ci.boulder.co.us/hhs/HHSMP%20homepage.htm

Staff

Lead staff for this project are Richard Johnson, Director of the HHS Division of Community Services and Administration (303/441-4196), and Linda Hill-Blakley, Housing and Human Services Planner (303/441-3158).

Attachments:

A. March 29, 2004 Meeting Summary: HHS Master Plan Advisory Committee

B. Members: Housing and Human Services Master Plan Advisory Committee

ATTACHMENT A

Housing & Human Services Master Plan Advisory Committee

March 29, 2004
Meeting Summary

The Spring meeting of the Housing and Human Services Master Plan Advisory Committee was held March 29, 2004 from 5:30 to 8:30 pm at the Boulder Public Library. Three members were not able to attend (George Epp, Chris King, and Laura Systra).

The meeting continued the data collection phase of the project, begun in December 2003. Presentations were made on Boulder's demographics, emerging trends in charitable giving, the impact of a growing Latino immigrant community, health care, and public health issues. A discussion of common themes followed individual presentations.

Materials distributed for the meeting included: City of Boulder: A Demographic Profile; Department of Housing and Human Services Programs and Service Summaries: Key Issues, Trends, Impacts, Research, Information, Data (Draft); The Boulder County Civic Forum's 2002 Community Indicator's Report and various materials provided by Committee members listing programs and services throughout the community.

Demographic Profile of Boulder

Staff presented an overview of information contained in the Boulder Demographic Profile booklet, which is based primarily on 2000 Census data. Much of the information of the report is presented *without* the inclusion of college students aged 18 – 22. While there are many aspects of City government where it is vitally important that the whole picture of the city – including students – is examined (e.g., transportation, water, law enforcement), in the area of human services it is also useful to profile the city excluding students, as students' health and human service needs are met largely by the University of Colorado.

Six major points were highlighted:

- *Age*. The median age of Boulder without students is 35 years, which is nearly identical to Boulder County (36), Colorado (34) and the U.S. (35). Not surprisingly, there has been a substantial increase in the 45-59 age group (baby boomers) over the past decade. Further, Boulder's median age is projected to peak at 51 years of age in 2030. As these people age, the swelling numbers of elderly people will impact the human services system.

- *Income*. The perception of Boulder as solely a "rich community" is misguided. In fact, even removing students from the equation, the percentage of people living under the federal poverty level in Boulder (14%) is higher than the national poverty rate (11.7% in 2001).

- *Education*. Boulder is a highly educated community, with over two-thirds of its residents over age 25 having received a Bachelor's, Master's or professional degree. This educational attainment varies over ethnicity, as discussed below.

- *Families*. Boulder has seen a drop in the percentage of family households from 1990 to 2000, with one quarter being single-parent families.

- *Children*. The percentage of children decreased slightly from 1990 to 2000 (20.9% to 19.9%). Still, there were nearly 14,000 children under the age of 18 in 2000.

- *Latino Immigrants*. As a proportion of Boulder's general population, Latinos grew from 4.5% to 8.2% from 1990 to 2000. This is due largely to a continuing influx of immigrants from Mexico; approximately half of Boulder's Latino population is foreign-born, and of the total Latino population over age five, 35% do not speak English well, or at all. In 1990, Latinos comprised 9% of Boulder's residents living under the federal poverty level; by 2000 this percentage had grown to 13%, representing 27% of all Boulder Latino residents.

Driving Trends and Emerging Issues: Committee Member Presentations

Four Committee members provided an outlook on driving trends and emerging issues in their respective fields. Following are topic areas discussed by the Committee, led by particular members. Some comments made by other Committee members are incorporated into the sections below.

United Way and Charitable Giving – Presented by Barbara Pingrey

Foothills United Way (FHUW) has been serving the Boulder community since 1922. Though the organization has gone through several name changes and service area expansions since its founding, the mission of the organization has remained to support health and human service programs that improve the quality of life in our communities. In its broadest overview, FHUW has three main tasks in support of this mission: (1) raise funds; (2) manage funds; and (3) distribute funds.

Foothills United Way's approach to investment in the community has changed within the past decade and reportable outcomes of services have become a more important aspect of judging success and allocations decision-making for the future. In 1997, FHUW moved to program funding rather than agency funding and now requires outcome measurement data from those programs that are funded (similar to the City of Boulder's human services funding process). This allows the United Way to determine not only what services are being provided to whom, but what changes in knowledge, attitudes, behavior, or life situation are occurring. These outcome data from each program are then used in future funding cycles to judge impact, success and, to

some extent, to help determine subsequent allocation amounts. Funding is based on a three-year cycle, which allows programs to have longer term goals and make adjustments as the need changes.

In 2000, United Way completed a community needs and assets assessment that ultimately showed that those people who received services were very satisfied with the quality of services and believed services were delivered in an appropriate manner, but that many people were unaware of services that may have been of value to them. To increase awareness and make existing programs more accessible, FHUW is participating in a statewide health and human services information and referral system, "2-1-1", in which Foothills collaborates with other UWs throughout the state, as well as nonprofit service providers. The 2-1-1 call center serving Boulder and Broomfield Counties went live in October 2003.

Looking at FHWU's total fundraising last year, 73% of gifts came from individuals and 27% from corporations. This is a slight shift from five years ago, when the proportion was 70% / 30%. In 1998 the total giving to United Way was $2.9 million; in 2003 it had grown to $3.75 million. (Boulder County's population in 2000 was 291,000.) While this is an important and much needed growth, it remains low when compared to the wealth of the community.

A comparison with other counties is illustrative: Mile High United Way in Denver (five counties) raises over $30 million. Weld County – which has a population of about 180,000 – raises $3 million. Larimer County has a population of 251,000 and raises over $4 million. The average donation by an individual in Denver is about $6,000, including all charities and faith-based giving. This compares with $2,900 for Boulder County.

One reason for this disparity is that people think that the need is not as great in Boulder County as in other areas. There is an invisible population of working poor that are in need of services that the rest of the population does not recognize. It should also be noted that Boulder County's charitable giving also includes monies for international humanitarian, social and ecological causes and, thus, a smaller proportion of the total remains in Boulder.

An interesting study was recently published that looks at what makes a "good neighborhood." Findings indicated that the biggest asset of a healthy community is civic engagement. The level of health care, safety, community involvement, senior centers, community activities, and taking care of each other are all significantly improved in communities with a high level of civic engagement.

Boulder's human services non-profit network is non-territorial and takes a collaborative approach to service provision. Duplication of services is kept to a minimum because of the information sharing within the network and because of the accountability required by the community.

Emerging Latino Population – Presented by Nino Gallo

The number of Latinos in Boulder nearly doubled from 1990 to 2000, a growth rate much faster than any other ethnic group. This is due primarily to an immigration of Latinos from Mexico and, to a lesser extent, other Latin American countries. This same time period has seen a increase in the percentage of Latinos below the poverty level (from 8.8% to 13.4%) and an increase in the gap between the median income for this population and the white population (the Latino median income dropped from 52% to 45% of the white median income).

Because of the drought in northern Mexico for the past eight years, an inability to work the land and a lack of employment there, people immigrate to this country. Those who come to Boulder are usually connected to friends or family who have already come here, primarily from three Mexican states. These immigration patterns are similar in other areas of the U.S. Boulder's growth of immigrant population is smaller than in other areas along the Front Range, due perhaps primarily to the high cost of housing here.

Many Latinos are losing jobs, working for extremely low wages or working part-time without benefits. Education is a very important factor for the Latino population's quality of life. Approximately six in ten Boulder Latinos have only a high school education or less. Over 41% have some college, a Bachelor's or professional degree, but, at the same time, over 45% have less than a high school degree. Many immigrants have only an elementary school level education. This severely limits the type of employment they may have.

Current trends include a growing population, families that are younger, incomes that are decreasing, and access to services – including health care – that is being denied because of immigration status. These factors are widening the gap between the poor and wealthy. Many Latinos work here but cannot afford to live here.

Latino immigrants contribute to the community through employment in service and labor jobs, paying taxes, and spending money in the community. They work in restaurants and take care of others' children, but are largely invisible to the broader community and do not have a voice representing their needs. They also struggle with language barriers, stereotypes and discrimination. Most of Boulder's immigrants come from Mexico (85%) where the economy is much worse. They come here for employment, and many times are exploited because they are willing to work for extremely low wages and may be denied basic employment rights due to their fear of detection for immigration violations.

It is very important that clients be included on the boards of directors of non-profits serving the Spanish speaking immigrant population. This will help ensure that agencies understand the services that are needed and the issues that are faced by clients, in order to alter policies, make programmatic changes, or determine if enough staff is capable of serving the client population. A greater effort needs to be made in this area.

There need to be opportunities and expectations for Latino immigrants to be responsible and to be included and accepted in the community. There is a strong work ethic in many Latino families. Often multiple generations will work to contribute to the household income. They have

moved here to work and to improve their lives. And there are many cases of incredible progress when people are given the chance.

There also needs to be affordable housing opportunities to enable people to live in Boulder. Immigrants need multiple opportunities to access English learning classes, providing a gateway to better employment, a more secure place in the community and greater civic participation.

Health Care – Presented by Jacob Blass

There are five major challenges driving health care availability in Boulder: (1) the uninsured; (2) Medicaid; (3) seniors; (4) immigration; and (5) people living in poverty.

The People's Clinic serves as the health care safety net for the community; if People's Clinic, Salud (Longmont) and Clinica Campesina (Lafayette) did not exist, the uninsured would not have anywhere to go for care except the hospital emergency room. People's Clinic serves 10,000 people a year, primarily from Boulder, or approximately one in eight people who live in Boulder.

There are some 45,000 uninsured people in Boulder County. Most other community health centers (CHCs) currently control their payer mix, meaning they cap the number of uninsured people they will serve. The People's Clinic receives some of these patients through spillover. If this trend continues, People's Clinic, too, may have to limit the number of uninsured clients, just to ensure that it can remain financially solvent. The other CHCs cap at about 50% uninsured; the rate at the People's Clinic is currently about 55%.

The problems will continue, particularly if health care continues its double digit percent cost increases. Additionally, the longer people go uninsured and untreated, the more their health will decline, leading to the need for more serious and expensive care. Immigration-related issues will exacerbate the challenges, especially as Medicaid continues to be squeezed and even documented immigrants are denied coverage. Medicaid accounts for 35% of People's Clinic patients. As reimbursements under this federal/state funded program are reduced (and they don't begin to cover costs now), the greatest impact will be on women and children.

Kaiser will be leaving Boulder Community Hospital (BCH) at the end of 2004 and transferring their patients to Good Samaritan Hospital in Louisville, about 35% of BHC's patient base. This will have a domino impact on People's Clinic, as BHC is a primary supporter of People's Clinic and other health care providers in the community.

Also of primary importance is the growing number of elderly in the community, with a corresponding rise in chronic health issues, and a variety of health-related issues surrounding the frail elderly. At the same time, the number of physicians who currently accept Medicare patients and who are willing to accept *new* Medicare patients is only 4%. It becomes clear that health care for seniors will be a major issue that needs attention throughout the coming decade. Statistics also show that 25% of Medicare expenses are incurred within the last six months of life. The need for transportation for seniors to their health care appointments will also grow in this period.

Immigration and poverty will also impact health care availability in the community. At present, 55% of People's Clinic client base is Latino, and continued increases in the immigrant population will challenge and stress the health care system in Boulder, with 27% of Latinos living below the poverty line ($18,850 for a family of four). Even at 200% of poverty ($37,700 for a family of four) access to health insurance is most often not feasible.

People's Clinic has several sources of funding to help cover the cost of care for the uninsured. As a "federally qualified health center" it gets a grant from the federal government to help defray these costs – but nowhere near enough. It also receives funds from the City of Boulder ($325,000 in 2004), Boulder County, Foothills United Way, Boulder Community Hospital and other, smaller sources. Many of these revenue sources are themselves strapped now.

Public Health – Presented by Chuck Stout

In Boulder County 30% of households have children under age 18. For the remaining 70% of households without children, there may be a lack of awareness about families in need with children. The figures for the city of Boulder are about 20% / 80%.

While 11.6% of Boulder County's total population is Latino, 35% of the children in the county are Latino and 34% of births to mothers under age 25 are Latino. Thus, in addition to the influx through immigration, the Latino population is growing due to birthrate as well. This is historically typical among all immigrant populations new to the U.S.; it takes several generations before birthrates approach national norms.

Because all children who are born in this country are U.S. citizens, we have a responsibility to invest in each child, including prenatal care for mothers who may not be citizens. If we deny these services to people based on their immigration status, the future of unborn citizens might be diminished because of inappropriate prenatal care. If that happens, the costs in the future will be much higher.

The economics of Boulder County are changing. The past few years have seen growing income disparities and a decline in the middle-class, creating an "us vs. them" environment.

Charity care is increasing, but uncompensated care is probably three to five times the amount of charity care. Hospitals do not have a sliding scale for individual payers, but have negotiated fees for insurance companies. For example, if they charge Kaiser $10,000 for a procedure, they may charge an uninsured individual $20,000 for the same procedure. So, in a sense, there are higher costs of care for those who can least afford it. For those who don't pay, their bills are passed to a collection agency, their credit goes bad, they'll never be able to buy a house and getting out from under their debt will be extremely difficult. Unpaid health care costs are the number one cause of bankruptcy in the United States.

Ours is a highly mobile community: 35% of current residents have lived in Boulder five years or less and 62% lived somewhere else ten years ago. This affects the civic engagement factor. Middle-class and the working poor are leaving Boulder and the wealthy, new to the area and as

yet unattached to the community, are moving in. The ability to build equity in a home is vital to success and civic engagement.

Boulder is not immune to communicable diseases, the threat of bio-terrorism, drug and alcohol use, and other public health concerns. The spread of communicable diseases is greatly increased by tight living conditions, poverty and the failure of those affected to seek treatment. For this last reason, it is vital that our immigrant population trust the human service and health care network. If they are afraid to accept treatment because of fear from unrelated consequences (e.g., INS), this will produce dangerous conditions where communicable disease may more easily spread.

In 2003, 8,000 people in Boulder County were infected with West Nile Virus at a cost of $2 million. The Latino population was hit especially hard. West Nile Virus will again be very serious in 2004. Health and human services leadership and staff need to expand bilingual capability and continue to build trust. When we look at this master plan we not only have to look at needed services, but also at needed policies.

Bioterriorism, while an important to the health and safety for residents, can also spark elevated levels of discrimination, bigotry, fear, and suspicion. This can result in cuts to services and programs that serve the immigrant population.

Drug and alcohol use continues to be a serious problem in Boulder County, being significantly higher than state and national levels. In Longmont, 50% child protective cases are because of methamphetamine. In addition, mental health needs are increasing at a time when state and federal funding is being cut.

Tobacco use continues to be a problem, but a positive trend is the growing number of smoke-free ordinances; 72% of people in the county live in communities that have smoke-free ordinances.

A county-wide youth risk behavior study of 9th – 12th graders to be released on May 6th will show major disparities between the general high school and the Latino populations, as well as issues of depression and suicide among gay/lesbian/bisexual/questioning teens. Boulder is not as affirming and open of a community as we think and needs to do a better job of taking care of all of its children.

Discussion of Common Themes and Threads

The Myth of Affluent Boulder

A widely held perception of Boulder is that it is a totally affluent community, with what lower income population it has being comprised of students of the University of Colorado who have basic needs met through their parents' financial resources and the services provided by the University. This notion is strengthened by an examination of Boulder's median income ($87,900 in 2002) which compares very favorably with the Colorado and national medians ($58,000 and

$53,700, respectively). Most people believe that lower income workers in Boulder – those in service and labor jobs – live in the outlying areas and commute to Boulder for their employment.

The large number of Boulder residents with high or very high incomes skews the way we think about the total picture when we look at the mean or median income level. An assessment of the true income distribution in Boulder gives significantly different picture, however.

If college students between the ages of 18 and 22 are excluded from consideration, an examination of Boulder residents' income reveals that 14% (or about one in every seven residents) live below the federal poverty level (currently $18,850 for a family of four). This is a higher poverty rate than the nation as a whole, 11.7% in 2001. The true graph of income distribution is bi-modal; that is, instead of a normal "bell curve" distribution, it has bulges at both ends of the income spectrum, making it possible to miss those who live at the lower end when a mean or median is pulled from the data.

Over the past decade, Boulder's median income level has outpaced those at the state and national levels. Simultaneously, its low income population has grown. Looking behind the numbers, this means that both the upper and lower ends of income levels have grown, at the expense of those of middle income. Stated another way, the gap between the "haves" and "have-nots" is widening, with those in the middle income levels declining in Boulder.

This phenomenon is not unique: it is the classic picture of an urban area, though we may not normally think of Boulder fitting an urban profile. Typically, core cities have this type of income distribution, with the middle class moving to the suburbs to be able to afford home ownership, access to good schools and a safer environment. Anecdotally, Boulder's "middle class flight" is based primarily on high housing costs (the median price of a single family home increased 244% from 1990 to its current level at $420,000; the median price of an attached home also rose 244% in this period).

A disappearing middle class has implications across housing and human services. To retain a middle class, Boulder needs to ensure that housing for young couples and young families remains affordable. On the human services side, the myths of Boulder as solely an affluent community need to be broken if those in need are to be given an opportunity to thrive and become contributing members of the community.

In part because of this misperception, donations to Foothills United Way and individual human services agencies are less than in surrounding or comparable areas. Boulder has a large number of high income individuals who have the capacity to contribute to worthy causes and a social philosophy that encourages them to assist those less fortunate, but, because of the myth of uniform affluence, they are less likely to do so.

Boulder's working poor remains invisible, and is becoming more so because the nature of this population is changing. Thirteen percent of Boulder's residents living below poverty are Latino, mostly immigrants new to this country. While many immigrant residents may have family support systems that are more active and healthy than those found in the dominant culture, many immigrant individuals may also have a greater variety of needs stemming from language barriers,

cultural barriers and ignorance of the services available for assistance. These factors – coupled with fear of discovery due to documentation status and a human services network that is struggling to increase its capacity to serve Spanish-speaking clients – can clearly limit people's access to services. And the rate of immigration does not seem to be leveling; it is increasing. Though hard numbers are not available, it is likely that at least an additional 1,000 immigrants have moved into Boulder since the 2000 Census.

Though Latinos are the fastest growing segment of the lower income population, 87% of non-students living under the poverty level are non-Latino. One quarter of Boulder families are single parent families, placing an added income burden on a single wage earner. For this reason (and for families where both parents are employed), quality child care and support services for families are important needs in the community.

Though poverty has been shown to be the most important risk factor for youth, low income status is not the sole risk factor. Despite the high numbers of well-educated, affluent residents in the Boulder County, the rate of 51.8 reports of child abuse and neglect per 1,000 children in the county far exceeds the national rate of 31.5 reports per 1,000 children. Alcohol and drug usage remains high in Boulder, highlighting the need for greater prevention and early intervention efforts that reach across the income spectrum.

Another dominant trend in Boulder is the aging of the population. While the emerging elderly may be more affluent than their parents were, access to health care is a current and growing problem, with 96% of physicians unwilling to accept new Medicare patients. Beyond health care, with the first wave of baby boomers retiring and turning 65 within the next decade, current systems for services, education and recreation for seniors will face significant challenges as demand rises.

Summer Meeting of the HHS Master Plan Advisory Commiteee

The Summer meeting of the Housing & Human Services Master Plan Advisory Committee (date to be determined) will finalize the Data Portfolio phase of the master plan project. Similar to the Spring meeting, presentations will be made by Committee members (and perhaps invited speakers) on driving trends and emerging issues within housing and human services. These areas are:

- Education
- Housing
- Justice system
- Mental health
- Social Services.

A discussion of common themes and trends will follow.

Following the Summer meeting, the current plan is to begin the second phase of the project: Analysis. For this, study groups will be formed along issue and service areas.

ATTACHMENT B

Housing & Human Services Master Plan
Advisory Committee

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