

Helping Our At Risk Children Become Our Needed Workforce and Our Future Entrepreneurs

by **Bob McEvoy, Managing Editor**

*Introducing this most important public policy analysis project is a great hero of our children in need and a distinguished leader of county administration, **Kathleen Kelley, County Administrator of Douglas County, Nebraska.** Kathleen's wisdom is presented for you here as she introduces the excellent work of the Center for Technology in Government's Dr. Natalie Helbig and Dr. Tony Cresswell.*

Boys Town and the State of Nebraska Emphasizing In Home Care for At Risk Children

by **Kathleen Kelley, County Administrator, Douglas County, Nebraska**



Over the past several years, research has been focused on studying foster care in the United States. Youths placed outside their homes are twice as likely to become law

violators as those youths receiving wrap around services in their home.

According to national news reports, children in foster care are more likely to be prescribed psychotropic drugs for behavioral and mental health disorders with little medical and psychological oversight. U.S. Senator Susan Collins recently wrote that the Government Accountability Office examined foster children in five states (Florida, Michigan, Massachusetts, Oregon and Texas) and found that they were prescribed psychotropic drugs at two to more than four times the rate these drugs were prescribed to non-foster children participating in Medicaid.

Conversely, recent literature indicates that programs designed to keep these youths in their homes with "Functional Family Therapy" and other family-based approaches achieve positive outcomes (Burke & Pennell, 2002). These outcomes include reduced recidivism for law violators, fewer institutional commitments, less drug and substance abuse, improved educational progress, improved family

relationships and reduced risks of subsequent child abuse and neglect.

In Nebraska, organizations such as Boys Town have adopted a strategic plan that involves keeping kids in their homes and providing help to them and their families there. The State of Nebraska Department of Health and Human Services has made a commitment to reverse their emphasis on placing youth in group homes and foster care and instead invest in in-home care. All policy changes based on the research conducted on outcomes, policies and practices.

Another aspect of foster care that needs further study is the difficulties experienced by youths turning 18, who are transitioning out of foster care into independent living. The National Youth in Transition Database was established in 2008 for the purpose of collecting data from this population. The Center for Technology in Government at the University of Albany has partnered with the New York State Office of Children and Family Services to design a data collection model that fits their current capabilities in order to provide a basis for policies and programming for youth in transition. Hopefully this effort will provide quality data for those of us engaged in and responsible for child welfare and those youth who crossover into the judicial system. The article that follows on page 3 describes the research efforts underway and some of the challenges. ■

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by Peter Crichton, County Administrator, Cumberland County, Maine



Welcome to this issue of the Journal. On behalf of the NACA Board and myself, I hope this finds you doing well. I am sure you would agree that these are challenging and exciting times for administrators. Sometimes it seems a little too challenging!

It is the goal of the Board to have this Journal be of value and benefit to you as a member of NACA. Your NACA Board has been going through a strategic planning process with the creation of a nationwide survey to find more ways to add value to your NACA membership. I am pleased to point out that our

West Region Vice President, Veronica Ferguson of Sonoma County, California, Midwest Director Pete Austin of McHenry County, Illinois, and our NACo representative Gene Smith of Dunn County, Wisconsin, with the able assistance of Patrick Wetzell, a graduate student from Milwaukee, and Rita Ossolinski, NACA's staff liaison at ICMA, have made especially important contributions to this effort.

We have had a good response to the survey from administrators throughout the nation which will be shared at our upcoming Board and General Membership Meetings in Washington, D.C. If you are planning to attend the NACo Legislative Conference, we hope you will join us.

The schedule of meetings at the Washington Hilton on March 3 & 4 can be found on this page of the NACA website at <http://countyadministrators.org>.

All of us from the NACA leadership team are very much looking forward to meeting old friends and creating new friendships. Our Program Chair, Robert Reece from Pottawatomie County, Kansas, with very able assistance from Jeff Greene, County Administrator of El Paso County, Colorado, developed an interesting program for the Idea Exchange with speakers from Jeff's regional federal coalition who will talk about federal lobbying, and in my words, "How to get what you want from the nation's Capital!" Jim Leddy, Community and Governmental Affairs Director of Sonoma County, will share his story and experiences about lobbying on the hill. In addition, we will have our usual round table with interesting discussions about various county specific topics.

Finally, as always, I appreciate the work that Bob McEvoy, the various authors, Rita and the ICMA staff have done in producing this issue of the Journal. The introduction by my friend and past NACA President Kathy Kelley on the subject of Foster Youth is an important subject as we think about the future of our communities and the nation. I have had positive personal experiences with foster kids. When I was in college I had the privilege of being a "big brother" to a young man who was in a foster program. I have also known a wonderful couple who had two foster children they eventually adopted.

I look forward to seeing many of you in D.C.! ■

Best regards,
Peter Crichton

President, National Association of County Administrators



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The Opportunity & Challenge of Street-level Information: Tracking Foster Youth in Transition Creating a New National Data Resource for Foster Care Administration

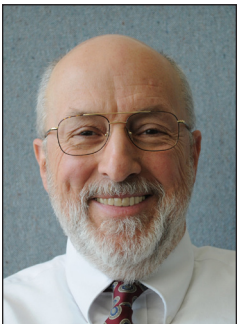
by Natalie Helbig, Senior Program Associate, Center for Technology in Government, University at Albany;
and Tony Cresswell, Deputy Director, Center for Technology in Government, University at Albany.



Natalie Helbig

In April 2010, *National Public Radio* ran a story entitled, *Report: Foster Kids Face Tough Times after Age 18*. The story called attention to the many difficulties

young people face as they transition out of foster care.¹ Following the journey of one young man in Tampa, Florida, the report described his abrupt departure from foster care when he turned 18 and his struggle learning basic life skills like cooking or finding an apartment. The story went



Tony Cresswell

on to profile other youths' ongoing need for various social services as they moved out of the foster care system. Despite these challenges, this young man in Tampa

remained energetic and optimistic about his transition into independent living. The conditions he faced certainly call for some serious review of policies and practices for this transition period. However while stories of transitions out of care like this one are interesting, one young man's story is not a sufficient foundation for policy reform or does not provide enough data to inform specific improvements in service delivery.

This 'lack of good data to inform policy and service delivery' problem is not limited to foster care. Since the early 1990s, governments around the world have faced pressures to create

systems to collect and analyze information in support of evidence-based strategies to improve performance in many program areas. Developing the organizational capability to collect, analyze, and use information and research are seen as key enablers for improving policy and service delivery. This article describes the issues in a Federal program to improve data resources and the way those issues can affect state and county agencies with examples from the recent experience in New York state.

With the hope of changing the lives of the youth profiled above, in 1999 the U.S. Congress enacted the *Foster Care Independence Act*, also known as the *Chaffee Independent Living Act* (Act), which provided \$140 million in block grants to states to support youths' transitions to independent living. In addition to monetary support, the Act also required the Federal Administration for Children and Families (ACF) to develop a national data collection and reporting system to track youth receiving independent living services and to trace outcomes for certain youth who remain in and age out of foster care. The legislation was passed with the hope of improving this transition process, in part by providing better data for program assessment.

ACF and its various collaborators took almost ten years to decide on the types of information needed to achieve this objective and to develop a plan for data collection. On February 26, 2008, the final data collection design emerged in the form of a final rule (Federal Register 73 FR 10338) that established the National Youth in Transition Database (NYTD). The NYTD would collect administrative data from state agencies *and* additional data directly from youth in the

transition population through surveys. NYTD was designed to be the first national, longitudinal data collection effort focused on youth in foster care as they move to independent living as adults. Starting in October 2010, states were required to collect data on cohorts of foster youth, beginning with those who reached their 17th birthday between October 1, 2010 and September 30, 2011.

The challenge of the NYTD data collection effort is that it reaches all the way to individual youth, and requires tracking some of them for five years. This is sure to be a difficult and costly undertaking, involving individual service providers and supervisors in foster homes or voluntary agencies, county social workers and supervisors, and state agency IT and program operations. Though the legal responsibility for the NYTD falls on state agencies, for a national project like this to succeed, states together with counties, must bear the main data collection and reporting burden. While the costs of data collection are shared across state and local levels, so is the benefit. Improved data about foster youth in transition can help policy makers, program administrators, and care givers at all levels to provide better services and support. Collecting the NYTD data is seen as an impetus for improving data collection, sharing, and analysis capabilities, leading potentially to more general improvements in foster care.

NYTD as "Clockwork" Reporting

Designing a national model for data collection and reporting requires a good understanding of research design, policy, technologies, and capabilities. The NYTD design and requirements created by the AFC has certain clockwork qualities, i.e., a reli-

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(“Tracking Foster Youth” from page 3)
ance on tightly linked, precise, highly predictable operations from one gear, or level of the system, to the next. The AFC designed and mandated a data collection and reporting program that requires the state to extract data from the local agencies, providers, and youth; then have it flow back to Washington. That logic can be summarized as:

1. States use foster care data to identify all youth in the transition populations and their location.
2. Surveyors (whether hired or in-house) locate all youth turning 17 while in foster care within 45 days of their 17th birthday.
3. Youth are invited, agree to participate, and complete the survey.
4. Surveyors re-locate a sample of the youth again at two-year intervals (at 19 and 21).
5. The 19 and 21 year olds, whether in or out of care, agree to and complete the follow-up surveys.
6. The state agency stores results in an NYTD compliant database and transmits the data to the AFC on time.
7. Repeat baseline cohort (a new group of 17 year olds) at three year intervals.

What this simple logic fails to take into account is the administrative complexity of the foster care context: hundreds of separate organizations, distributed data collection processes, extensive possibilities for data errors, and inevitable gaps in the records.

The weight of the data collection and reporting burden can vary substantially from state to state and county to county depending on their foster care systems and technical and administrative capabilities. In October 2010, some states already had information and management systems designed for and capable of responding to most of the NYTD administrative data reporting requirements. And any state with such an existing information system and administrative

authority for foster care would be well positioned to find and survey the youth as they reached their 17th birthday. Other states, those with data in multiple statewide and local level systems, were not configured to respond in the same way to the NYTD task. For state-run, county-administered settings, a large portion of the administrative authority for foster care resides at the county level. These states and county agencies faced different, and in some cases a more difficult challenge in becoming NYTD compliant. Non-compliance risked financial penalties to states, penalties that could reduce foster care funds for counties as well.

NYTD Data Collection Challenges

In 2010, the Center for Technology in Government at the University at Albany (CTG), partnered with the New York State Office of Children and Family Services (OCFS) to design a model to fit their current capabilities for surveying youth when they turned 17. CTG’s mission is to work with governments on information technology related issues and our expertise is related to information-centric public management problems. The New York data collection model included phone and paper surveys. CTG recruited another partner, the Center for Survey Research at Stony Brook University² to conduct the telephone surveys. Paper surveys were coordinated by CTG, but administered to youth through caseworkers at facilities.

State supervised, locally administered systems like New York’s have few clockwork qualities. Foster care in New York involves 62 semi-autonomous counties outside New York City and hundreds of voluntary service providers of all sizes. And, like other states, and perhaps most importantly, New York faces the significant challenge of maintaining contact with youth over several years and securing participation with a population of mobile, diverse, and often circumstance-challenged youth.

To acquire the completed surveys the agency team, CTG, and survey staff had to solve a mix in interrelated problems that grew primarily out of the loosely coupled nature of the foster care system.³ The main problems resulting from a ‘clockwork’ model for data collection, as implemented in a loosely coupled foster care system, are outlined briefly below.

Direct participation. Administrative data is collected on individuals receiving services as a matter of course without those individuals necessarily knowing it. It is standard practice and allowed, mainly because that data is stripped of identifying information. The NYTD requires youth turning 17 to actually complete the survey themselves. Youth in this cohort are minors and the state, local providers, caseworkers, and parents have a responsibility to protect the privacy and safety of the youth. Despite outreach and education about the merits and legitimacy of the NYTD, various gatekeepers to the youth refused access to the youth.

Contact information accuracy. Casework systems are designed to serve several purposes. Therefore, the “fitness for use” of the state’s administrative databases or local databases was not as helpful as one might anticipate. In a complex administrative system like New York’s, the data elements related to “contact information” may have many different meanings depending on use and who owns the data. The contact information in the system may be accurate and correct for billing purposes or for other legal requirements, but is not set up to track movements of individual youths within an agency. Contact information may be in the ‘notes’ sections of the database systems or in the paper files of caseworkers. The data quality issues we experienced with contact information vividly illustrates the extent of the problem: Approximately 80 percent of the initial contact information we received

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(“Tracking Foster Youth” from page 4) from the state systems was not “fit for our purpose” or incomplete or both. That does not mean it is not “fit for other purposes” already established and required by previous mandates for data collection.

Tracking youth over time. The follow-up surveys of youth when they turn 19 will not begin until September 2012. States are experimenting with various ways of keeping in touch with youth, who in many cases, will have elected to move out of foster care, or more commonly, will have aged-out of the system. The NYTD design creates more strict regulations for compliance on that population, with an expected survey response rate of 60% for youth not in care as of their 19th birthday and an 80% response rate for youth still in care. County level data, perhaps on other services these youth receive, may be integral in finding and staying in touch with youth. Again, the burden of compliance may result in fines being passed from the state to the counties.

While not designed as a ‘real-time’ data collection and reporting model, the NYTD approach mandates certain reporting time frames. The first timeframe is that youth must take the survey within 45 days of their 17th birthday. The second is that states must transmit data back to Washington every 6 months during the reporting period. In our experience, the average time to complete a survey was around 30 days, mostly due to the need to navigate around local gate keepers. When contacting over 100 different agencies, the surveyors had to navigate different organizational structures and work practices to find the right person that could put them in touch with the youth. State and county records were of little help in this regard. Even with cooperative respondents, the many organizational layers often slowed responses and prevented contact during the

45 day window. Every delay due to additional time needed to repeatedly explain participation or correct contact information errors reduced the likelihood of contacting the youth within the required time period. This was a symptom of the difficulty, in spite of repeated efforts, of establishing effective communication lines from the state level down to the hundreds of different locations and care givers spread throughout the state, and maintaining that relationship.

Lessons learned

Our experience with implementing the survey portion of NYTD brought to light very clear and important issues regarding implementing a national information resource. The design of the NYTD guidelines and regulations for surveying youth makes sense if you consider the task of collecting data from within the foster care system as a kind of administrative clockwork. In such a system, the motion of a policy gear in Washington gets translated in a direct and predictable ways to act at the state government level, through to the local government, and on to the contractor agencies providing foster care services, to the managers and caseworkers, to the foster parents, and finally to the foster youth themselves. That ‘clockwork’ view of the system and the policies and plans that emanate from it generate many challenges to the efforts on the ground to implement the NYTD so it can be used as a foundation for changing the stories and the lives of foster care youth.

The 1999 legislation seeking better data about the experiences of foster youth in transition is a visionary idea. However, when the data collection requirements are designed from afar and with “clockwork administrative systems” in mind, the distance between that view and the reality on the ground will cause a number of unexpected consequences. These

include overly cumbersome data collection processes, less than adequate data, and mismatches between data collected and data needed, among others. From our experience, the cost to government agencies that do not possess the technical capabilities required to engage in innovative data collection, transmission, and analytics will make it increasingly difficult to be compliant. While the experiences in the first wave of NYTD data collection have varied, the lessons learned in New York shed light on ways to improve upon the NYTD design and system going forward, as well as provide insight to similar efforts in other policy domains.

The NYTD is an ongoing reporting requirement. All levels of government have an opportunity to learn from this initial implementation of NYTD. Commissioner Gladys Carrión, Esq., Office of Children and Family Services in New York states, “It is crucial that federal, state, and local governments work together to develop new tools and systems that facilitate better practices and help improve outcomes. The goal is to collect and report data that is useable to help policymakers, program administrators, and caregivers at all levels to provide better services and support to our youth.” Going forward, the aim should be to make the necessary adjustments to account for the range of capabilities at the state and local level, the relationships, and the complexity of the service delivery system and enact new policies and practices to achieve this end. ■

1 Pam Fessler, *NPR*, (2010). Can be retrieved at: <http://www.npr.org/templates/story/story.php?storyId=125594259>.

2 The Center for Survey Research at Stony Brook University (<http://www.stonybrook.edu/surveys/NewCSR/>)

3 The term loosely-coupled comes from Karl E. Weick, “Educational Organizations as Loosely Coupled Systems.” *Administrative Science Quarterly* 21:1 (1976) 1–19, and has become widely applied to many kinds of organizational settings.

It's not about your iPhone...



A good friend of mine in county government sent me a snippet the other day to proudly proclaim that her county had just approved the purchase of several I phones and I pads for county employees. Of course congratulations were in order, as the “trendy” devices were sure to bring on new perspectives to the county employees and suggest countless new ways for services to be delivered.

But once the euphoria settled down a bit, a more somber reflection had to be dealt with- that it was not about her I Phone but the I phone and all the other smart phones and I pads and tablets and a bewildering array of devices in the hands of ... gasp!! ... the county residents! It is this astounding transformation in the IT equation that has gone almost unnoticed in many local governments. Before, government had the machines and the data and the print outs, and the residents had to be informed and helped along so they could become involved with their government in simple ways: a town hall meeting, a call-in with the County Manager or the Commission Chair, a deeper than usual article in the local newspaper on a Sunday edition. But today, many residents have the ability themselves to parse data bases looking for useful tidbits or wanting to provide a photograph showing just how bad the pothole in front of their house is, and and ... And it is this new information fighter, the resident, that we are not prepared to empower and provision with the one thing their devices really want: raw data, arrayed in simple and

useful fashion for further processing, and easy to upload, analyze and draw conclusions.

Many county leaders are not sure this is the case. After all, our staff may remind us that we publish the county budget on line, by scanning them and providing their images to any one who cares to come on the county web page. So if you want to READ the budget, no problem- we are ready for you. But if you want to analyze the budget, well, that's a different thing. Analysis is still reserved for government officials with access to the special, and out-of-sight raw data.

I have heard the strangest excuses why we should not indeed make the raw data of the county's workings available to our residents. Some may fear that our information may have errors that could lead someone to drawing wrongful or even “dangerous” conclusions! Of course, wise reader, you know the answer to that worry- what better way to correct errors than to find them, and with cheap labor (read free) to boot! Similarly, others may prefer not to really tell residents these things in direct fashion; suppose they organize an analysis that shows that our own decisions were not really evidence-based? Once again, the voice of reason suggests that the best decisions are made with the participation of the governed, who many times can give us great ideas to boot that we had not even thought about! And so the dialog and the debate might go... .

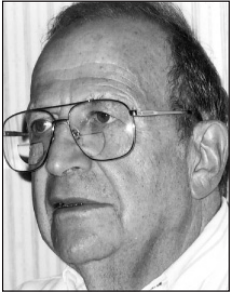
Not only is citizen access to data good, common sense management, but it can also lead to cost reductions on the county staffing ledgers. Many times citizens come to visit their government in order to look up a permit, to see a formula that computed a tax levy or to provide an address. Whether they do

this in person or by phone, it robs our county employees of time that is used to look up and provide information. Why not let the residents do it on their own time (which includes weekends, of course, leading to instant resident gratification, and even perceived service improvement at no additional cost!) and allow our employees to focus on more important matters?

This demand for direct data access is growing- part with the existence of the mobile devices and apps in the hands of our residents, but also because of the increased flexibility of our own tools like GIS and data analytics which thrive on multiple user approaches. Responding to this push for access to data, governments around the world are passing “Open Government” legislation which encourages and in some parts mandates governmental agencies to begin publishing data in forms accessible to citizen applications—a veritable land rush of access. In our own country, President Obama signed legislation on the first day he took office asking all federal agencies to develop openness plans and to start publishing data bases in ways that citizens can access and use. And many countries are passing legislation that gives citizens the right of access to information, and provides redress when that access is blocked. Indeed a sea of change is about us, supported by real actions and made practical by the newer generations of citizens who expect instant answers on small devices in the palm of their hands. And why not? It is their data after all! Data that remains confidential or private becomes the exception rather than the rule, and data-driven decisions carry the day on both sides of the Council dais ... ■

The Schenectady County Free Clinic

by Arnold B. Ritterband, MD



In October 2003, this journal published a paper I had been asked to write describing the creation and early operations of a free health

clinic in Schenectady County, New York. In February 2005, a brief follow-up report was published. The Clinic had been set up to meet some of the medical needs of Schenectady County residents who had no health insurance of any kind. At that time some 16,000–20,000 persons were uninsured. In that year of 2003, there were 41 million Americans without health insurance, predominantly the working poor. Now there are 50 million. People without health insurance get their medical care mostly from hospital emergency rooms. The care is episodic, sporadic and fragmentary. It rarely includes any preventive care or follow-up. Prescriptions often go unfilled, particularly for chronic illnesses such as diabetes, hypertension, asthma and psychiatric disorders. The *absence* of health insurance continues to be a major cause of death and disability among Americans, a national disgrace.

This is a follow-up report on our clinic, which on Aug. 3, 2011 began its 9th year of operations. I wrote in the 2003 paper that it was intended to encourage and provide useful information for county managers and administrators who might wish to start up free clinics in their own communities. It did not succeed in that purpose. It did however result in visits or inquiries from a dozen or more groups of interested physicians and lay people around New York State, and probably helped in the formation of new free clinics in Ithaca and Syracuse, NY. Later in this paper, I will comment on the reasons I believe free clinics,

which number a little over one thousand in the United States, are such rare birds in New York State. I will also suggest measures which might significantly increase their number.

This is what the Schenectady Free Clinic has done during the eight years of its operation, from August 2003 through August 2011:

1. Provided high quality *primary* care for approximately 2,600 of Schenectady County's now estimated 20,000 residents without health insurance of any kind. This has been done in two weekly walk-in clinics, Mondays and Thursdays, in which patients are seen from 1:00 P.M. to 6–7:00 P.M. Over the past eight years, the Clinic has had almost 35,000 visits; referred 3,800 patients to a network of specialists in every specialty for consultation, and where needed, continuing care, provided without charge.
Set up specialty clinics on-site, by appointment, in psychiatry, diabetes/endocrinology, dermatology, orthopedics, gynecology, rheumatology and pulmonary disease. Some diagnostic and treatment procedures are done by our orthopedists and rheumatologist.
2. The Clinic has done both of these using the volunteered services of some 80 physicians, nurses and other medical personnel. Most of these volunteers are retired persons in their 70's and 80's with well-functioning brains as well as great enthusiasm and dedication.
3. Provided free medications for many of our patients with samples donated by community physicians as well as by pharmaceutical representatives. The Clinic has also arranged with a large locally owned grocery chain, Price Chopper, to have one of its conveniently located pharmacies fill our patients' prescriptions for generic

drugs for a \$5, co-pay with the Clinic paying the balance of the cost.

4. Provided access, without charge, for consultations and continuing care in all medical specialties as well as in dentistry, optometry and podiatry by a network of Schenectady doctors in private practice. Examples of such continuing care are performance of upper endoscopies and colonoscopies; stress tests; thyroid and other biopsies; coronary artery bypass surgery and stent placements; cataract surgery and laser treatments; resection of brain tumors and colon cancers; radio and chemotherapy for malignancies. We have also arranged some dental and gynecologic care at Hometown Health, a federally qualified community health center.
5. Provided all laboratory studies, X rays and other imaging studies (ultrasound, CT, MRI) without charge to our patients, through Ellis/ St. Clare's and Bellevue Hospitals and Schenectady Radiologists, a private group.
6. With the cooperation of Seton Health Center, trained a group of 9 Union College health management students in smoking cessation counseling for use with our patients. Recently, the students began on-site smoking cessation clinics meetings two evenings each week, with an expected duration of 10 weeks for each group. Smoking cessation aids are provided free.
7. Provided free employment physicals as well as camp and school examinations for children. Last year, we did 550 work physicals, which often enabled the recipients to obtain or retain employment. Many of these patients continued under our care.

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(“Free Clinic” from page 7)

8. Arranged innovative weekly case conference teaching sessions for our volunteer physicians, nurses and other staff. These focused on patients’ presenting complaints and sought to answer the questions 1) What disease or disorder which might produce the complaint may quickly kill or seriously impair the health of the patient, if not recognized promptly? 2) What are the most prevalent disorders in our clinic population which might account for the complaint? 3) For what do we have good treatment if correctly diagnosed?
9. Set up a rotation through our Clinic of Albany Medical Center Internal Medicine residents who provide service, and receive training. After negotiations with the Columbia College of Physicians and Surgeons—conducted at our behest—received their agreement to have our Clinic serve as one of their off-campus sites for the 5 week primary care rotation of two-3rd year medical students, year-round. Unfortunately, however, we were unable to provide the funding we thought necessary for recruiting a full-time clinician/teacher who would have made this possible, as well as provided medical services for our patients.
10. Generated in the first eight years of operation over 10.9 million dollars in donated medical and nursing services, with funds provided by N.Y. State and Schenectady County totaling \$900,000. The remaining 2.5 million required to support the Clinic was raised by private and foundation donations.

Discussion

Slightly more than 1,000 free clinics operate in the United States, but only a handful in New York State.

Why aren’t there many more free clinics in New York—and for that matter, all over our country—providing desperately needed medical care for

many more of our people? I believe there are three main reasons for this:

1. There is a massive burden of health care regulations, particularly in N.Y. State, which were set up to protect patients in hospitals, nursing homes and other traditional sites of medical care, but are often inappropriate in other sites. These however, quickly discourage physicians, nurses and other interested persons from providing this care in other venues. I spoke of our own experience in this regard in my October 2003 paper in this journal. It was only because of the interest, encouragement and initial financial help arranged by a single individual, Dennis Whalen, then Deputy Commissioner in the N.Y. State Department of Health., that the Schenectady Free Clinic was born.
2. There is a mistaken fear of many potential volunteers that poor people, those most apt to attend free clinics, present a significant risk for malpractice suits. The truth is quite the contrary. The universal experience of volunteer doctors and nurses in free clinics is that they are sued extremely rarely, and virtually never successfully. Given this experience, 43 of our 50 states—New York State not among them—provide malpractice protection for volunteers in free clinics. This is crucial for recruiting volunteers. They do this in one of two ways. The first is by using their powers of “sovereign immunity” to provide legal defense or any sued physician, as well as by assuming responsibility for any financial judgment resulting from such a suit. The second is by raising the standard of negligence for malpractice suits and by restricting punitive damages.

In 1997, Congress passed the Volunteer Protection Act which offered some malpractice protection for volunteers in free clinics. In 2004, implementing regulations issued by the U.S. of Health and

Human Services established that a free clinic patient alleging malpractice would have to sue the federal government, rather than the Clinic. However the extremely onerous and time consuming process of obtaining such federal coverage has resulted in only a small number of free clinics applying for and obtaining it. Incidentally, there have been no malpractice suits lodged against any of the clinics covered. .

3. There is a critical need for start-up moneys for free clinics. Most U.S. free clinics live from hand-to-mouth, seldom receiving federal, state or local government support. Our own Schenectady Clinic was an uncommon exception, as I have previously noted. Before free clinics can garner significant local, non-governmental support which will sustain them, they have to be up and running. Thus money is almost always needed for an executive director (our own, William Spolyar, has been indispensable for organizing the running of the clinic, fund raising and a hundred other functions including, until a year ago, literally cleaning the clinic with the help of his wife). Funds are also needed for renting office space, for the purchase of drugs and supplies, for the provision of Board liability insurance and sometimes malpractice insurance. Our own Clinic’s premiums are \$35, 000 each year.

Conclusion

In an excellent, detailed, national survey of U.S. free Clinics, administered between Oct. 2005 and December 2006, (Free Clinics in the United States. Arch Intern Med 170: 946, 2010), Dr. Julie Darnell suggested that free clinics were a much more important component of the ambulatory care safety net than generally recognized. I certainly agree with that view, and would add that they are also highly cost-effective—an extremely important

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Learning Under Stress

by Amanda Relyea



“I have been in foster care for one year; in that year I felt like my world had come to an end and that I had no meaning in my life.”

This is a quote from an essay that Beatrice, age 16, wrote for the Foster Family-Based Treatment Association (ffa.org). These words sound sad and full of despair until you read on.

“But with the help from people that worked with me I have found out differently ... without them I wouldn’t have come to the conclusion that I am special and that I am a person who deserves to be loved.”

The front page of this publication discusses an ongoing survey of foster care and how many young people are going through the trauma of living with a family that is not their own. As you would expect, these experiences are quite stressful even if the foster home is a good fit. Foster children live under emotionally trying circumstances with their birth families for many years, often seeing firsthand the effects of drugs, alcohol, abuse, poverty, and multiple moves.

Then, when children are removed from their homes and placed into foster care, it can cause even more tumult in their young lives. They can experience feelings of guilt, shame, and loss. Many of them put up defensive emotional walls to avoid getting close to anyone new. This makes it difficult for foster families and educators to help them, and it can lead to behavioral problems. It is completely understandable, though, when you reflect on how many times adults have let them down in the past and how much they must be hurting.

As Beatrice and the people who worked with her found out, however, it is possible to change the course of a life. One way to do this is through education.

Unfortunately, it is quite difficult for chronically stressed people to focus on learning. What can foster parents and educators do to overcome this difficulty? According to a 2008 *L. A. Times* article by Rosemary Clandos, titled “Too Stressed out to Learn,” researchers and educators say that “there are science-supported ways to mitigate these accentuated fear and stress responses and nurture the brain.” One researcher, Eric Jensen, developed a teachers’ training program called “Enriching the Brains of Poverty.” He recommends that teachers focus on areas proven by research to be lagging in poor children, including attention, memory, sequencing and long-term orientation. To build attention skills, for example, use stories and theater.

John Medina, developmental molecular biologist and author of *Brain Rules*, agrees. He recommends that educators use compelling stories to get children’s attention. When emotions are involved in initial learning, individuals become more interested in the subject and learning is recalled with greater accuracy. To improve memory, repeat salient points throughout the day and review them a few days later. Also be sure not to drone on and on. Ten minutes is about the most anyone can handle on one point. Use a compelling story to give their brains a break and introduce the next point.

Also consider physical exercise and naps. Physical exercise gives the brain a break from studying and improves oxygen flow so that learning comes easier when studies are resumed. Thirty-minute afternoon naps are also a good idea—one nap study showed

over 34 percent performance improvement in NASA pilots.

According to Medina, it is also important to stimulate more of the senses. Most people, from age 1 to 100, find it easier to pay attention and retain information when two or more senses are involved. Chronically stressed foster children are no different in this regard, and they may need such stimulation even more than children from stable homes. Use computer animation and pictures during lectures. Choose textbooks with a lot of examples and illustrations. Pass physical examples or representations of concepts around the classroom so that touch is engaged. Allow children to physically participate in learning when possible.

Even more importantly, Jensen says to promote self-determination, hope, and security. Ask about students’ dreams and help them set small daily goals to realize those dreams. Provide a safe, secret place for them to store their written goals or encourage them to find a safe place of their own, if possible.

Such long-term orientation and goal-setting is important because it helps chronically stressed people to feel more in control of their lives and futures. It allows them to forget the moment, if just for a little while, and consider what they can personally do to fulfill their dreams, both now and in the future when they are on their own. Loss of control is one of the biggest stressors that at-risk children face, so focusing on the things that they can control helps them to make it through trying times.

In sum, the last and most important point comes from Beatrice—foster children and other at-risk learners need to know that they are special and that they deserve to be loved. ■

Legislation Changing Required Beneficiary Distributions Introduced in Senate; Regulations Finalizing Fee Disclosure Regulations Released by Department of Labor

by **Joan McCallen, President and CEO, ICMA-RC**
and **John Saeli, Vice President, Marketing Services & Industry Analytics, ICMA-RC**



Retirement issues received less attention in 2011, with Congress focusing on the debt and budget deficit. Although several bills introduced last year to address specific

retirement plan issues currently appear to have little chance of passage in this election year, targeted legislation addressing Federal revenue shortfalls could be enacted in 2012 and some of the shortfalls could be eliminated by scaling back tax benefits for retirement savings. Broader legislation to more substantially address the Federal budget deficit and potentially affect retirement plans in a more significant manner may be considered in 2013.

In February Senate Finance Committee Chairman Max Baucus (D-MT) introduced legislation to reauthorize the Highway Trust Fund that would include a revenue offset requiring distributions from inherited IRAs and defined contribution plans to be made within five years, rather than over a beneficiary's life or life expectancy. This provision of the bill would raise a substantial portion of total funding for the Highway Trust Fund reauthorization. Although the Finance Committee approved the bill with this provision intact, Chairman Baucus agreed to Republican Senators' request to identify a substitute revenue offset. Nevertheless, this offset will likely resurface in future debates.

Last year the Tax Parity for Health Plan Beneficiaries Act was introduced

on a bi-partisan basis in both the House and Senate. The legislation would permit employees to reimburse medical expenses of non-spouse, non-dependent beneficiaries from health reimbursement arrangements ("HRAs"). The Internal Revenue Code currently excludes from income the value of employer-provided benefits received by employees for coverage of a spouse and dependents, but does not extend this treatment to non-spouse, non-dependent beneficiaries.

Provisions of the bill would reverse the Treasury's revenue ruling on HRA beneficiaries, directing the Treasury to issue rules that permit employees to elect to have their HRAs reimburse the uninsured medical expenses of non-spouse, non-dependent designated beneficiaries. Comparable treatment would be afforded health flexible spending arrangements ("Health FSAs"), and health savings accounts ("HSAs").

The Department of Labor ("DOL") released final regulations this February for provider disclosures of fees to ERISA plan fiduciaries. The regulations mandate substantially enhanced disclosures in advance of entering, renewing or extending a plan service contract and disclosure by record keepers of fund fee changes at least annually thereafter. Among other disclosures, record keepers are required to provide a description of the compensation they expect to receive for services provided as well as the fees of each fund administered for the plan. Contracts or arrangements entered into on or after July 1, 2012, must comply with the final rule, and contracts or arrangements in existence prior to July 1, also

must be brought into compliance as of that date.

The deadline for making initial fee disclosures to ERISA plan participants under the DOL's participant fee disclosure regulations has been delayed. For calendar year plans, the initial disclosure deadline is now August 30, 2012, with the deadline for the first quarterly statement with the disclosures now set at November 14, 2012. The regulations require that employees eligible to participate in a plan that allows them to invest their own account receive disclosures prior to their initial investment and at least annually thereafter. Key components of the regulation require disclosure of plan level fees, the total annualized operating expense (expense ratio) of each fund and the total annualized operating expenses expressed as dollar amount for a \$1,000 investment. Employees also must receive information on the historical performance of each fund.

Although the DOL's fee disclosure regulations for ERISA plans generally do not apply to public-sector retirement plans, many providers may provide comparable disclosures to both public plan sponsors and participants as a matter of best practice. Disclosures to plan sponsors may enhance plan fiduciary knowledge and understanding of the cost of services contracted for the plan, while participant disclosures may increase awareness of fees and sensitivity to plan costs.

In November 2011, the Internal Revenue Service (IRS) and Treasury Department issued an Advance Notice of Proposed Rulemaking describing

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regulations they are considering proposing on the determination of whether a plan is a governmental plan within Section 414(d) of the Internal Revenue Code. The proposal would define key terms relating to the governmental plan determination and set forth “major” and “other” factors that should be considered in determining whether an entity is eligible to sponsor a governmental plan. The proposal would apply a facts and circumstances test to the determination of whether a plan meets the governmental plan definition in Section 414(d).

The Advance Notice of Proposed Rulemaking is the first step in the

regulatory process. Comments on the preliminary proposal are due June 18, 2012. The IRS and Treasury Department have scheduled hearings on July 9, 2012. Outlines of topics to be discussed at the public hearing also must be received by June 18, 2012. Subsequent to the hearings, proposed regulations may be released by the IRS and Treasury Department for further comment prior to release of final regulations. Given the current anticipated timeline for formalizing proposed regulations, it is likely that final regulations would be issued in 2013 or later. ■

(“Free Clinic” from page 8)

consideration in these difficult economic times.

For those readers who might consider beginning or joining an effort to start a free clinic in their own community, I would also recommend a paper by Stephen Isaacs and Paul Jellinek, *Is There A (Volunteer) Doctor in the House? Free Clinics and Volunteer Physician Networks in the United States Health Affairs 26: 871, 2007.*

William P. Spolyar, the Executive Director of the Schenectady Free Clinic, and the author, may be reached at 600 Franklin Street, Schenectady, NY 12305. Tel (518) 344-7067. ■

ICMA Vice Presidents Elected

On February 17, 2012, ICMA canvassed 1,406 ballots to select vice presidents who will take office with the 2012-2013 ICMA Executive Board. This was the sixth year that ICMA provided online voting. Of the 1,406 ballots, 1,360 were received online and 46 by regular mail. The vice presidents who were elected are:

Rodney S. Gould, city manager, Santa Monica, California, West Coast

Jennifer Kimball, interim city manager/assistant city manager, Rockville, Maryland, Northeast

Mark L. McDaniel, city manager, Tyler, Texas, Mountain Plains

Stephen Parry, chief executive, Gore District, New Zealand, International

Andrew K. Pederson, village manager, Bayside, Wisconsin, Midwest

Edwin Lee Worsley, Jr., deputy county manager, Durham County, North Carolina, Southeast

ICMA Corporate members who served on the canvassing committee were Ron Carlee, chief operating officer/executive in residence, ICMA; Debra R. Collins, assistant city manager, Alexandria, VA; and David J. Robertson, executive director, Metropolitan Washington Council of Governments, Washington, DC. ICMA staff members assisted with the counting.