JOINT MANAGEMENT TASK FORCE RECOMMENDATIONS

Background

On July 18, 2002, the *Katie A. v. Bonta* lawsuit was filed seeking declaratory and injunctive relief on behalf of a class of children in California who (1) are in foster care or are at imminent risk of foster care placement, (2) have a mental illness or condition that has been documented or—if an assessment had been conducted—would have been documented, and (3) need individualized mental health services, including, but not limited to, professionally acceptable assessments, behavioral support and case management services, family support, crisis support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition.

In December 2011, a settlement agreement was reached in the case. As part of this agreement and subsequent implementation plan, the California Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) agreed to perform a number of actions including the establishment of a Shared Management Structure (SMS) to develop a shared vision and mission statement, policy and program direction, clear and consistent guidance, and outcomes and accountability measures consistent with the Core Practice Model (CPM)[1]. To this end, the Agreement called for the establishment of a Joint Management Task Force (JMT) (20d), Accountability, Communications and Oversight Task Force (20j) and a CPM Fiscal Task Force (20m)[2]. The charters of these task forces are included in Appendix A and this document reflects the work and recommendations of these groups.

The JMT recommends that the SMS shared vision, mission and values statements incorporate the concepts below.[3] Final statements will be developed and adopted by the SMS teams and published on the DHCS and CDSS websites.

Shared Vision

- All children in California live in a safe, stable and permanent home, nurtured by healthy families[4] with the capacity to meet a child's basic needs and to support a child's well-being so that every child is prepared to transition into adulthood, ready to become a contributing member of society.
- Fewer children need foster care and have shorter lengths of stay overall; children and youth get the services they need in their families and communities; and that

[1] In this document, the term Core Practice Model (CPM) refers to the Core Practice Model described in the Katie A Settlement Agreement

[2] References are to the paragraphs of the Katie A Settlement Agreement

[3] These are drawn from the vision, mission and values within the Katie A Settlement and from Systems of Care, Wraparound and the California Partnership for Permanency Initiatives.

[4] In this document, the definition of the term "family" includes biological parents, extended members of the youth's biological family, foster parents and caregivers. The terms "child" and "youth" are used interchangeably. When children and youth are included in an activity or process, it is assumed that their involvement will be developmentally appropriate.

congregate care (e.g., psychiatric hospitalization, group home) only occurs when children require intensive stabilization services that cannot be provided in a family setting, and then for as short a time as possible to ensure their safety and well-being.

- Collaborative efforts among children, youth and families, communities across California, public and private sector policy makers and community-based service providers result in improved support for children and families in their communities, with access to appropriate and effective mental health and other services and resources as needed to assure healthy development and well-being.

Mission

- To ensure that the goals set forth in the *Katie A v. Bonta* Settlement Agreement are met. Those goals are to:
    - Facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery, and transition into a coherent and all-inclusive approach;
    - Support the development and delivery of a service structure and a fiscal system that supports a core practices and services model, as described above;
    - Support an effective and sustainable solution that will involve standards and methods to achieve quality-based oversight, along with training and education that supports and ensures successful implementation of the practice and fiscal models;
    - Address the need for certain youth and family members with more intensive needs to receive medically necessary mental health services in their own home, a family setting or the most homelike setting appropriate to their needs, in order to facilitate reunification, and to meet their needs for safety, permanence, and well-being[5]
- To improve system performance and individual outcomes for children and families in the child welfare system who have mental health needs
- To develop, direct, communicate and coordinate statewide policies and programs; to provide clear and consistent guidance to program managers and stakeholders in the implementation of policies and programs consistent with the Core Practice Model (CPM)
- To direct and ensure the development, analysis, reporting and interpretation of outcome and accountability measures using a comprehensive Continuous Quality Improvement (CQI) framework
- To ensure that family and youth are involved in the Shared Management Structure
- To perform other activities that further the achievement of the shared vision

[5] Katie A Settlement Agreement, Paragraph 19 (a) through (d).

Values

- A child-centered and family-focused system, with families and youth as full participants in all aspects of the planning and development of policies, programs, services and supports
- A culturally competent system, with agencies, programs and services that reflect understanding and respect for the culture of the children, youth, families and service providers
- A transparent system, where organizational operations and decisions are conducted with transparency and with the goal of building and maintaining trust among staff, children, youth and family members
- A trauma-informed system that embodies a strength-based approach and believes in resilience and the ability of individuals, organizations, and communities to heal and promote recovery from trauma
- A system that shares accountability for performance and outcomes across multiple agencies and organizations and that is integrated and eliminates redundancies

In addition to reflecting the vision, mission and values as recommended above, the recommendations of the JMT embody three concepts:

- Statewide practice change of this magnitude requires integrated state and county leadership and direction, with input from youth, families, community-based providers and other stakeholders at all levels.
- Shared accountability and outcomes drive policy and practice activities.
- Practice change to improve provision and coordination of services for children and youth in foster care is a complex task involving a myriad of issues. Doing so correctly will take time and require a balanced and measured approach from government, youth, families and community partners. It is important to improve on what we have with timelines that satisfy both mandates and the needs of youth and families.

While the recommendations in this report focus on the population defined in the Katie A Settlement Agreement and the collaboration between child welfare and mental health, the JMT envisions that the shared governance structure and the policy and practice changes recommended could ultimately serve as a model for working with children and families across all systems.

As indicated in the Settlement Agreement, DHCS and CDSS will share structures, policies and practices intended to serve at-risk young people that have proven to be successful using, but not limited to, existing structures such as the Child Welfare Council and the State Interagency Team.

In the implementation of the Shared Management Structure the JMT recommends that efforts integrate guidance and practices from *Collective Impact theory*, *Implementation Science research* and the concept of *Continuous Quality Improvement*.

The theory of Collective Impact has been widely adopted as an effective way to address complex social and environmental challenges. *Collective Impact* hinges on the idea that in order for organizations to create lasting solutions to social problems on a large-scale, they need to coordinate their efforts and work together around a clearly defined goal.[6]

Implementation Science is the study of the process of implementing policies, programs and practices. It provides an approach to effectively translating "what we know" into "what we do". Implementation Science research demonstrates that in order to be successful, one not only has to identify effective practices, but they must be implemented as intended.[7]

Continuous Quality Improvement (CQI) is the process of identifying, describing, and analyzing strengths and problems and then testing, implementing, learning from, and revising solutions.[8] Adopting a Shared Management Structure and all of the other elements of the Core Practice Model represent a true transformation in the way child welfare and mental health work together and it is expected that as these changes are implemented, they will need to go through several stages of evolution and development. It will be important to regularly assess how things are working and where and how improvements can be made.

Joint Management Task Force Recommendations

The recommendations of the JMT fall in four areas:

1. **Shared Governance**
2. **Policies and Procedures**
3. **Accountability, Communication and Oversight**
4. **Fiscal Strategies**

1. Shared Governance

The primary goals of the shared management structure are:

[6] Kania, John and Kramer, Mark. "Collective Impact". Stanford Social Innovation Review, Winter 2011. p. 36-41. [3]

[7] Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). "Implementation Research: A Synthesis of the Literature". Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

[8] Casey Family Programs and the National Child Welfare Resource Center for Organizational Improvement, "Using CQI To Improve Child Welfare Practice - A Framework for Implementation", 2005.

- To assure that the Katie A Settlement is fully implemented such that all children, youth and families in the population defined in the agreement are receiving needed services under the Core Practice Model; and
- To create an accountability structure that has a truly shared responsibility for outcomes at both the state and county levels.

The JMT recommends that DCHS and CDSS adopt a shared governance model consisting of a Transformation Manager/Facilitator and two leadership teams. Together, they will constitute the Shared Management Structure (SMS)

The intended cross-systems changes in policy and practice at both the State and county levels represent a transformation in the way child welfare and mental health agencies and organizations serve children, youth and families needing child welfare and mental health services. Just as counties and service providers are implementing the Core Practice Model's foundational concept of teaming, this concept will be adopted at the State level as well. DHCS and CDSS will create a team structure that provides for shared governance, leadership, communication and accountability between departments, and among the State, counties, parents, youth, community-based providers and advocates.

a. Transformation Manager/Facilitator

The JMT recommends hiring a Transformation Manager/Facilitator (Transformation Manager) as a critical part of the shared management structure. The person in this position will provide staff support and facilitation for both of the shared management teams.

This person must have the time and skills to work across both departments; become familiar with the work of the shared management teams and other related activities of both departments; understand how the pieces fit together; and help the departments and stakeholders understand and eliminate barriers hindering interagency collaboration and achievement of goals and outcomes. The Transformation Manager will also be responsible for preparing youth and family members for team meetings and for ensuring a focus on youth and family engagement within the meetings.

This person must have lived experience[9] or substantial experience with families and youth with lived experience. Additional suggested qualifications are in Appendix B.

This position will report directly to the Executive Team. DHCS and DSS will evaluate the advantages and disadvantages of having this position be either a staff person or an independent contractor.

[9] "Lived experience" is a term commonly used to indicate someone who has experienced certain conditions. In this case it would include family members and/or youth, who may now be adults, who have had mental health needs and experienced mental health and child welfare services.

Managing this level of transformational change requires a level of focus and infrastructure support that is not typically available as an added responsibility to staff and leadership in the midst of on-going operational responsibilities. This person's time will be fully dedicated to the SMS. Achieving the changes desired will take time, patience, expertise and the ability and availability to focus solely on this effort over time.

b. Executive Team

The Executive Team will consist of executive and senior management staff within DCHS and CDSS who have decision-making authority within their respective departments. With direction and input from the Community Team, the Executive Team will provide leadership and decision-making in the implementation of Child Welfare/Mental Health state interagency and intra-agency collaborative policy and practice consistent with the CPM for serving foster children, youth and families. The Executive Team will:

- Provide State leadership
- Make final decisions on state policy and practice with input from the Community Team
- Assume shared responsibility for impact of state policies on shared populations
- Develop State Memoranda of Agreement (MOA) with input from the Community Team
- Assume shared responsibility for collaborative actions
- Based upon recommendations from the Community Team, make the final decisions on an overall Continuous Quality Improvement and Accountability System ("CQI System") including
    - Policies on data and information sharing
    - Methods to measure child and family outcomes
    - Methods to assess fidelity to the CPM at the county Mental Health Plan (MHP)[10], Child Welfare and provider level (practice change)
    - An integrated quality improvement system
- Assume joint accountability for outcomes for children, youth and families in the child welfare system
- Identify policy and practice issues which need attention

[10] Under the Medi-Cal Specialty Mental Health Services Consolidation Waiver Program, Mental Health Plans (MHPs) are required to contract with DHCS (formerly DMH) for the provision of Specialty Mental Health Services (defined at California Code of Regulations (CCR), Title 9, section 18180.247) to Medi-Cal recipients. An MHP may be a county, counties acting jointly, or another governmental or non-governmental entity. DHCS (formerly DMH) and MHPs share the financial risk of providing services. (DHCS Website, contractual obligations) In this case counties have contracted with DHCS to provide the services required under the Katie A settlement and for other EPSDT services as well.

CDSS and DHCS will share leadership of the Executive Team. Matters that cannot be resolved by this team will be elevated to the Secretary of the Health and Human Services Agency for resolution. The Transformation Manager will staff the Executive Team and facilitate their meetings.

c. Community Team

The SMS Community Team will consist of:

- Two family members with lived experience
- Two youth members with lived experience
- Two child and youth advocates
- Two provider representatives
- One local county Mental Health Plan (MHP) representative
- One local county child welfare representative
- One representative from the County Welfare Directors Association (CWDA)
- One representative from the County Behavioral Health Directors Association (CBHDA - formerly CMHDA)
- One representative from CDSS who also participates on the Executive Team
- One representative from DHCS who also participates on the Executive Team

The JMT considered the desire for the Community Team to be a larger inclusive group versus the need to have a team that can effectively provide leadership, complete tasks and make recommendations. The experience of the initial JMT demonstrates how difficult it is for large bodies to come to decisions, make specific recommendations, resolve issues and solve complex matters efficiently and effectively within a short period of time. For this reason the Community Team will not be a fully representative group, but will be a team of experts in order for the team to be able to accomplish its work effectively. The membership consists of eight participants who do not work for counties or the state and six who do. The balance is intentional, reflecting a desire for strong community input in all deliberations.

The role of the Community Team is to ensure that stakeholders are engaged and are equal partners in leading the collaborative effort to change policy and practice. The team will provide leadership, direction, advice, and feedback about state policies and programs relevant to service delivery, data collection, quality improvement and accountability regarding child welfare youth and families who need mental health services. In addition to identifying issues and making recommendations to the Executive Team, members will also receive regular updates from the Executive Team. The Community Team will:

- Provide direction, input and feedback to Executive Team on state policy and practice from the youth, family, advocate, provider community and local government perspectives

- Make recommendations to the Executive Team on an overall CQI System including:
  - Policies on data and information sharing
  - Methods to measure child and family outcomes
  - Methods to assess fidelity to the CPM at the county MHP, Child Welfare and provider level (practice change)
  - An integrated quality improvement system
- Monitor state performance, local performance and outcomes
- Identify and work on policy and practice issues which need attention

Within the SMS, information will flow between the teams, to and from counties and communities and the State departments. Final decision-making authority for state policies and state oversight will be centralized in the Executive Team with input from the Community Team.

The Community Team will have two co-chairs who will both be community, non-governmental members. The State will pay for the time and expenses of team members who cannot be paid by organizations to participate. Both the Executive Team and the Community Team will meet at least monthly. It is important that team membership be consistent, so that work can be completed efficiently and effectively. The Community Team will determine its rules for membership and terms of membership, with the initial term being one year.

The SMS will be assessed using a CQI approach.

This recommended management structure is a new way of working together at the state level. Both teams, together with the Transformation Manager, will need to continually evaluate how the teams and teaming structure is functioning and make changes as needed to insure that goals and objectives are being accomplished, necessary work is getting done and the process reflects the vision, mission and values as they are articulated. For example, if it becomes apparent that major policy decisions are being made outside of the SMS without transparency, it will be important to identify why this is happening. Is it due to a team or teams not functioning effectively, or does the structure itself need to be modified? This model requires building trust within and between the teams. Evaluating the structure and how the individual teams are functioning on a regular basis using a CQI approach will build trust and competence.

FixIT Teams

There will be a need for time-limited focused work groups with subject matter experts. FixIT Teams will be created as needed to:

- Reduce barriers to effective collaboration and service delivery arising from a lack of understanding of federal rules and regulations;
- Facilitate revision or elimination of state and local rules that impede access to care and implementation of the CPM; and

- Propose solutions to particularly complex and challenging issues between and within departments.

FixIT Teams will not be permanent teams, but will be created and function when there is a need to deal with a specific issue identified anywhere within the governance structure. FixIT team membership will be fluid, depending upon the issue needing to be resolved, but will include youth and family representation. A team could include staff at any level within CDSS and DHCS, cultural experts, families, youth and/or county staff and/or provider organizations/agencies and/or community advocates and partners, as well as technical assistants and consultants. Specific tasks for focused FixIT teams will include areas of policy or practice not readily resolvable through existing channels or structures. A FixIT team will meet as long as needed to remove the barriers and/or make recommendations to the two SMS teams as to resolution of the issue. Either of the SMS teams or departmental staff, with approval of the SMS, can identify the need for a FixIT team. The Executive Team will resolve differences regarding whether or not to establish a particular FixIT team.

Timelines

The Executive Team and the Community Team will convene and hold their first meetings no later than October 1, 2014.

The Transformation Manager will be in place by December 31, 2014.

Transition

The current JMT will be responsible for working with the Executive Team to establish the Community Team and hire the Transformation Manager.

Once the Transformation Manager is hired and the SMS is in place, the JMT recommends that the JMT be disbanded.

2. Policies and Procedure Recommendations

The JMT recommends that DHCS and CDSS enter into an MOA regarding Interagency Policies and Procedures by December 1, 2014, in order to better coordinate child welfare and mental health efforts to serve foster youth with mental health needs. The MOA will include but not be limited to:

a. Agreement to align departmental policies and procedures relating to children and families in the child welfare system with mental health needs through joint development, review and revision of such policies and procedures. This will include:
    i. Coordinating routine communication prior to departmental action to assure alignment of direction and expectations.

Communication between departments will be on-going: meetings will occur as needed.

ii. Establishing joint departmental protocols for the production and distribution of information relating to and/or impacting both departments, such as the publishing of outcomes on both DHCS and CDSS websites, informing counties about best practices with shared populations, etc.

iii. Jointly issuing and signing All County Letters (ACLs) and All County Information Notices (ACINs) when both child welfare and county MHPs are or may be affected by the policy or practice. This would include issues such as data sharing information, defining data elements, changes in quality review processes involving child welfare and mental health, changes in requirements for counties and other policy and/or practice issues.

Working collaboratively does not mean doing everything together. For collaborative practice to be successful, an atmosphere of trust and shared understanding is critical. Both departments will need to make decisions about when their actions need to involve one another and when independent action will clearly not impact collaborative work. Whenever possible, the first choice should be inclusion. The process is one of learning—starting with clear first steps and continually improving and building trust, recognizing that mistakes will happen, but both respect and trust will allow those involved to move forward and learn from the mistakes.

3. Accountability, Communication and Oversight

The JMT recommends that the Community Team develop recommendations for a comprehensive Continuous Quality Improvement and Accountability System that further integrates CDSS and DHCS efforts such as the Performance Outcomes System (POS), Congregate Care Reform (CCR), Case Management System (CMS) and other activities. The report should also:

a. Clarify the intended uses of information and data within the CQI System, and describe existing, or recommend new, sufficient feedback methods that embed quality improvement opportunities at every level of the system;

b. Identify or propose practical mechanisms for amending programs, policies, procedures and practices at every level of the system based on quality improvement learning; and

c. Identify methodologies and/or tools to measure, assess and provide feedback on system competencies necessary for building, using and sustaining a comprehensive CQI System for the purpose of guiding the state and counties in improving performance.

The recommendations should be submitted to the Executive Team by June 30, 2015, for review and adoption as State policy. As part of the process of developing the framework, the JMT recommends that the SMS teams hold a stakeholder meeting to get specific input for the CQI System as per the Settlement Agreement.

The data and quality assurance commitments within the Settlement Agreement call for a statewide data-informed system of oversight, accountability and communication that promotes the development and use of the Core Practice Model for all children served jointly by the child welfare and mental health systems; fosters delivery of effective, quality mental health services within the Core Practice Model; efficiently monitors, measures, evaluates, and communicates access, quality, effectiveness, costs and outcomes at the individual service, program and system levels.[11] A CQI System is needed in order to achieve these commitments and improve system performance and outcomes.

This system will include data collection, case reviews, and analysis of performance and outcomes, with results used to inform policies, practice and training. In addition, just as service practice and delivery must be managed for quality, so too must leadership, management and communication activities. Social science researchers have developed methods and tools for this task, which are intended to be used to prioritize efforts and measure progress on leadership, administration, training, infrastructure and communication. The CQI system will bring together and integrate the work being done by the POS effort within DHCS, the CCR work in CDSS, EQRO and C-CFSR processes and other work to integrate data, outcomes, system performance and quality improvement initiatives, now and in the future.

Because this approach is a transformation of the way mental health and child welfare systems operate, creating a comprehensive and complete CQI System will take a significant amount of time and effort. The JMT anticipates the Community Team will need to bring in technical assistance and/or consultants and/or convene groups of subject matter experts to complete its recommendations.

Prior to finalizing the overall CQI System, the JMT recommends that CDSS and DHCS meet the commitments of the Katie A Service Delivery Action Plan ("Action Plan") and the ACO report that have yet to occur. The Community Team will work with the State to re-establish appropriate dates and timelines for these activities.

Fulfilling the actions that are included in the Action Plan is an essential initial step towards meeting the State's commitments and developing an effective CQI System. Copies of both the Action Plan and the Katie A Joint Management Task Force: Accountability and Oversight Short-term, Mid-term and Long-term Goals are included in Appendix C.

The SMS teams will monitor fidelity and outcome measures and DHCS and CDSS will be accountable for progress in achieving the defined goals. Within the overall CQI System, DHCS and CDSS will develop incremental steps to integrate compliance and quality review activities to achieve efficiency, improve service collaboration and ensure alignment of expectations, building upon Action Plan accomplishments.

[11] Accountability, Communication, and Oversight (ACO) Charter, p. 1.

Wherever possible, compliance and quality improvement activities will be integrated and/or coordinated to increase efficiency and reduce duplication.

4. Fiscal Strategies

The JMT recommends that DHCS and CDSS develop and adopt the recommendations of the Core Practice Model Fiscal Task Force (see Appendix D) and collaboratively address budgeting and fiscal strategies that maximize the use of resources.

The JMT has highlighted the following recommendations from the Task Force as a strong starting point.

a. The Executive Team commit to a state fiscal strategy to support the work of the SMS and CQI System.
b. Executive Team members agree to work with each other when developing budget plans for activities and new initiatives that affect shared populations.
c. The SMS create a FixIT team to develop a plan no later than March 31, 2015, that invests available federal, state, and county resources, including private foundation grants, into the provision of coordinated and aligned training and coaching for county child welfare and mental health line staff and supervisors, community-based contractors, family members, and other support persons to acquire skills needed to implement and sustain the practice changes within the CPM. Resources to be considered include:
    i. CDSS Title IV-E funds
    ii. MHSA funds, including Workforce, Education and Training Funds (WET)
    iii. DHCS contract funds with CiMH
    iv. CDSS contract funds with Regional Academies
    v. Private foundation grants
d. Work through the CCR process to develop a plan to reinvest savings from reduced high level foster care placements based upon partnerships between departments of social services and MHPs to maximize funds available for Medi- Cal reimbursable youth permanency programs to improve outcomes and lower short and long- term costs for both departments.
e. With input from the Community Team, CDSS and DHCS jointly produce clear written guidelines by June 1, 2015, for counties and contract providers regarding proper cost allocation for programs that render both child welfare and specialty mental health services in order to maximize resources and reduce audit risk.
f. CDSS and the DHCS explore with the Community Team opportunities for county child welfare and county MHPs to share and maximize resources in providing care to children and youth in the child welfare system who need mental health treatment.
g. CDSS and DHCS explore with the Community Team the idea of publishing a document that describes how county child welfare and county MHPs may negotiate agreements to share the fiscal risks and benefits associated with group home placements.