State of California

LITTLE HOOVER COMMISSION

May 5, 2004

The Honorable Arnold Schwarzenegger
Governor of California

The Honorable John L. Burton
President pro Tempore of the Senate
and members of the Senate

The Honorable James L. Brulte
Senate Minority Leader

The Honorable Fabian Núñez
Speaker of the Assembly
and members of the Assembly

The Honorable Kevin McCarthy
Assembly Minority Leader

Dear Governor and Members of the Legislature:

California is enduring a fourth year of financial difficulty. The sluggish economy and the government's fiscal straits are ripping holes in the public safety net when Californians need it most. The crisis also has laid bare the fundamental defects in how the State organizes, manages and funds public efforts to keep people safe, healthy and self-sufficient.

From a broader perspective, the turbulent start to this young century has brought into focus three imperatives for California's leaders: 1) A state government that lives within its means. 2) A state government that provides high-quality services to its residents. 3) A state that is competitive in terms of economic opportunity.

A high-performing network of health and human services is integral to each of these objectives.

California spends some $60 billion a year in state and federal money on health and human services that even before the fiscal crisis were not adequately meeting essential needs. Each year the demands on the system grow, but the system is not designed to become more efficient or effective. As a result, California spends more each year to maintain the unacceptable status quo. As organized, managed and funded, the system is simply unsustainable.

And yet many of the services are essential. These programs help those who are most vulnerable to poverty, neglect and disease move toward self-sufficiency, safety and well-being. These services help those who cannot help themselves, a prerequisite for a healthy and prosperous society.

Finally, many of these services directly benefit all Californians by contributing to quality health care, reliable emergency response and a reduction in violence and addiction. These services are part of the infrastructure that enables all Californians to be safe and healthy, so they can pursue their economic and other personal goals.

The bureaucracy that has evolved to administer these programs is a testimony to their importance, and the need for reform. The departments within the Health and Human Services Agency employ 12,000 people, not counting those who provide direct services. Of the $60 billion spent each year, more than $1.1 billion is spent in Sacramento. The plethora of programs and regulations increases administrative costs, distracts workers from the central task of providing high quality services, and contributes to a culture of distrust.

Over the last year, the Commission has explored how the State could re-engineer departments, its relationship with local governments, the funding streams that support essential programs and accountability mechanisms to improve the performance of these services. The Commission also examined opportunities to improve the State's relationship with the federal government, by being more responsive to federal statutes that require citizen oversight, by seeking waivers to federal funding rules to better serve Californians, and by seeking the support of California's congressional delegation to change federal policy where necessary.

The Commission began by looking to the most innovative service providers working in the most innovative counties, to determine what they were doing to meet the multiple challenges of clients, and how they have organized their administrative operations. The Commission then critiqued how the State could adapt its organizational structure and decision-making procedures to better support those community-based efforts.

What emerges is a vision – drawn heavily from these counties – for a system that provides high quality services to those in need at a price that the State can afford. Children and families should be at home, in school or working, healthy, safe and out of trouble.

The State is not alone in the pursuit of these goals and government cannot cure all of these ills. But what the government takes on it should do with extreme competence. And by its example, and with all of its policy tools, the State can inspire businesses, community organizations and individuals to do their part to help those who need help.

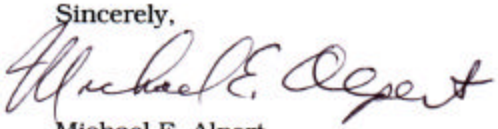
To achieve that vision, state and local policy-makers will have to change how they do business, and how public agencies are organized and managed. As a result, the recommendations in this report describe what needs to be done and how all decision-makers can align their efforts to these goals.

By re-engineering state functions, the State could save tens of millions of dollars in its own operations. More importantly, a refocused state effort could drive improvements in how tens of billions of dollars are spent each year at the local level. Those improvements can reduce costs, expand the availability of services, or both.

Because resources are always limited, California must establish priorities among clients and services that are essential to meeting shared goals. Those services must be provided at a cost comparable to similar services elsewhere. Research must be done to prepare cost-delivery comparisons. And the services must be of the quality necessary to protect and support individuals and families in California's communities.

Reforms will be difficult, but worth the effort. Importantly, the scale of reforms that are necessary may only be possible when faced with a crisis of this magnitude. The Commission is prepared to do its part to improve these essential public programs.

Sincerely,



Michael E. Alpert
Chairman

Real Lives, Real Reforms:

Improving Health and Human Services

May 2004

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Executive Summary

California has made a noble commitment to help people overcome challenges that have long plagued individuals and communities, from mental illness to physical disabilities. Our ambitions are lofty. In many cases progress has been dramatic. And across the board, these programs save lives and restore opportunity.

But progress has stalled. The price tag for health and human services continues to grow, yet people are still turned away or do not receive the quality of care that could change their lives. In some cases, there are heart-breaking failures – children who are abused while in foster care or in state facilities – despite repeated investigations exposing these failures. Moreover, California is not performing well when compared with other states, as measured by an array of indicators that other states use to assess their own performance.

The reasons for these problems are numerous. And ironically, many of the flaws in the system are the unintended consequences of well-intended reforms. Researchers develop a new treatment, so the State creates a new program. An investigation uncovers an abuse, and so a new restriction is enacted. An unmet need is identified, and so a new program is launched; but dollars are limited and so only a few counties are funded. A problem is identified, but a solution is not – so a pilot project is born. A respected service provider needs permission to offer an innovative service – so another pilot project is born. A pilot project is completed, but going to scale would be costly, so the pilot is extended.

Rule upon rule, program upon program, year upon year. By trying to solve all problems, California solves none. By neglecting the evidence of which programs work and which do not, dollars flow based on the persuasive powers of special interest lobbyists – not the ability of their clients to save lives. By refusing to fix programs, new initiatives are layered on top of old initiatives, victory is declared and little improves.

In turn, the bureaucracy has grown large and complex. As fashioned, the Health and Human Services Agency has not been able to coordinate state activities among its 13 diverse departments. And the relationship between the state departments and local agencies that provide most of the actual services is defined by distrust and suspicion. One county representative described the relationship as “spy vs. spy.”

County health and human service agencies have scores of contracts with half a dozen state departments. For years, some counties have been working to develop a consolidated contract with just one department –

Health Services – but with limited success, perpetuating useless costs to administering programs. Just developing common reporting terms would ease tensions – and shift more resources to actually serving clients.

The state has five departments that license health-related facilities. And even if they were all using limited resources to their best ability, those resources are not being collectively used to steadily reduce the bad outcomes that licensing is intended to prevent.

The "system" of services has been hard-wired over decades of political compromises, necessary at the time, but never re-examined. Met by this convoluted bureaucracy, many Californians seeking help give up in frustration, if they are not denied assistance because of inefficiency.

Occasionally the State attempts to solve these interconnected problems, but has not been able to stay the course. For example, in the decade that followed Program Realignment, the State created scores of grant and other programs that targeted specific individuals with specific services, often in specific counties. Each one added administrative costs and complexity, and attempted to direct the counties to serve an unmet need.

Two of those programs had the same goal – keeping people with mental illness out of jails and prisons. Both programs were touted as cost-effective. But as funding has dried up, so have the programs – despite evidence that the programs saved money and lives.

These facts would be reason enough to reorganize these programs, but there is more. Given demographic and political trends, the health and human service system will be expected to do more for more Californians in the future. But unless the system is fundamentally restructured, clients will receive less and the public will benefit less.

Fundamental change holds the potential for multiple returns:

- A better performing system will help the State to live within its means. A foster care system that protects children and heals families stems the costly flow of victims and criminals.
- Reorganizing departments, restructuring state and local responsibilities, reforming funding mechanisms and creating accountability will do more to cure addiction, reduce crime and violence, and break the cycle of poverty than a hundred pilot projects.
- And a growing economy, supported by efficient and effective human services, will do what government services cannot do: Provide living-wage jobs with health benefits so individuals will become less dependent on public programs.

With that premise, the Commission examined how innovative providers, county governments and other local agencies are organizing their efforts. Many counties have demonstrated the benefits of a new business model: specific goals, coordinated bureaucracies, consolidated funding streams, integrated services, and accountability for outcomes. The Commission then examined how the State should re-engineer itself to best support these local efforts. Reforms are essential in these areas:

Goal-oriented leadership. The lack of focused and persistent leadership has resulted in sporadic and piecemeal reforms that often only made matters worse. The first task for leadership will be to forge an agenda for meaningful improvements by establishing shared goals and imposing a collective discipline to make difficult decisions to pursue those common objectives. Clear statewide goals should inform and drive county-based strategies for providing high-quality services that meet community needs.

State reorganization. State entities need to change what they do and how they do it. The focus of the Health and Human Services Agency, and its component parts, should be to build strong partnerships with counties to provide high quality services.

- The Agency needs to be equipped to streamline requirements and define quality standards, gather and disseminate information on best practices, advocate for California's concerns with the federal government, and help state and community policy-makers to provide research-based policies, budgets and accountability.
- Administrative and support functions – such as fiscal operations and data management – should be consolidated strategically and over time into service centers, reducing expenditures and organizing the Agency's operations to support state and local activities.
- Departments, relieved of bureaucratic tasks, should dedicate smaller staffs to helping counties build high-quality systems of care.

Strong state-local partnership. California must give counties the authority to competently provide the services that they are responsible for administering. Clarifying the roles of state and local agencies and simplifying the system are essential to improving performance and accountability. Counties should develop individual plans that will accomplish broad state goals and minimum standards, are largely based on local needs and priorities, and will improve outcomes at less cost.

Effective funding. The State needs to align federal and state dollars with its priorities and give counties greater flexibility in how those dollars are used to serve Californians. The State can begin by systematically consolidating state-only programs and funds to provide that flexibility.

Meaningful accountability. State, local and civic leaders must make decisions based on outcomes: where to allocate resources, how to change structures, when to change programs. To do this, California must reclaim the vast resources spent on compliance activities and focus them to provide meaningful accountability mechanisms.

These "structural" solutions are essential to bringing focus to these important programs. But the ultimate success of these reforms will rest on the caliber and competencies of public employees – and managers, in particular – who with clear direction, the necessary training, and the required authority will be able to get the job done.

The scale and scope of these changes are daunting, but the case for change is compelling. And how California government responds to the fiscal crisis will echo throughout our communities for years to come.

Fundamental Reforms Essential

Finding 1: California cannot sustain its existing health and human services. An overly complex organizational structure, perverse funding incentives and weak oversight undermine efforts to better serve more Californians with limited resources.

California cannot afford to operate health and human services as presently designed. Existing programs are serving too few Californians. And demands are increasing even as policy-makers are scaling back on existing obligations to people receiving care.

There are important and on-going roles for the Governor and the Legislature, because every budget decision, every bill will either move California closer to its goals or farther away.

Some of this political focus needs to be used to build stronger bridges; with counties and other local partners, and the federal government.

Recommendation 1: The Governor and Legislature should champion health and human service reforms that involve local and federal officials, civic leaders and the public. Reforms should restructure state operations, realign state-local roles and responsibilities, streamline funding and enhance accountability.

California's elected leaders must make reform a priority

- ***The Governor, in consultation with other California leaders, should declare clear goals for Californians.*** California's goals – such as all Californians should be self-sufficient, safe, healthy, and

emotionally well, in adequate housing, ready to learn and work – should drive fundamental reform, as well as ongoing policy-making, budgeting and oversight.

- ***The Governor should target state resources to address statewide goals.*** Public resources should be dedicated to providing efficient, effective, accountable health and human services. Specifically:
  - ✓ **Organizational reform.** The Governor should reorganize state entities in the Health and Human Services Agency to better position the State to improve outcomes, as outlined in Recommendation 2.
  - ✓ **State-local realignment.** The Governor and Legislature, working with county officials and other local leaders should consolidate services into a responsive, seamless system-of-care under county authority, as discussed in Recommendation 3.
  - ✓ **Fiscal reform.** The Governor should advance proposals for fiscal reform that will increase flexibility, stability and incentives for excellence in public funding, as outlined in Recommendation 4.

- ***The Legislature should adopt into statute and the budget clear goals for Californians.*** Goals should guide legislative action, particularly policy-making, budgeting and oversight. Policy and budget analyses performed by the Legislative Analyst, the Department of Finance, and the policy and fiscal committees of the Legislature, in particular, should reflect those goals. Specifically:
  - ✓ **Improve policy analysis.** The policy-making process should be based on rigorous analysis of whether proposals will move California toward the State's goals. Analyses should clearly identify the objectives of proposed policy changes, who is responsible for meeting those objectives, and how progress will be monitored by the administration and the Legislature. Particular attention should be dedicated to the following issues:
    - ➢ **Recognize proven and promising practices.** Analyses should document whether proposals reflect proven and promising practices and indicate what evidence has been cited.
    - ➢ **Encourage seamless services and tailored care.** Analyses should document whether proposals will enhance or restrict efforts to collaborate, coordinate or integrate services for purposes of tailoring services to the needs of individual Californians.
  - ✓ **Bolster fiscal analyses and deliberation.** Budget and funding decisions should be based on rigorous analyses that recognize

priorities, facilitate reallocation decisions and ensure that fiscal policies promote stability, flexibility and improvement.

- ✓ **Monitor progress.** The Legislature should bolster its ability – as well as the ability of the public – to monitor progress. Policy-makers should continuously track efforts, monitor progress, and make decisions based on goals for children, adults and families.

Seek federal and local support

- ❑ ***Seek federal authority to further reforms.*** The Governor and Legislature should enlist California's congressional delegation to become a persistent, unified advocate for federal reforms needed to achieve California's goals for children, adults and families. Congressional approval is needed to shift state and local roles and responsibilities, to infuse greater flexibility into federal dollars and link funding with outcomes.

- ❑ ***Locally elected officials should become full partners in reforms.*** The Governor and Legislature should tap locally elected officials to guide reforms in State operations, and align local operations with statewide goals for children, adults and families.

Public agencies must develop a cohesive network of services to achieve goals for children, adults and families

- ❑ ***The Health and Human Services Agency secretary and department directors should implement reforms.*** Senior public administrators should assist in the development and implementation of organizational, fiscal and operational reforms. Recommendations 2, 3, 4 and 5 outline the role of administrators in reforms.

Establish a Reform Team

California's health and human services require reforms of an unprecedented scale. Success will require a strong commitment from the Governor and Legislature, a vision for excellence and a detailed understanding of current operations. The reform process must build upon the strengths of public employees and institutions and minimize the personal and organizational risks associated with change.

To make reforms reality, the Governor and Legislature should establish a leadership team. Reforms should be led by the Governor, with detailed involvement of legislative leaders, guided by experienced public administrators and clients, and implemented in conjunction with community partners.

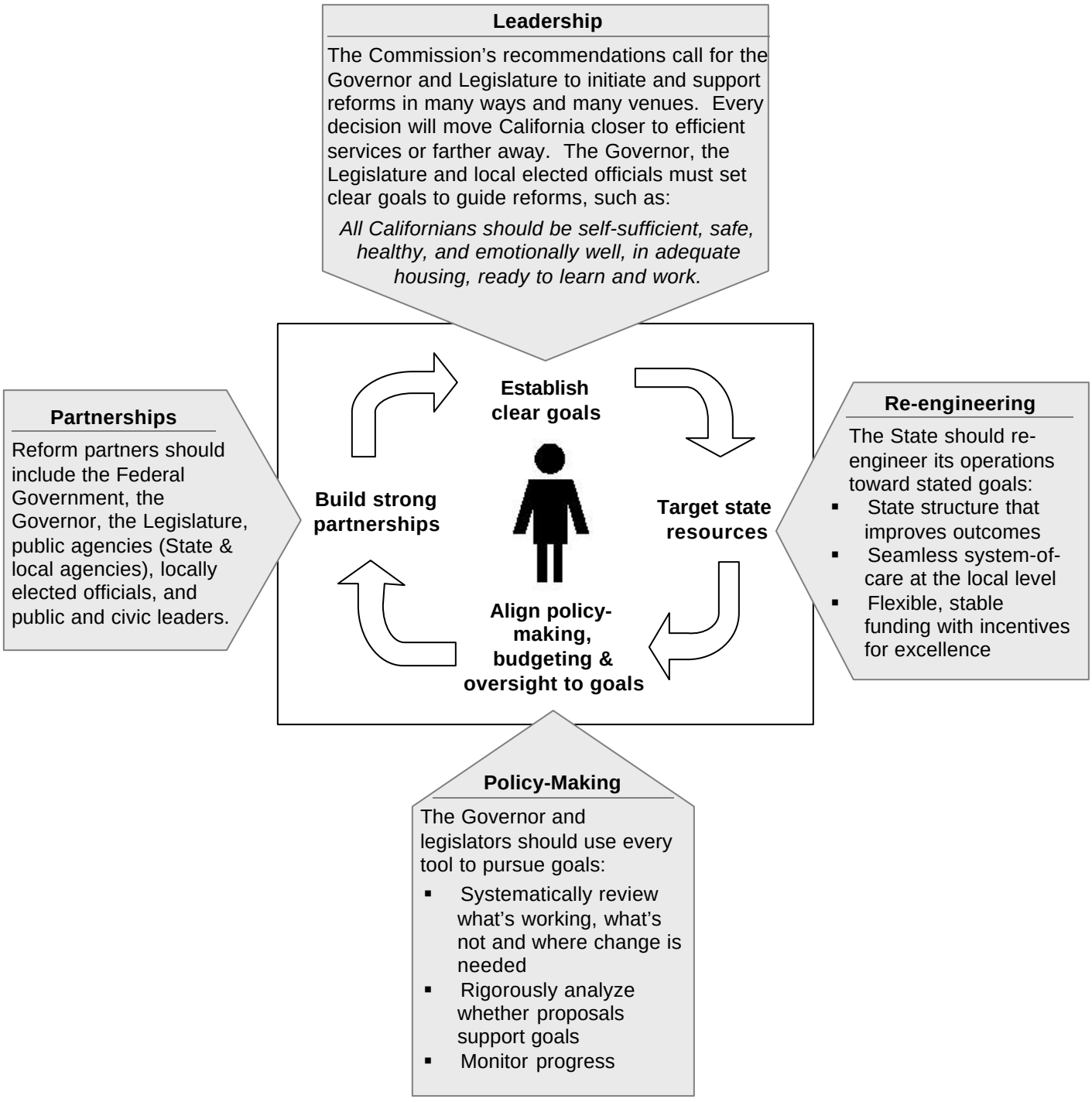
- ❑ ***Local agencies should become partners in reforms.*** Local agencies must ensure that statewide reforms support the needs and realities of health and human service clients.

- ❑ ***Federal agencies should facilitate reforms in federal policies and practices.*** Federal cooperation is essential to reforming California's health and human service networks. Federal agencies must be full partners in efforts to improve efficiency, effectiveness and accountability.

The public and civic leaders should monitor outcomes, expenditures

- ***Public oversight is key to improvement.*** Public officials and senior administrators should consult with the public and civic leaders on California's goals, the progress of reforms and outcomes.

Reform that Leads to Results for Clients



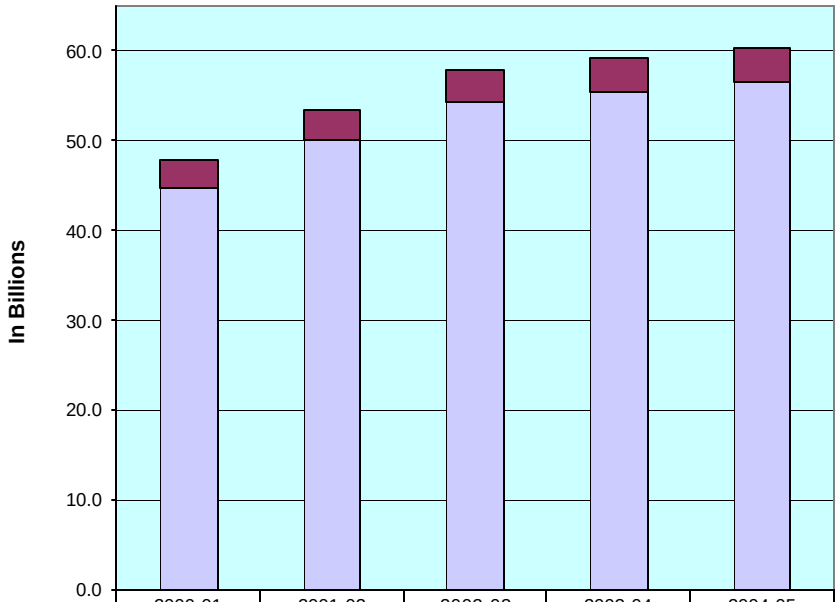
Focus State Operations on Outcomes

Finding 2: State operations are not designed and equipped to improve efficiency, effectiveness and accountability.

The Budget Act divides the resources of the Health and Human Services Agency and the 18 entities under its authority into two general categories: 1) state operations, and 2) funding that goes to local agencies to provide services, which is commonly referred to as local assistance. State operations encompass a variety of activities including policy development, fiscal administration, oversight, and technical assistance.

As displayed in the chart, far more resources go to communities each year than for state operations. To improve outcomes, the State must reorganize state functions to streamline operations, enhance the capacity of state departments to support improvements in local operations and improve internal efficiencies.

Health & Human Services Expenditures
State Operations & Local Assistance



	2000-01	2001-02	2002-03	2003-04	2004-05
State Operations	3.2	3.4	3.5	3.8	3.8
Local Assistance	44.7	50.0	54.3	55.5	56.5

Source: Governor's Budgets for 2002-03, 2003-04 and 2004-05. These figures represent the budgets for the Agency and 13 major departments. Does not include the Employment Development Department or the California Workforce Investment Board which were reorganized into the Labor and Workforce Development Agency.

Recommendation 2: State operations should be reorganized to provide unified leadership, efficient support of local programs and to focus on improving quality.

Unified leadership

- ***Bolster the Health and Human Services Agency.*** The Agency should ensure consistency across state operations, promote collaboration among departments and track progress toward the State's goals for children, adults and families. To fulfill these obligations, departmental resources currently dedicated to budgeting, policy-making, legal and external affairs should be shifted to the Agency and department directors should come together as an agency cabinet.

Efficient support

- ***Create service centers around functions shared by multiple state departments.*** Strategically and over time, the State should consolidate shared functions into service centers that report to the Agency and are responsive to the departments. Service centers should be established for the following functions and designed to enhance state support for local health and human services.
  - ✓ **Fiscal Operations**. State functions associated with payments, audits, eligibility, and benefit computation now handled by each department should be consolidated into a fiscal service center. The center should be charged with streamlining operations, reducing costs and improving accountability.
  - ✓ **Licensing and Certification.** Facility and personnel licensing and certification activities should be consolidated. Standards and regulations governing licensees should continue to be established by programmatic departments.
  - ✓ **Data Collection and Management.** Data collection and management activities should be consolidated, strategically and over time, to streamline state requirements, improve data analysis and identify opportunities to use data to enhance outcomes.

Enhance Management Capacity

The Agency Secretary should develop a strong leadership team and management structure to implement reforms, continuously improve internal operations and enhance state support for local operations. Among the components:

- **Designate chief operating officers for each department.** A chief operating officer should be established for each department and service center. The COO should report to the director and be charged with professionally managing operations under the direction of the department director. Chief operating officer positions should be required to meet rigorous minimum qualifications.
  - ✓ Significant experience managing public sector operations.
  - ✓ Comprehensive understanding of mission and operations of department or service center.
  - ✓ Demonstrated leadership applying principles of performance management and continuous improvement.
- **Establish an Agency Management Council.** The Agency Secretary should appoint a panel of public and private experts on health and human service management to provide advice on state-of-the-art management practices applicable to state and local agencies.

- ✓ **Technical Assistance and Training.** Multiple technical assistance and training efforts should be consolidated to improve the quality and consistency of services provided to state and local agencies. The Technical Assistance and Training Service Center should develop benchmarks and training programs for fiscal operations, licensing and regulatory compliance, and data collection and management. The center should initially receive General Fund support, but over time should be funded primarily through client fees.

Departments focused on improving service quality

- ❑ ***Refocus the departments.*** California's health and human service departments – smaller and more focused following organizational reforms – should enhance the effectiveness and efficiency of health and human services received by Californians. The strategic efforts of each department should provide leadership, planning, research and capacity building, to enhance the ability of local agencies to improve quality, efficiency and accessibility.

Advanced Research Office

The Office should report to the Agency Secretary, be small and flexible, infused with substantial autonomy, and be able to draw technical staff from state and local agencies, universities and the private sector. Activities should be project-based, typically 12 to 36 months, but longer when necessary. Project managers, who should be the core staff, should be technically outstanding and chosen for their vision and entrepreneurial spirit. Management should provide good stewardship of taxpayer funds but focus on enabling project managers to be successful. The Office should operate and be held to standards that allow failure in areas where the payoff of success is sufficiently high to require significant risk taking.

Invest in innovation

- ❑ ***Establish an Advanced Research Office.*** California must invest in improving the delivery of services. The Advanced Research Office should lead the State's efforts to identify innovative practices and create incentives to improve and enhance accountability. Initial tasks of the Advanced Research Office should include:

- ✓ **Scrutinize the distribution of responsibilities.** Once shared functions are consolidated, the Office should scrutinize the remaining state operations and submit a plan to the Agency to further reduce areas of duplication and overlap. State departments should be maintained where there is a uniqueness of client need, disorder or disease that cannot be addressed adequately through combined departmental efforts.

- ✓ **Expand the number of Californians with appropriate, affordable private sector insurance coverage.** The Office should document the adequacy and penetration rate of private sector insurance for health and human service needs – including physical health care, addiction treatment and mental health care – and propose to the Agency ways to increase the number of Californians covered by private insurance.

Realign State-Local Relationships

Finding 3: The complexity of California's health and human services increases costs, inhibits flexibility, limits improvement and undermines accountability.

Health and human services are provided through federal, state and local agencies, often working with non-profit and for-profit contractors. In some areas, the federal government is a direct service provider, as with services for veterans. In other areas, the State is a direct provider; the State operates mental hospitals and vocational centers. In most instances, however, federal and state agencies fund programs that are locally operated, often through the counties, but sometimes through regional entities, school and community college districts, or through direct contracts with private providers. In no two communities are the bundles of services provided in the same way.

> ***"To move forward, the State and local agencies must bring clarity and simplicity to health and human services and the state-local relationship."***

California has debated the right mix of state and local responsibilities for years, without resolution. To move forward, the State and local agencies must bring clarity and simplicity to health and human services and the state-local relationship.

Recommendation 3: California should transition to a strong county-based system of care for providing health and human services. Start with willing and capable counties, refine efforts and rollout statewide.

Simplify responsibilities

- ***The State should ensure adequate funding, personnel and other resources to support county programs and monitor progress toward statewide goals for children, adults and families.*** The Health and Human Services Agency should ensure the necessary elements are available to counties to improve outcomes, including sufficient qualified personnel, adequate and stable resources to meet needs and appropriate training and technical assistance to adopt and adapt proven and promising practices.

- ***Each county should develop a responsive, seamless system of care.*** Local systems of care should prioritize prevention, tailor services to needs, consistently improve, and produce high quality outcomes in line with California's goals for children, adults and families. Each county Board of Supervisors should designate a lead agency and position responsible for developing and operating its system of care.

Support counties as hubs for health and human services

- ***Realign state direct services to the counties.*** The Health and Human Services Agency should systematically review those direct services currently provided by the State and develop a transition plan to realign programmatic responsibilities and funding to the counties. That review should include services offered through state hospitals, developmental centers and vocational centers. The Agency should provide clear and compelling analyses – linked to goals for children, adults and families – to justify any decision to maintain the State's role as a service provider.

- ***Shift funding and programmatic authority to counties.*** The Health and Human Services Agency, in conjunction with the counties and other local agencies, should develop a transition plan to realign all local health and human services and funding to the counties. The plan should shift all local health and human services currently provided by non-county entities to the counties – including services offered by regional centers, Area Agencies on Aging and others – unless the Agency determines that doing so would inhibit progress toward California's goals for children, adults and families. The counties should be given complete discretion to contract out or broker services through non-county providers, including the option to continue the existing network of services but under county direction. Pages 49 and 50 include four maps which reflect four disparate service delivery systems and the state's role as service provider.

Move with determination

- ***Start with early adopters, rollout statewide.*** The Health and Human Services Agency, in conjunction with local officials and program administrators, should initiate reforms with a small number of counties, refine those efforts and rollout reforms statewide. A system of care should be in operation in all counties within five years. The State should provide support and inducements to encourage counties to invest in reforms, shoulder additional responsibilities and accept the inherent risks and rewards.

  - ✓ **Planning support.** Reforms will require adequate planning and consultation, which should be funded by the State.

  - ✓ **Technical and programmatic assistance.** The Health and Human Services Agency should provide technical assistance, consultation, support and regulatory relief to address any and all barriers in state and federal policy that would limit opportunities to develop an integrated system of care.

- ✓ **Shared liability.** The State should take responsibility for liabilities it creates and share with counties the risks of federal liabilities associated with reforms.
- ✓ **Discretionary funding.** The State should buy-out an appropriate portion of state, federal or other funding that restricts local efforts to integrate services.

Undertake Fiscal Reform

Finding 4: The demand for public health and human services far outpaces capacity. Yet the State is not managing public dollars to spur private sector investment, target limited resources to priority needs, and ensure the use of cost effective strategies to improve outcomes.

California annually spends nearly one-third of its General Fund expenditures on health and human services. Adding in federal funds, California spends upwards of $60 billion a year on programs tied to the health and well-being of Californians that are administered through the Health and Human Services Agency.

Many spending decisions are on auto-pilot – driven by entitlements, court rulings, the state constitution, federal rules and contracts. Thus the annual budget exercise focuses on the margins: how to allocate new revenue or make necessary cuts. But policy-makers have more latitude than they recognize in deciding how much to spend and where it should be spent. And how money is allocated is just as important as how much.

Recommendation 4: Shift health and human service funding to counties. Align programmatic and fiscal authority to recognize priorities and target the cost-effective use of limited public funds.

Shift funding control to the counties

- ❑ ***Create a local trust fund for health and human services.*** The Health and Human Services Agency should systematically review all health and human service funding to identify state, federal, legal and other barriers to consolidating funding into a trust fund. The Agency should propose strategies for addressing those barriers and, to the extent possible, shift fiscal authority for those funds to the counties.
- ❑ ***Identify a baseline and growth formula for health and human service funding.*** The Health and Human Services Agency, in conjunction with local agencies, should propose a baseline and

growth formula and a distribution formula for local health and human service trust funds.

- ✓ **Stabilize funding.** The growth formula proposal should include provisions to stabilize funding across economic cycles. Options to be explored should include State pre-payment of future growth obligations during periods of economic strength in exchange for foregoing payments during periods of economic shortfall.
- ✓ **Create incentives to reduce state costs.** Funding formulas should include incentives for local agencies to reduce State costs. The Agency should develop formulas that promote prevention, encourage the adoption of proven and promising practices, motivate local agencies to develop innovative strategies to address complex needs, and result in a reduction in the number of people who move from local programs to state-operated programs.

- ❑ ***Create an innovation block grant program for health and human services.*** Ten percent of trust funds should be set aside for state control. Innovation funding should provide block grants to counties to address persistent challenges to improving outcomes.

- ❑ ***Inventory and seek federal waivers.*** The Health and Human Services Agency should report to the Legislature within 60 days on federal waivers currently available that would infuse greater flexibility into funding streams. The Agency should indicate which waivers are in place in California, which are in place in other states, and which additional waivers it intends to pursue and justify its decisions not to pursue others, if any.

- ❑ ***Strengthen the sunset review process.*** The Legislature should extend its sunset review process to review funding not included in the local health and human service trust fund. No less than once every three years, each categorical program and its funding should be reviewed and one of three options exercised: 1) Reauthorize the categorical program and funding. 2) Sunset the categorical program, but shift funding into the trust fund. 3) Sunset the categorical program and funding.

Enhance revenue authority and options

- ❑ ***Create local government revenue options to support programs.*** The Health and Human Services Agency, in conjunction with county officials, should transmit to the Governor and Legislature proposals to develop local revenue streams to support health and human services. County specific alcohol taxes, vehicle license fees and other potential revenue sources should be explored.

- ***Seek federal reimbursement for unallocated Social Security taxes.*** The Governor and Legislature should work with California's congressional delegation to secure the return of Social Security taxes paid on behalf of undocumented immigrants working in California who will not benefit from Social Security. Recovered revenue should be dedicated to reimbursing the State and local agencies for providing services to immigrants and other clients not eligible for federal support.

Unallocated Social Security Taxes

The State may have an opportunity to claim $10 billion or more paid to the federal government by Californians for benefits that the federal government is not providing. Significant research remains to be done to determine the viability of this opportunity.

The Social Security Administration reports that a small percentage of social security tax payments cannot be linked to workers because of mismatched or false Social Security numbers. Rough calculations suggested that $57.3 billion has been paid on behalf of workers who cannot be identified. Thirty-five percent of those payments came from California. And a significant percentage was paid on behalf of undocumented immigrants, who are not eligible for Social Security or Medicare. In essence, employers and workers have paid an insurance premium for a benefit that does not exist.

While employers have been paying Social Security taxes for undocumented immigrants, the State and local governments have been providing health care and other services to these workers. Had Social Security benefits been available, State and local costs could have been greatly reduced.

The Commission has urged the Governor and Legislature to advocate for increased federal support. The State could ask the federal government to return to the State those premiums that Californians have paid on behalf of undocumented immigrants who are not eligible for federal benefits but are receiving state and local services. Reimbursement would require congressional approval.

A number of arguments support California's claim:

1. States are in a better position to link unallocated taxes with services. Unallocated Social Security taxes are theoretically held in trust by the federal government. In reality, the federal government spends against those funds with no direct link between the payer and services to the payer. States also can hold funds in trust, and in the meantime use them to support retired and disabled individuals as the Social Security law intends. Counties currently provide health and human services to undocumented immigrants in line with public health and safety needs.
2. Californians are taxed twice. Employers and employees each pay half of mandated Social Security taxes. Social Security benefits allow individuals to pay for medical and other essential needs. In the absence of those benefits, the State and counties tap the General Fund to provide essential services. California employers and workers are essentially taxed twice to pay for these services.
3. California has an opportunity to recognize the dignity of undocumented immigrants. Social Security was designed to help workers prepare for retirement and address their needs should they become disabled. Millions of Californians rely on Social Security without stigma. In contrast, undocumented immigrants who are denied benefits but need public services are derided as not paying their fair share for community programs. Directly drawing upon the tax payments of undocumented immigrants to reimburse the State and local governments for health and human services would recognize the contributions of these workers to California.
4. Improve accountability for Social Security taxes. Californians pay billions in Social Security taxes with no clear accounting of where the money goes. Preliminary research suggests that the federal government has never explored the ownership of unallocated funds. The employees on whose behalf the payments were made have a clear claim on those funds, as do employers. But returning funds to employees is problematic because the Social Security Administration cannot identify them. Returning the funds to employers would create perverse incentives in the labor market. The states and federal government also have claims but in the absence of dialogue, the mounting payments go unnoticed and their ownership uncontested.

Promote Meaningful Accountability

Finding 5: Public agencies spend extraordinary resources on compliance, auditing and other "oversight" activities that do not provide meaningful accountability that leads to improved performance.

State and local agencies spend millions of dollars tracking expenditures, monitoring compliance with detailed rules and regulations and reporting their actions. Similarly, policy-makers and oversight agencies conduct sunset reviews, audits and evaluations and hold oversight hearings. These efforts are intended to ensure that departments and service providers are following the law, but they do little to determine whether people are being helped or if programs are successful.

Recommendation 5: The public, policy-makers and program administrators must have clear and easy access to reliable information on progress toward goals, the effectiveness of programs, and the agencies responsible for making improvements.

The Governor and Legislature should agree on benchmarks and measures

- ***Adopt performance indicators, outputs and efficiency measures.*** Policy-makers and the public must understand why public programs are in place and how well they are functioning. The Legislature and the Governor should adopt performance indicators, outputs and efficiency measures that chart the State's progress in meeting core goals for children, adults and families.
  - ✓ **Performance Indicators.** Used to demonstrate whether the State is making progress toward its objectives, such as the poverty rate, recidivism, infant mortality rate, etc.
  - ✓ **Output Measures.** Reflects activities performed – units produced, services provided, or people served – to achieve goals.
  - ✓ **Efficiency Measures.** Describes the costs associated with efforts to improve performance.

The Administration should focus its advisory and monitoring efforts

- ***Establish and empower a Health and Human Services Advisory Board.*** The existing advisory and oversight boards are largely ineffective. They should be replaced with an agency-wide board with the authority and resources to monitor state operations and make recommendations for reform.
  - ✓ **Membership.** The board should be composed of citizens, clients, service providers and local government representatives with the

expertise to monitor programs and outcomes, and to identify and recommend opportunities for improvement.

- ✓ **Authority.** The board should be authorized to review any and all aspects of California's health and human service system. It should report directly to the Agency Secretary. Its meetings and reports should be easily accessible by the public.
- ✓ **Funding.** Funding for the board should be reliable and adequate to meet its mandate. To solidify the relationship between the board and the departments it oversees, board funding should reflect a percentage of the budget of each department and be drawn directly from those budgets.

The Administration should strengthen its response to weak performance

- ❑ ***Bolster the State's response to weak county performance.*** The State's response to weak performance should be clear, swift and compel action.
  - ✓ **Require Improvement Plan.** County agencies that fail to make progress toward statewide goals for children, adults and families should be required to submit an improvement plan that details strategies underway to bolster performance. The Health and Human Services Agency should provide technical assistance, training and other supports to enable counties to successfully address barriers to improvement.
  - ✓ **Require reform.** Counties that continue to show weak performance should be required to implement specific reforms developed by a state-local improvement team. The team should be appointed by the Agency, include representatives of counties with superior performance and state departments, and be authorized to review any and all practices, policies and information relating to the under-performing county.
  - ✓ **State takeover.** Counties that fail to show progress within five years, after efforts to initiate improvement plans and reforms have been unsuccessful, should be subject to state takeover. The Agency should be given the authority to appoint an administrator of county health and human services with the authority to make needed changes, spend federal, state and local funds allocated to the county for health and human services and shift additional county funds, as needed, to improve outcomes. The Agency should have the authority to bill the county for the costs associated with state takeover.

The Legislature should enhance its oversight activities

- ***Establish an Inspector General for Health and Human Services.*** The Inspector General should be empowered with all the necessary authority to thoroughly investigate and monitor state and local health and human service programs. It should report directly to the Governor and its reports, except those involving criminal investigations, should be public.

The public needs clear and consistent information

- ***Create real-time Web-based reporting on goals for children, adults and families.*** The Health and Human Services Agency should develop a Web-based reporting system to chart California's progress toward its goals for children, adults and families. The reporting system should clearly identify goals, progress by county and indicate which public officials are responsible for meeting those goals and the avenues available to the public to express their concerns when programs falter.

Introduction

Over the last decade, the Little Hoover Commission has looked at hundreds of health and human service programs that work with struggling children, adults and families. It has explored how government intervenes in the lives of Californians and the outcomes achieved.

The Commission also has examined the gains made in understanding the roots and progression of illnesses, poverty, addictions and violence – and the breakthroughs of public administrators and service providers in applying that knowledge. Compelling evidence shows that preventing and responding to these maladies requires diverse strategies that draw from multiple specialties to tailor services to needs.

But despite this evidence, the Commission has consistently found that the State continues to operate disparate programs that are designed around specialty services, with little or no cross-program communication and scant support for tailored care. The result is a collection of isolated services, so rule-bound unto themselves – and incapable of operating in a systematic or strategic manner – that they are unresponsive to the lives of real Californians. These findings guided the Commission's decision to take a system-wide look at health and human services.

The Commission initiated this project in the Spring of 2003 and benefited from the time and energy of many generous individuals who also believe that strong health and human service programs are essential to California's recovery and the well-being of all Californians. These individuals participated in three public hearings and an advisory committee to guide the Commission's inquiry, identify state-of-the-art practices and reveal opportunities for reform.

In March 2003, the Commission brought together the architects of past reforms and central figures in the inner-workings of state government. They conveyed the frustration that California's government is not focused on excellence, but instead strives to avoid harm and thus settles for mediocrity. They asserted that reforms happen when leaders seize a crisis to bring about fundamental change. And leaders need a plan that links reforms with the strengths of existing institutions.

A second hearing in April 2003 brought together county leaders, service providers and others who have brought innovation to their programs and raised expectations for government. They argued that the State creates more barriers to improvement than incentives for excellence, and has failed to adopt effective practices. They cautioned the Commission to be

practical in its proposals and suggested the State should be a better advocate for local agencies, service providers and ultimately, clients.

A third hearing, convened in October 2003, brought together experts in reform, a former Speaker of the Assembly familiar with the capacities and limits of the legislative process, public administrators with intimate knowledge of state and federal executive branch agencies, and a broker of change. They said decision-makers need to understand that systems are broken and that lives and dollars are being lost. They emphasized that policy-makers need specific and practical solutions that are built around the incentives that policy-makers face and the limitations to their understanding and ability.

Throughout these discussions, these experts urged the Commission to focus on the core challenges facing California – the underlying structures where these problems originate.

This report also is informed by the numerous programmatic reviews the Commission has undertaken. The Commission revisited information sources from past studies, updated its understanding of service delivery systems and reforms. It consulted with national and state leaders across the country working to improve outcomes, as well as analysts and administrators in the trenches who are struggling to be more responsive to needs.

Finally, the Commission drew from the experiences of those who rely on these services: Families struggling to overcome mental illness. Crime victims coming to terms with their trauma. The professionals and the destitute caught in the unrelenting grip of addiction. And parolees searching for a path away from their pasts. No more informed source can convey the fatigue of fighting against a system that has gone astray than talking with these Californians and the service providers and administrators who stand by them diligently each day.

If implemented, the recommendations included in this report would fundamentally transform how California responds to health and human service needs. They would focus the enormous investment that California makes in these programs on outcomes, provide administrators and service providers with the tools they need to continuously improve, and bring hope to children, adults and families who at times are lost in a maze of public programs.

The Commission benefited greatly from the contributions of all who shared their expertise, but the findings and recommendations in this report are the Commission's own.

The Case for Change

The performance of California's health and human services is among the worst in the nation. Despite progress in some areas, and stellar performance in some communities, California ranks among the lowest performing states on many indicators. The consequences are profound: Weak performance threatens the health and quality of life of all Californians. Stifled progress undermines economic growth – because more Californians could be moved toward self-sufficiency and because tax dollars are wasted on ineffective strategies.

Many services are restricted to low-income Californians, but others are not. California's network of health and human services are designed to help keep our communities and families safe, support vulnerable individuals and promote financial independence. And the challenges facing these programs will only grow. As California's population expands – and includes more children and older adults – it also must grapple with greater poverty and increased demands on health and human services. Fundamental reforms must be pursued, because Californians deserve better, for themselves, and for their tax dollars.

What ails California's health and human services defies simple solutions. Barriers to improvement are embedded in the core of how policies are developed, programs organized, funding distributed, and services delivered. Wholesale reform is necessary.

California's performance is among the worst in the nation

Hundreds of thousands of Californians are not safe. California ranks 36th in the nation for the number of children who experience abuse and neglect and 49th for the percentage removed from their homes as a result.[1] The state is 24th in the nation for crime overall and 41st for violent crime, including homicide.[2] While the crime rate has fallen from the highs of the early 1990s, progress has stalled and strategies for further reducing recidivism, drug abuse and violence need to be re-examined.[3]

Californians struggle to remain healthy. One in six children in California does not have health insurance, ranking California 43rd in the nation for ensuring health coverage for its youngest residents.[4] The State ranks 48th on health coverage for the population overall, with six million uninsured and another six million dependent on Medi-Cal.[5] One in four young children in California is not getting recommended immunizations; 36 states out perform California in attacking childhood

Exemplary Performance

Persistence and strategic efforts have contributed to California's ability to address health and human service challenges.

- California ranks 2nd in the nation for the percentage of adolescents who avoid tobacco use.
- California ranks 3rd in the nation for the percentage of adults who avoid tobacco use.
- Life expectancy in California is greater than the national average.
- Californians experience among the lowest rates for cancer, kidney disease and suicide, each a leading cause of death in the U.S.
- California has one of the lowest rates for infant mortality and low birth weight infants.

Appendix C includes information on the State's performance over time on these health and human service challenges and others mentioned in this chapter.

diseases.[6] And California ranks 23rd in the nation in dealing with heart disease, the leading cause of premature death in the country.[7]

Many Californians are overwhelmed by mental health needs. Some 400,000 children in California will go without needed mental health treatment this year. One in seven adults in California struggles with serious mental illness. But mental health care is rationed only to those with the most severe illnesses.[8]

The state has nearly the highest rate of illicit drug use in the nation.[9] Yet California has the greatest gap between the demand for treatment and treatment resources.[10] Dealing with drug and alcohol abuse costs the State's General Fund $11 billion a year, but that money is not strategically spent to reduce crime, violence and drug abuse.[11]

Too many Californians struggle to learn. California is ranked 44th in the country for adult literacy and 42nd for high school completion rates.[12] For hundreds of thousands of California children, effective health and human services will influence whether they are ready and able to learn.

California has one of the highest unemployment rates in the nation.[13] Despite one of the strongest economies in the nation, many Californians face barriers to work. One in seven of California's workers can only find part-time work.[14] One in five remain poor despite holding a job.[15]

For the poorest Californians, affordable housing is an issue of survival. The rate of homeownership in California places the state at 48th in the nation.[16] An estimated 360,000 Californians are homeless on any given day.[17] Some 80,000 to 95,000 children are living in cardboard boxes, the family car or are shuttled from shelter to shelter because their families cannot afford minimal levels of housing.[18]

While some of these maladies are outside the direct purview of health and human service agencies, the public response to them is integral to the health, safety and well-being of struggling families who are involved in a range of government programs. In many ways, these challenges are the result of rapid population growth, changing demographics and the

geographic size and diversity of California. But, these unacceptable outcomes also are the product of how California delivers services.

California's future is tied to the quality of these services

Health and human services should move Californians from dependence to independence. They can stop illnesses from stopping life. They can support vibrant communities, by preventing institutionalization. And they can intervene when addiction, abuse and trauma smother opportunity. Health and human services safeguard California's future and quality programs are a smart investment that can hold down other public costs.

Many programs serve the general public. The primary mission of the Department of Health Services is to promote the health and well-being of all Californians. The department works to ensure that drinking water is safe, to halt the spread of communicable diseases, and to ensure that hospitals and nursing homes provide quality care. These responsibilities often are overshadowed by the responsibility of the department to provide health care through the State's Medical Assistance Program (Medi-Cal). Similarly, the Department of Mental Health is responsible for ensuring the mental health of all Californians. In that capacity, the department has statewide responsibilities beyond serving people with serious mental illnesses. It funds and coordinates the response of mental health professionals during natural disasters and other emergencies and provides services to mentally ill offenders to ensure public safety.

Other departments also have statewide responsibilities. The Office of Statewide Health Planning and Development ensures that health care facilities can withstand natural disasters and provide appropriate health care during emergencies. The office helps to attract and retain medical personnel to work in underserved communities and tracks and analyzes data to understand health needs and how they can best be addressed. And the Emergency Medical Services Authority trains and builds the capabilities of emergency medical personnel statewide.

The bulk of programs serve vulnerable Californians. But vulnerability is not restricted to low-income residents. The Department of Aging administers programs that provide nutrition services, health insurance counseling, social and supportive services, protection from elder abuse and other supports that are generally restricted by age, but not income.

The Department of Social Services licenses and monitors facilities that provide childcare, and residential care for adults and the elderly. The

department provides adoption services in some areas and oversees child protection efforts operated by counties.

The Department of Developmental Services serves Californians with qualifying diagnoses, regardless of income. Californians, regardless of income, are eligible for public programs administered by the Department of Alcohol and Drug Programs, California Children and Families Commission, and the Managed Risk Medical Insurance Board. The Department of Mental Health oversees local mental health agencies, which provide emergency and on-going care to Californians with insurance, as well as the uninsured.

These programs also help poor Californians, with the short-term goal of preventing illness, disability and death, and the long-term goal of promoting self-sufficiency.

Challenges facing the State will grow

Two trends drive demand for health and human services. The first is demographic. The bulk of health and human services are targeted primarily to three groups: low-income residents, children and the elderly. And researchers project that an increasing percentage of Californians will fall into one of these categories. Second, access to services is determined by eligibility rules. Advocates have successfully argued that more Californians should receive publicly funded services. And there is no reason to think that pressure to expand access will let up.

Demographic Trends

Over the next three years, the state's population is expected to grow by over half a million residents annually – about half due to new births, and half because of migration from other states and countries.[19] The current population of 36.4 million is expected to grow to 39.9 million by 2010 and reach 45.4 million in 2020.[20] Population growth alone will increase demand for services. But three trends suggest that demands will grow faster than overall population.

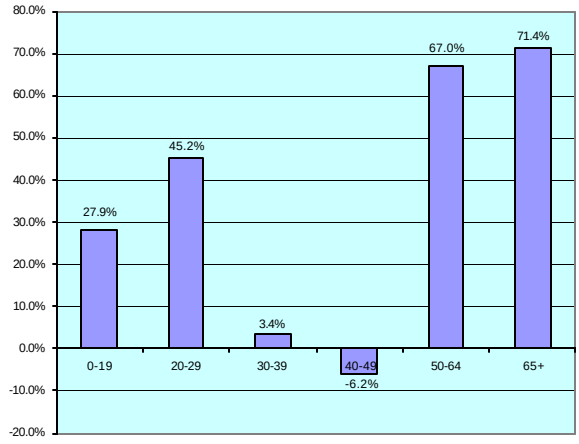
1. ***Poverty levels are expected to increase***. Poverty in California fell notably during the economic boom of the mid-1990s. But historically high poverty rates and persistently high immigration rates suggest that challenge will continue. Among ethnic groups, Hispanics represent the fastest growing segment of the state's population and have the highest rate of poverty. Hispanics make up 32 percent of California's population and are expected to reach 39 percent in 2020.[21] The poverty rate among foreign-born Hispanics is 24 percent and 13 percent for their U.S.-born counterparts.[22] Continued high

poverty rates among a growing population will further strain state and local budgets and the services they support.

2. ***California continues to have a large number of children and high rates of child poverty***. In 2000, California was home to 10.7 million children. In 2005, that number will grow to 11.5 million.[23] Research suggests slower growth rates for the youngest Californians as fertility among baby boomers tapers off. But research suggests that a higher proportion of children in some parts of California will experience greater difficulties. Some 30 percent of California's young children live in Los Angeles County, which has a relatively high child poverty rate – 28 percent. The San Joaquin Valley also has a growing population of young children and the greatest level of poverty for this group – 37 percent.[24] While the overall growth rate for children in California may go down, the State will face added pressure to respond to a growing proportion of children living in poverty.

3. ***California's population is graying***. The aging of California's baby boomers will place increased demands on services that target older adults. Programs operated by the Department of Aging target older Californians. Services to older Californians made up nearly a quarter of Medi-Cal spending in 1998 and one-third of state supplemental payments to Social Security Insurance recipients in 1999. In 2000, the leading edge of baby boomers reached 55 years old and in 2010, will turn 65. Today, adults over 65 years old are increasing in numbers faster than other age groups, and between 2000 and 2030, this age group will more than double in size. And the number of Californians age 85 and older is expected to increase by almost 400 percent in the next 40 years.[25] As baby boomers reach retirement age and beyond, the State will be faced with expanded demands for dependency care, additional health care costs and other quality of life issues.

Percentage Change in Population by Age Group, 2000-2020



Source: California Department of Finance. "County Population Projections with Age, Sex and Race/Ethnic Detail." December 1998.

Expanding Eligibility

Policy-makers are under increasing pressure to expand access to publicly funded programs and limit reductions in care and corresponding costs. Almost one in five Californians lack health insurance and the corresponding access to health care and related services.[26] In recent decades, as residents have struggled to find affordable, quality services

through private-pay health care systems, they have turned to the public sector. And policy-makers have made accommodations.

Under state law, Californians with certain developmental disabilities are entitled to life-long services to address an array of needs. And advocates have pushed back attempts to chip away at available services. Mental health advocates have long sought a parallel entitlement and have prepared an initiative that would guarantee mental health services to children.[27]

The State is under pressure to intervene earlier for more children. Under federal rules governing Medi-Cal – through the Early and Periodic Screening, Diagnosis and Treatment program – all children enrolled in Medi-Cal are supposed to receive annual check-ups and corresponding treatment, but many do not.[28] Advocates have successfully sued the State to require more care for more children.[29] And in 1998, California established Healthy Families to provide low-cost health care to children who don't qualify for the State's primary low-income health insurance program, but cannot afford other health insurance.[30]

As more and more Californians struggle to find adequate, affordable health care and related services, policy-makers – and public budgets – will face growing pressures to serve more people in more ways. California's health care, mental health, drug and alcohol treatment programs, food stamp services, affordable housing efforts, developmental services and other programs are increasingly forced to turn people away, reduce services or limit reimbursements as demands for care outpace resources. There is no evidence that advocates will give up the fight. Rather, history suggests that stakeholders will seek ways to force the State to provide additional care and expand eligibility, even during periods of limited resources.

Barriers to improvement are well documented

Dozens of reports have documented the symptoms of systemic failure, as well as the causes.[31] Barriers to improvement are embedded in how policies are developed, programs are organized, funds are distributed, and services are delivered. Additional funding, pilot projects or the consolidation of one department into another will not revitalize the State's ability to assist Californians. Wholesale reform in the following areas is required.

Strategic Efforts. Policies and programs are not working strategically and consistently toward shared goals. The result is missed opportunities to leverage cross-agency efforts, learn from past experiences and stabilize efforts.

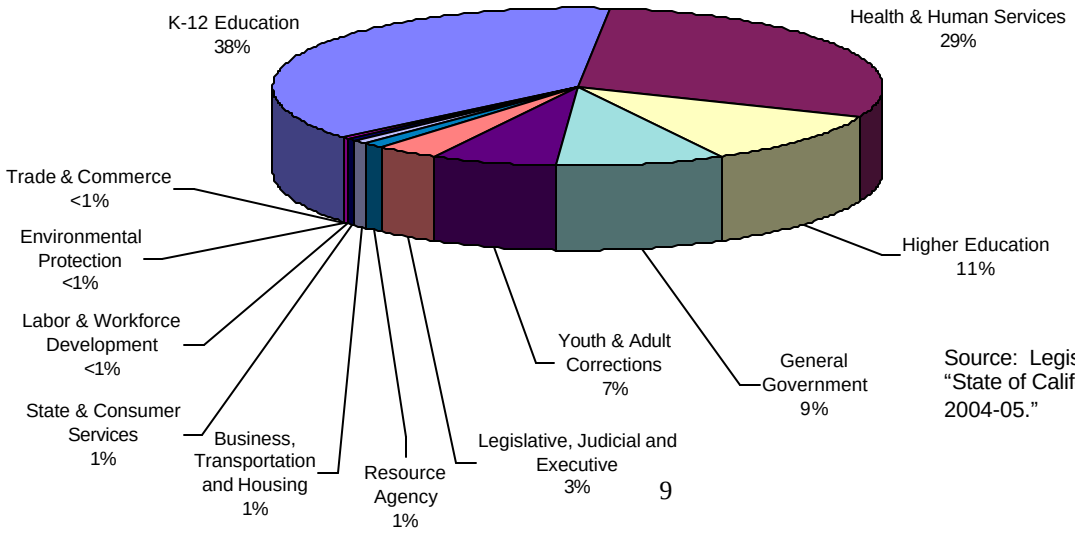
Organizing for Effectiveness. State, federal, regional and local governments are involved in providing health and human services. And each level of government distributes responsibilities across multiple departments. Coordination is hampered, efficiencies lost, and confusion reigns. As a result, it is extremely difficult to determine where changes are needed, who is responsible for failure and even what is working.

Funding with Incentive. Funding is on auto-pilot and inadequate for the job given how funds are distributed. Allocation decisions do not reflect quality, effectiveness or efficiency. Policy-makers and administrators focus their energies on making marginal changes to funding streams – based on how much money is available – with little attention on what is being purchased.

Fostering Accountability. State and local agencies are tied up by rules and regulations that require administrators to track minutes of service, dictate how many chairs can be in a room or insist that doors get shut, but pay little attention to whether people are helped. Thus administrators monitor minutes, chairs and doors, and state agencies collect paperwork showing that regulations are adhered to, but neither local nor state agencies have time left over to monitor whether people receive the support they need.

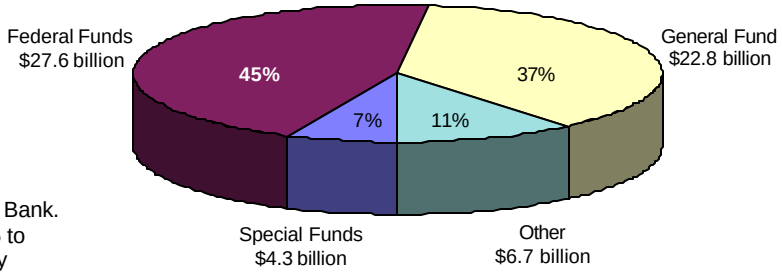
California annually dedicates some 30 percent of General Fund dollars to health and human service programs. For 2004-05, the Governor has proposed $24.6 billion in state General Fund allocations for these programs.[32] In each of the last four years, combined state and federal spending on these programs exceeded $60 billion, and peaked to $66.7 billion in 2002-03.[33] But for that level of commitment, Californians should be confident the system is working as well as it could – and getting better. But programs are not measured for performance and California does not require programs to adopt proven models.

General Fund Expenditures by Agency
Fiscal Year 2003-04



Source: Legislative Analyst's Office, Data Bank. "State of California Expenditures, 1984-85 to 2004-05."

Health & Human Services
More than $61 Billion Invested in 2003-04



Source: Legislative Analyst's Office, Data Bank. "State of California Expenditures, 1984-85 to 2004-05." HHS funds in the other category include funds from reimbursements, realignment and other sources.

Federal investigations, state audits and independent reviews charge that public agencies are failing to follow state and federal laws in how they deliver services. Public administrators have been charged with failing to meet even minimum standards for care. And federal agencies have accused California officials of failing to adopt generally accepted practices successfully used in other states to improve care and outcomes.[34] Similar concerns have been raised for years.

Over the last 10 years, the Little Hoover Commission has documented the nearly unanimous critique of current policies. While problems are understood, no substantial reforms have been implemented, often because local agencies and providers fear change even more than they are frustrated by these problems.

The calculus is different for those on the receiving end of services and those who support these services through state and federal taxes. But they carry less weight in the policy-making process. Californians expect and deserve the following problems to be solved:

Core public health functions have been neglected. California's public health system provides less protection than it should against everyday hazards, and is unprepared to adequately protect Californians against the remote but substantial threats of terrorism. Hospital-acquired infections kill an estimated 8,400 Californians a year. A robust public health system could prevent the majority of those deaths.[35]

"I had other dreams…"

At the age of seven Dellena Hoyer-Johnson entered the foster care system. The physical and sexual abuse she experienced at home led to a life of addiction to drugs and alcohol. At age 13 she ran away from her foster home and became a prostitute. At age 14 she had a son. He spent the first twelve years of his life watching her be physically abused, using drugs and in and out of jail. He later ended up in the foster care system, became a marijuana user and entered prison for domestic violence. She also had another son during one of her stays in jail.

Dellena had other dreams. But neither the foster care system nor the justice system ever addressed her childhood abuse or drug addiction.

At the age of 30 she got sober and has stayed that way. Her younger son never saw her use drugs and is a healthy 15-year-old. She is now married, working, saving for retirement and is dedicated to helping others beat addiction.

Dellena Hoyer-Johnson testified at a Little Hoover Commission public hearing on April 25, 2002.

Abused and neglected children are not protected. California annually spends over $2 billion on children who have been removed from their homes to protect them from abuse and neglect. But for many of these children, the State and counties who partner to operate the child welfare system have not been able to meet minimum standards for health care, mental health services, education and housing. One in four children in foster care do not receive timely medical care, half do not receive needed mental health services.[36] Unemployment for emancipated foster youth hovers at 50 percent and an estimated 2,800 children age-out of the system and become homeless.[37] Focused efforts in select California counties and other states have profoundly improved outcomes, and could benefit all children in the State's care.[38]

Mental illness steals more lives than it should. More than 1 million children will need mental health care this year, but less than half will receive adequate care.[39] Many are shuttled into juvenile justice programs, some locked into wire cages while they are supposed to be learning.[40] Others are easily identified by teachers, but eligibility rules, waiting lists and lack of services leave them to struggle on their own to ultimately fail in school because they alone could not extinguish their symptoms. Adults hardly fare better. California rations care to only the most severely mentally ill and directs thousands into jails and prisons rather than treatment. Advances in treatment mean that recovery is possible for nearly all who struggle with mental illness. But California has not developed a mental health system that prioritizes prevention, equips practitioners with the most effective tools and ensures quality outcomes.

Jails Have Become Treatment Centers

After several days of taking over-the-counter antihistamines, Ron was manic. His father describes him as "bouncing off the walls and slamming doors."

At one point his father called 911 because Ron was making noise, it was late and he was concerned about the neighbors and his son's safety. When the police responded Ron walked out the front door, raised his arms straight in the air and said to the police, "I will (expletive) kill you."

After spraying Ron with pepper spray and handcuffing him, the police officers called the county mental health facility to see if there was room for Ron. There was no space. They called the psychiatric hospital in the neighboring county, no space. They called a facility two counties over, no space. With no other option they charged Ron with assault and took him to jail.

The cycle of crime and violence is unbroken. Crime and violence among California's young people can be prevented. Simple intervention into the lives of troubled families – home visits by nurses for instance, mentoring and adequate educational support – can help children overcome the adversity that saps their confidence, steals their opportunity and pushes them into violence, both as victims and perpetrators. But while the State has made progress, officials have not pulled together disparate efforts into a coherent statewide strategy to support positive youth development.[41]

The scourge of drug and alcohol abuse continues. One in nine Californians suffers from an addiction to alcohol or other drugs.[42] And addiction underlies the abuse and neglect of thousands of children, a majority of domestic assaults and many other crimes.[43] Some 80 percent of felons abuse drugs or alcohol.[44] But the State has not marshaled its resources into a strategic effort that integrates prevention, treatment and law enforcement to make the best use of limited resources.[45]

Parolees fail and fill expensive prisons. Each year California releases 125,000 felons from state prisons with little or no preparation for life in their community and then returns the vast majority to a cell block out of concern that they pose a danger to the community.[46] The State spends about $1.5 billion annually on the parole system, but is not providing an equal amount of public safety.[47] Forty-eight other states do a better job transitioning parolees from prison to employment. And their tools are simple: education, job training and drug treatment. California's over-reliance on incarceration fails to safeguard communities or make the best use of public funding. [48]

The streets are still home. California has not built enough housing for its residents. As a result, 2.2 million low-income homeowners and renters are paying more for housing than they should at the expense of adequate food, clothing and medical care.[49] Homelessness is a chronic concern. The consequences extend far beyond not having an adequate roof. Children with inadequate housing struggle to learn. Adults face insurmountable barriers to finding and keeping work. California's housing shortages are not the byproduct of rapid prosperity or population growth, but the mounting consequence of failed policies.[50]

"Here is the truth…"

Father Boyle tells the story of a 12-year-old named Beto, gunned down one night – along with a 19-year-old gang-member who was the intended target:

"All kids know in this neighborhood that when you hear gunfire you run, you hide, you hide behind a dumpster. But Beto froze and took one in the side. An extremely large bullet entered one side and exited out the other. The sheer size of the bullet rendered him paralyzed.

"He went through seven hours of surgery and survived. Then in the last hour of his life I remember looking through this window and watching seven or so nurses and doctors pounding on his heart, massaging his heart, begging and pleading with his heart to cooperate. But it just couldn't do it.

"Here is the truth: He was 12-years-old and he was exactly what God had in mind when God made him.

"This is equally true, and this is the hard one: The kids in that van, kids I know, also were exactly what God had in mind when God created them, but they didn't know it. They had not been surrounded by that truth. They didn't have enough people in their lives to hold the mirror to say, 'Here is who you are and it is all good,' so those kids could inhabit that truth.

"Any community that wants to deal with this issue effectively has to do prevention, intervention and enforcement and has to do them all at the same time, with equal allocation of resources."

Source: Reverend Gregory Boyle S.J., Director, Jobs for A Future/Homeboy Industries. Little Hoover Commission Los Angeles Community Forum on Youth Violence Prevention, October 11, 2000.

Independent Investigations Document On-Going Challenges

The Commission is one voice among a chorus of concerns about the performance of public programs intended to support the health and well-being of Californians. In some instances, investigations have found programs overwhelmed by demands for services. Other investigations have documented that programs have failed to meet minimum standards for care. Several health and human service programs are operating under scrutiny of federal agencies or the courts as a result of the State failing to meet its obligations.

Metropolitan State Hospital – Children's Program. In 2003, the U.S. Department of Justice documented significant and wide-ranging problems in how the State serves children with significant mental health needs. Federal investigators identified multiple areas where the Department of Mental Health failed to protect the rights of children in its care, inflicted additional harm on them and impeded their recovery. Children were universally kept from attending community schools without justification, given the wrong medications, drugged to control their behavior and locked in the hospital long after they should have been discharged.

Metropolitan State Hospital – Adult Program. In 2004, the U.S. Department of Justice identified similar concerns in the State's adult treatment programs. Investigators found that patients were denied treatment, excessively restrained and given inadequate care. Overall, investigators found the hospital fails to adhere to guidelines established to protect patients and ensure quality care.

California Youth Authority. In 2004, investigators found deficiencies that were reported as early as 1997 but have not been addressed. In response to a class action lawsuit, the California Youth Authority (CYA) and state Attorney General commissioned independent investigations into the operations of the CYA. Investigators found instances of stellar programs. But reviewers also found deficiencies that threaten the health of children in custody and identified organizational challenges – not limited resources – as the primary cause. They found inadequate training for staff working with youth involved with gangs – leading to preventable violence and injury to children and staff. And they documented inconsistent and inadequate mental health care that undermined rehabilitation goals.

Foster Care. In 2003 the U.S. Department of Health and Human Services threatened California with $18.2 million in fines for failing to provide adequate care. Researchers at U.C. Berkeley documented disturbing realities of California's foster care system: Substantial numbers of teenage girls become pregnant while in foster care. Girls who emancipate from foster care are four times as likely to depend on welfare as their counterparts. A small but significant number of boys leaving foster care end up in state prison. And despite genuine desires to graduate from college – even with a 2-year degree - too few are able to meet their goals for higher education.

Sources: U.S. Department of Justice. Letter to Governor Schwarzenegger, February 19, 2004; U.S. Department of Justice. Letter to Governor Gray Davis. May 13, 2003; Michael Puisis, DO and Madie LaMarre, MN, CFNP. "Review of Health Care Services in the California Youth Authority." August 22, 2003; Brian Parry. "A Review of Gang Programs in the California Youth Authority." July 30, 2003; Eric W. Trupin, PhD and Raymond Patterson, MD. "Report of Findings of Mental Health and Substance Abuse Treatment Services to Youth in California Youth Authority Facilities. December 2003; Mareva Brown. Sacramento Bee. "Foster Care System Blasted." January 24, 2003; UC, Berkeley. Center for Social Services Research. "Youth Emancipating from Foster Care in California: Findings Using Linked Administrative Data." May 2002.

In summary, the system is unsustainable given the mix of demands it faces, available funding and its inability to operate effectively and efficiently. Marginal changes in the budget or incremental amendments to the statutes will not be enough to adequately fortify the public response to these intransigent social and physical ills. The public response must be equal to the original War on Poverty plus the reform of welfare.

The most pressing challenges are how these services are organized, how programs are funded, how performance is measured and how public decisions are made. Spending more on these programs has not solved these problems. And where more resources are warranted, the structural mechanisms are not in place to make sure that money is well spent.

To California's credit, leaders within these programs have long recognized the structural problems described in this report prevent these public endeavors from doing what is possible to help communities reach their goals. Pilot projects have been launched to test solutions and pockets of localized excellence have emerged.

Fundamental Reforms Essential

Finding 1: California cannot sustain its existing health and human services. An overly complex organizational structure, perverse funding incentives and weak oversight undermine efforts to better serve more Californians with limited resources.

California cannot afford to operate health and human services as presently designed. Existing programs are serving too few Californians. And demands are increasing even as policy-makers pull back on public obligations to people who are already receiving care. The bottom line for California: the system must be re-engineered if the State expects to live within its means and deliver the high quality services that Californians need to be safe, healthy and self-sufficient.

Reform is Possible

Virtually every critique of why California has not addressed structural problems attributes the failure to a lack of leadership. Some critiques go on to recognize that given the size and diversity of California, the leadership necessary to overcome the momentum of the status quo is larger than life. Some go so far as to say that no one has the capacity, that California has become ungovernable.[51]

But in the last 10 years, a large number and variety of governments, including the federal government, have taken on the same set of issues addressed in this report. Other states have reorganized their health and human service system. They have set goals, adopted performance measures, changed how budgets and policy are made, and focused on accountability and responsibility.

Other governments have focused on the internal operations of large departments or agencies to streamline operations, bolster performance and improve customer service.

Federal Reform. In 1993, President Clinton launched the National Performance Review, later known as the National Partnership for Reinventing Government (NPR). In the first six months the effort resulted in recommendations to reinvent programs and organizations. That same year, Congress enacted the Government Performance and Results Act (GPRA) to bring greater emphasis on planning and accountability in federal offices. Through GPRA and NPR, federal agencies are using customer satisfaction surveys, they have consolidated outdated organizational structures, improved collaboration, and developed outcome-oriented performance goals and measures. Federal agencies

continue to struggle with performance, but performance is part of the bureaucratic vernacular like never before.[52]

Maryland. Like many other states, in the mid-1990s Maryland began to experiment with tools for outcome-oriented government. During budget hearings, legislators were beginning to ask state departments what results they had produced with prior year funding. Frustrated that administrators were unable to respond, policy-makers indicated their expectations for the state to move toward measurable goals. In 1999, the Maryland General Assembly created a Joint Committee on Children, Youth and Families to think more strategically about how best to use state resources to meet goals. In 2001, both houses of the Legislature convened a budget hearing on results. Progress continues. Budget documents include goals and measures of success. Legislative analyses look beyond categorical funding to inform policy-makers how disparate funding streams are used to support common goals, such as school readiness. And policy and budget deliberations are coordinated.[53]

Missouri. In 1993, the Governor established the Missouri Commission on Management and Productivity (COMAP) to improve efficiency and productivity in state government operations. COMAP led efforts across state agencies to implement and use strategic planning, performance-based budgeting, performance measures and a focus on results to improve services to residents. Key to Missouri's efforts is the sustained attention of the Governor, training for state staff and improved collaboration across state agencies.[54] While the administration has continued to use results-based management tools, the State's General Assembly has been more reluctant. But in 2003, the General Assembly passed legislation requiring the use of performance measures in its budget documents and deliberations.[55]

Oregon, Texas, Washington, Minnesota, Arizona and other states also are making progress with results-based governance.

California has made several forays into results-based government, with mixed results. In the 1970s, California experimented with zero-based budgeting, which was not embraced by budget writers or budget committees.[56] In the mid-1990s, Governor Wilson required each state department to develop a strategic plan and link budget requests to approved plans.[57] Four state departments experimented with performance based budgeting, but neither the administration nor the Legislature tied budget and policy decisions to strategic plans or performance information.

California Performance Review

The Governor's performance review offers promise. It is the right first step. But substantive reform will require recognition of the complex roles of the Legislature, counties and other local agencies, Congress and federal agencies, unions and professional guilds, and the public, - in addition to the administration – in influencing the quality of services and outcomes.

The goal of the California Performance Review is to restructure, reorganize and reform state government to make it more responsive to the needs of its citizens and business community. The Review has four components:

1. **Reorganization of the executive branch.** The review intends to consolidate common functions and responsibilities into single departments, group departments with analogous responsibilities, eliminate or restructure boards and commissions, reduce the total number of departments and modify control processes to facilitate innovation and improvement.
2. **Program performance assessment and budgeting.** The review intends to modify business operations – including budgeting – to eliminate duplication and waste, improve responsiveness and transparency and make government more efficient.
3. **Improved services and productivity.** The review intends to identify opportunities for strategic automation and consolidation of cross-departmental processes to reduce the cost of government and improve service to the public.
4. **Acquision reform.** The review intends to overhaul California's procurement processes to streamline operations, improve transparency, reduce bureaucracy and increase performance.

Lessons Learned

The critiques of these stories – successful and otherwise – list common ingredients, and leadership almost always tops the list. The lessons learned:

1. ***Reforms will require persistent leadership.*** While executive leadership is essential, in most instances the support of legislative leaders, key public administrators and civic allies also is necessary to overcome the inertia of the status quo.

2. ***Reforms will require a clear and compelling mission.*** A well-articulated mission must inform state and local efforts and have a clear nexus with high-level decision-making and the day-to-day activities of administrators, employees, contractors, the public and others.

3. ***Reforms will require changing how business is done.*** Change will require sustained support for new ways of operating that penetrate throughout all aspects of the health and human service system.

4. ***Reforms will require new partnerships.*** Partnerships and networks that leverage opportunities to do better must replace adversarial relations and disparate efforts.

The necessary reforms to California's health and human services are of an unprecedented scale. They must focus on state operations, which are rife with duplication, conflict, and competition that prevents the State from offering real support to communities hoping to improve outcomes. They must rethink funding rules that stifle innovation, ignore opportunities for prevention, and increase long-term costs. Reforms will require state leaders to sit down with local officials – to bring order and rationality to state-local relations – and with federal officials to gain their participation in reforms. Finally, they must examine their own budget process and the rules governing policy-making – and align their decisions with goals for children, adults and families.

The greatest lesson from other states is that reform is possible, even in California, with sufficient political capital, and with cooperation among levels of government, between the administration and Legislature, as well as state and local public servants.

Because the challenges run so deep, and changes need to be made in so many places, at so many levels, reforms must be meticulously

A Case of Fundamental Reform: Welfare

The lessons of welfare reform continue to be debated. For some, reforms have left too many vulnerable families without the support they need. For others, reform has moved more families from dependency to independence than otherwise would have been possible. While disagreement on the value of particular components of welfare reform continues, there are lessons that are valuable to human service reforms in California. The primary lesson of welfare reform is that change is possible. Reforms are possible even in those areas of policy thought to be cast in stone.

By the mid-1990s, there was a broad consensus that "welfare" – the government's most visible assistance to families struggling in poverty – had four fundamental flaws:

- Federal rules did not provide sufficient flexibility to the states.
- Policies in place did not encourage work and self-sufficiency.
- Eligibility requirements had the unintended consequence of encouraging family breakdown.
- Welfare did little to address poverty, particularly for children.

In 1996, the federal government reformed welfare, and in turn so did the states. Reforms sought to provide greater flexibility to the States. They were intended to clarify federal and state roles in maintaining a safety net, and address poverty by moving people into employment.

Shared recognition of problems, coupled with pressure to enact reforms under a specific timeframe, pushed policy-makers and advocates to change what otherwise was thought of as an immovable institution of government. Advocates continue to debate the impact of welfare reform, but reforms clarified goals, solidified federal, state and local partnerships in serving vulnerable families, and put in place performance measures to monitor outcomes and create incentives for improvement.

Source Isabel V. Sawhill. 1995. "Welfare Reform: An Analysis of the Issues." Washington, D.C.: Urban Institute.

orchestrated. Simple organizational changes will be inadequate. The State needs a new way of doing business that focuses every decision, each dollar, and all efforts on improving outcomes for children, adults and families.

Reform Must be a Priority

To succeed, reform must be a priority that is endorsed by the Governor, Legislature, senior and mid-level managers and line staff. Reforms must be built around clear and shared goals. Budget, policy and oversight discussions need to reflect commitment to those goals. But the State alone cannot reform health and human services. State leaders must receive the endorsement and support of federal and local partners.

Begin with Health and Human Services

Public assistance to struggling families comes in so many ways that it is hard to know where to begin.

Ultimately, reform of health and human service programs should not be confined to the Health and Human Services Agency. The State operates or administers scores of related programs – targeted to vulnerable Californians – that are housed in other agencies. Education, workforce development, juvenile and criminal justice, professional licensing, housing and the regulation of health plans are all components of the State's efforts to support vulnerable families, yet are outside the jurisdiction of the Health and Human Services Agency.

This agency is the right place to start, but the need for reform extends beyond its boundaries.

1. Persistent Leadership

The lessons of reform highlight the significance of leadership. The Governor and Legislative leaders must support change for reforms to take hold. But reforms also must be managed by a capable leader with responsibility for orchestrating change, bringing along stakeholders and addressing day-to-day challenges. The Agency Secretary is the right champion for health and human service reforms. In Recommendation 2, the Commission urges the Governor and Legislature to rethink and bolster the work of the Health and Human Services Agency to promote consistency, collaboration and stability across health and human service programs. State leaders also should entrust the Secretary with making reforms a reality.

2. A Clear and Compelling Mission

An increasing number of states and local agencies are establishing goal statements for public programs and communities, often starting with goals for children. And policy-makers are beginning to use those statements to guide budgeting, policy-making and oversight. California has a history of developing master plans, articulating mission statements and encouraging strategic planning. But the State has not taken the important step of translating a goal statement into a policy-making and budgeting tool.

3. Change How Business is Done

To change how public agencies operate, policy-makers also must change how they do business. The public sector is in a constant state of flux as funding and policy-making decisions reflect shifting priorities, new economic realities and improved understanding of challenges. On-going policy and fiscal decisions can reinforce efforts to meet goals and they can distract from those efforts. Current policy and budgeting practices are not consistently organized to make progress toward specific goals.

Establish Clear Goals and Move Forward

Several efforts are underway to establish clear goals, develop performance measures and use indicators to focus community efforts and improve the health, safety, and well-being of Californians.

The California Center for Regional Leadership. Working with a number of partners, the center has documented the development of indicators by 14 regional collaboratives. (The report is available at www.calregions.org) The indicators are being used to:

- ✓ track community conditions
- ✓ measure progress toward shared goals
- ✓ and mobilize action to improve community outcomes.

The center also is exploring how to develop indicators of statewide importance based on the regional preferences.

Similarly, several counties have developed their own goal statements, report cards and indicators to identify problems and opportunities, drive decisions within agencies, or guide policy-makers.

Los Angeles County Children's Scorecard. The Los Angeles County Children's Planning Council has developed the Children's Scorecard. The document is intended to measure outcomes in five areas of concern: "Good Health; Social and Emotional Well-being; Safety and Survival; Economic Well-being; and, Education and Workforce Readiness." The scorecard provides data for eight service areas within the county.

The project is evolving in importance, from one that documents the status for the nearly 10 million residents (2.6 million children) to one that drives community action and public decision-making within the service areas and by county officials. The Scorecard contributed to creation by the county of a "children's budget," which captures and translates information from the traditional county budget into a format that allows decision-makers and the public to understand how resources are allocated to address specific needs tied to outcome indicators.

Placer County SMART Team. Placer County has established a goal statement for children and families and used it to identify specific problems that undermine progress, and then to work across systems to find the resources to solve those problems.

> *All Placer County families would be self-sufficient in keeping their children safe, healthy, at home, in school and out of trouble.*

Shasta County. In Shasta County, officials established a vision statement for children and youth: Children and youth should be safe, healthy, in school, out of trouble, have real permanency, and a chance to be productive citizens. Using this statement, administrators have developed a team approach to delivering services.

Piecemeal policy approaches. The policy-making process favors piecemeal policy solutions. Committees are organized around specialty issues. Bills face tests of germaneness. The media, stakeholders and clients clamor for quick fixes, even for poorly understood problems, which require complex solutions. Decisions on managed care, realignment, special education funding and other complex challenges are pushed up against unrealistic deadlines, with inadequate public and policy discussion until compromises are forced. The fast-paced legislative calendar motivates policy-makers and lobbyists to push for small fixes, that produce little controversy, cost nothing and quite often, do little to resolve underlying problems.

One strategy, proven to be of short-term effectiveness, is to create "boutique" programs in response to structural problems. The State requires counties to work with multiple state offices as a condition of receiving state and federal funding. In recognition of the barriers that the State creates, the law allows counties to seek waivers to state rules or propose alternative strategies to streamline operations. The Youth Pilot Project, Wraparound and similar legislation tells counties to figure out how to better work with the state bureaucracy and then ask for temporary relief from cumbersome requirements, but does nothing to address the organizational barriers or cumbersome requirements within that bureaucracy.

Incremental budgeting. The annual baseline budget process encourages policy-makers to tinker around the edge of program funding, with little time or energy dedicated to understanding how money is spent or what is purchased. To control costs, eligibility rules are ratcheted up and down. Access is limited to children under the age of 4, rather than 6, 8 or 10-years of age.[58] Budget controls penalize departments that pay too much and assume that single year savings translate into perpetual savings. Thus departments face tremendous incentives to ask for all they can get, spend it all and avoid any savings. The pressure to capture new funding forces departments to compete for new money, shift liability onto others and deny that problems exist. New administrators quickly learn that there is little room for trust among departments and even among divisions within a single department.

Just as other states have made progress, California must orient budgeting and policy-making around a core set of shared goals.

Focused monitoring and oversight. The bulk of organizational and fiscal reforms happen within the administration. But policy-makers determine whether they take hold and are sustained. Analyses of past reform efforts suggest that both the executive and legislative branches must persistently champion reforms if they are to be successful. Either

branch can initiate reform efforts, but the branches must work in tandem toward shared goals.

But policy-makers need clear and consistent information on whether reforms make a difference. They need performance information that can tell them what's working, what is not and where change is needed. And they need information on how funding and budget changes impact outcomes. Whether the Legislature has more or less money to spend, it needs reliable information on what services cost, what they produced, options for allocating more money or reducing expenditures, and what funding decisions will mean in terms of priorities for California.

4. New Partnerships Required

But the State acting alone will not be successful. Federal, county and other partners play key roles in providing health and human service to Californians. And federal and local policies and practices influence outcomes, as much if not more than state operations. Federal funding comes through multiple and disparate silos. Like their state counterparts, county departments operate in isolation and often work at cross-purposes. Reforms on the scale needed in California will require the State to lead a state-local-federal partnership in reform.

Recommendation 1: The Governor and Legislature should champion health and human service reforms that involve local and federal officials, civic leaders and the public. Reforms should restructure state operations, realign state-local roles and responsibilities, streamline funding and enhance accountability.

California's elected leaders must make reform a priority

- ***The Governor, in consultation with other California leaders, should declare clear goals for Californians.*** California's goals – such as all Californians should be self-sufficient, safe, healthy, and emotionally well, in adequate housing, ready to learn and work – should drive fundamental reform, as well as ongoing policy-making, budgeting and oversight.

- ***The Governor should target state resources to address statewide goals.*** Public resources should be dedicated to providing efficient, effective, accountable health and human services. Specifically:

  - ✓ **Organizational reform.** The Governor should reorganize state entities in the Health and Human Services Agency to better position the State to improve outcomes, as outlined in Recommendation 2.

- ✓ **State-local realignment.** The Governor and Legislature, working with county officials and other local leaders should consolidate services into a responsive, seamless system-of-care under county authority, as discussed in Recommendation 3.
- ✓ **Fiscal reform.** The Governor should advance proposals for fiscal reform that will increase flexibility, stability and incentives for excellence in public funding, as outlined in Recommendation 4.

- ❑ ***The Legislature should adopt into statute and the budget clear goals for Californians.*** Goals should guide legislative action, particularly policy-making, budgeting and oversight. Policy and budget analyses performed by the Legislative Analyst, the Department of Finance, and the policy and fiscal committees of the Legislature, in particular, should reflect those goals. Specifically:
  - ✓ **Improve policy analysis.** The policy-making process should be based on rigorous analysis of whether proposals will move California toward the State's goals. Analyses should clearly identify the objectives of proposed policy changes, who is responsible for meeting those objectives, and how progress will be monitored by the administration and the Legislature. Particular attention should be dedicated to the following issues:
    - ➢ **Recognize proven and promising practices.** Analyses should document whether proposals reflect proven and promising practices and indicate what evidence has been cited.
    - ➢ **Encourage seamless services and tailored care.** Analyses should document whether proposals will enhance or restrict efforts to collaborate, coordinate or integrate services for purposes of tailoring services to the needs of individual Californians.
  - ✓ **Bolster fiscal analyses and deliberation.** Budget and funding decisions should be based on rigorous analyses that recognize priorities, facilitate reallocation decisions and ensure that fiscal policies promote stability, flexibility and improvement.
  - ✓ **Monitor progress.** The Legislature should bolster its ability – as well as the ability of the public – to monitor progress. Policy-makers should continuously track efforts, monitor progress, and make decisions based on goals for children, adults and families.

Seek federal and local support

- ❑ ***Seek federal authority to further reforms.*** The Governor and Legislature should enlist California's congressional delegation to become a persistent, unified advocate for federal reforms needed to

achieve California's goals for children, adults and families. Congressional approval is needed to shift state and local roles and responsibilities, to infuse greater flexibility into federal dollars and link funding with outcomes.

- ***Locally elected officials should become full partners in reforms.*** The Governor and Legislature should tap locally elected officials to guide reforms in State operations, and align local operations with statewide goals for children, adults and families.

Public agencies must develop a cohesive network of services to achieve goals for children, adults and families

- ***The Health and Human Services Agency secretary and department directors should implement reforms.*** Senior public administrators should assist in the development and implementation of organizational, fiscal and operational reforms. Recommendations 2, 3, 4 and 5 outline the role of administrators in reforms.

Establish a Reform Team

California's health and human services require reforms of an unprecedented scale. Success will require a strong commitment from the Governor and Legislature, a vision for excellence and a detailed understanding of current operations. The reform process must build upon the strengths of public employees and institutions and minimize the personal and organizational risks associated with change.

To make reforms reality, the Governor and Legislature should establish a leadership team. Reforms should be led by the Governor, with detailed involvement of legislative leaders, guided by experienced public administrators and clients, and implemented in conjunction with community partners.

- ***Local agencies should become partners in reforms.*** Local agencies must ensure that statewide reforms support the needs and realities of health and human service clients.

- ***Federal agencies should facilitate reforms in federal policies and practices.*** Federal cooperation is essential to reforming California's health and human service networks. Federal agencies must be full partners in efforts to improve efficiency, effectiveness and accountability.

The public and civic leaders should monitor outcomes, expenditures

- ***Public oversight is key to improvement.*** Public officials and senior administrators should consult with the public and civic leaders on California's goals, the progress of reforms and outcomes.

Reform that Leads to Results for Clients

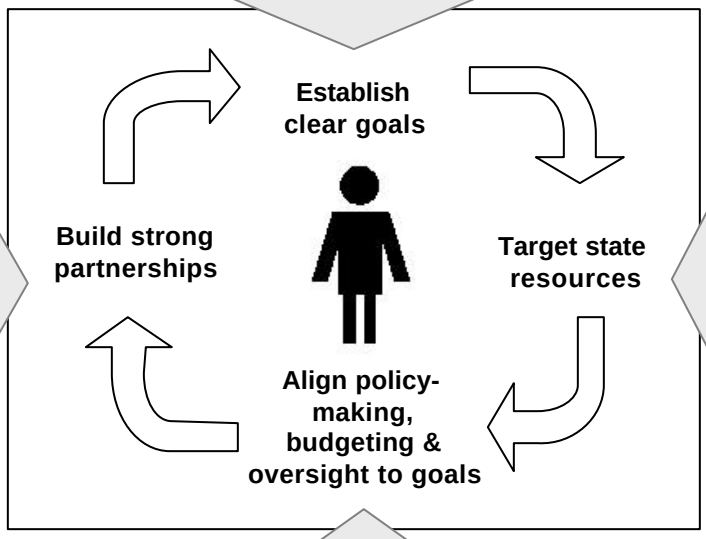
Leadership

The Commission's recommendations call for the Governor and Legislature to initiate and support reforms in many ways and many venues. Every decision will move California closer to efficient services or farther away. The Governor, the Legislature and local elected officials must set clear goals to guide reforms, such as:

All Californians should be self-sufficient, safe, healthy, and emotionally well, in adequate housing, ready to learn and work.

Partnerships

Reform partners should include the Federal Government, the Governor, the Legislature, public agencies (State & local agencies), locally elected officials, and public and civic leaders.



Re-engineering

The State should re-engineer its operations toward stated goals:

- State structure that improves outcomes
- Seamless system-of-care at the local level
- Flexible, stable funding with incentives for excellence

Policy-Making

The Governor and legislators should use every tool to pursue goals:

- Systematically review what's working, what's not and where change is needed
- Rigorously analyze whether proposals support goals
- Monitor progress

Focus State Operations on Outcomes

Finding 2: State operations are not designed and equipped to improve efficiency, effectiveness and accountability.

The Budget Act divides the resources of the Health and Human Services Agency and the 18 entities under its authority into two general categories: 1) state operations, and 2) funding that goes to local agencies to provide services, which is commonly referred to as local assistance.[59] State operations encompass a variety of activities including policy development, fiscal administration, oversight, and technical assistance.

As displayed in the chart below, far more resources go to communities each year than for state operations. To improve outcomes, the State must reorganize state functions to streamline operations, enhance the capacity of state departments to support improvements in local operations and improve internal efficiencies.

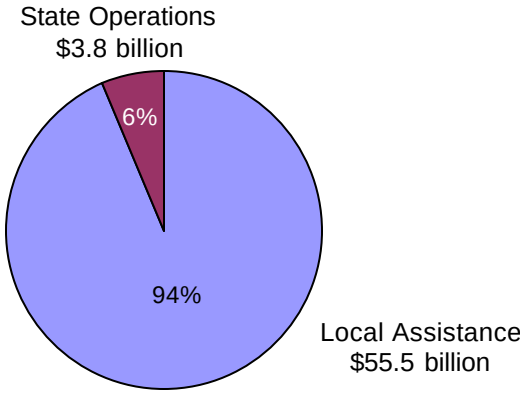
Organizational Structure is Flawed

The organization of California's health and human service departments is largely the product of piecemeal evolution. As new programs have been authorized, they have been housed in various departments, often based on compromises, without the periodic reorganization necessary to make the multitude of programs work in concert. As a result, the missions of these departments are incongruent, some responsibilities overlap and there are unintended gaps in authority and responsibility.

Some departments serve people with particular diagnoses – such as mental health or developmental needs. The Department of Health Services is responsible for an overwhelming set of programs, from health care for the poor and elderly and nursing home regulation, to bioterrorism. And at least one – the Department of Aging – serves a particular demographic. Another – the Department of Rehabilitation – is organized around a particular service.

The chart on the following pages briefly describes the 13 departments within the Health and Human Services Agency.

Health & Human Services Expenditures
State Operations & Local Assistance

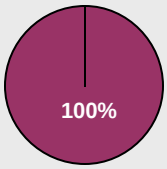


Source: Governor's Budget 2004-05, figures are for 2003-04.

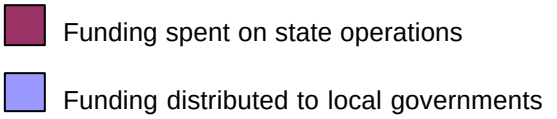
Health & Human Services Agency

The Health and Human Services Agency oversees 13 departments that promote the health and well-being of Californians. Five additional entities fall under the Agency for the purposes of organization and budgeting.

Total Staff: 25



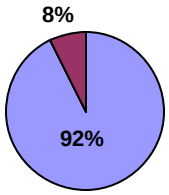
Total: $5,843,000



Department of Aging

Primary Activities: Administers funds to local governments allocated under the federal Older Americans Act, the State's Older Californians Act, and through the Medi-Cal program. Contracts with Area Agencies on Aging to provide services.

Total Staff: 125

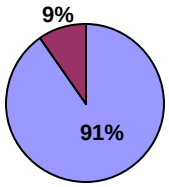


Total: $185,311,000

Department of Child Support Services

Primary Activities: Created in 2000, the department administers funding to the 52 local child support offices that locate absent parents; establish paternity; obtain, enforce, and modify child support orders; and collect and distribute payments.

Total Staff: 282

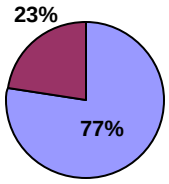


Total: $1,245,902,000

Department of Developmental Services

Primary Activities: Administers programs for persons with developmental disabilities through a network of 21 regional centers.

Total Staff: 8,876



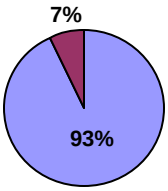
Total: $3,298,784,000

Direct Service: The department operates five developmental centers and two community facilities. Over 96 percent of department employees work in the centers.

Department of Alcohol & Drug Programs

Primary Activities: Administers State and federal statutes for alcohol and drug treatment programs and administers funds to counties for these programs.

Total Staff: 297

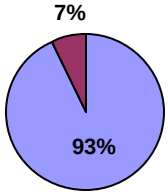


Total: $597,779,000

Department of Community Services & Development

Primary Activities: Administers an array of programs through 200 community agencies including programs to assist low-income residents reduce energy use and address other needs.

Total Staff: 107

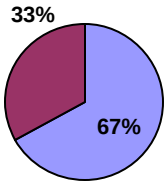


Total: $160,584,000

Emergency Medical Services Authority

Primary Activities: Coordinates emergency medical services and disaster response, develops guidelines, and regulates the education, training, and work certification of EMS personnel.

Total Staff: 42

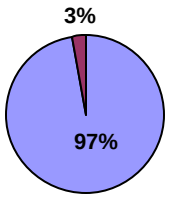


Total: $21,101,000

Source: Governor's Budget 2004-05, figures are for 2003-04. The overall budget for health and human services amounted to more than $61 billion in 2003-04. Other entities not shown here that fall under the Agency include the Commission on Aging, the California Children and Families Commission, the California Medical Assistance Commission, the State Council on Developmental Disabilities, and the State Independent Living Council.

Department of Health Services

Primary Activities: Administers the Medi-Cal program, which represents 91 percent of its overall budget and 37 percent of all employees. Licenses and certifies health facilities and health care workers. Operates laboratories and administers public health programs.

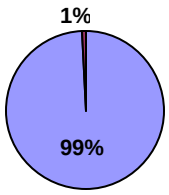


Total: $32,537,518,000

Total Staff: 5,386

Managed Risk Medical Insurance Board

Primary Activities: The Board administers three programs that provide health coverage through private health plans to certain groups having no health insurance.

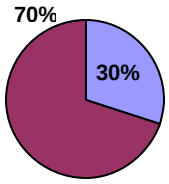


Total: $1,121,086,000

Total Staff: 59

Department of Rehabilitation

Primary Activities: The department assists people with disabilities in obtaining and retaining employment and maximizing their ability to live independently in their communities.



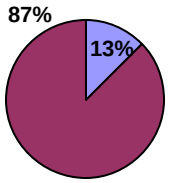
Total: $473,989,000

Total Staff: 1,910

Direct Service: Vocational rehabilitation services are provided through 100 field offices with approximately 86 percent of employees dedicated to these services.

Office of Statewide Health Planning & Development

Primary Activities: The Office regulates the design and construction of health facilities to ensure they are safe and available to provide care in the event of a major disaster. Also collects information on the costs, capacity, and utilization of health facilities as well as the services provided and patients served by these facilities.

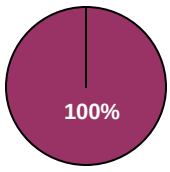


Total: $56,952,000

Total Staff: 351

Health & Human Services Agency Data Center

Primary Activities: The Data Center is one of three consolidated data centers in state government intended to ensure effective, efficient, and economical use of data to support state and local operations.

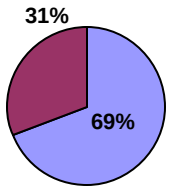


Total: $313,674,000

Total Staff: 457

Department of Mental Health

Primary Activities: The department sets overall policy for the delivery of mental health services statewide, contracts with county mental health departments to provide services and monitors compliance with state and federal statutes.



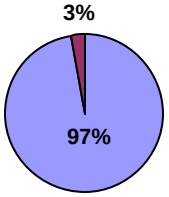
Total: $2,376,836,000

Total Staff: 8,294

Direct Service: The department operates the State's Long-Term Care program through Atascadero, Metropolitan, Napa and Patton State Hospitals. Over 97 percent of department employees are involved with hospital operations.

Department of Social Services

Primary Activities: The department administers funding to local governments to provide payments and services for welfare recipients, the elderly, blind, disabled, and other adults and children. It also regulates group homes, foster homes, childcare, and residential care facilities.



Total: $16,829,953,000

Total Staff: 3,865

Agency-wide Totals

Staff:
30,076

Funding:
$59,225,312,000

The current organizational structure undermines quality and efficiency in three key ways:

1. ***Agency cannot fulfill its intended role.*** The size, complexity and political weight of individual departments undermine efforts by the Agency to streamline operations, reduce competition and promote collaboration. The Agency simply cannot compete with the departments and so the value of the agency structure is not realized.

2. ***Overlapping responsibilities, incongruent missions, operational silos hinder the State's capacity to ensure best use of local assistance funding.*** Competition, conflict and confusion among state departments inhibit efforts to develop a unified approach to supporting local programs. And local agencies are required to work through disparate rules and regulations emanating from multiple departments. For innovative and assertive local agencies, costs increase as reforms are delayed and administrative costs escalate. For others, improvements are thwarted by state bureaucratic barriers – or not initiated at all – because they are not required.

3. ***State departments perform duplicate functions.*** Duplication results in increased costs from lost economies of scale and added complexity in working across programs. Improvements are delayed because of confusion over who is responsible for programs, outcomes and change. And opportunities are missed because departments compete rather than collaborate.

Resolving these structural challenges is essential to achieving two important goals: First and foremost, refocusing state operations to aid counties in the development of strong systems of care. State operations that facilitate strong systems of care will ensure the best use of the State's significant investment in local assistance. Second, improving internal operations. Streamlining state programs will reduce costs, improve effectiveness and allow administrators to focus on achieving overall health and human service goals.

Agency Structure has not Captured Benefits

By the early 1960s the size of California government had grown and the complexity of functions made executive-level management difficult. There was poor communication between the Governor and departments, as well as among the departments. There was no effective means for the formulation and execution of unified and coordinated policies. And there

was insufficient high-level attention to program planning and evaluation.[60] Governor Edmund G. Brown created the agency structure to address those challenges by grouping related functions and creating a cabinet-level secretary to coordinate related efforts.

But four decades later, many of the same problems remain.

Leadership has been missing. One challenge of having multiple entities involved in providing services to a shared population is lack of clarity on who is in charge. In the case of foster care, no public agency has the responsibility or adequate authority to ensure that children in foster care have their educational and health needs met.[61] Numerous reports underscore the impact that shortages of health care workers have on community programs, but no one has stepped forward to ensure that workforce and training funds are prioritized to meet this need.[62]

Programs are not coordinated. Overlapping responsibilities create challenges to coordination. More than a dozen state entities administer more than 50 youth crime prevention programs.[63] Sixteen state entities provide direct services or fund programs that serve victims of crime.[64] Multiple programs have different application requirements, definitions of the problem and the solution, conflicting timelines and oversight strategies, even though these programs target funding to the same local agencies which apply to many different programs for assistance.

Fragmentation to Frustration

California has no single door to access services. Disparate programs require families to open many doors to find what they need. Costs go up as efforts are repeated. Frustration goes up as services are delayed. Outcomes are delayed as systems stutter. And not all Californian's receive equal treatment.

Six-year-old Lucy is a beautiful child struggling with a life-long challenge. At 10-months of age she was diagnosed with cerebral palsy. To help her access services, the local school district sent a staff member to her home for an early intervention assessment. She qualified for a preschool program. The regional center in her community sent over its own social worker for a separate assessment. Because of her diagnosis, the regional center would pay for physical and occupational therapy. Her family was directed to set an appointment with the regional center to meet her treatment team. In that meeting the team indicated that the center would pay for respite care and swim therapy. Her family was instructed to seek an assessment from the United Cerebral Palsy Association, which would provide the swim therapy. Despite a middle class income, the treatment team determined that Lucy would likely qualify for some Medi-Cal services, and the family underwent a Medi-Cal eligibility assessment.

Lucy's mother works in healthcare and she was able to successfully navigate all the doors. Lucy receives quality care. But less persistent families, those who don't speak English, lack the resources to take time from work to follow-up with phone calls, arrange for home visits and advocate for their children, are routinely turned away. They are shut out of all doors, or find only some are open and thus are unable to ensure their children receive the care they need.

Efforts are not strategic. The enormity of state government and diffuse responsibilities challenge efforts to strategically marshal public resources. For example, California fails to coordinate its prevention, treatment and enforcement efforts that have been shown to be the most effective strategy to reduce the consequences of addiction.[65] Multiple reports have documented the benefits of unifying efforts to serve children, but the State still does not leverage multiple programs into an effective strategy.[66]

Outcomes are not monitored. The public and policy-makers have limited information on the impact of public programs. In seven separate reports on health and human service programs, the Commission has documented gaps in gathering data, research and analyses to track outcomes. Information is not used to monitor outcomes, improve operations and identify opportunities to shift investments from struggling programs to those showing results.

The Agency is particularly challenged to ensure uniformity of policy development, budgeting consistent with policy goals and unity of effort among departments. With most of the resources for these functions allocated to departments, the Agency's ability to perform its role is undermined. One former political appointee commented that the money and power, and thus the "action," are in the departments – not the Agency.

Policy development. The Health and Human Services Agency was created, in part, to coordinate policy across the departments. But coordination is difficult as each department has its own policy unit and the Agency's resources are limited. The Governor's office and Legislature routinely turn directly to departments for policy guidance, with little input from the Agency. Senior administrators privately report that animosity, distrust and competition discourage departments from collaborating on cross-cutting issues. And departments compete to build strong relations with the Department of Finance and the Governor's personal staff – further undermining the role of the Agency.

The Agency has 25 authorized positions, plus additional staff borrowed from other departments.[67] In contrast, budget documents for nine departments within the Agency indicate 48 positions dedicated to legislation and policy development alone, with $3.6 million in salary and benefits allocated for these positions. Departments report that additional staff also work on policy issues.[68]

Budgeting. Each department has primary responsibility for budgeting in its programmatic area – for state operations and local assistance. Budget proposals are evaluated by the Agency and Department of

Finance. But staffing limitations within the Agency and the Department of Finance limit their capacity to ensure strategic budgeting across departments. Budget divisions in the HHS departments are supported by 117 staff, with personnel expenses exceeding $8 million, not including executive positions. In contrast, the Department of Finance has 25 positions working on those same budgets.[69]

The Role of the State

In many respects, the State and counties operate parallel systems. Both jurisdictions administer funding, manage contracts, and provide direct services. Some tasks, however, only the State can manage.

Ensuring quality care. One disadvantage of a county-based service delivery system is the challenge of ensuring consistent care statewide. As Californians move across county lines, they face new obstacles in establishing access to care, and ensuring consistent and uninterrupted services. In the Commission's work on mental health, clients complained that dramatic differences in service availability and quality created inequities across the state. And they asserted that the only way to improve the quality of care they receive is to move to a county with a better service record. Only the State has the resources and perspective to ensure quality care statewide.

Addressing human resource shortages. California faces dramatic shortages of health and human service workers with particular skills. Nurses, child psychiatrists, case managers and licensed social workers are in demand in many areas of the state. Professionals with bilingual and bi-cultural skills are in particular demand and the shortage of these professionals will grow as California's population becomes more linguistically and culturally diverse.

The ability of the State and counties to ensure that children, adults and families receive adequate care is dependent on finding sufficient qualified personnel. Counties cannot open more training slots, graduate and license more professionals. Only the State can meet this need with its multi-billion dollar investment in education and workforce development.

Capacity building. Statewide, counties face dramatic limits to their ability to meet service needs. Alcohol and drug treatment programs, mental health programs, child welfare systems and other community programs are under increasing pressure to expand. In the case of mental health care, people are turned away until they are a danger to themselves or others because mental health funding cannot keep pace with needs. In the case of foster care, counties place children in harms way because they face staffing shortages and are unable to recruit sufficient foster families with the skills and resources to meet the needs of increasingly troubled children.

Counties focused on stretching their resources, ensuring the safety and well-being of clients and staff are unable to explore alternative approaches or invest in training that could extend capacity. Aggressive counties report that innovation and capacity building take a backseat to coping with daily workload. They liken these challenges to rebuilding an airplane in mid-flight. Only the State has the resources to focus on capacity building to make better use of limited resources and ensure the adequacy of care.

Best practices. Standards of practice continuously evolve. Systems of care, wraparound services, therapeutic behavioral services, family interventions and other approaches to providing services hold promise or are proven to dramatically improve outcomes. Yet many counties employ inadequate or disproven service approaches that waste money, time and fail to address needs. Small counties, in particular, need assistance understanding how to maximize billing, minimize costs and make best use of community-based resources to better serve clients. The on-going operational demands facing counties precludes most from exploring what works, what's possible or where to turn for assistance. Only the State has the resources to explore how best to blend services and funding, leverage state and local dollars to draw down additional federal funding and provide service providers with the greatest opportunities to tailor care to needs.

In limited ways, the State has tried to develop a system of services. But those projects have been costly, time intensive, and of little real value. And efforts to build cooperation have been undermined by several challenges, including historically inconsistent leadership in the Health and Human Services Agency. Staff from different departments are discouraged from talking to each other or working together. Competing regulations pit departments against each another. Fiscal pressures encourage departments to shift costs on to others. Cumbersome personnel rules encourage departments to poach quality staff from sister agencies. And confidentiality and data management regulations prevent agencies from sharing information maintained in public databases.

California adopted an agency structure to address these issues, but the Agency lacks the resources and the expectation that it will do its job, and so the job does not get done.

Enhancing Local Assistance

The greatest opportunity to make better use of existing resources is to ensure that the State is leveraging its investment in state operations to improve the value of local assistance funding.

With some exceptions, state departments are operated in virtual isolation from other departments. They are responsible for policy development, budgeting, oversight of local operations, licensing and certifications, administering local funding, contracts, audits and in some cases operating large direct service programs. With each department taking on many responsibilities, particularly when providing direct services, officials have little time to do what is most important: Focus on improving quality and building local systems of care that could provide efficient, effective services to more Californians.

Cross-Cutting Needs

Research conducted in Oregon found that nearly 70 percent of health and human service clients accessed services through more than one public program.[70] Vermont found similar patterns of service use.[71] Comparable research has not been done in California. But the nature of health and human service needs suggests that many clients, particularly those with the greatest and most complex needs – who also are the most expensive to serve – are customers of multiple departments.[72] And when components of the system fail to work in unison, quality and outcomes for Californians suffer, and costs escalate.

County officials report that disparate fiscal, reporting and licensing requirements, which originate in distinct state departments, undermine efforts to improve service delivery systems. The results include increased operational costs, reduced flexibility, and barriers to innovation and improvement.

Costs go up. A majority of local assistance funding goes to California's 58 counties. In most instances, state departments work with county counterparts, which receive the bulk of local assistance funding that passes through those state departments. Thus the California Department of Mental Health works with county mental health departments, the Department of Social Services works with county social service agencies and the Department of Alcohol and Drug Programs works with its county peers. Recognizing that families in need of services often have multiple, complex needs, many counties have begun to integrate their services. In moving more families from welfare to work, service providers have found that in addition to education and job training, many potential workers need substance abuse, mental health, and child care before they can be meaningfully employed.[73]

But local efforts to tailor services to the needs of clients can run afoul of the State's organizational structure. As counties have developed community-based facilities to more effectively meet client needs, they have exposed overlapping responsibilities within state departments. Three separate state departments are involved in licensing Adult Day Health Centers. And both the Department of Mental Health and the Department of Health Services license psychiatric health facilities. The requirements to work through multiple licensing and certification processes delays services and increases costs.

Many county programs also draw funding from multiple sources to address multiple needs. But blending funding causes problems for state departments organized around specific programs. Counties are required to submit to the State reports on services provided, clients served, and costs. Some reports are required on an annual basis, others quarterly, still more are submitted monthly.[74] Counties that insist on unifying disparate programs have to monitor their blended system and then unblend each component to comply with state requirements. In some instances, local officials claim that administrative costs match service costs, reducing the value of local assistance funding by up to 50 percent.

Even when funding is not blended, the existing organizational structure drives up costs. The Department of Health Services administers more than 20 separate health programs, each with unique administrative requirements.[75]

The State has made some progress. Through the Youth Pilot Project, Placer County negotiated a consolidated contract to pull together 16 separate contracts with the Department of Health Services. Under the consolidated contract, the county submits one annual report to the State, replacing more than 45 quarterly and semi-annual reports that previously were required.

And attorneys for the State and county, along with administrators, review and approve one contract rather than 16. But many challenges remain, for Placer County, and other counties not operating under a consolidated approach to funding health programs.

The inability of the State to bring together the multiple divisions that fund, administer and oversee community-based services drives up costs and delays improvements.

Flexibility is restricted. State requirements restrict the ability of local agencies to respond to the needs of a community or its residents. Counties commonly hire health educators who bring prevention and early intervention messages to youth and other community members, generally on topics related to tobacco and alcohol or drug use. But state staff working on tobacco control efforts have admonished county staff not to discuss alcohol or drug use concerns with kids while talking about tobacco use. And alcohol and drug use prevention programs are equally concerned that health educators working on their dime might instead spend time discussing issues associated with tobacco. For health educators, a captive audience allows them to discuss both tobacco and alcohol and drug use issues, but they risk running afoul of state staff or regulations. The State's seeming inability to unify its efforts, even those programs with similar messages, a shared audience and shared local staff, prevents local agencies from making the best use of limited public resources.

Similarly, rules that must be implemented statewide can be at odds with the diversity of California's communities and geography. The transportation challenges in San Francisco are quite different from those in Modoc County, where the closest hospital may be in Oregon. Requirements that counties hire staff with technical expertise, such as graduate degrees in public health, is challenging for counties where not a single resident holds that degree.

Different Agencies Different Accounting Methods

Counties contract with the Department of Health Services to operate the Women, Infants and Children's (WIC) Program, under the direction of the U.S. Department of Agriculture (USDA). The USDA also is in charge of Food Stamp programs, which also are administered by the State but operated by the counties. These two nutritional programs operate on separate fiscal years. WIC follows the federal fiscal year, (October to September), while Food Stamps operates under California's fiscal year (July to June). And counties are allowed to claim administrative costs under Food Stamps using a time-study methodology, but State officials require a separate accounting of overhead for WIC, claiming that USDA will not accept the time-study approach, despite its use in the other USDA funded program.

Cross-cutting innovations are undermined. Most improvements are the result of inter-agency collaboration, but without on-going funding, inter-agency efforts are orphaned or lessons are abandoned. California has gained national recognition for its efforts to improve services to mentally ill offenders and reduce their involvement with the criminal justice system. The State's Integrated Services to Homeless Adults program (AB 34) and the Mentally Ill Offender Crime Reduction grants (MIOCR) each provide funding to counties to integrate law enforcement and mental health responses to mental health clients at risk of incarceration. But the State's fiscal crisis has resulted in ending these special funding sources, as the Department of Mental Health and the Board of Corrections, which administers these programs, instead focus on programs within their core mission.

And local agencies seem not to have learned from the experiences that integrated funding provided. Both AB 34 and MIOCR are reported to have reduced local costs, but participating counties have not signaled a willingness to use local funds to replace lost state revenue.

Youth Pilot Program

In 1993 the Legislature and Governor authorized the Youth Pilot Project (AB 1741) to encourage counties to integrate services to better tailor programs to the needs of clients. AB 1741 was drafted with the recognition that innovation and integrated services were much more likely at the local level. Six pilot counties signed up for the project: Alameda, Contra Costa, Fresno, Marin, Placer, and San Diego. The State does not provide funding for the program, but provides technical assistance and flexibility with regard to federal and state statutes and regulations. State agencies also have designated staff within their departments to coordinate YPP activities.

Pilot counties are required to develop a strategic plan that identifies the target population to be served, programs to be included, and funding sources to be blended. Each county is required to conduct a community needs assessment and establish a collaborative structure, such as coordinating councils, to develop shared visions and goals designed to meet community needs. Each county must submit annual reports and an evaluation of the project once the pilot ends.

> *Stated goal: High-risk, multi-need youth in six counties will receive better services through the development of new ways to integrate and coordinate health and human services and funding. Lessons learned from these six pilot counties can be expanded to other counties to improve services for high-risk youth throughout California.*

In Placer County, the Youth Pilot Project has led to the creation of a Consolidated Health Contract to unify contract language and streamline accounting, contracting, claiming, and reporting process for 16 public health programs administered by the Department of Health Services. But Placer and state staff found that consolidated contracting has not required waivers to state or federal rules, instead, it required state staff to change the way they do business. The primary challenge that the consolidated contract had to overcome was encouraging disparate divisions within the Department of Health Services to work together.

Sources: California Department of Health Services, Maternal and Child Health. "Youth Pilot Program: Fact Sheet." http://www.dhs.cahwnet.gov/pcfh/mchb/programs/ypp/yppfacts.htm, accessed Oct. 21, 2003; Foundation Consortium for California Children and Youth. "The Placer County Consolidated Model Health Contract: A State-County Partnership To Improve Public Health Systems." December 2002.

A lesson that can be drawn from the experiences of these three innovations – Youth Pilot Project, AB 34 and MIOCR – is that special funding or directed legislation that requires integrated efforts can move state and local departments to work together. But without dedicated funding, or persistent requirements, those efforts are difficult to sustain, particularly at the state level. Health and human service departments concede that they have fiscal and regulatory incentives to focus their energies on programs for which they are solely responsible, to the detriment of efforts to tailor services to needs.

Departments Perform Duplicate Functions

Most human service departments perform similar functions – fiscal operations, licensing and certification, technical assistance and training, data management and analysis. But the State has made limited efforts to streamline operations by linking similar functions or consolidating operations. A review of budget documents for fiscal year 2003-04 provides a preliminary glimpse at the costs associated with overlapping efforts in select divisions of these departments:

Licensing and Certification. Five departments license or certify personnel or facilities to provide health and human services. In some instances, these activities overlap, as with the licensing of group homes that serve children in foster care and provide mental health treatment. The departments of Alcohol and Drug Programs, Health Services, Mental Health and Social Services have 1,951 staff dedicated to these units with personnel costs exceeding $127 million. Certification activities performed by the Department of Aging are not broken out in budget documents.

Fiscal Operations. Ten departments have dedicated units that administer funding to the counties or other local agencies. Collectively, these units have 866 employees with $51 million in personnel costs. Seven of those departments are involved with Medi-Cal. An

Licensing and Certification

Licensing and certification is a regulatory tool the State uses to prevent and respond to threats to the health and well-being of Californians. Several departments within the Health and Human Services Agency provide this service. In recent years, resources dedicated to licensing have fallen short of public goals for monitoring the quality of community and institutional care facilities. But the State has not designed its licensing and certification efforts as part of a concerted effort to promote best practices and create incentive for service providers to improve inputs and outcomes. And thus it fails to see opportunities to shift existing resources into licensing activities that could have exponential impacts. Licensing should not be confused with the work of experts charged with setting quality standards. The development of standards of quality should remain the responsibility of the programmatic departments. But as a tool for measuring activities against standards, licensing can become a more proactive and effective tool for ensuring minimum standards, creating incentives for excellence and monitoring quality.

additional 1,269 staff work in Medi-Cal units with $90.5 million in personnel costs. Five departments also have stand-alone fiscal divisions managing grants or contracts. These divisions house another 38 employees with $2.6 million in salaries and benefits. And eight departments operate separate audit units to monitor fiscal compliance, with 815 staff and $57 million in personnel costs. In total, 2,988 state employees administer health and human service funds with $201 million in personnel costs.

Information Systems. Eleven departments and the Agency operate their own information systems divisions. These programs employ 1,157 persons with personnel costs of $91 million. The California Health and Human Services Agency Data Center represents less than half the employees working on information systems within the Agency.

Point-in-Time Figures

Budget figures used here reflect point-in-time allocations at the beginning of the 2003-04 fiscal year. At that time, the Legislature authorized 30,076 personnel years for the Health and Human Services Agency and its 13 component departments. Mid-year reductions for these departments have resulted in 1,538 fewer positions distributed across all divisions. The number of positions in each department is in constant flux due to retirements, lay-offs, movement between divisions and other changes. Thus the figures are for illustrative purposes only; real-time data would be needed to calculate cost savings achievable through organizational reforms.

Source: Governor's Budget 2004-05. Department of Finance. "Control Section 4.10 Recap of Reduction Plans." December 22, 2003

Research and Analysis. Six departments have units dedicated to research and data analysis, with a total of 216 personnel and $15 million in salaries and benefits.

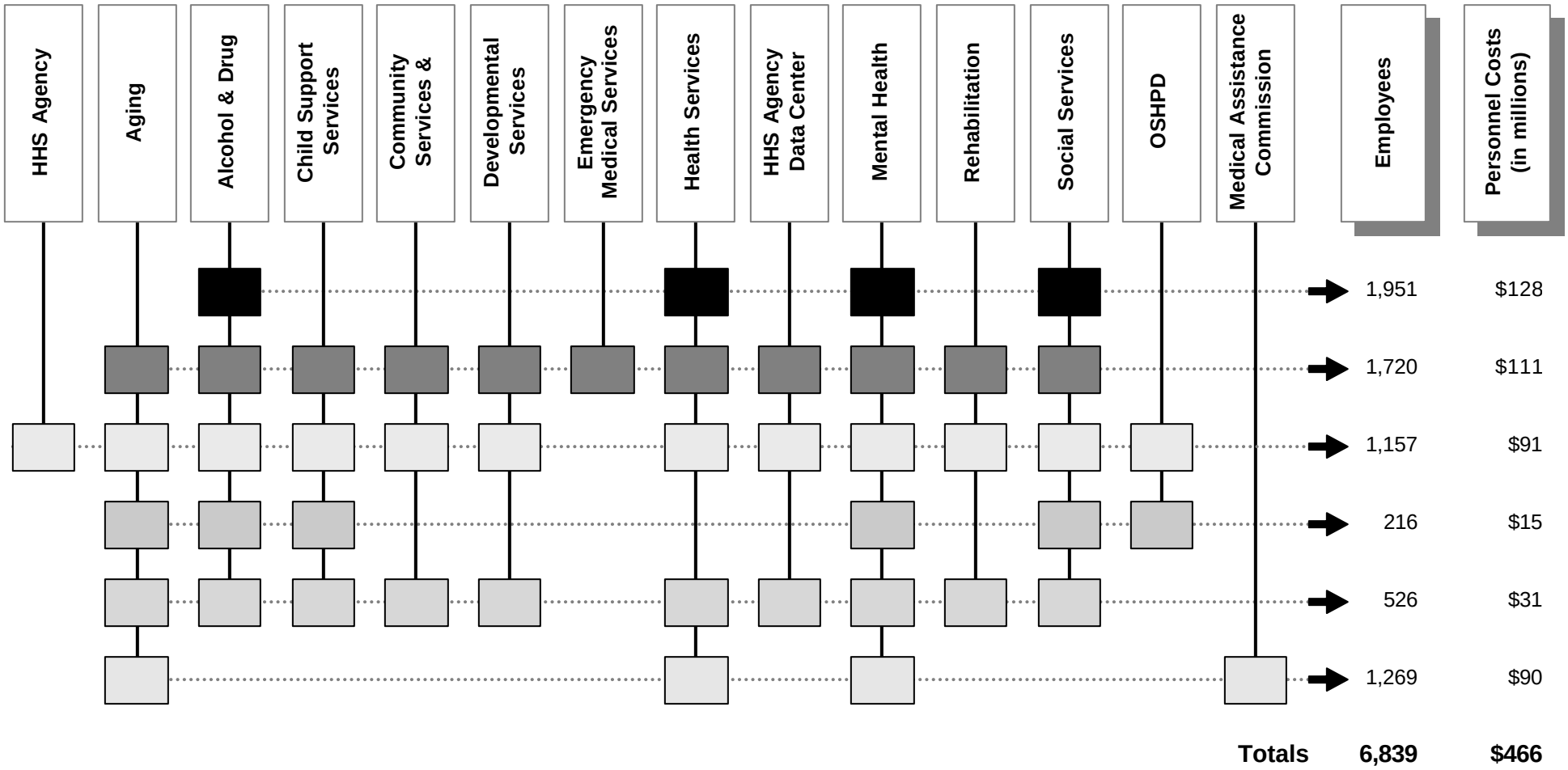
Human Resources

Personnel activities within state departments are handled in several ways. The Department of Personnel Administration is responsible for all issues related to collective bargaining, including salaries and benefits, job classifications, and training. Some departments manage hiring and other personnel activities through in-house divisions, others contract for services through the Department of General Services. No single approach is appropriate for all state departments given differences in the size of departments, turnover and the need for staff with specialized or technical skills. Ten departments within the Health and Human Services Agency operate stand-alone personnel divisions. Among these departments, 526 employees work on personnel issues, with salaries and benefits exceeding $31 million. The departments of Developmental Services and Mental Health have particularly large personnel operations associated with the developmental centers and state hospitals, dedicating $7.5 million and $5.3 million respectively. The Department of Health Services spends over $3.3 million on its personnel and recruitment divisions. These expenditures are in addition to those of the Department of Personnel Administration and the State Personnel Board.

Some personnel practices would improve through consolidation or collaboration. The departments of Mental Health, Developmental Services, Corrections and Veterans Affairs each hire medical staff with similar or identical skills to work in state-operated facilities. And some facilities operated by these departments are in close proximity to each other. Yet despite high turnover within particular job classifications and staff movement among departments, these departments do not share personnel resources to reduce costs.

Source: Governor's Budget 2004-05, Salaries and Wages Supplement, figures are for 2003-04. March 2004.

Duplication of Functions Among Select Health & Human Service Departments



Note: Fiscal operations include grants management units and audit units. The Commission on Aging, the Managed Risk Medical Insurance Board, the State Council on Developmental Disabilities and the State Independent Living Council were not included in this chart because they had no units with these functions. Detail for this chart is provided in Appendix D.

Legend

- Licensing & Certification
- Fiscal Operations
- Information Systems
- Research & Analysis
- Human Resources
- Medi-Cal

Hidden Duplication

Several departments have staff dedicated to the functions listed here but are not included in the table. For instance, the Department of Aging conducts licensing activities and the Department of Health Services has research staff. Those functions are not reflected in this chart because the chart uses budget figures, and budgets for those departments do not identify those activities.

Streamlining State Operations

Streamlined functions could reduce costs and improve the quality of state functions. A 10 percent reduction in personnel costs associated with overlapping functions in fiscal operations, licensing and certifications and information systems alone would reduce state costs by nearly $33 million with commensurate reductions in operating expenses. Moreover, consolidation that separates administrative tasks from capacity building and leadership could free departments to focus on building a sustainable system capable of meeting needs.

In turn, re-engineering that improves the ability of the State to support, guide and monitor local operations also could best leverage efficiencies in local assistance funding. A 10 percent improvement in the efficiency of local assistance funding – either through increased prevention, reduced demand for services, or lower administrative costs – could translate into the equivalent of $5.5 billion in new funding. Improving the quality and efficiency of health and human services will require reorganizing functions at the State level, because organizational lines determine priorities and focus. What happens within those boxes also is important. To improve outcomes, organizational reforms must reshape the structure and re-orient the work of state departments. Specifically:

Improved leadership. Organizational reforms must focus leadership on building capacity, adopting proven and promising practices, and providing tailored care at the local level.

Bolstered coordination. Reforms must bolster coordination among health and human service departments. A fortified agency structure could systematically lower barriers to sharing information, facilities and resources at the state and local levels.

Streamlined operations. Consolidation of administrative practices into service centers would afford administrators greater opportunities to streamline operations, lower administrative costs and identify policies and practices that are barriers to improvement.

Strategic use of resources. Freeing up executives from routine administrative responsibilities would enable them to focus on using limited resources strategically and in innovative ways.

Focus on outcomes. The State has not kept pace with the development and use of performance measures, indicators and benchmarks to create meaningful accountability. Reforms could highlight the importance of focusing on outcomes.

State Operations Focused on Outcomes

Inspector General

An Inspector General should be empowered with all the necessary authority to thoroughly investigate and monitor state and local health and human service programs. It should report directly to the Governor and its reports, except those involving criminal investigations, should be public.

This is addressed in Finding 5.

Advisory Board

The existing advisory and oversight boards are largely ineffective. They should be replaced with an agency-wide board with the authority and resources to monitor state operations and make recommendations for reform.

This is addressed in Finding 5.

Health & Human Services Agency

The Agency should ensure consistency across state operations, promote collaboration among departments and track progress toward the State's goals for children, adults and families. Departmental resources dedicated to budgeting, policy-making, legal and external affairs should be shifted to the Agency and department directors should come together as an agency cabinet.

Agency Management Council

Advanced Research Office

In April 2003, the Commission recommended the creation of a public health department directed by a surgeon general who reports directly to the Governor. Under the Commission's recommendation, the Department of Public Health would not be part of HHS. The new DPH would incorporate those functions currently in HHS that protect the health of the entire population.

Department of Public Health

The Department would include:

- From DHS, the following functions:
  - ✓ Prevention Services
  - ✓ Health Information & Strategic Planning
  - ✓ Other components of DHS that are public health, e.g. Maternal & Child Health.
- Office of Statewide Health Planning & Development
- Emergency Medical Services Authority

Director	Director	Director	Director	Director
Department of Aging	Department of Child Support	Department of Developmental Services	Department of Health Services	Managed Risk Medical Insurance Board
Director	**Director**	**Director**	**Director**	**Director**
Department of Rehabilitation	Department of Alcohol & Drug Programs	Community Services & Development	Department of Mental Health	Department of Social Services

Service Centers

- Fiscal Operations
- Licensing & Certification
- Technical Assistance & Training
- Data Collections Management (Health & Human Services Agency Data Center)

Departments: Strategic efforts of each department should provide leadership, planning, research and capacity building, to enhance the ability of local agencies to improve quality, efficiency and accessibility.

Service Centers: These centers should enhance state support for local health and human services. The centers should report to the Agency Secretary and respond to the needs of the departments.

Other States are Reforming Human Services

Many states are reforming their human service systems. Some reforms focus on specific groups of clients while others aim to reform the entire system. Many focus on a "no wrong door" approach, placing clients at the center of how services are delivered.

Iowa: In 1998, the State created a partnership between the State and communities to improve the well being of families with children ages 0-5. The Iowa Community Empowerment Initiative created 58 citizen-dominated boards representing 99 counties and supported by a state-level governing board, advisory board and multi-agency state staff. The vision guiding the project states, "Every child, beginning at birth, will be healthy and successful" and asserts that communities know what is best and with support from the state desired results can be achieved.

Louisiana: In 2003, the Louisiana Legislature directed the Department of Social Services to develop a reorganization plan by March 2004. The plan would align the 41 regions of five offices into nine regions, the pooling of finances into a single appropriation, and the consolidation of administrative functions. A Governance Committee for the department will provide leadership and management, with input from an advisory group. The plan creates a single point of entry to services with the use of multidisciplinary teams to provide integrated care.

Nebraska: In 1996, the Nebraska Partnership for Health and Human Services reduced the health and human services system from five agencies to three: 1) services, 2) regulation and licensure, and 3) finance and support. These agencies are governed by a policy cabinet made up of a secretary, the three agency directors and a chief medical officer. A partnership council advises the cabinet. The new system operates under the five C's: communication, cooperation, collaboration, customer service and confidence.

Oregon: Recognizing that almost 70 percent of clients receive two or more services, the Department of Human Services undertook reforms. Services previously provided through five networks of field offices are now provided through one network. Twelve departments have been pared to five and services are now delivered through 16 service delivery areas that provide a single point of entry. The department is tracking performance, consolidating data systems and training its workforce to be client-focused. The department's goal is to have people healthy, living as independently as possible, safe, and able to support themselves and their families.

Texas: To serve consumers better, increase administrative efficiency and emphasize accountability, the legislature in 2003 directed the Health and Human Services Agency (HHS) to consolidate departments, eliminate duplication and streamline services to Texans. HHS is to consolidate its departments from twelve to five, each advised by a council composed of nine gubernatorial appointees. An executive commissioner, appointed by the Governor, will appoint the directors of four departments and head the Health and Human Services Commission (HHSC). The agency must consolidate administrative functions and eligibility determinations, and abolish advisory committees unless required by federal law or determined necessary by HHSC. It is anticipated that the consolidation will take four to six years to complete.

Vermont: Realizing that clients were interfacing with multiple departments, the Agency of Human Services decided to reorganize into policy clusters and place the client at the center of its efforts. Seven clusters were created in 2002. The agency has submitted a plan to the legislature to reorganize around 10 themes: Respectful service; Valuing the assets and strengths of clients; Access to services; Prevention; Effective service coordination; Flexible funding to address gaps in services; Services provided before a crisis; Collaboration with key partners; Support for people through transition; Continuous improvement and accountability; and Information systems and communication. The agency plans to track progress with indicators, reduce in size from eight departments to five, and create a field services director in each of twelve districts to manage district staff and consolidated district budgets, and oversee all agency expenditures on grants and contracts.

Washington: The Department of Social and Health Services has already reorganized using the "no wrong door" approach. The department is divided into seven administrative units with a Management Services Administration that conducts all administrative functions for DSHS programs. Leadership, coordination, accountability and fiscal oversight are centrally located in the Secretary's office.

Sources: Iowa Community Empowerment. http://www.empowerment.state.ia.us/; Louisiana Department of Social Services. 2003. No Wrong Door: Proposal for a Reformed Department of Social Services; Nebraska Health and Human Services. http://www.hhs.state.ne.us/poc/npphist.htm; Oregon Department of Human Services. Remaking DHS. http://www.dhs.state.or.us/aboutdhs/remakingdhs/; Texas Health and Human Services Agency. HB 2292 Transition Plan. http://www.hhsc.state.tx.us/Consolidation/HB_2292/110303_HB2292TP1.html; Vermont Agency of Human Services Reorganization Project. https://www.ahsnet.ahs.state.vt.us/council/; Washington Department of Social and Health Services. No Wrong Door. http://www1.dshs.wa.gov/basicneeds/.

Recommendation 2: State operations should be reorganized to provide unified leadership, efficient support of local programs and to focus on improving quality.

Unified leadership

- ***Bolster the Health and Human Services Agency.*** The Agency should ensure consistency across state operations, promote collaboration among departments and track progress toward the State's goals for children, adults and families. To fulfill these obligations, departmental resources currently dedicated to budgeting, policy-making, legal and external affairs should be shifted to the Agency and department directors should come together as an agency cabinet.

Enhance Management Capacity

The Agency Secretary should develop a strong leadership team and management structure to implement reforms, continuously improve internal operations and enhance state support for local operations. Among the components:

- **Designate chief operating officers for each department.** A chief operating officer should be established for each department and service center. The COO should report to the director and be charged with professionally managing operations under the direction of the department director. Chief operating officer positions should be required to meet rigorous minimum qualifications.
  - ✓ Significant experience managing public sector operations.
  - ✓ Comprehensive understanding of mission and operations of department or service center.
  - ✓ Demonstrated leadership applying principles of performance management and continuous improvement.
- **Establish an Agency Management Council.** The Agency Secretary should appoint a panel of public and private experts on health and human service management to provide advice on state-of-the-art management practices applicable to state and local agencies.

Efficient support

- ***Create service centers around functions shared by multiple state departments.*** Strategically and over time, the State should consolidate shared functions into service centers that report to the Agency and are responsive to the departments. Service centers should be established for the following functions and designed to enhance state support for local health and human services.

✓ **Fiscal Operations**. State functions associated with payments, audits, eligibility, and benefit computation now handled by each department should be consolidated into a fiscal service center. The center should be charged with streamlining operations, reducing costs and improving accountability.

✓ **Licensing and Certification.** Facility and personnel licensing and certification activities should be consolidated. Standards and regulations governing licensees should continue to be established by programmatic departments.

✓ **Data Collection and Management.** Data collection and management activities should be consolidated, strategically and over time, to streamline state requirements, improve data analysis and identify opportunities to use data to enhance outcomes.

- ✓ **Technical Assistance and Training.** Multiple technical assistance and training efforts should be consolidated to improve the quality and consistency of services provided to state and local agencies. The Technical Assistance and Training Service Center should develop benchmarks and training programs for fiscal operations, licensing and regulatory compliance, and data collection and management. The center should initially receive General Fund support, but over time should be funded primarily through client fees.

Departments focused on improving service quality

- ❑ ***Refocus the departments.*** California's health and human service departments – smaller and more focused following organizational reforms – should enhance the effectiveness and efficiency of health and human services received by Californians. The strategic efforts of each department should provide leadership, planning, research and capacity building, to enhance the ability of local agencies to improve quality, efficiency and accessibility.

Invest in innovation

- ❑ ***Establish an Advanced Research Office.*** California must invest in improving the delivery of services. The Advanced Research Office should lead the State's efforts to identify innovative practices and create incentives to improve and enhance accountability. Initial tasks of the Advanced Research Office should include:

  - ✓ **Scrutinize the distribution of responsibilities.** Once shared functions are consolidated, the Office should scrutinize the remaining state operations and submit a plan to the Agency to further reduce areas of duplication and overlap. State departments should be maintained where there is a uniqueness of client need, disorder or disease that cannot be addressed adequately through combined departmental efforts.

  - ✓ **Expand the number of Californians with appropriate, affordable private sector insurance coverage.** The Office should document the adequacy and penetration rate of private sector insurance for health and human service needs – including physical health care, addiction treatment and mental health care – and propose to the Agency ways to increase the number of Californians covered by private insurance.

Advanced Research Office

The Office should report to the Agency Secretary, be small and flexible, infused with substantial autonomy, and be able to draw technical staff from state and local agencies, universities and the private sector. Activities should be project-based, typically 12 to 36 months, but longer when necessary. Project managers, who should be the core staff, should be technically outstanding and chosen for their vision and entrepreneurial spirit. Management should provide good stewardship of taxpayer funds but focus on enabling project managers to be successful. The Office should operate and be held to standards that allow failure in areas where the payoff of success is sufficiently high to require significant risk taking.

Realign State-Local Relationships

Finding 3: The complexity of California's health and human services increases costs, inhibits flexibility, limits improvement and undermines accountability.

Health and human services are provided through federal, state and local agencies, often working with non-profit and for-profit contractors. In some areas, the federal government is a direct service provider, as with services for veterans. In other areas, the State is a direct provider; the State operates mental hospitals and vocational centers. In most instances, however, federal and state agencies fund programs that are locally operated, often through the counties, but sometimes through regional entities, school and community college districts, or through direct contracts with private providers. In no two communities are the bundles of services provided in the same way.

"To move forward, the State and local agencies must bring clarity and simplicity to health and human services and the state-local relationship."

California has debated the right mix of state and local responsibilities for years, without resolution.[76] Finding common ground has been thwarted by decades of distrust as the State and local agencies have been at odds over the distribution of resources, authority over local programs, liabilities and priorities. California may not be able to solve all of these problems, and certainly not in the short term. But to move forward, the State and local agencies must bring clarity and simplicity to health and human services and the state-local relationship.

No Single System of Care

Counties administer an array of health and human services. Child welfare, mental health, alcohol and drug programs, adult protective services, and employment services are operated by counties or by contractors under the authority of county departments.

But other programs are operated through other local agencies. The Department of Aging works with 33 Area Agencies on Aging to manage programs serving older adults. Adults and children with developmental disabilities are

What the Customer Wants…

In testimony before the Legislature, an older Californian advocated for a service delivery system that makes sense from the perspective of her life.

I envision a single point of entry where I could go to review my status with a competent individual. An individual who could lay out an array of services that might assist me to remain in my home and community, as independent as possible, and with as much dignity as possible.

At the single point of entry, I could determine what pieces of the array of services I was eligible for, saving me time, money, and my dignity, in having to reveal my personal and financial affairs only once.

And I envision a system which would assist me as needed in moving from one set of services I might need to another as my condition and needs change. This would happen without having to be requalified, without having to visit new agencies to determine what is available, and without losing my dignity in having to ask for assistance over and over again.

Source: California Commission on Aging.

served through community programs operated by 21 regional centers. And childcare is offered through school districts, community colleges, and community providers working directly with the state Department of Education.

Direct Services

Three departments under the Health and Human Services Agency have significant direct service programs, which dominate the attention of senior administrators and leave few staff dedicated to building strong community systems of care.

Department of Developmental Services operates five developmental centers and two community facilities that collectively serve approximately 3,500 persons. Over 96 percent of DDS staff work in developmental centers.

Department of Mental Health operates two acute psychiatric programs that serve the Department of Corrections and four mental hospitals. Approximately 4,700 clients are served by the hospitals. Over 97 percent of DMH staff are involved with hospital operations.

Department of Rehabilitation operates 100 field offices that provide counseling, job training, transportation and other services to some 109,000 Californians with disabilities. More than 86 percent of department staff work in these offices.

And in some instances, the State is a direct service provider, or contractor for community services, acting in a capacity similar to a local agency. The State operates vocational centers, developmental centers and mental hospitals, which provide direct services. And state departments typically contract for community services without working through the counties.

The maps on the following pages reflect the disparate organization of four health and human service programs.

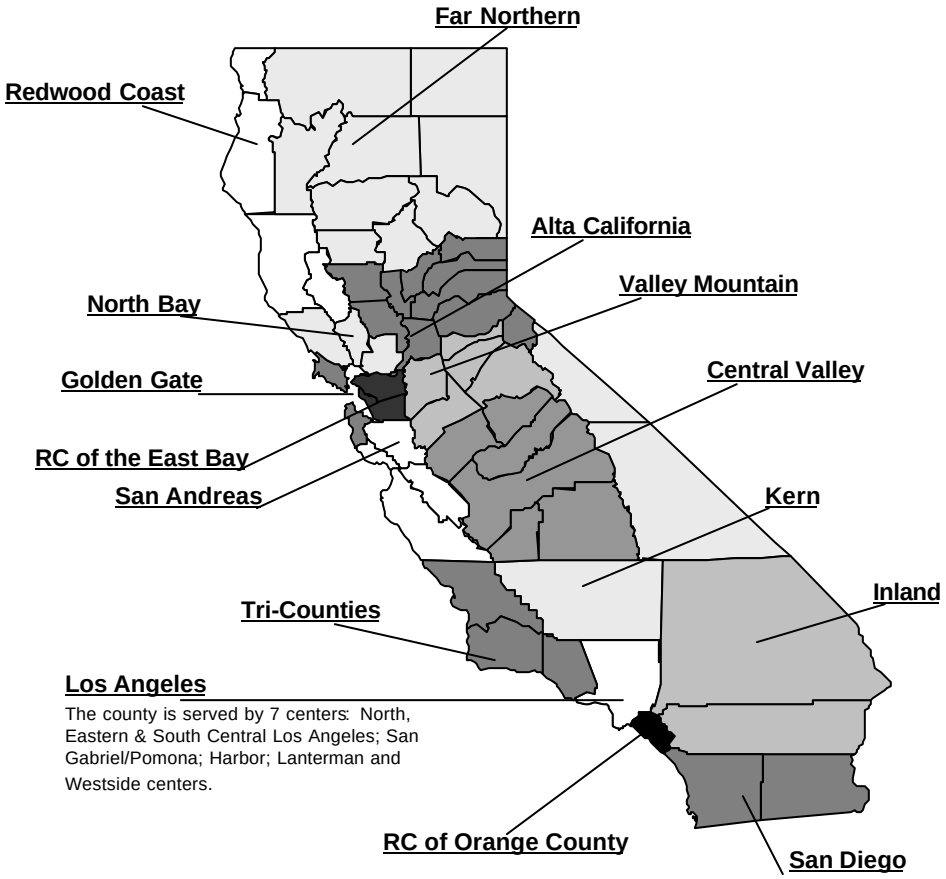
This organizational structure reflects decades of political tug-of-war and compromise, rather than a rational business plan for delivering related services to groups of clients. For government and service providers, it creates expensive and frustrating challenges as they face dramatic barriers to building systems of care that can strategically marshal resources to address community needs. And for individuals and families, it results in missed opportunities, delayed services and ineffective programs, as organizational structures hinder efforts to tailor services to needs.

Responsibility for services is too fragmented.

The complexity of the system is the greatest barrier to improved service. Working through multiple levels of government and disparate programs to build collaborative or integrated services can frustrate the most ambitious administrator. In some cases, strong and collaborative administrators can build partnerships that overcome these barriers.[77] But in many cases institutional, cultural and even legal barriers thwart efforts to share information, facilities, resources and strategies, even when agencies are serving the same clients and ostensibly are working toward the same ends. For example, the California Mental Health Planning Council has defined the elements of a comprehensive system of care, but recognizes that no county has been able to implement the full range of needed services.[78]

Developmental Services

Californians with qualifying developmental disabilities can access services through a network of 21 Regional Centers, which are operated by private, non-profit organizations under contract with the State. The State also operates seven community facilities which provide in-patient care.



Mental Health Services

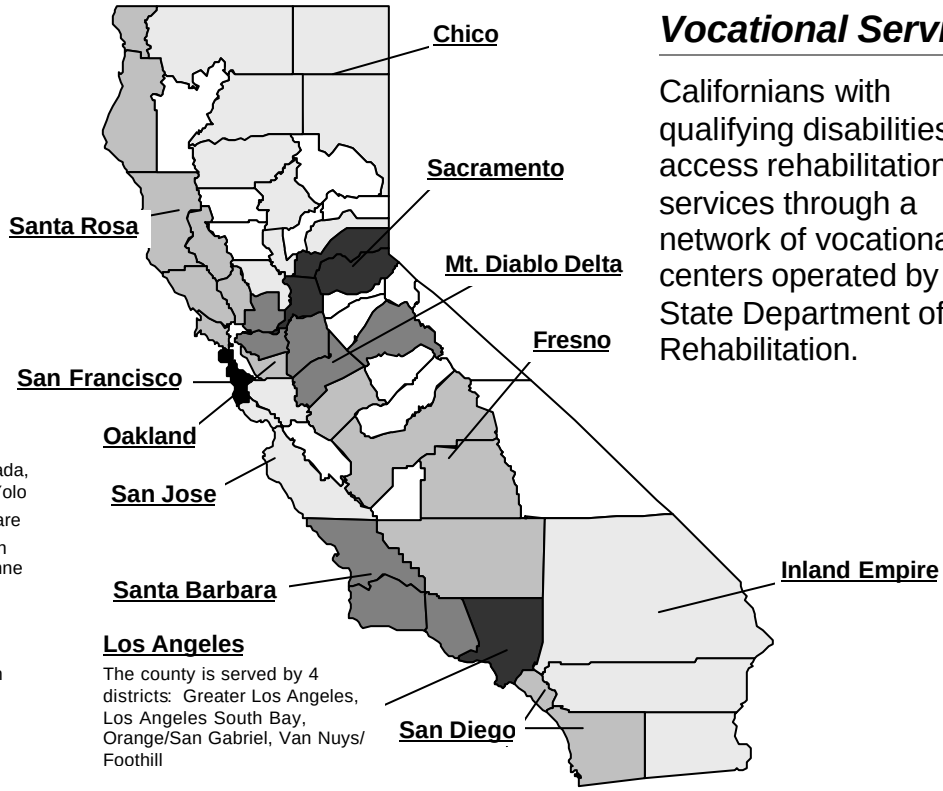
Mental health services in California are provided through a county-based network of local mental health agencies, which operate under contract with the State Department of Mental Health. The State also operates four mental hospitals that provide intensive in-patient treatment. A fifth hospital is set to open in 2005 in Coalinga.

South Region Districts

- Greater Los Angeles: Los Angeles County Central, Los Angeles County West, Los Angeles County East
- Los Angeles South Bay: Los Angeles County Central, Los Angeles County South Bay
- Orange/San Gabriel: Orange, Los Angeles County San Gabriel Valley, Los Angeles County East
- Inland Empire: Imperial, Riverside, San Bernardino
- San Diego: Orange, San Diego
- Van Nuys/Foothill: Los Angeles County High Desert, Los Angeles County San Fernando Valley, Los Angeles County San Gabriel Valley

North Central Region Districts

- Chico: Butte, Lassen, Modoc, Nevada, Shasta, Siskiyou, Sutter, Tehama, Yolo
- Fresno: Fresno, Kern, Merced, Tulare
- Mt. Diablo Delta: Contra Costa, San Joaquin, Solano, Stanislaus, Tuolumne
- Oakland: Alameda
- Sacramento: El Dorado, Placer, Sacramento
- San Francisco: San Francisco, San Mateo
- San Jose: Monterey, Santa Clara, Santa Cruz
- Santa Barbara: San Luis Obispo, Santa Barbara, Ventura
- Santa Rosa: Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Sonoma

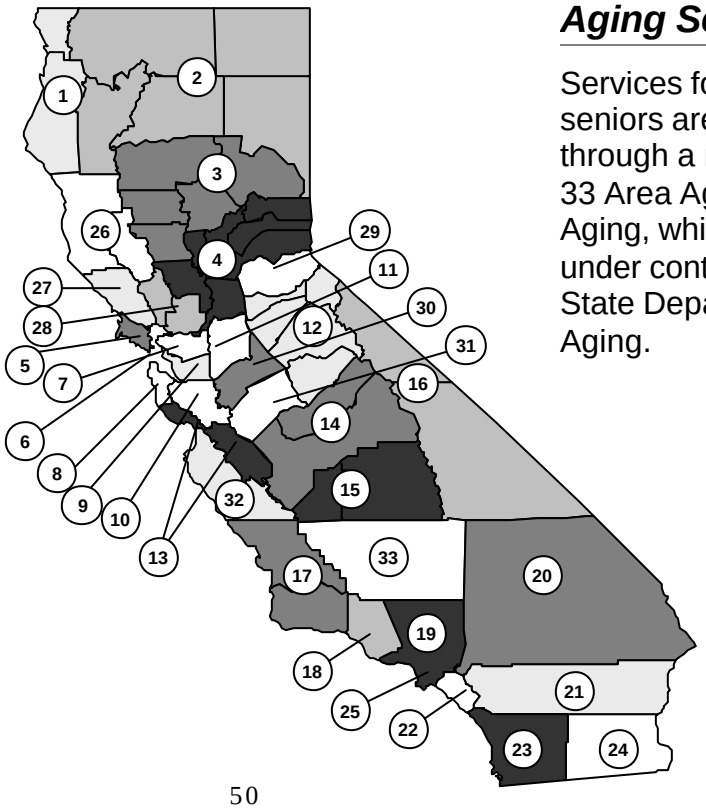


Vocational Services

Californians with qualifying disabilities access rehabilitation services through a network of vocational centers operated by the State Department of Rehabilitation.

Counties without shading have no offices: Alpine, Amador, Calaveras, Colusa, Glenn, Inyo, Kings, Madera, Mariposa, Mono, Plumas, San Benito, Sierra, Trinity, Yuba

1. Del Norte & Humboldt
2. Lassen, Modoc, Shasta, Siskiyou, Trinity
3. Butte, Colusa, Glenn, Plumas, Tehema
4. Nevada, Placer, Sacramento, Sierra, Sutter, Yuba, Yolo
5. Marin
6. San Francisco (City & County)
7. Contra Costa
8. San Mateo
9. Alameda
10. Santa Clara
11. San Joaquin
12. Alpine, Amador, Calaveras, Mariposa, Tuolumne
13. Santa Cruz & San Benito
14. Fresno & Madera
15. Kings & Tulare
16. Inyo & Mono
17. Santa Barbara & San Luis Obispo
18. Ventura
19. Los Angeles County
20. San Bernardino
21. Riverside
22. Orange
23. San Diego
24. Imperial
25. Los Angeles City
26. Lake & Mendocino
27. Sonoma
28. Napa & Solano
29. El Dorado
30. Stanislaus
31. Merced
32. Monterey
33. Kern



Aging Services

Services for California's seniors are provided through a network of 33 Area Agencies on Aging, which operate under contract with the State Department of Aging.

Counties do not have authority to do what needs to be done.

Local agencies lack administrative and fiscal control of the programs they operate. The State typically controls program rules – such as who can be served, what services can be provided, and for how long. And the State sets spending limits. Funding generally includes a mix of federal, state and local funds, each with limits on how they can be used.

California has extensive rules on who can be served by various programs, which services are offered and how care is delivered. For instance, under child welfare rules, federal funding is available to pay for housing, medical and mental health care and other needs, but only when the threat is serious enough to warrant removing children from their homes. Only limited funding is available to assist families before serious neglect or abuse necessitates removing children from their parents.[79] This is not only an example of inflexibility, but inaction. The enormously hurtful consequences of this policy have long been understood. But the State has not been able to adequately resolve this problem, either through its own means or by working with the congressional delegation to change federal policy.

Integrating services under the existing system is costly and difficult.

Several counties have developed integrated services with good outcomes. But they report high administrative costs associated with getting the

Integrated Services

Responsibility for providing services to children, adults and families rests with multiple levels of government and disparate departments within each level of government. Child welfare programs, mental health agencies, school districts, the courts, medical providers, housing agencies, workforce development and job training programs and other service providers can play vital roles in helping families transition from vulnerability to stability.

Many programs function exceptionally well when delivering specific services. But there is increasing realization that transition points between programs are problematic for Californians accessing multiple services. And a majority of clients have multiple, often inter-related needs tied to poverty, poor overall health or unemployment. Eligibility rules change from program to program. And families must endure duplicate assessments, long waiting lists, as well as program requirements that conflict. As a classic example, adults accessing mental health services often are prescribed psychotropic medications as part of a treatment regimen. But those needing simultaneous drug treatment often are informed that they must not be under the influence of any drugs to receive addiction services – even prescribed medications.

For decades, administrators and practitioners have debated and piloted efforts to better integrate services. Analyses have pointed out that for programs to work together, they must share authority and responsibility for providing services and bring together funding, planning, staffing, data systems, training, monitoring and other administrative functions which otherwise can hinder integration.

Sources: David Wittenburg and Melissa Favreault. 2003. "Safety Net or Tangled Web? An Overview of Programs and Services for Adults with Disabilities." Occasional Paper Number 68. Washington, D.C.: The Urban Institute. Sharon Lynn Kagen. 1993. Understanding the Past to Shape the Future. Binghamton, NY: Vail-Ballou Press. Kathy Hepburn and Jan McCarthy. 2003. "#3: Making Interagency Initiatives Work for Children and Families in the Child Welfare System." Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

right "partners" to the table and complying with multiple reporting and administrative responsibilities.[80] For instance, those counties that take on the challenge of pulling together funding from disparate sources to provide integrated or tailored care, must track their expenses in a bundled format and as disparate expenditures. State and federal rules allow funding to be packaged to support bundled services, but continue to insist that fiscal reports be filed as if money were not blended.

These unnecessary expenses constitute "waste," and the greatest "waste" results when local agencies – deterred by the complexity of California's service delivery system – cannot provide tailored care, thus compromising program effectiveness and efficiency. Streamlining the state-local relationship could improve internal efficiencies, and improve outcomes.

No incentive or requirement to do better.

Many children and families are served by multiple programs. And when quality or outcomes are poor, efforts to improve results can be stymied by the complexity of the system. It can be unclear who has the authority to initiate changes, whether barriers to improvement are in state law, local policies or simply matters of practice that dominate organizational cultures.[81]

Californians Endure the Consequences

The complexity of health and human services challenges all who are involved with the system.

- **Clients:** Clients who need to understand what services are available, how to access them and what outcomes to expect can face tremendous barriers to sorting out what is in place or where to go for help.
- **Providers:** Community agencies must navigate complex and competing rules and requirements that originate in multiple state departments.
- **County administrators:** Program administrators face parallel challenges. It is unclear who is responsible for making changes, who has the authority to permit those changes, and where to begin. And counties also must negotiate incongruent state rules and regulations.
- **State administrators.** Program administrators also are constrained when it is unclear who is empowered to make decisions.
- **Policy-makers.** State and local policy-makers are thwarted in their efforts to improve programs. Because no single agency or level of government is really in charge of the entire system, or even its major components, policy-makers are limited in the changes they can affect. Complexity also undermines accountability. The ability of the public and policy-makers to understand how programs operate, who is in charge and where to turn for help is diminished by the enormity of decision-makers involved in determining who gets care and how they are served.

Program officials also face disincentives to taking responsibility for poor outcomes or initiating complex reforms that promise to alienate employees, contractors and other stakeholders, particularly if blame can be shifted elsewhere. As a case in point, in Commission hearings on foster care, state and local officials have argued that the other must lead efforts to make improvements.[82]

Local Systems of Care Respond Well to Needs

In 1991, the State and counties negotiated reforms to California's mental health, public health and social services that became known as Program Realignment. Realignment shifted some program responsibility and authority from the State to the counties and provided dedicated revenue to pay for the new obligations.[83]

In 2003, Governor Davis proposed to further realign to the counties childcare, social services, health and additional mental health programs. Under his proposal, which ultimately was not adopted, counties would receive dedicated revenue and would take on added responsibilities for these programs.[84] Both realignment proposals recognized that health and human service outcomes – both program effectiveness and efficiency – are improved when local agencies have sufficient programmatic and fiscal authority, flexibility, incentives to improve, and can work across programs in innovative ways. Both proposals also recognized the need for the State to maintain oversight responsibilities.

Realigning Authority and Responsibility

The state-local relationship in California is poisoned by distrust that has grown out of a history of shifting liability for poor outcomes, skirting fiscal responsibility and failing to negotiate in good faith. This distrust, combined with the reality of State and county entanglement in a network of fiscal and programmatic interdependence, prevents either level of government from taking responsibility to improve outcomes. California's 58 counties are further hindered by their diversity and thus limited ability to work in concert. State and local policy-makers must learn from history, simplify the distribution of responsibilities and hold each other accountable for outcomes.

- **State responsibilities.** The State has far greater resources than the counties and thus certain responsibilities lend themselves to state control. The State is far more able to forecast the need for funding, grow the economy and ensure adequate resources for health and human service programs. Through its significant education and workforce development infrastructure, the State is better positioned to address workforce shortages. And by virtue of its statewide authority, the State is well positioned to provide technical assistance and training, promote best practices, create incentives for innovation and excellence and monitor outcomes.
- **County responsibilities.** Counties have a far better understanding of community priorities than the State and they bear the consequences when services fail or falter. Counties therefore are better positioned to provide services. But responsibility for providing services must be paired with the authority and discretion to get the job done. Ultimately, counties need the flexibility to design their service delivery systems to improve outcomes and reduce costs.

Policy-makers need to develop the next generation of realignment. The elements of this realignment need to include a concerted effort to move as much service delivery as possible to the county level. It needs to give counties the authority, and not just the responsibility, to operate programs in ways that improve efficiency and accountability. The State's responsibilities also need to be clarified. They should include setting statewide goals, supporting local systems of care and ensuring that local agencies have sufficient funding, personnel and other resources to operate efficiently and improve outcomes.

The goal of this realignment should be a system of care to serve each community, organized around the needs of clients, operated by the counties in ways that exceed minimum standards and continuously improve. Vested stakeholders will resist reforms, because clarity of responsibilities would undermine "venue shopping" to find responses favorable to their cause. And barriers in federal laws must be addressed. But the State must take on the challenge to bring greater clarity, improve performance and stretch available public resources.

Moving forward will require the State and counties to be clear on state and local roles and then support those roles through fiscal, programmatic and oversight policies. The current state-local relationship is, for the most part, defined through fiscal policies and there is no quick fix to resolve decades of mistrust. But policy-makers have at their disposal a number of tools to reshape that relationship and build trust, including performance contracts, compacts, trust funds and block grants, and other mechanisms that can clarify roles, specify authority and transmit resources.

Recommendation 3: California should transition to a strong county-based system of care for providing health and human services. Start with willing and capable counties, refine efforts and rollout statewide.

Simplify responsibilities

- ***The State should ensure adequate funding, personnel and other resources to support county programs and monitor progress toward statewide goals for children, adults and families.*** The Health and Human Services Agency should ensure the necessary elements are available to counties to improve outcomes, including sufficient qualified personnel, adequate and stable resources to meet needs and appropriate training and technical assistance to adopt and adapt proven and promising practices.

- ***Each county should develop a responsive, seamless system of care.*** Local systems of care should prioritize prevention, tailor services to needs, consistently improve, and produce high quality outcomes in line with California's goals for children, adults and families. Each county Board of Supervisors should designate a lead agency and position responsible for developing and operating its system of care.

Support counties as hubs for health and human services

- ***Realign state direct services to the counties.*** The Health and Human Services Agency should systematically review those direct services currently provided by the State and develop a transition plan to realign programmatic responsibilities and funding to the counties. That review should include services offered through state hospitals, developmental centers and vocational centers. The Agency should provide clear and compelling analyses – linked to goals for children, adults and families – to justify any decision to maintain the State's role as a service provider.

- ***Shift funding and programmatic authority to counties.*** The Health and Human Services Agency, in conjunction with the counties and other local agencies, should develop a transition plan to realign all local health and human services and funding to the counties. The plan should shift all local health and human services currently provided by non-county entities to the counties – including services offered by regional centers, Area Agencies on Aging and others – unless the Agency determines that doing so would inhibit progress toward California's goals for children, adults and families. The counties should be given complete discretion to contract out or broker services through non-county providers, including the option to continue the existing network of services but under county direction. Pages 49 and 50 include four maps which reflect four disparate service delivery systems and the state's role as service provider.

Move with determination

- ***Start with early adopters, rollout statewide.*** The Health and Human Services Agency, in conjunction with local officials and program administrators, should initiate reforms with a small number of counties, refine those efforts and rollout reforms statewide. A system of care should be in operation in all counties within five years. The State should provide support and inducements to encourage counties to invest in reforms, shoulder additional responsibilities and accept the inherent risks and rewards.

- ✓ **Planning support.** Reforms will require adequate planning and consultation, which should be funded by the State.
- ✓ **Technical and programmatic assistance.** The Health and Human Services Agency should provide technical assistance, consultation, support and regulatory relief to address any and all barriers in state and federal policy that would limit opportunities to develop an integrated system of care.
- ✓ **Shared liability.** The State should take responsibility for liabilities it creates and share with counties the risks of federal liabilities associated with reforms.
- ✓ **Discretionary funding.** The State should buy-out an appropriate portion of state, federal or other funding that restricts local efforts to integrate services.

Undertake Fiscal Reform

Finding 4: The demand for public health and human services far outpaces capacity. Yet the State is not managing public dollars to spur private sector investment, target limited resources to priority needs, and ensure the use of cost-effective strategies to improve outcomes.

California annually spends nearly one-third of its General Fund expenditures on health and human services. Adding in federal funds, California spends upwards of $60 billion a year on programs tied to the health and well-being of Californians that are operated through the Health and Human Services Agency.

Many spending decisions are on autopilot – driven by entitlements, court rulings, the state constitution, federal rules and contracts. Thus the annual budget exercise focuses on the margins: how to allocate new revenue or make necessary cuts. But policy-makers have more latitude than they recognize in deciding how much to spend and where it should be spent. The State's 1991 program realignment demonstrates just how much control California really has over funding decisions. And how money is allocated is just as important as how much.

The flaws in how California allocates resources are well documented. There is scant funding for prevention, despite evidence that targeted prevention reduces the need for costly interventions.[85] Money is not allocated with equity in mind. Some Californians are entitled to non-essential services, despite their ability to pay for those services, while others only qualify for emergency care, even though they are destitute. And some communities receive generous allocations, while others are grossly underfunded.[86] Funding rules and requirements also do not encourage administrators to improve services. Despite considerable evidence that some programs fail to produce results, funding continues. Meanwhile, proven programs are not implemented. Finally, disputes over who is responsible for paying the bills has created significant tensions – between state and local agencies, as well as among local agencies.

These long-standing problems can be distilled into four central challenges:

- ***Public funding is not responsive to evolving needs and emerging technologies.*** The bulk of funding is tied up in a handful of programs that operate according to policy decisions made years ago, even though many of those decisions no longer reflect current realities. For example, federal funding is available to support the

needs of children taken from their parents, but there is little federal funding to help parents who are having trouble caring for their children. The result is a foster care system bursting at the seams that can cause additional harm to the children it is intended to help. Despite evidence that children are best served by keeping families together and assisting them to overcome problems, funding rules encourage the removal of children from their homes.

- ***Funding is not tied to outcomes.*** Debates over budget cuts and increases earn national attention for their acrimony, but once allocation decisions are made, there is little discussion about how money is spent or whether services are effective. As a result, funding is not redirected from ineffective programs to those that work. And in turn, program administrators and providers have little incentive to improve the quality of services and document how clients have benefited.

- ***Marginal revenue changes undermine program stability.*** Economic cycles, which drive the direction of marginal shifts in annual budgeting, have undue influence on program quality. Base funding is so inadequate – because of increasing demands on an inefficient system – that core community services are paid for with categorical funds or limited-term grants. As a result, administrators spend time and energy competing for dollars, stretching categorical funds to meet local needs and patching shortfalls, leaving little time for improving the quality of care.

- ***The State retains fiscal control, while local agencies are responsible for programs.*** The State typically makes allocation decisions, sets reimbursement rates, establishes eligibility rules and in some instances even dictates how many people must participate in group treatment programs. The State has maintained fiscal and administrative authority to ensure consistency across counties, to manage costs and safeguard funding for targeted clients. But these strategies are costly, hamper innovation and fail to ensure the desired consistency.

All of these problems exist regardless of whether policy-makers have more resources to dedicate to these issues or less revenue to dedicate to these issues. All of these problems undermine efforts to increase efficiency and improve the quality of services. All of these problems are well understood, and some policy-makers have even tried to resolve them.

So Why Do Problems Persist?

Washington controls key purse strings. As in the case of foster care, a substantial portion of resources are federal and Congress is often prescriptive in how that money is spent. Those rules can limit who is eligible for services, how those services should be provided and even who should provide those services.

California's Major Federal Grants for Health and Human Services and Related Programs: State and Local Government – Federal Fiscal Year 2001

Federal funds account for 45 percent of funding that is administered by the departments within the Health and Human Services Agency. But the impact of federal funding is even larger. Federal rules require the State to match federal dollars with state funds and thus federal rules also limit how the State can spend its own money. Additional federal funding that does not come through the Health and Human Services Agency also is used to serve vulnerable individuals and families.

Program	Funding
Medicaid Vendor Payments	$12,306,727,000
Temporary Assistance for Needy Families	$3,731,149,000
Food Stamp Benefits	$1,823,684,000
Medicaid – Administration	$1,079,269,000
Foster Care	$1,078,777,000
Title I (remedial education) – Local Education Agencies	$1,051,566,000
Children's Health Insurance Program	$765,548,000
Head Start	$749,463,000
Child Nutrition – School Lunch	$739,811,000
Women, Infants & Children Supplemental Feeding Program	$690,892,000
Special Education – Basic State Grant	$641,214,000
Community Development Block Grant – Entitlement	$493,263,000
Unemployment – State Administration Base	$350,635,000
Food Stamp Administration	$288,828,000
Rehabilitation Services – Basic State Grant	$270,087,000
Child Care Entitlement – Mandatory and Matching	$261,503,000
Child Care and Development Block Grant	$237,741,000
Substance Abuse and Prevention Block Grant	$232,353,000
Child Nutrition – School Breakfast	$214,575,000
Child and Adult Care Food Program	$214,465,000
Social Services Block Grants	$206,844,000
Workforce Investment Act – Youth Activities	$182,592,000
Adoption Assistance	$143,820,000
Public Housing Capital Fund	$128,334,000
Vocational Education – Basic State Grant	$118,026,000
Operation of Low Income Housing	$100,845,000
Consolidated Health Centers	$89,945,000
Low-Income Home Energy Assistance Program	$62,417,000
Community Development Block Grant – Nonentitlement	$46,089,000
Totals	**$28,300,462,000**

Source: Federal Funds Information for States. December 2000.

But the State has at least three opportunities to overcome these limitations, and none of them have been aggressively pursued: 1) The federal government allows for federal rules to be waived, but California has not pursued those waivers as assertively as other states. 2) State funds could be strategically used to give counties and providers the flexibility denied by federal rules, but it usually opts to impose its own restrictions. 3) California, with the largest congressional delegation, could push for statutory and regulatory changes that recognize state goals.

Federal Waivers Can Align Federal Rules with California's Needs

In previous studies, the Commission has recommended pursuing federal waivers to customize health and human service programs to California's needs. Federal statutes allow federal officials to grant waivers from certain requirements in particular programs. The State also can pursue relief through congressional action.

California currently has 24 Medicaid waivers, and under a child welfare program waiver five California counties are testing wraparound services designed to help especially needy children.

Legal experts note that waivers are expected to meet two common tests: (1) waivers should further the federal program's purposes, and (2) should be cost-neutral.

Common Waivers:

1115 waivers allow states to undertake demonstration projects that will test new strategies for administering programs and delivering care. For example, Florida is testing a combined Food Stamp and TANF eligibility determination process in six counties that utilizes non-state employees. These waivers are generally time-limited and not applied on a statewide basis.

1915(b) waivers allow states to provide Medicaid services through designated health care systems, such as managed care programs. These waivers apply to specific groups of clients, such as recipients of Social Security Insurance, who otherwise would not be directed into such programs. The Legislative Analyst has suggested that California consider expanding managed care coverage to Medi-Cal recipients currently provided services through the State's fee-for-service program.

1915(c) waivers allow states to provide services to individuals in their homes or communities, who otherwise would only be eligible for services if placed in an institution. In 1982, California was granted a Medicaid program waiver allowing the state to serve persons with developmental disabilities in their communities rather than in institutional settings. In 1993, the waiver was expanded allowing the State to waive spousal and parental income and resources for purposes of determining Medicaid eligibility for such individuals.

Encouraged by federal support for innovation, some states are exploring bundling waivers into "Super Waiver" packages that will allow broad cross-cutting realignment of state health and social service programs. But some advocates express concerns about waivers. While they can be used to improve care and outcomes, state and federal administrators seeking to control costs also may set aside congressional protections and thus undermine access and quality.

Sources: Sharon Parrott and Stacy Dean. Aligning Policies and Procedures In Benefit Programs: An Overview of the Opportunities and Challenges Under Current Federal Laws and Regulations, Washington, D.C.: Center on Budget and Policy Priorities. All County Welfare Directors Letter Number 95-10, Department of Health Services, February 6, 1995. Lourdes Rivera, National Health Law Program, e-mail March 29, 2004 to Little Hoover Commission staff.

California Must Recognize the Value of Federal Partners

Federal rules and regulations influence the performance of California's health and human service system. Federal funds amount to approximately 45 percent of overall funding, and a significant proportion of state dollars are tied up by federal rules that require a match. But the State has not aggressively pursued opportunities to align federal rules and regulations with State priorities.

Federal Funding Formulas. One-sixth of federal funds are allocated to the states through federal funding formulas. In 2002, California received 11.8 percent, or $48 billion, of the $407 billion allocated through more than 170 federal formula grant programs. Medicaid is the largest federal grant program that allocates funding on a formula basis. Under Medicaid, known as Medi-Cal in California, states have different federal matching rates for services. The federal government reimburses California for 50 percent of Medi-Cal expenditures. Thirty-seven states have a higher reimbursement rate. In 12 states, the federal government funds 70 percent or more of Medicaid expenditures. A recent analysis suggests that the way in which poverty is measured for purposes of Medicaid, underestimates need and disadvantages California. Revisiting formulas to better reflect the realities of poverty, the cost of living and other challenges in California could greatly improve the ability of the State to address needs.

Federal Contribution to State Medicaid Programs

State	2004 FMAP	State	2004 FMAP	State	2004 FMAP	State	2004 FMAP
Alabama	70.75	Illinois	50.00	Montana	72.85	Rhode Island	56.03
Alaska	58.39	Indiana	62.32	Nebraska	59.89	South Carolina	69.86
Arizona	67.26	Iowa	63.93	Nevada	54.93	South Dakota	65.67
Arkansas	74.67	Kansas	60.82	New Hampshire	50.00	Tennessee	64.40
California	**50.00**	Kentucky	70.09	New Jersey	50.00	Texas	60.22
Colorado	50.00	Louisiana	71.63	New Mexico	74.85	Utah	71.72
Connecticut	50.00	Maine	66.01	New York	50.00	Vermont	61.34
Delaware	50.00	Maryland	50.00	North Carolina	62.85	Virginia	50.00
D.C.	70.00	Massachusetts	50.00	North Dakota	68.31	Washington	50.00
Florida	58.93	Michigan	55.89	Ohio	59.23	West Virginia	75.19
Georgia	59.58	Minnesota	50.00	Oklahoma	70.24	Wisconsin	58.41
Hawaii	58.90	Mississippi	77.08	Oregon	60.81	Wyoming	59.77
Idaho	70.46	Missouri	61.47	Pennsylvania	54.76		

Federal Rules. Discrepancies in state and federal rules also limit the availability of federal funding. Under the In-Home Supportive Services Program, California pays relatives to serve as caregivers to eligible clients. But federal rules make these relative caregivers ineligible for reimbursement. A recent analysis suggests that revising state policies to match federal rules could reduce state and local expenditures by $48 million. Similarly, in an effort to ensure that children are served in the least restrictive environment, fewer children in California are enrolled in special education programs, and thus the State receives fewer federal dollars relative to other states. California could alter its policies to draw down additional federal funding, but these changes would disrupt state efforts to support family members as caregivers and to best meet the educational needs of children. Alternatively, the State could seek federal recognition of California's strategies and thus capture additional federal dollars while preserving state priorities.

Federal Expertise. California faces many enduring challenges, some of which lend themselves to federal or other outside expertise, such as California's dismal record on parole policies, the inappropriate incarceration of people with mental illness, and persistent challenges in improving outcomes for children in foster care. A number of states have made significant progress in addressing these challenges. But California has been stymied in its efforts. In some instances the State does not have the discretionary resources to invest in innovation, in others the State may lack the appropriate expertise. Federal experts could help the State identify and investigate practices with a record of success elsewhere and guide the State in how best to transition from unsuccessful strategies to proven approaches, as well as how to document outcomes.

Sources: Centers for Medicare and Medicaid Services. 2003. "Medicaid At-a-Glance 2003: A Medicaid Information Source. Washington, D.C.: Centers for Medicare and Medicaid. Page 7. Tim Ransdell. 2004. Federal Formula Grants and California: Factors Determining California's Share of Federal Formula Grants. Second Edition. San Francisco, CA: Public Policy Institute of California. Page 40. California State Auditor. 2003. Federal Funds: The State of California Takes Advantage of Available Federal Grants, but Budget Constraints and Other Issues Keep It from Maximizing This Resource. Sacramento, CA: California State Auditor. Page 1.

Budgeting and policy-making in California is inconsistent. Because California does not have a coordinated and articulated strategy for responding to struggling children and families, budget and policy decisions do not regularly move California toward an efficient and effective system of care. It is easier (and there are greater political

Programs Addressing Pregnancy are not Strategic

The State's efforts to improve prenatal care and reduce teen pregnancy are spread across four state departments, under the direction of two separate constitutional officers. Some funding goes to school districts, other resources are allocated to counties, and still more goes directly to contractors. Funding for some programs has expired, other programs continue. But without clear and compelling information on what works, what does not and how best to target resources, policy-makers have little guidance on what to fund, who should do the work and which Californians to serve. The result is a patchwork of programs that are uncoordinated and inconsistent and therefore unable to work strategically toward common goals.

Teenage Pregnancy Prevention Program. The California Department of Education provides grants to schools with high teen birth rates to reduce teen pregnancy by delaying the onset of sexual activity. Funding for the program ended January 1, 2004.

Cal-Learn Program. The Department of Social Services provides funding to county welfare departments to assist pregnant and parenting teenagers to complete their high school education.

California Mentor Program. The Department of Community Services and Development provides funding to community-based organizations to identify mentors for at-risk children. Pregnancy prevention is a primary goal of the mentoring program.

Adolescent Family Life Program. The Department of Health Services provides funding to county agencies and community-based organizations to provide services to approximately 17,000 parenting adolescents and their children.

Adolescent Sibling Pregnancy Prevention Program. The Department of Health Services funds county agencies and community-based organizations' initiatives that help teens delay sexual activity and prevent pregnancy among adolescent siblings of pregnant and parenting teens.

Pregnancy Special Needs Payment. The Department of Social Services provides funding to county welfare departments to administer additional payments to teen mothers to meet their health care, housing and related needs during pregnancy.

Teen Pregnancy Disincentive Program. Through the Department of Social Services' CalWORKs program, county welfare agencies discourage teen pregnancy by eliminating financial incentives for teen pregnancy and work to strengthen parent-teen relationships.

Comprehensive Perinatal Services Program. The Department of Health Services provides funding and technical assistance to county health departments to train and assist physicians who work with pregnant women and newborns.

Regional Perinatal Program. The Department of Health Services funds regional planning, surveys, assessments and other region-level activities to improve quality and promote access to perinatal care.

California Diabetes and Pregnancy Prevention Program. The Department of Health Services provides funding to health care providers for prenatal and diabetes care that includes education about the risks of pregnancy for women with diabetes.

rewards) for creating a new program (even a short-lived and ineffective pilot program) than it is to fix a complicated, essential but inadequate program that is already in law. Policy-makers routinely identify fleeting priorities and respond to headlines. The result is a proliferation of categorical funds, pilot efforts and special projects that do not result in continuous improvement in the quality of services.

Policy-makers must change standard practice in budgeting and policy-making. Funding must be tied to outcomes. And goals should drive decision-making on policy, budgeting, monitoring and accountability.

People want more than they are willing to pay for. California's funding system is particularly challenged by the number of people seeking publicly funded care. And ideological gridlock on the role of government results in ambitious goals that are inadequately supported by uninspired budgets. As a result, California has developed sophisticated programs that end up rationing care in ways that result in higher costs and lost lives. And while there is considerable angst about failures in the system, California has not had a thoughtful dialogue, particularly with civic and community leaders, about what it would take, financially and politically, to meet important goals. The discussion should go far beyond the right level of taxation to include tax policy, the role of employment-related benefit programs, philanthropy and community-based organizations in supporting vulnerable individuals and families.

Sacramento is not willing to give up control. Those rules that are not set in Washington are usually set in Sacramento. And given the relationship between the State and its counties, the consequences of these tensions can be even more severe. While funding rules can limit who receives care, unfunded mandates can undermine entire programs. And while the State has an elaborate bureaucracy dedicated to control spending (an adversarial task), few resources are dedicated to improving progress toward shared goals (which requires cooperative partnerships).

Counties and other local service providers have adapted to these realities in their efforts to best meet local needs. Innovative counties have become adept at leveraging funding to build systems of care that can tailor services to needs.

Scores of Rules are Set in Sacramento

California lawmakers have adopted detailed requirements that limit flexibility and innovation and require counties to dedicate time and money to comply with state standards and reporting requirements.

Legislation Dictates Rules. In some health and human service areas, the State sets goals and relies on service providers to manage programs. In other areas, detailed standards are set in law. For example:

- AB 464 - Requires education agencies to include a group home representative in meetings to discuss educational decisions for a child residing in a group home.
- AB 333 – Requires that the monthly visit of a social worker to a foster child in a group home include a private and confidential discussion.
- SB 1089 – Requires child welfare workers to receive training on post-traumatic stress disorder as it applies to children.
- SB 292 – To reduce medication errors, requires labels on pharmacy prescription containers to include a physical description of the drug, including its color, shape, etc.
- AB 464 – Prohibits an adult day health care center from requiring the assistance of family members at the center.

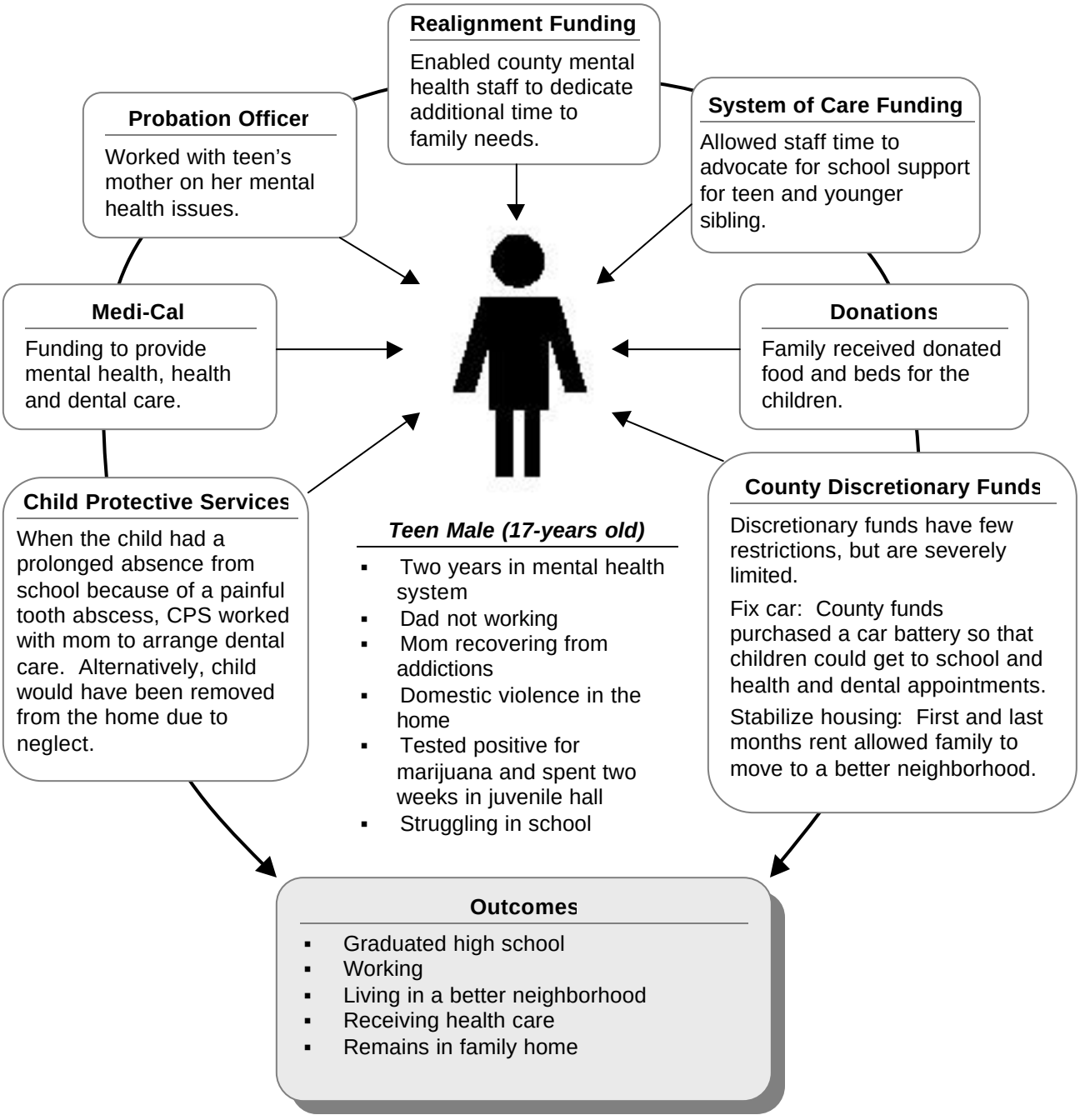
This Approach Adds Costs and Complications. Detailed state rules have fiscal implications. The State is required to reimburse counties for the cost of mandated activities. Thus the State is required to undertake detailed cost calculations for scores of programs.

- **Group Home Monthly Visits**. To monitor the quality of care, the State requires county social workers to visit children placed in group homes. The Department of Social Services projects that 12,317 children will be visited in fiscal year 2004-05. The hourly cost of a social worker is set at $72.60 for the fiscal year. The department assumes that social workers will visit two children placed out of state on each trip and that all children will be visited 10 times each year. Visits will last two hours for children in California and visits out of state will require 12 hours. Based on this calculation, along with travel costs, the department estimates that group home visits will cost the State $19.7 million. The federal government will fund $7.5 million, leaving the State to pay the balance of $12.5 million.
- **Background Checks**. State law requires counties to conduct background checks on relatives or others caring for children through the child welfare system. The Department of Social Services estimates that in 2004-05, there will be 23,212 new children needing placements. It assumes that, on average, two children will be placed in each home and two people in each home will need a background check. The law requires counties to request information on prospective caregivers from three sources, which have fees of $15, $48 and $24. At $87 per inquiry, multiplied by 23,212 inquiries, the department projects background checks to cost the State just over $2 million. The federal government will pick up $768,000 of the tab.
- **Dog Food Allowance**. State law authorizes the payment of $50 per month to eligible persons who have guide or service dogs. The Department of Social Services estimates that just 15 people qualify for this payment. At $50 per month, the department estimates the State will need to budget $9,000 to meet costs.

Trade Rules for Outcomes Calculating these costs and tracking compliance with detailed rules is expensive, time consuming and can hinder good outcomes as they limit county discretion and draw attention to compliance with detailed rules and budgets rather than goals and outcomes. Alternatively, the State could set clear goals, provide counties with adequate discretion, create incentives for improvement, and monitor outcomes, such as educational attainment, child safety and medication errors.

It Takes a Team:
Piecing together disparate funding to help a child

Innovative counties are pulling together staff and funding from multiple departments to better meet the needs of individuals and families. But many funding sources have rigid rules that do not permit flexibility and thus compromise outcomes. The following example is based on an actual case.



Services – Without Team

- 1 hour a week counseling
- No school support
- No job support
- No housing support
- No car support
- No face-to-face time with probation officer
- Likely removal from home by CPS

Sacramento Must Change Course

Virtually every debate about financial resources for health and human services begins with the assertion that programs are under-funded, in part because there are many legitimate unmet needs. But there will never be enough public money to meet all needs, particularly if public programs are not operating effectively.

The debate over financial resources should begin with California's goals, include all of the resources that are available to pursue those goals, and then focus on how available public funds are being spent. One essential principal must be to give the level of government responsible for serving Californians as much flexibility as possible in how those funds are spent. In exchange, the public and their policy-makers should be assured that resources are being spent on proven practices that improve lives at least possible cost.

Goals, not available funding, should drive programs. California makes an enormous investment in health and human service programs. But because funding is allocated through scores of programs, which operate under disparate rules and organizational structures, the State and counties have little idea how much is spent on particular needs or what they are getting for their money. Modern financial management practices start with the establishment of clear goals: what do we want to achieve. They then work backward to determine how to get there and in what timeframe. Government is challenged to see beyond one or two

Funding Structures Can Infuse Flexibility with Accountability

Policy-makers have several options for allocating funding in ways that are flexible and infused with incentives without sacrificing accountability. The type of funding mechanism also determines how costs can be controlled.

Block grants are generally used to consolidate a number of categorical programs and provide greater flexibility. They allow for fixed allocations, rather than funding tied to eligible beneficiaries or costs. Block grants are commonly thought of as reducing regulation and oversight tied to reimbursements, but allocations are often not augmented as needs grow and policy-makers are reluctant to delegate all discretion to a lower level of government.

Entitlements create a legal obligation to provide services or funding when eligibility criteria are met. Entitlements are considered mandated spending, therefore to control costs they commonly include significant restrictions on who can be served, what services can be provided and who can provide those services.

Trust Funds are supported by a dedicated revenue stream with limits on how money can be used. The use of funds are defined by a trust agreement or statute and traditionally are not available for general purpose expenditures. The amount of funding is determined by the revenue source used to support the fund.

Cost Reimbursements are payments for costs incurred for administration of a specific program or service.

fiscal years, therefore it is hampered in its efforts to understand how it could better invest in the future of its citizens. Starting with goals could allow policy-makers to better marshal existing resources and identify additional resources where needed.

How money is spent is as important as how much. California's baseline budget approach locks in funding for most programs. But there is ample evidence that shifting funding to relatively inexpensive, cost-effective prevention strategies, can reduce the need to fund expensive services to respond to problems. For example, a recent study of 10,000 mental health clients in Los Angeles County found 40 percent had some involvement with the criminal justice system. In nearly all instances, that involvement was for non-violent crimes.[87] Follow-up research explores which mental health interventions can best reduce criminal justice costs. But budget practices do not reveal the nexus of mental health and criminal justice spending or create incentives for counties to move funding across budgets. And inadequate local mental health systems thus result in higher local jail costs and higher state costs associated with the courts and prison system.

Flexible spending structures that allow counties to move money across programs, that create incentives for prevention and the reduction of local and state costs, can dramatically extend the value of existing budget allocations.

Limited, reliable funding is more valuable than cycles of forced cuts and temporary windfalls. Clear goals permit administrators to prioritize spending and shift resources to more cost-effective approaches to meeting needs. But the reliability of funding also is important. Health and human service agencies need time to build capacity. Budget swings shift valuable attention away from long-term, goal-oriented strategies to deal with short-term emergencies, to patch shortfalls or spend new-found but temporary riches. Policy-makers that can commit to a sound and stable investment in health and human services can allow administrators and service providers to dedicate their energy to meeting goals.

Creating Fiscal Stability

The State's treasury is dependent on the overall economy, which undergoes periods of expansion and contraction. These cycles present challenges to policy-makers trying to ensure the stability of public programs with unstable revenue streams.

- The State has not been able to keep a reserve of sufficient size to weather fiscal downturns.
- "New," limited term funding, linked to short-term economic growth, creates incentives to design policies and programs around funding rather than goals.
- Fiscal instability creates distrust between the State and local governments, as spending reductions result in unfunded mandates or the State preserves programs that meet its priorities and thus restricts discretionary spending by local agencies.

But the State has not fully explored opportunities to use periods of economic expansion in anticipation of periods of decline.

The State uses reserves, debt and other tools to address short-term challenges and long-term obligations. Policy-makers also could consider expanding the use of trust funds, local reserve funds or other strategies to pre-pay local assistance obligations during the good times to ward off the need for cuts during down times.

Sunset Reviews Can Shift Funding from Categoricals to Discretionary Accounts

Sunset reviews generally determine whether programs and funding continue. But the review process also can transform categorical dollars into discretionary funding and replace program requirements and compliance monitoring with performance reports that better allow policy-makers and the public to monitor outcomes. Sunset reviews could start with programs funded with primarily state dollars. For example:

Women and Children's Residential Treatment Services. Provides $6.4 million to provide alcohol and drug treatment for women in residential treatment programs and their children.

Parolee Services Networks. Provides $10.7 million from the Department of Corrections to counties for alcohol and drug treatment and recovery services to inmates and parolees in 17 counties.

Drug Court Partnership Program Grant. Provides $7.6 million to fund court supervision, drug testing, substance abuse treatment and other services.

Children's System of Care. Provides $20 million to fund interagency services to meet the needs of children at risk of psychiatric hospitalization, school failure, involvement with the juvenile justice system and out-of-home placement. The Governor's budget proposes to eliminate all funding for this program.

Kinship Support Services. Provides $1.5 million to 11 counties to provide community-based family support services to relative caregivers and the dependent children placed in their homes by the juvenile court and to those who are at risk of dependency or delinquency.

Emancipating Foster Youth Stipends. Provides $3.6 million to provide assistance to emancipating foster youth to find affordable housing, cover the cost of tuition, books, vocational training, transportation and meet other needs.

Substance Abuse/HIV Infant Program. Provides $5.9 million ($4.3 million state and county funds) for recruitment, training and respite service for foster family providers caring for children with specialized medical needs.

Supportive and Therapeutic Options Program. Provides $9.9 million in state funds to provide therapeutic day services to youth at risk of out-of-home placement or returning home from a placement.

Transitional Housing for Foster Youth. Provides $1.37 million in state funds to provide transitional housing opportunities for youth emancipating from foster care.

State Children's Trust Fund Program. Provides $6.3 million to fund innovative child abuse and neglect prevention and intervention activities.

Sources: Department of Alcohol and Drug Programs. "Funding Descriptions, Fiscal Year 2002-03." Department of Alcohol and Drug Programs. "FY 2004-2005 Governor's Preliminary Budget Allocation Statewide Summary Sheet." California Department of Alcohol and Drug Programs. "Highlights of the Governor's Budget Fiscal Year 2004-05." Department of Mental Health. "Children's System of Care." Department of Social Services. "Local Assistance Estimates. Governor's 2004-05 Budget."

In Sum: Funding Should Improve Outcomes

Traditional budget practices rarely question the value of programs or shift funding from one strategy to another, with the exception of periods of severe economic constraints. And even under a climate of budget cuts, across the board reductions or wholesale elimination of programs are more common than strategic elimination of ineffective or inefficient programs. Sound monitoring of results can inform decisions whether resources are stable, falling or expanding. And fiscal incentives and flexibility can push agencies to set priorities, shift dollars to cost-effective strategies and make the best use of available resources. Along with technical assistance and monitoring, funding should be recognized as a tool for meeting goals.

Recommendation 4: Shift health and human service funding to counties. Align programmatic and fiscal authority to recognize priorities and target the cost-effective use of limited public funds.

Shift funding control to the counties

- ***Create a local trust fund for health and human services.*** The Health and Human Services Agency should systematically review all health and human service funding to identify state, federal, legal and other barriers to consolidating funding into a trust fund. The Agency should propose strategies for addressing those barriers and, to the extent possible, shift fiscal authority for those funds to the counties.

- ***Identify a baseline and growth formula for health and human service funding.*** The Health and Human Services Agency, in conjunction with local agencies, should propose a baseline and growth formula and a distribution formula for local health and human service trust funds.

  - ✓ **Stabilize funding.** The growth formula proposal should include provisions to stabilize funding across economic cycles. Options to be explored should include State pre-payment of future growth obligations during periods of economic strength in exchange for foregoing payments during periods of economic shortfall.

  - ✓ **Create incentives to reduce state costs.** Funding formulas should include incentives for local agencies to reduce State costs. The Agency should develop formulas that promote prevention, encourage the adoption of proven and promising practices, motivate local agencies to develop innovative strategies to address complex needs, and result in a reduction in the number of people who move from local programs to state-operated programs.

- ***Create an innovation block grant program for health and human services.*** Ten percent of trust funds should be set aside for state control. Innovation funding should provide block grants to counties to address persistent challenges to improving outcomes.

- ***Inventory and seek federal waivers.*** The Health and Human Services Agency should report to the Legislature within 60 days on federal waivers currently available that would infuse greater flexibility into funding streams. The Agency should indicate which waivers are in place in California, which are in place in other states, and which additional waivers it intends to pursue and justify its decisions not to pursue others, if any.

- ***Strengthen the sunset review process.*** The Legislature should extend its sunset review process to review funding not included in the local health and human service trust fund. No less than once every three years, each categorical program and its funding should be reviewed and one of three options exercised: 1) Reauthorize the categorical program and funding. 2) Sunset the categorical program, but shift funding into the trust fund. 3) Sunset the categorical program and funding.

Enhance revenue authority and options

- ***Create local government revenue options to support programs.*** The Health and Human Services Agency, in conjunction with county officials, should transmit to the Governor and Legislature proposals to develop local revenue streams to support health and human services. County specific alcohol taxes, vehicle license fees and other potential revenue sources should be explored.

- ***Seek federal reimbursement for unallocated Social Security taxes.*** The Governor and Legislature should work with California's congressional delegation to secure the return of Social Security taxes paid on behalf of undocumented immigrants working in California who will not benefit from Social Security. Recovered revenue should be dedicated to reimbursing the State and local agencies for providing services to immigrants and other clients not eligible for federal support.

Unallocated Social Security Taxes

The State may have an opportunity to claim $10 billion or more paid to the federal government by Californians for benefits that the federal government is not providing. Significant research remains to be done to determine the viability of this opportunity.

The Social Security Administration reports that a small percentage of social security tax payments cannot be linked to workers because of mismatched or false Social Security numbers. Rough calculations suggested that $57.3 billion has been paid on behalf of workers who cannot be identified. Thirty-five percent of those payments came from California. And a significant percentage was paid on behalf of undocumented immigrants, who are not eligible for Social Security or Medicare. In essence, employers and workers have paid an insurance premium for a benefit that does not exist.

While employers have been paying Social Security taxes for undocumented immigrants, the State and local governments have been providing health care and other services to these workers. Had Social Security benefits been available, State and local costs could have been greatly reduced.

The Commission has urged the Governor and Legislature to advocate for increased federal support. The State could ask the federal government to return to the State those premiums that Californians have paid on behalf of undocumented immigrants who are not eligible for federal benefits but are receiving state and local services. Reimbursement would require congressional approval.

A number of arguments support California's claim:

1. States are in a better position to link unallocated taxes with services. Unallocated Social Security taxes are theoretically held in trust by the federal government. In reality, the federal government spends against those funds with no direct link between the payer and services to the payer. States also can hold funds in trust, and in the meantime use them to support retired and disabled individuals as the Social Security law intends. Counties currently provide health and human services to undocumented immigrants in line with public health and safety needs.
2. Californians are taxed twice. Employers and employees each pay half of mandated Social Security taxes. Social Security benefits allow individuals to pay for medical and other essential needs. In the absence of those benefits, the State and counties tap the General Fund to provide essential services. California employers and workers are essentially taxed twice to pay for these services.
3. California has an opportunity to recognize the dignity of undocumented immigrants. Social Security was designed to help workers prepare for retirement and address their needs should they become disabled. Millions of Californians rely on Social Security without stigma. In contrast, undocumented immigrants who are denied benefits but need public services are derided as not paying their fair share for community programs. Directly drawing upon the tax payments of undocumented immigrants to reimburse the State and local governments for health and human services would recognize the contributions of these workers to California.
4. Improve accountability for Social Security taxes. Californians pay billions in Social Security taxes with no clear accounting of where the money goes. Preliminary research suggests that the federal government has never explored the ownership of unallocated funds. The employees on whose behalf the payments were made have a clear claim on those funds, as do employers. But returning funds to employees is problematic because the Social Security Administration cannot identify them. Returning the funds to employers would create perverse incentives in the labor market. The states and federal government also have claims but in the absence of dialogue, the mounting payments go unnoticed and their ownership uncontested.

Promote Meaningful Accountability

Finding 5: Public agencies spend extraordinary resources on compliance, auditing and other "oversight" activities that do not provide meaningful accountability that leads to improved performance.

California invests tens of millions of dollars monitoring compliance with complicated rules that govern health and human service systems. In some instances, monitoring uncovers fraudulent or inappropriate practices. But in general, monitoring is costly and inadequate. Despite significant time and attention to monitoring, administrators and policy-makers lack the information they need to ensure programs are operating effectively or efficiently.

Monitoring is Costly

The State has detailed rules on what local agencies and service providers can do and how they must track and report their activities. In some instances, these requirements are derived from sincere efforts to promote uniformity across local agencies or to clamp down on questionable uses of public funds. But county officials say that reporting requirements increase administrative burdens and distract staff from directing their energies and time to serving clients.

For example, California maintains a relatively detailed data system on children served by county child welfare agencies. The Child Welfare Services Case Management System (CWS/CMS) tracks caseloads, the overall number of children being served and the types of services they receive. But state officials complain that county caseworkers have failed to input data in a timely manner or ensure the reliability of the data that are entered. In turn, county social workers claim that reporting rules and complicated data entry systems keep them at their desks when they should be helping vulnerable children. Both complaints are accurate.

Meaningful Accountability

Policy-makers must set clear goals. They must understand the needs of clients as they relate to those goals, and the State's role in the complex interactions of policy, funding, regulation and service delivery that ultimately will influence outcomes.

Findings 1 through 4 address those challenges. But the work is not done. Policy-makers and administrators also must prioritize data-driven decision-making over the emotional appeals of lobbyists and Luddites. They must continuously assess and benchmark performance and efforts to improve outcomes.

County child welfare agencies alone handle more than 40 state forms, many of them mandatory, dealing with children and families. Across the major health and human service programs, more than 200 forms are used to gather information on clients, assess eligibility, authorize services and report information. Much of the information is duplicative. A preliminary review of state health and human service departments identified 63 unique data systems. A listing of these data systems is

Monitoring Disparate Systems

The State's ability to monitor county operations is confounded by rigid monitoring requirements and the disparate nature of county programs. In the end, the State has little meaningful information.

Complex state and federal statutes, regulations and contracts determine what state departments must monitor, what information they must collect and how frequently they must do so. As these rules are applied to 58 counties with disparate organizational structures, distinct bundles of funding and programs, coupled with varying capacities to handle data and different caseloads, monitoring becomes increasingly complex.

Counties view the State as inflexible and uncompromising. In turn, state departments view county requests for special treatment as unreasonable, given the number of counties they oversee, the complex nature of workloads and the scrutiny of federal monitors and other oversight agencies.

included in Appendix F. These departments have more than 1,150 employees assigned to information systems, with personnel costs alone exceeding $90 million. In addition to state costs are those incurred by 58 counties, 33 Area Agencies on Aging, 21 Regional Centers, 523 hospitals and numerous other reporting entities that must collect, organize and transmit data to the State.

Monitoring is Inadequate

Despite significant monitoring requirements, policy-makers have little meaningful information on what is in place, where progress is being made or where improvement is needed. Monitoring is an exercise that tracks paperwork, not outcomes. Some examples of missed opportunities:

Actions, not outcomes, are tracked. Children in California's foster care system are routinely denied their rights, including health care, appropriate education and contact with siblings. As a remedy, in 2001 the Legislature passed a law requiring social workers to inform children in foster care of those rights. Group homes also are required to post a list of rights in a conspicuous place.[88] The law empowers the Department of Social Services to ensure that social workers explain to children their rights at least once every six months, with the hope that older children will be their own best advocates, particularly in court.

But posting a list of rights and explaining them to teenagers does little to ensure these rights are protected. And children are the least empowered to hold judges accountable. The State has the capability to monitor whether children in foster care actually are in school, whether they graduate and if they find employment, their wages and tenure in jobs. The State could track whether children are receiving health care while in foster care and if they have stayed in touch with their siblings. But it does not. Instead, the State monitors whether rights are posted, and whether they were explained according to mandated timelines.

Compliance is monitored, not effectiveness. Detailed rules are written and actions are tracked to promote consistency, even at the expense of improvement. California's drug Medi-Cal program, for example, is highly structured. Rules dictate who can receive services, under what conditions, from whom and for how many hours each week

or month. The State even dictates how many people must participate in group counseling sessions.[89] Deviate from the rules and the State can deny payment, levy fines and increase scrutiny. But the State does not monitor whether particular programs work, increase employment opportunities or help families weather other challenges.

Sacramento County found that substance abuse was a significant factor among clients in almost every human service department. The county prioritized drug treatment for high-cost populations to help them rebuild their lives and reduce demand for other services.[90] The State has the potential to track whether outcomes improve in health and human service programs when drug treatment dollars are used to prevent other needs. But it doesn't. Instead, the State simply completes "desk-reviews," in which an analyst – far removed from where services are delivered – examines paperwork to monitor compliance.

Dollars are tracked, not people. The state Department of Mental Health tracks county expenditures on mental health programs to ensure appropriate distribution of county and state costs. The State can document the cost of direct services, administrative costs and even the price of evaluation and research. Cost data are transmitted from each county to the State through automated systems that allow for immediate feedback, validation of accuracy, year-to-year and cross-county comparisons. Cost reports allow the State to monitor units of service for specific types of care and which funds were used to pay for that care.[91] But neither the State nor counties can report the results of those services, whether people are better off having received care or what it costs to serve them over time.

Monitoring is not driven by mission. Despite a mission to ensure care, state leaders and oversight agencies look the other way. In 2002, mental health clients in Lassen County complained to state officials that their county had an unwritten policy that resulted in children under the age of five being turned away from care they were entitled to, in violation of state law. If true, the practice is inconsistent with state goals prioritizing prevention as a cost-effective use of limited funds.[92]

An investigation by the state Department of Mental Health found that during a 12-month period the county had served 11 children in this age group (0.5 percent of the county's preschool-age population), and concluded the allegation could not be substantiated.[93] Clients appealed to the California Mental Health Planning Council – an oversight agency – which declined to visit the county and found the department's review adequate.[94] But prevalence rates suggest that 10 to 20 times as many children need care in Lassen.[95] And while the department found that

some children were served, it failed to assess whether children were inappropriately denied care.

The Legislature gave the department a mission to ensure care: "The California Department of Mental Health, entrusted with leadership of the California mental health system, ensures through partnerships the availability and accessibility of effective, efficient, culturally competent services. This is accomplished by advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services."[96] The Legislature also empowered the Mental Health Planning Council to oversee the department.[97] Both receive funding to monitor care; in this case, neither fulfilled its mission.

Monitoring Fails to Produce Improvement

State law authorizes state departments to assume control over county programs that persistently fail to meet legal or regulatory requirements.[98] The State can levy fines, demand improvements and require detailed reports on activities, expenditures and improvement plans. But there are few intermediate levers the State can flex to compel improvements and almost no resources to offer sustained guidance and support for counties that want to do better.

State Administered, Locally Operated

State and federal laws designate the State as the responsible entity for the bulk of health and human service programs. The State, in turn, delegates authority to the counties or other local agencies to provide direct services. But the State retains authority to intervene when necessary.

California's Welfare and Institutions Code (10605) states that if counties fail to comply with rules governing social service programs, the State has the authority to: (1) Withhold all or part of state and federal funds from the county. (2) Assume, temporarily, direct responsibility for the administration of programs.

But the law is unclear on what conditions warrant takeover. And despite dramatic problems in local operations, the State does not have a record of assuming control. When the State has intervened, mostly in the operation of school districts, it has been because of fiscal mismanagement, not a lack of quality, efficiency or outcomes.

In many cases, the State is reluctant to assert its authority – particularly the drastic step of taking over local operations. State agencies themselves have limited capacity to do better, given how services are organized, funded and operated. With the potential for independent action poisoned by state-local interdependence, the State fails to act. Problems are managed. Solutions are not delivered.

As a case in point, the State is in arrears to the counties for mandated mental health services to children in special education programs. Estimates suggest the bill to the State, following several years of avoided payments, approaches $250 million. Policy-makers and budget writers are concerned that the State is hemorrhaging money it does not have. School officials are concerned that children are being turned away from mental health programs because the State has not paid for services provided

in the past. Mental health agencies are concerned that the State is not making good on commitments to care for these children.

Rather than address the underlying problem, the State is practicing fire-alarm management. Problems are ignored until they flare out of control. Then action is taken to put out fires, but problems go unsolved. In the case of special education funding, state officials are considering shifting the burden of paying for services from local mental health agencies to local education agencies.

The State has an obligation, under state and federal laws, to provide services to these children. Rather than working to understand what drives needs and how the State and local agencies can best prevent the need for costly services, policy-makers struggle mightily to avoid liability, or shift it on to those least able to complain.

Changing Strategies

To improve the performance of health and human services, state leaders must understand the needs of clients and how the complex interactions of policy, funding, and practice support particular outcomes. State operations and funding mechanisms need to be re-engineered. And policy-makers must use data to drive decision-making. Moving forward with reforms will require policy-makers and administrators to continuously assess and benchmark performance. And they need valid, reliable information to guide their efforts.

Using Performance Measures

The State has spent more than a decade experimenting with performance measures. Under Program Realignment in 1991, the Legislature required local mental health agencies to collect and report outcome measures for mental health services. The Department of Mental Health continues to develop its system.[99] Under welfare reform, Congress established performance measures for transitioning welfare recipients to independence and California has adopted those measures into state statutes.[100] The Department of Social Services also has turned to using performance measures to track outcomes in the child welfare system.[101]

San Diego County

Since 2000, San Diego County has used a report card to track progress on child and family health and well-being in the county. The county has strategic indicators for three issues: kids, environment and communities.

San Diego's indicators for kids measure progress in child health, safety, education and involvement with crime. Environmental indicators monitor public health, open space, and development. Community indicators measure crime rates, emergency preparedness, population health, employment, income, and housing affordability.

The county also monitors the quality of its operations through a variety of indicators.

Source: Kay A. Johnson and Sandra L. McBrayer. 2003. "San Diego Children's Budget: Financial Data to Improve Future Returns."

The Child Welfare Outcomes and Accountability System, created by AB 636, requires DSS to measure the following outcomes:

1. Children are, first and foremost, protected from abuse and neglect.
2. Children are maintained safely in their homes whenever possible and appropriate.
3. Children have permanency and stability in their living situations without increasing reentry to foster care.
4. The family relationships and connections of the children served by the child welfare system will be preserved, as appropriate.
5. Children receive services adequate to their physical, emotional, and mental health needs.
6. Children receive services appropriate to their educational needs.
7. Families have enhanced capacity to provide for their children's needs.
8. Youth emancipating from foster care are prepared to transition to adulthood.

Performance measures also are used at the local level. County child death review teams routinely report on outcomes and performance measures in their annual reports on child deaths.[102] Several counties track outcomes through their Interagency System of Care for children and youth.[103] Several counties, including San Diego and Los Angeles, have used or are developing report cards and other strategies to monitor child and family well-being.[104]

Performance measures can clarify expectations, indicate progress relative to goals and motivate staff and officials to strive for improvement. The use of performance measures to monitor outcomes also can take the place of expensive compliance monitoring activities that restrict behavior and stifle innovation.

But the State has not incorporated performance measures into planning, budgeting, or oversight activities. Despite significant data capacities, the State has not used data to drive decision-making.

Using Data to Improve Outcomes

The public sector is quickly recognizing the value of data to improve outcomes. Data allow policy-makers to understand needs and design policies and programs to meet them. Data enable administrators to benchmark performance and track efforts to improve outcomes, streamline operations and reduce costs. And data allow the public, clients and others to assess what's in place, convey their support or call for change.

California makes a significant investment in data collection. The State maintains vast amounts of program data. Some data are linked to general programs – such as residence, age and identifying information collected by the Department of Motor Vehicles. Other information is more specific, such as data collected by law enforcement agencies and the courts to track people through criminal and juvenile justice programs. Still more information is gathered to determine whether children, adults and families are eligible for programs and the services they received, as is the case with many health and human service programs. And the State and counties also collect and share information to track program costs, monitor compliance with state and federal rules, and in some cases, track performance.

The State has made some effort to use data in cost-effective ways. But in general, California has not used data to improve program operations and outcomes.

Consolidating Data Collection, Storage and Processing: Other states have found that a majority of beneficiaries receive assistance from multiple programs. Eliminating redundant collection of eligibility data and sharing data storage and processing capacity among programs with overlapping client populations reduces costs and increases data accuracy by creating multiple points of verification. The State has made some progress in this area. County health and welfare agencies use a common automated eligibility determination system – SAWS – for Medi-Cal, CalWORKs, Foster Care, Food Stamp, Refugee Assistance and County Medical Services. But many of the beneficiaries of these programs also receive mental health and drug or alcohol treatment and these programs are not part of the SAWS.

Expand Data Sharing: The principles the State promotes for "system-of-care" and "wrap-around" case management systems could be applied to sharing data among programs serving the same client. But separate social, mental health, and alcohol and drug treatment caseworkers make service and care decisions without sharing information. Santa Cruz County has pioneered a shared database of information about services and care provided to juvenile wards. While respecting and honoring confidentially and privacy requirements, the county used shared information to reduce costs and reshape probation, mental health and alcohol-drug treatment programs to better meet needs.

Measure Long-Term Impacts: A number of long-term studies concerning the public's return on investments in pre-school programs, home nurse visits, and child abuse prevention show that later health, welfare, educational and criminal justice impacts are significantly influenced by early public assistance, child development and health interventions with families and children. But while the State has health and welfare data going back many years, the data are not routinely used to shape and improve health and welfare investments. In previous studies of child care, mental health, and foster care the Commission found significant opportunities to reap improved economies and efficiencies by tracking long-term outcomes and using this data to better deliver early services that prevent costs later.

To move forward, California must rethink how it uses data. As recommended in Finding 1, state and local leaders must agree on the goals of public programs. They also must development consistent and reliable strategies for gathering data on outcomes, benchmark performance and track improvement.

Measuring Performance is Not Enough

Several states have identified performance measures and are collecting data to monitor performance. But data alone are insufficient to create accountability. Information must be meaningful, accessible and understandable. It also must be used in funding and policy decisions.

Policy-makers must find value in performance measures. They need information that can guide decisions on when, where and how additional funding or policy changes can best improve outcomes. Service providers and administrators need information that indicates which approaches are successful, and at what cost. And the public – if they are expected to provide continued support for programs – must recognize the value of public funding and efforts to improve outcomes.

Public health and human service programs are not accustomed to documenting how they have change the lives of the people they have served. But they are experienced in struggling with budget cuts and turning away truly needy people who can be helped. A well-designed accountability system can help service providers document their contributions to the State and local communities, and justify the use of public funding.

For health and human service programs, policy-makers and the public must recognize the contributions of programs for the overall health and well-being of communities. Performance measures, as a component of

Developing Outcome Measurement Systems

In 2000, Anne Morris, Ph.D., of the Center for Mental Health Service Research, University of California, summarized five general principles from recent literature guiding outcome measurement systems in mental health. Those lessons apply equally well to other health and human services.

Principle #1: Success depends upon a shared sense of urgency about the need for change. Although there may be an urgency about accountability and the need to implement outcome assessments at the state level, this may not be fully shared by administrators and staff on the "front lines" of care.

Principle #2: There must be a clear vision at the top defining the need for change and the goals of the new system. This vision must be widely communicated throughout the organization. There must be a consensus about the "worthiness" of those goals.

Principle #3: There must be "buy-in" from front-line managers and direct care staff. Without the "buy-in" of managers and staff, implementation efforts are doomed to failure.

Principle #4: Information should flow in both directions. Managers and staff in health and human service organizations should receive feedback about consumer outcomes and program performance on an ongoing basis. This information should be user-friendly and guide decisions about programs and the allocation of scarce resources.

Principle #5: Implementation of new technology/change efforts should be tied directly to the organization's mission and goals, and should be anchored in the culture and climate of the organization. Implementation must be clearly linked to the goals of quality improvement in services to consumers.

an accountability system, motivate improvement, guide public investments and build confidence in leaders, administrators and service providers. Performance measures are an essential component of an accountability system that makes the previous recommendations meaningful.

Performance Measures in Other States

Arizona. Under the direction of the Governor, Arizona is developing a comprehensive accountability system to monitor substance abuse and gang activities and related interventions. State leaders in Arizona are developing statewide and community scorecards to monitor progress toward goals. They are developing an inventory of programs, systematically assessing needs, promoting the use of proven and promising practices. Arizona also is developing a Geographic Information System to map challenges, identify effective interventions and monitor improvement.

Washington. In 2002 Washington's Governor Locke established the following "Priorities in Government" to guide budgeting and performance management:

- ✓ Improve student achievement in elementary, middle, and high school
- ✓ Improve the quality and productivity of our workforce
- ✓ Improve the value of a state college or university education
- ✓ Improve the health of Washington citizens
- ✓ Improve the security of Washington's vulnerable children and adults
- ✓ Improve the economic vitality of businesses and individuals
- ✓ Improve statewide mobility of people, goods, information, and energy
- ✓ Improve the safety of people and property
- ✓ Improve the quality of Washington's natural resources
- ✓ Improve cultural and recreational opportunities throughout the state
- ✓ Strengthen the ability of state government to achieve its results efficiently and effectively

Under the Governor's direction, each state department is required to develop performance measures, and produce quarterly reports on performance. And each member of the Governor's cabinet has a performance agreement with the Governor that communicates mutual expectations around mission, performance measures to be used, and benchmarks.

Source: Alan Brown. "Achieving Greater Impact in Arizona's Communities: Building the Capacity and Accountability in Arizona's Substance Abuse and Violence Prevention Programs." On file. Governor Locke. Executive Order 03-01. State of Washington. . Governor Locke. Executive Order 97-03. State of Washington. Office of Finance and Management. 2003. "2003-05 Governor Locke's Proposed Budget." www.ofm.wa.gov/budget/priorities2.htm. Accessed February 24, 2004.

Meaningful Compliance Monitoring

Compliance monitoring is important, but it must be part of an overall strategy to understand what is working, what is not and where improvement is needed. And compliance monitoring must move beyond rote examination of whether or not the rules are followed. It should provide meaningful information on the fidelity of administration, fiscal operations and services to rules and regulations designed to ensure quality outcomes. Monitoring should be geared to improve both operations and the rules and regulations that guide them.

And compliance monitoring is key to the detection of fraud and abuse as well as inefficient operations. Targeted investigations, rather than the status quo tracking of inputs, can provide greater confidence that limited public dollars are well spent.

The federal government has made smart investments in inspectors general for all major departments. A competent, appropriately staffed inspector general can provide policy-makers with the valid and reliable information they need to recognize and thwart abuse, fraud and wasteful practices.

Federal Inspectors General

For the last 25 years the federal government has expanded the use of an inspector general (IG) in its core agencies. Fifty-seven statutory IGs oversee 59 federal agencies, promoting open, honest, effective and accountable government by providing an important source of non-partisan, independent oversight for the public and policy-makers.

Appointment Process. Twenty-nine IGs at cabinet-level departments and major sub-cabinet agencies are nominated by the President with Senate confirmation. These IGs can only be removed by the President. Twenty-eight IGs at smaller independent agencies and other designated federal entities are appointed by the heads of those agencies and can be removed by them. Both houses of Congress must be notified if an IG is removed by the President or an agency.

Oversight. Even though they are under the general supervision of the agency, by statute, IGs have a dual and independent reporting relationship to the agency and to Congress. Any allegations of misconduct are reported to the integrity committee of the President's Council on Integrity and Efficiency.

Authorized to:

- have direct access to all records and information of the agency,
- have ready access to the agency head,
- conduct such investigations and issue such reports as the IG thinks appropriate (with limited national security and law enforcement exceptions),
- issue subpoenas for information and documents outside the agency (with same limited exceptions),
- administer oaths for taking testimony, and
- hire and control their own staff and contract resources.

Charged with:

- preventing and detecting fraud and abuse;
- conducting audits and investigations; and,
- recommending policies to promote economy, efficiency, and effectiveness.

Return on investment in fiscal year 2000:

- Potential savings of $9.5 billion;
- Recoveries of almost $5.5 billion;
- More than 5,500 successful prosecutions;
- Suspensions or debarments of nearly 7,000 individuals or businesses;
- Over 2,600 civil or personnel actions; and,
- About 120 testimonies before Congress on issues of national interest.

In fiscal year 2002, $1.4 billion was invested in presidentially-appointed IGs and $162 million was invested in agency head appointees. A General Accounting Office review found that inspectors general have made a significant difference, saving the federal government billions of dollars.

Source: U.S. General Accounting Office. "Inspectors General. Enhancing Federal Accountability." GAO-04-117T. October 8, 2003. http://www.ignet.gov.

Citizen Review Panels: Providing Independent Oversight

In 1996 the President and Congress recognized that citizens could provide effective oversight of the child welfare system. The federal Child Abuse Prevention and Treatment Act (CAPTA) was amended to require states to establish citizen review panels to evaluate state and local efforts to protect children. Federal law requires California to establish three panels. Each panel must evaluate California's child protective services based on the State's child abuse prevention plan, federal standards and other criteria the panels deem important.

Federal law requires states to provide the panels with information necessary for effective oversight, including confidential case materials, and staff assistance to support the panel's duties. Federal requirements allow states to use existing panels to perform the oversight functions, if the existing panels meet the federal requirements for membership, meetings and responsibilities. Regional or local panels are allowed, if they meet statutory requirements to examine policies and procedures of state and local agencies.

California's Panels Fall Short

In 1999, California established three local panels: in Placer, Napa and San Mateo counties. A fourth panel was formed in Kern County in 2002. And the Department of Social Services has designated the Child Welfare Services Stakeholders group as a statewide panel for purposes of the federal requirements.

The three original local panels have each reviewed local programs and activities and made recommendations for improvement. But none of the local panels have reviewed the programs and policies of state agencies, as required by federal law and they have not benefited the children living in the other 55 counties that collectively represent the vast majority of children in foster care. California's Stakeholders group undertook an ambitious review of the State's child welfare system, but the mission of the Stakeholders group and the requirements of the citizen review panels are not consistent.

Representatives of the Department of Social Services report that the efforts of California's citizen review panels are clearly documented in the State's annual report to the U.S. Department of Health and Human Services, Administration for Children and Families. But in response to inquiries from the Commission regarding the adequacy of state efforts, staff in the federal agency have stated that the agency is unwilling to question how the State uses funding for citizen review panels or whether it is in compliance with federal rules.

The Commission in early 2003 raised concerns that California is not in compliance with the federal requirement to establish citizen oversight of California's efforts to protect children. From the Commission's perspective, the efforts of those panels designated by the Department of Social Services as citizen review panels fall far short of the charge outlined in federal law. Congress and the President recognized the potential for effective citizen review. California needs to comply with this federal mandate.

Sources: Veronika Kot, et. al. 1998. "Citizen Review Panels for the Child Protective Services System: Guidelines and Protocols." Des Moines, IA: Child and Family Policy Center. Office of Child Abuse Prevention. "Annual Report of the California Citizen Review Panels Fiscal Year 1999-2000." May 2001. Sacramento, CA: California Department of Social Services. Office of Child Abuse Prevention. "Second Report of the California Citizen Review Panels, July 1, 2000 – December 31, 2001." October 2002. Sacramento, CA: California Department of Social Services. Debra Sample, U.S. HHS, ACF. Personal Communication. January 22, 2003.

Continuous Oversight

Performance measures and compliance monitoring can provide policy-makers and the public with much of the information they need to assess quality and identify opportunities for improvement. But the complex and technical nature of health and human services can challenge the understanding of non-experts or even experts when they lack the time and resources to grasp the nature of sophisticated service delivery systems.

To address this challenge, the State funds, staffs or otherwise supports scores of oversight, planning and advisory bodies working on health and human services. Many are mandated in federal law and are required to provide annual reports on progress toward state goals. Others operate at the discretion of state officials or under the authority of state statutes.

But California receives less than the potential value of these entities. In some instances, oversight entities are appointed by the very departments they are intended to monitor, creating obvious conflicts of interest. The California Mental Health Planning Council is an example of one such conflict of interest. In other instances, state agencies limit the effectiveness of oversight or advisory bodies by limiting their funding or scope of work, as is the case with citizen review panels for the child welfare system.

To create meaningful accountability, the State must collect, monitor and embrace performance information. It must monitor compliance in ways that provide information that is meaningful to policy-makers and the public. And it must move away from supporting oversight and advisory bodies that do not guide policy-makers and administrators toward improved outcomes. Meaningful accountability requires independent information on performance, rigorous investigations that are uncompromised by loyalties to the status quo, and continuous monitoring by the public and experts who can ferret out problems and guide improvement.

Disparate and Duplicate Oversight and Advisory Bodies

California maintains scores of oversight and advisory entities for health and human services, and each represents a cost to the State. Many entities operate within state departments, with dedicated staff. Some are recognized in statute, others are not. Still more function as stand-alone entities, often as required under federal law and may receive federal funding to support their operation.

The disparate nature of these entities complicates efforts to understand their value to health and human service programs. Some are recognized as providing essential services, others are not. But the State has not explored how best to organize these entities to take strategic advantage of their expertise. Nor has the State made consistent decisions on what level of funding is necessary for oversight and advisory bodies to do their job. Too little funding, and their value is compromised. Too much funding takes money away from other priorities.

Stand-alone Entities. Several stand-alone advisory or oversight bodies operate in California, such as the Commission on Aging, the State Independent Living Council, and the State Council on Developmental Disabilities. Budget documents for 2003-04 show 105 staff working for these three entities and $14.6 million in total funding. The bulk of staff and funding are dedicated to the State Council on Developmental Disabilities, which in addition to planning and oversight, provides some direct services.

Embedded Entities. Several departments maintain staff to work on human rights and civil rights issues, provide advocacy services through an Office of Ombudsman. Departments also fund and operate advisory entities, such as the Rural Health Policy Council that is funded through the Office of Statewide Health Planning and Development or the California Mental Health Planning Council that is housed within the Department of Mental Health. Budget documents for 2003-04 indicate 66 staff working for these entities, with $6.1 million in personnel costs.

Additionally, departments within HHS operate other panels, boards and commissions for which costs are not itemized in budget documents. The following is a partial list:

- Advisory Loan Insurance Committee (OSHPD)
- Area Agencies on Aging Advisory Council of California (CDA)
- Agnews State Hospital Advisory Board (DMH)
- Atascadero State Hospital Advisory Board (DMH)
- California Health Policy and Data Advisory Commission (OSHPD)
- California Healthcare Workforce Policy Commission (OSHPD)
- Child Abuse and Neglect Reporting Act Task Force (DSS/DOJ)
- Clinical Laboratory Technology Advisory Committee (DHS)
- Commission on Emergency Medical Services (EMSA)
- Committee for the Protection of Human Subjects (OSHPD)
- Consumer Advisory Committee (DDS)
- Dept. of Social Services Continuing Care Advisory Committee (DSS)
- Domestic Violence Advisory Panel (DHS)
- Environmental Laboratory Technical Advisory Committee (DHS)
- Emergency Response Training Advisory Committee (EMSA/DHS)
- Fairview State Hospital Advisory Board (DMH)
- Frank Lanterman State Hospital Advisory Board (DMH)
- Health Manpower Policy Commission (OSHPD)
- Health Care Quality Improvement and Cost Containment Commission (OSHPD)
- Health Professions Education Foundation, Board of Trustees (OSHPD)
- Heart Disease and Stroke Prevention Task Force (DHS)
- Hospital Building Safety Board (OSHPD)
- Interagency Coordinating Council on Early Intervention (DDS/ADP/DHS)
- Lyme Disease Advisory Committee (DHS)
- Managed Care Policy Advisory Committee (ADP)
- Metropolitan State Hospital Advisory Board (DMH)
- Napa State Hospital Advisory Board (DMH)
- Office of Deaf Access (DSS)
- Patton State Hospital Advisory Board (DMH)
- Porterville State Hospital Advisory Board (DMH)
- Quality Improvement Committee (DMH)
- Rehabilitation Appeals Board (DOR)
- Rural Health Policy Council (OSHPD)
- Sonoma State Hospital Advisory Board (DMH)
- State Rehabilitation Council (DOR)
- System of Care Redesign External Advisory Workgroup (ADP)
- Tobacco Education and Research Oversight Committee (DHS)
- Women's Health Council (DHS)

Recommendation 5: The public, policy-makers and program administrators must have clear and easy access to reliable information on progress toward goals, the effectiveness of programs, and the agencies responsible for making improvements.

The Governor and Legislature should agree on benchmarks and measures

- ***Adopt performance indicators, outputs and efficiency measures.*** Policy-makers and the public must understand why public programs are in place and how well they are functioning. The Legislature and the Governor should adopt performance indicators, outputs and efficiency measures that chart the State's progress in meeting core goals for children, adults and families.
  - ✓ **Performance Indicators.** Used to demonstrate whether the State is making progress toward its objectives, such as the poverty rate, recidivism, infant mortality rate, etc.
  - ✓ **Output Measures.** Reflects activities performed – units produced, services provided, or people served – to achieve goals.
  - ✓ **Efficiency Measures.** Describes the costs associated with efforts to improve performance.

The Administration should focus its advisory and monitoring efforts

- ***Establish and empower a Health and Human Services Advisory Board.*** The existing advisory and oversight boards are largely ineffective. They should be replaced with an agency-wide board with the authority and resources to monitor state operations and make recommendations for reform.
  - ✓ **Membership.** The board should be composed of citizens, clients, service providers and local government representatives with the expertise to monitor programs and outcomes, and to identify and recommend opportunities for improvement.
  - ✓ **Authority.** The board should be authorized to review any and all aspects of California's health and human service system. It should report directly to the Agency Secretary. Its meetings and reports should be easily accessible by the public.
  - ✓ **Funding.** Funding for the board should be reliable and adequate to meet its mandate. To solidify the relationship between the board and the departments it oversees, board funding should reflect a percentage of the budget of each department and be drawn directly from those budgets.

The Administration should strengthen its response to weak performance

- ***Bolster the State's response to weak county performance.*** The State's response to weak performance should be clear, swift and compel action.
  - ✓ **Require Improvement Plan.** County agencies that fail to make progress toward statewide goals for children, adults and families should be required to submit an improvement plan that details strategies underway to bolster performance. The Health and Human Services Agency should provide technical assistance, training and other supports to enable counties to successfully address barriers to improvement.
  - ✓ **Require reform.** Counties that continue to show weak performance should be required to implement specific reforms developed by a state-local improvement team. The team should be appointed by the Agency, include representatives of counties with superior performance and state departments, and be authorized to review any and all practices, policies and information relating to the under-performing county.
  - ✓ **State takeover.** Counties that fail to show progress within five years, after efforts to initiate improvement plans and reforms have been unsuccessful, should be subject to state takeover. The Agency should be given the authority to appoint an administrator of county health and human services with the authority to make needed changes, spend federal, state and local funds allocated to the county for health and human services and shift additional county funds, as needed, to improve outcomes. The Agency should have the authority to bill the county for the costs associated with state takeover.

The Legislature should enhance its oversight activities

- ***Establish an Inspector General for Health and Human Services.*** The Inspector General should be empowered with all the necessary authority to thoroughly investigate and monitor state and local health and human service programs. It should report directly to the Governor and its reports, except those involving criminal investigations, should be public.

The public needs clear and consistent information

- ***Create real-time Web-based reporting on goals for children, adults and families.*** The Health and Human Services Agency should develop a Web-based reporting system to chart California's progress toward its goals for children, adults and families. The reporting

system should clearly identify goals, progress by county and indicate which public officials are responsible for meeting those goals and the avenues available to the public to express their concerns when programs falter.

Conclusion

A robust and efficient health and human service system is key to sustaining California's prosperity. But the current system is faltering, and unsustainable. State departments have ambitious missions, and the public and policy-makers have entrusted them with incredible resources – $60 billion annually – but the value of those missions and this investment is undermined because resources are not wielded strategically.

The Commission has distilled the challenges facing health and human services into five findings and recommendations. First, elected leaders must make reform a priority. Second, they must use their political capital and tools to persistently implement reforms in four areas: state organization, state-local relations, funding and accountability.

These recommendations implement the Commission's mandate to assist the Governor and Legislature in promoting economy, efficiency, and improved service in the transaction of the public business.

But for Californians to see improvements, its elected leaders must also seek change. And moving forward will require uncommon leadership. But leadership is not the exclusive domain of elected officials. Ordinary Californians can lead. And they do. The Commission stands ready to assist elected leaders and ordinary Californians in understanding the challenges facing the state and opportunities for improvement.

And the Commission looks forward to an open dialogue with elected leaders on the scope, nature and pace of change. Over the coming months the Commission would like to engage state and county leaders on opportunities for reform, the information and support they need to initiate change, and state and local progress in improving outcomes. It is through these efforts that the Commission intends to fulfill its commitment to the people of California and its obligations to assist elected leaders.

Appendices & Notes

- ✓ ***Public Hearing Witnesses***
- ✓ ***Advisory Committee***
- ✓ ***California Indicators***
- ✓ ***Detail for Chart on Duplicate Functions***
- ✓ ***Licensing & Certification Duplication Among Departments***
- ✓ ***Major Health & Human Service Data Systems***
- ✓ ***Notes***

Appendix A

Little Hoover Commission Public Hearing Witnesses

Witnesses Appearing at Little Hoover Commission Human Services Redesign Hearing on March 27, 2003

Dion Aroner
Legislator-in-Residence
Institute of Industrial Relations
University of California, Berkeley

Todd Bland, Director
Legislative Analyst's Office
Social Services Section

Catherine Camp, Former Director
California Mental Health Directors Association

B. Timothy Gage, Former Director
California Department of Finance

Pat Leary, Legislative Representative
California State Association of Counties

Terri Parker, Executive Director
California Housing Finance Agency

Jean M. Ross, Executive Director
California Budget Project

Witnesses Appearing at Little Hoover Commission Human Services Redesign Hearing on April 24, 2003

Charlene Chase, Director
Department of Social Services
Santa Barbara County

Alisa Drakodaidis
Acting Assistant Administrative Officer
Chief Administrative Office
Service Integration Branch
Los Angeles County

Jerry Doyle, President
Chief Executive Officer
EMQ Children and Family Services

Margaret Dunkle, Senior Fellow
Health Insurance Reform Project
George Washington University

Raymond J. Merz, Director
Department of Health and Human Services
Placer County

Elliott Robinson, Director
Department of Social Services
Monterey County

Participants at Little Hoover Commission
Human Services Redesign Roundtable Meeting on October 23, 2003

Lewis Butler

Emery "Soap" Dowell

Robert Hertzberg
Former Speaker of the California
State Assembly

John Kamensky
Associate Partner and Senior Fellow
IBM Center for the Business of Government

Susan Sherry, Executive Director
Center for Collaborative Policy

Appendix B

Little Hoover Commission Human Services Redesign Advisory Committee

The following people served on the Human Services Redesign Advisory Committee. Under the Little Hoover Commission's process, advisory committee members provide expertise and information but do not vote or comment on the final product. The list below reflects the titles and positions of committee members at the time of the advisory committee meetings in 2003.

Bonnie Armstrong, Senior Fellow
Foundation Consortium for California's Children & Youth

Bud Bautista, Director
Health and Human Services Agency, Children's System of Care
Placer County

Charlene Chase, Director
Department of Social Services
Santa Barbara County

Judy Chynoweth, Executive Director
Foundation Consortium

Richard Dana
Mutual Assistance Network of Del Paso Heights

Carmen Delgado
Assistant Deputy Director
Program Operations Division
California Department of Alcohol and Drug Programs

Jerry Doyle, President
Chief Executive Officer
EMQ Children and Family Services

Alisa Drakodaidis
Acting Assistant Administrative Officer
Chief Administrative Office
Service Integration Branch
Los Angeles County

Margaret Dunkle, Senior Fellow
Health Insurance Reform Project
George Washington University

Yolie Flores Aguilar, Executive Director
Children's Planning Council
Los Angeles

Megan Hafenstein, Legislative Aide
Assemblymember Cindy Montañez

Jim L'Etoile, Chief
California Department of Corrections
Office of Substance Abuse Programs

Pat Leary, Legislative Representative
California State Association of Counties

Raymond C. Mastalish, Executive Director
California Commission on Aging

Sara McCarthy, Consultant
Senate Office of Research

Frank Mecca, Executive Director
County Welfare Directors Association

Edward P. Melia, M.D.

Elliot Robinson, Director
Department of Social Services
Monterey County

Pat Ryan, Executive Director
California Mental Health Directors Association

Rusty Selix, Executive Director
Mental Health Association in California and
California Council of Community Mental Health Agencies

Steve Trippe, Executive Director
New Ways to Work

Stewart Wakeling, Executive Director
Juvenile Justice Coordinator
Community Partnership for Families of
San Joaquin County

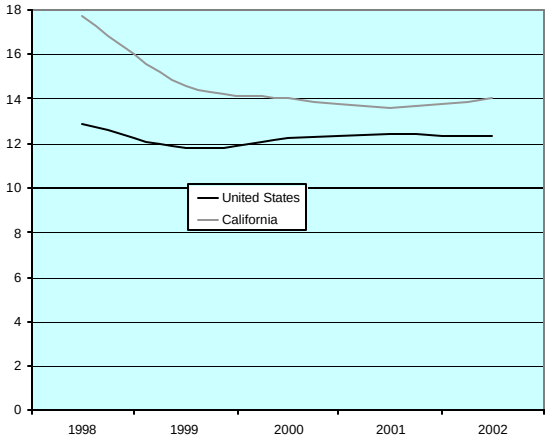
Nancy Westergaard, Consultant
Office of Assemblyman Leland Yee

Appendix C

California Indicators

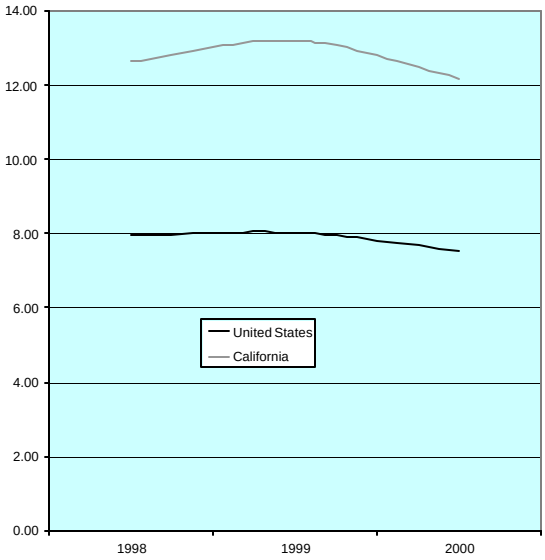
The following charts show California's performance over time, as compared to the national average, on a range of health and human service challenges.

Child Abuse & Neglect
per 1,000 children



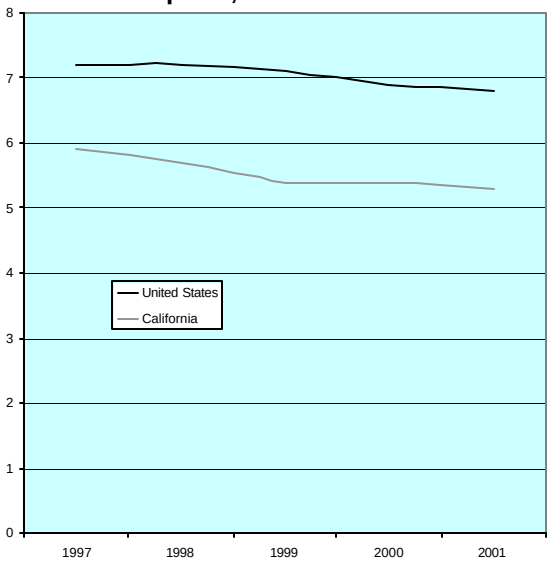
Source: Administration for Children and Families. Children's Bureau. Child Maltreatment Reports. For 1998: Table G4-1, Victimization Rates by State. For 1999: Table 2-2, Child Victims. For 2000 to 2002: Table 3-2, Child Victims by Disposition. http://www.acf.hhs.gov/programs/cb/publications/cmreports.htm.

Children in Foster Care
per 1,000 children under 18



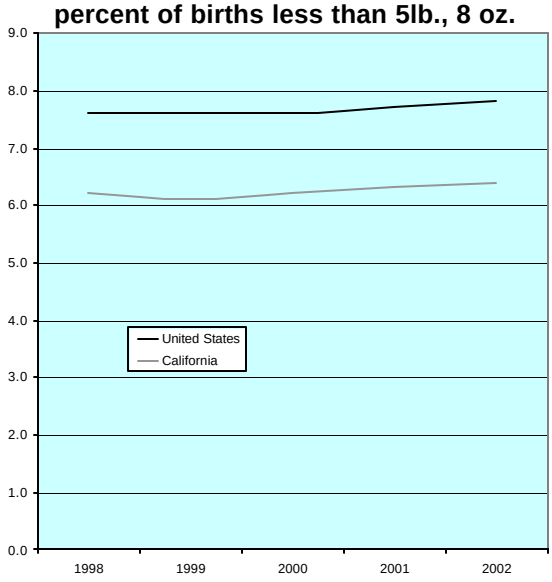
Source: Administration for Children and Families. Children's Bureau. "Safety, Permanency, Well-Being. Child Welfare Outcomes 2000: Annual Report." Chapter IV. No 1998 data for eight states.

Infant Mortality
Rate of infant deaths (under one year)
per 1,000 live births



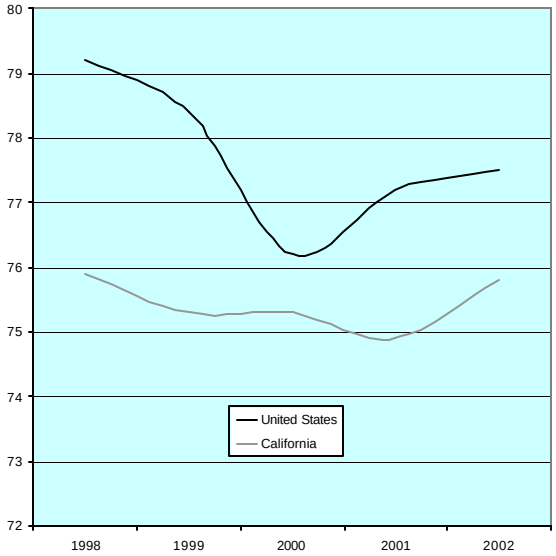
Source: For U.S.: Centers for Disease Control. National Center for Health Statistics. National Vital Statistics Report, Vol. 52, No. 3. Table 31. For California: California Department of Health Services. Center for Health Statistics. "2001 Vital Statistics Data Tables." Table 4-5.

Low Birthweight Infants
percent of births less than 5lb., 8 oz.



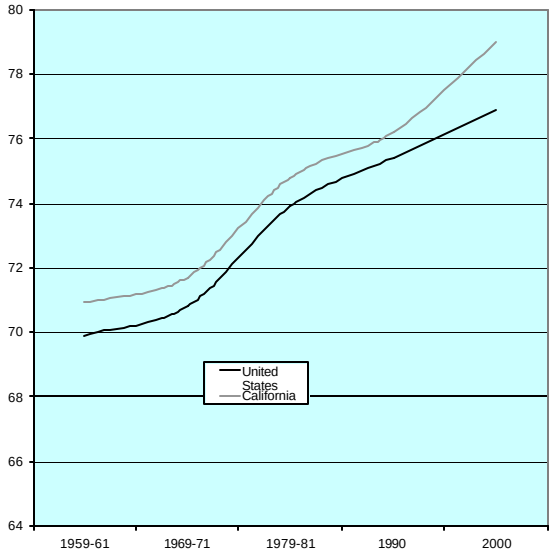
Source: Centers for Disease Control. National Center for Health Statistics. National Vital Statistics Reports. Table 46 from the following reports: Vol. 48, No. 3; Vol. 49, No. 1; Vol. 50, No. 5; Vol. 51, No. 2; Vol. 52, No. 10;.

Childhood Immunizations (aged 19-35 months) percent vaccinated with 4:3:1:3 series



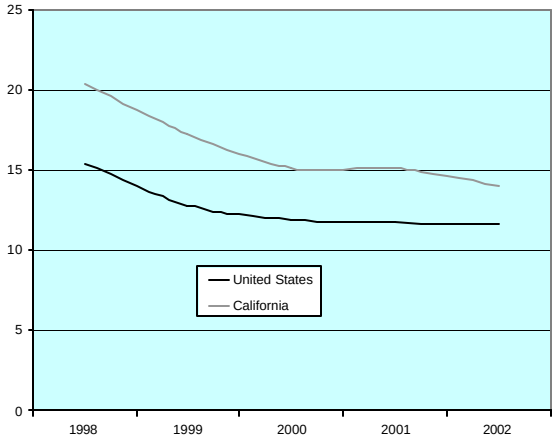
Source: Centers for Disease Control. National Immunization Survey. http://www.cdc.gov/nip/coverage/default.htm#chart

Life Expectancy at Birth



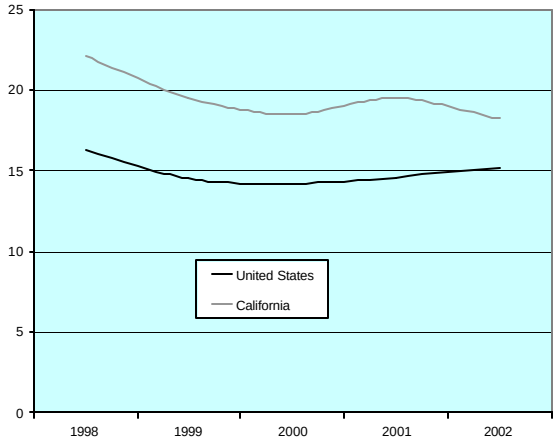
Source: California Department of Health Services. Center for Health Statistics. "Abridged Life Tables for California, 2000."

Uninsured Children (under 18) as a percentage of the population



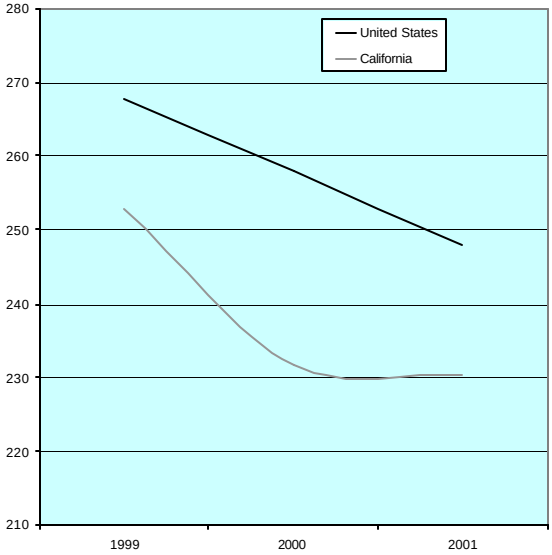
Source: U.S. Census Bureau. Historical Health Insurance Tables. Table HI-5. Health Insurance Coverage Status and Type of Coverage by State. Children Under 18: 1987 to 2002. http://www.census.gov/hhes/hlthins/historic/hihistt5.html.

Uninsured People (all) as a percentage of the population



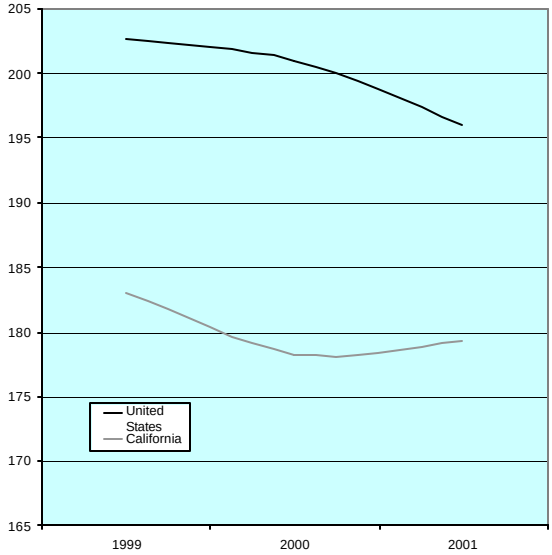
Source: U.S. Census Bureau. Historical Health Insurance Tables. Table HI-4. Health Insurance Coverage Status and Type of Coverage by State. All People: 1987 to 2002. http://www.census.gov/hhes/hlthins/historic/hihistt4.html.

Heart Disease Deaths
age-adjusted rate per 100,000 population



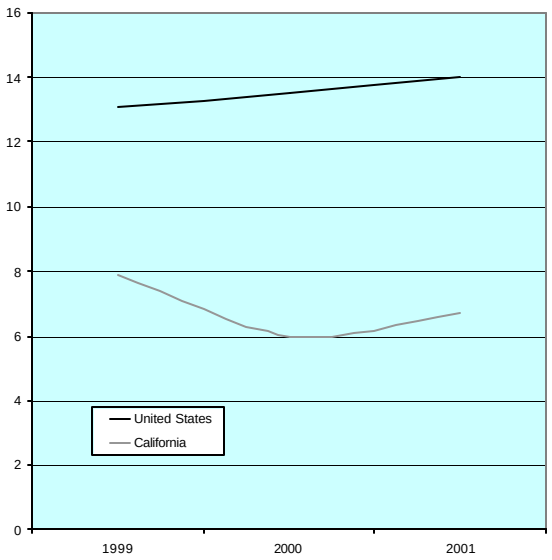
Source: Centers for Disease Control. National Center for Health Statistics. National Vital Statistics Reports. Vol. 49, No. 8: Table 26; Vol. 50, No. 15: Table 33; Vol. 52, No. 3; Table 30.

Cancer Deaths
age-adjusted rate per 100,000 population



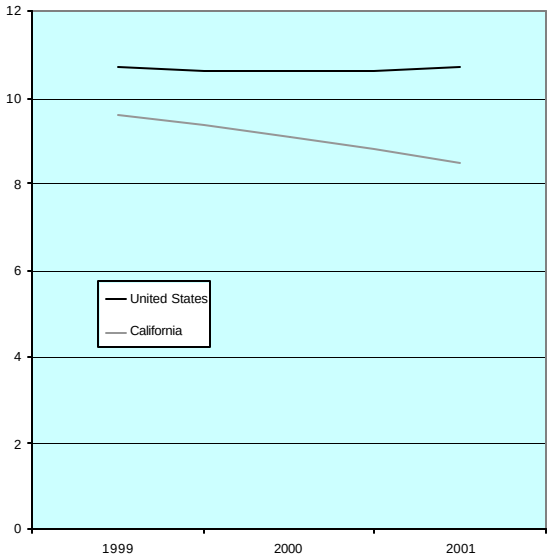
Source: Centers for Disease Control. National Center for Health Statistics. National Vital Statistics Reports. Vol. 49, No. 8: Table 26; Vol. 50, No. 15: Table 33; Vol. 52, No. 3; Table 30.

Kidney Disease Deaths
age-adjusted rate per 100,000 population



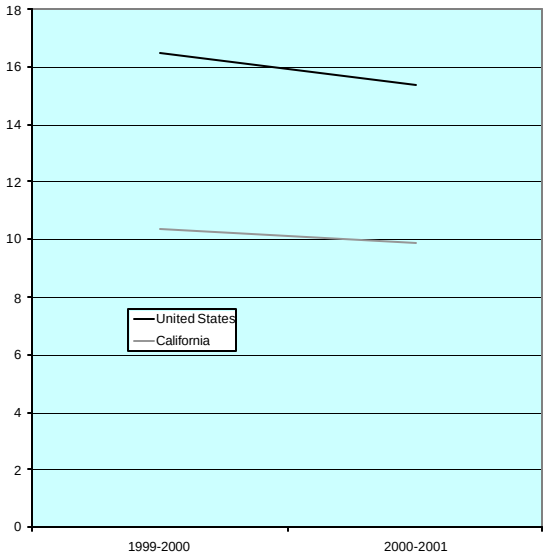
Source: Centers for Disease Control. National Center for Health Statistics. National Vital Statistics Reports. Vol. 49, No. 8: Table 26; Vol. 50, No. 15: Table 33; Vol. 52, No. 3; Table 30.

Suicide Deaths
age-adjusted rate per 100,000 population



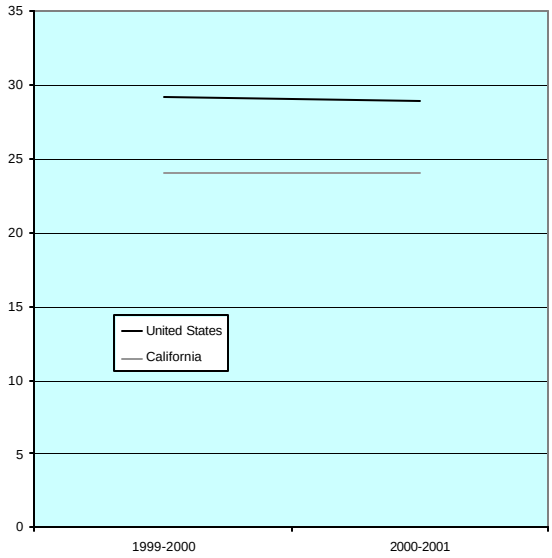
Source: Centers for Disease Control. National Center for Health Statistics. National Vital Statistics Reports. Vol. 49, No. 8: Table 26; Vol. 50, No. 15: Table 33; Vol. 52, No. 3; Table 30.

Adolescent Tobacco Use
percent using any tobacco product
in past month, ages 12-17



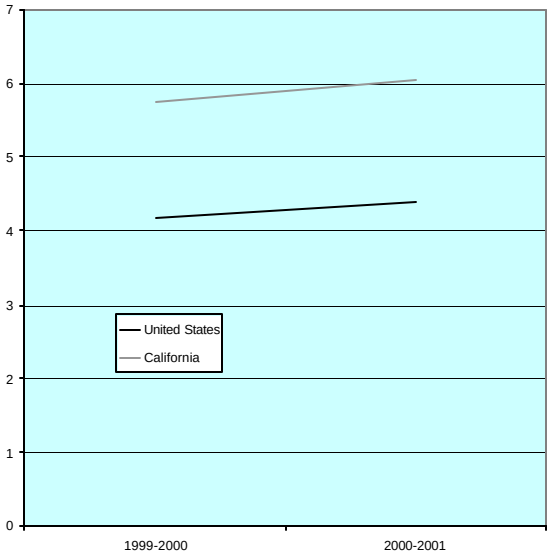
Source: SAMSHA. Office of Applied Studies. "2001 State Estimates of Substance Use." Table A.10 Percentages Reporting Past Month Use of Any Tobacco Product, by Age Group and State: 1999-2000 and 2000-2001. http://www.samhsa.gov/oas/nhsda/2k1State/vol1/appa.htm .

Adult Tobacco Use
percent using any tobacco product
in past month, ages 26 or older



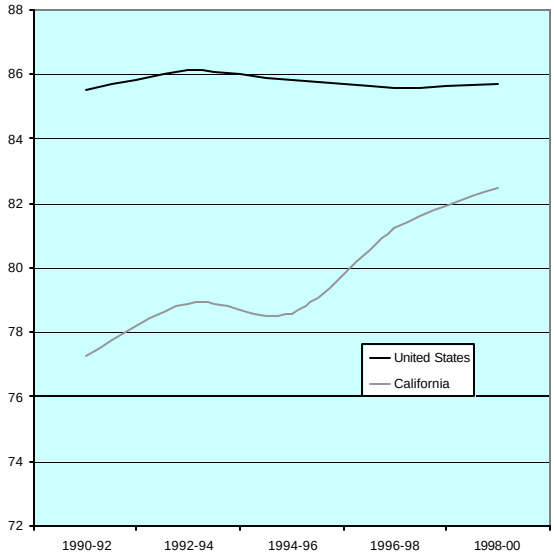
Source: SAMSHA. Office of Applied Studies. "2001 State Estimates of Substance Use." Table A.10 Percentages Reporting Past Month Use of Any Tobacco Product, by Age Group and State: 1999-2000 and 2000-2001. http://www.samhsa.gov/oas/nhsda/2k1State/vol1/appa.htm .

Adult Drug Use
percent using any illicit drug in
past month, ages 26 or older



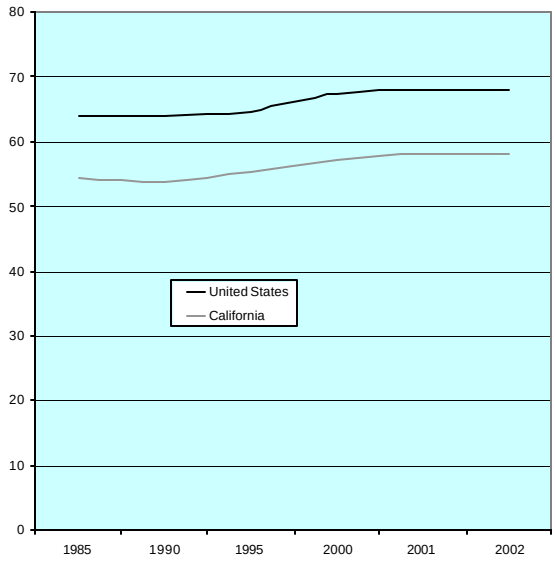
Source: SAMSHA. Office of Applied Studies. "2001 State Estimates of Substance Use." Table A.1 Percentages Reporting Past Month Use of Any Illicit Drug, by Age Group and State: 1999-2000 and 2000-2001. http://www.samhsa.gov/oas/nhsda/2k1State/vol1/appa.htm

High School Completion Rate
For 18- to 24-year olds not currently
enrolled in high school or below



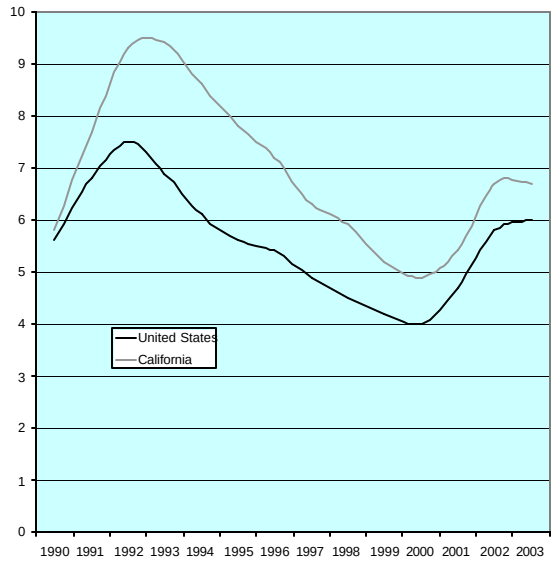
Source: National Center for Education Statistics. "Dropout Rates in the United States: 2000." Table C7. High school completion rates of 18- through 24-year-olds not currently enrolled in high school or below, by state: October 1989–91 through 1998–00. http://nces.ed.gov/pubs2002/2002114.pdf .

Homeownership Rate



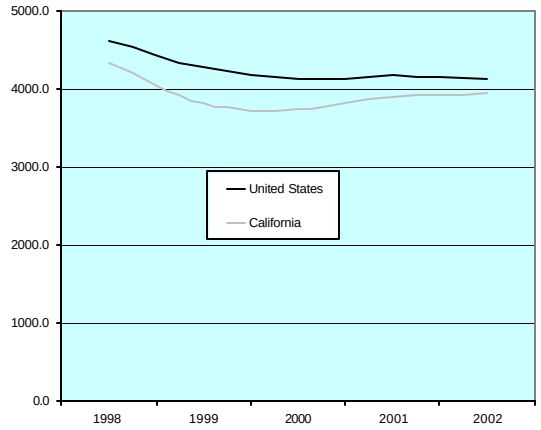
Source: U.S. Census Bureau. "Statistical Abstract of the United States: 2003." Section 20. Construction and Housing. No. 964. Homeownership Rates by State: 1985 to 2002.

Unemployment Rate

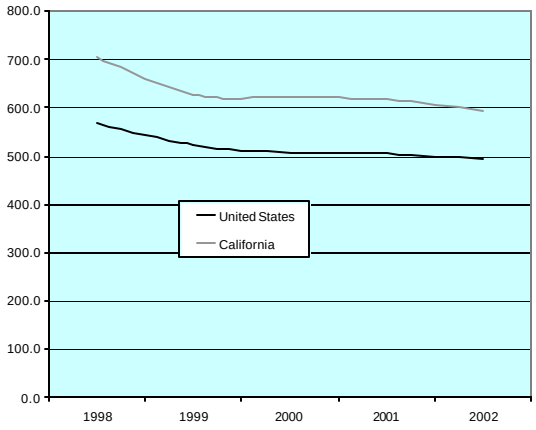


Source: U.S. Department of Labor. Bureau of Labor Statistics. Annual unemployment rate, not seasonally adjusted.

Overall Crime Rate per 100,000



Violent Crime Rate per 100,000



Source: Department of Justice. Federal Bureau of Investigation. "Crime in the United States." Reports for years 1998 to 2002, Table 5. And from the 2002 report, Table 1, Index of Crime, United States, 1983-2002.

Appendix D

Detail for Chart on Duplicate Functions Among Health & Human Service Departments

The following tables present the data used for the chart on page 40. The figures for these tables were taken from the Governor's Salary and Wages Supplement 2004-05 using information for fiscal year 2003-04.

Licensing & Certification

Department	Employees	Personnel Costs
Alcohol & Drug Programs *Licensing & Certification Division*	64.4	$3,435,173
Health Services *Licensing & Certification Division*	810.1	$45,066,773
Mental Health *Program Compliance – Licensing & Certification*	13.0	$658,414
Social Services *Community Care Licensing Division*	1063.8	$52,375,328
Total	**1951.3**	Subtotal $101,535,688 +Benefits (26%) $26,399,279 **Total** **$127,934,967**

Fiscal Operations

Department	Employees	Personnel Costs
Aging *Administration Division – Fiscal Operations Branch*	16.3	$794,993
Alcohol & Drug Programs *Program Operations Division – Program & Fiscal Policy Branch, Contracts Management Branch, and Fiscal Management and Accountability*	63.8	$3,288,125
Child Support Services *Administrative Services Division – Financial Services Branch*	28.0	$1,575,970
Community Services & Development *Administration Division – Financial Services*	8.0	$382,775
Developmental Services *Administration Division – Financial Services Branch less the Budget Section*	95.0	$4,380,783
Health Services *Payment Systems Division less the Medi-Cal Dental Services Branch, the Office of Medi-Cal Payment Systems, the Medi-Cal Dental Services Branch and the Office of HIPAA Compliance*	429.6	$19,234,454

HHS Agency Data Center *Administrative Services Division – Financial Services Branch, Accounting Section*		17.0		$756,318
Mental Health *Administrative Services – Financial Services, Fiscal Systems, County Financial Program Support and Cost Reporting/Data Collection*		12.0		$707,212
Rehabilitation *Administrative Services Division – Fiscal/Business Services and Accounting Section*		49.8		$1,894,354
Social Services *Children & Family Services Division – Foster Care Rates Bureau and Administrative Division – Fiscal Systems & Accounting Branch*		147.0		$7,319,010
	Total	**866.5**	Subtotal	$40,333,994
			+Benefits (26%)	$10,486,838
			Total	**$50,820,832**

Grants Management

Department	**Employees**	**Personnel Costs**
Alcohol & Drug Programs *Directorate – Office of Grants Management*	3.0	$187,848
Community Services & Development *Administrative Division – Contracts/Management Analysis*	6.6	$319,362
Emergency Medical Services Authority *Prevention Health & Health Service Program Grant*	15.0	$798,185
Mental Health *Systems of Care – Planning, Grants and Revenues*	1.0	$71,844
Social Services *Administrative Division – Financial Planning Branch, Contracts Bureau*	12.8	$662,541
Total	**38.4**	Subtotal $2,039,780
		+Benefits (26%) $530,343
		Total **$2,570,123**

Audits

Department	**Employees**	**Personnel Costs**
Aging *Administration Division – Audits Branch*	10.0	$555,460
Alcohol & Drug Programs *Division of Administration – Audit Services Branch*	25.0	$1,374,574
Community Services & Development *Administration Division – Audit Services*	4.0	$245,328

Developmental Services *Administration Division – Human Resources, Audits & Support Services Branch, Audit Section*		24.0		$1,212,146
Health Services *Audits & Investigations Division*		674.8		$37,979,964
Mental Health *Program Compliance – Audits*		21.0		$1,141,533
Rehabilitation *Executive Branch – Audit Services*		14.0		$716,489
Social Services *Children & Family Services Division – Foster Care Audits & Rates Branch less the Foster Care Rates Bureau*		41.9		$2,326,980
	Total	**814.7**	Subtotal	$45,552,474
			+Benefits (26%)	$11,843,643
			Total	**$57,396,117**

Information Systems

Department	**Employees**	**Personnel Costs**
HHS Agency *Office of HIPAA Implementation*	12.0	$888,719
Aging *Administration Division – Information Technology Branch*	9.0	$547,742
Alcohol & Drug Programs *Information Management Services Division*	30.5	$1,920,342
Child Support Services *Technology Services Division – Interim Systems Management Branch*	16.0	$966,339
Community Services & Development *Administration Division – Information Technology Services*	15.9	$950,860
Developmental Services *Information Services Division*	69.0	$4,215,148
Health Services *Information Technology & Services Division and Office of HIPAA Compliance*	223.7	$14,629,784
HHS Agency Data Center *Total budget less the Director's Office, the Administrative Services Division and the Customer Relations Division*	442.1	$27,716,286
Mental Health *Administrative Services – Information Technology and HIPAA Implementation*	45.4	$2,845,924
Office of Statewide Health Planning & Development *Administration – Information Systems Section and the Healthcare Information Division*	83.0	$4,558,279
Rehabilitation *Administrative Services Division – Information Systems Services Section*	51.0	$2,874,130

Social Services *CWS/CMS Support Branch Office – Case Management System Support Branch and the Information Systems Division*		159.4		$9,796,574
	Total	**1157.0**	Subtotal	$71,910,127
			+Benefits (26%)	$18,696,633
			Total	**$90,606,760**

Research & Analysis

Department	**Employees**	**Personnel Costs**
Aging *Long Term Care/Aging Services Division – Data Analysis & Regulations Branch*	7.0	$386,284
Alcohol & Drug Programs *Directorate – Office of Applied Research & Analysis*	12.9	$739,478
Child Support Services *Child Support Services Division – Data & Performance Analysis Branch*	12.2	$697,716
Mental Health *Systems of Care – Statistics & Data Analysis and Research & Performance Outcomes Development*	19.0	$959,525
Office of Statewide Health Planning & Development *Healthcare Quality & Analysis*	30.3	$1,688,704
Social Services *Research & Development Division*	134.5	$7,397,467
Total	**215.9**	Subtotal $11,869,174
		+Benefits (26%) $3,085,985
		Total **$14,955,159**

Human Resources

Department	**Employees**	**Personnel Costs**
Aging *Administration Division – Human Resources Branch*	14.7	$734,912
Alcohol & Drug Programs *Division of Administration – Human Resources Branch*	11.0	$556,503
Child Support Services *Administrative Services Division – Human Services Section*	7.6	$439,003
Community Services & Development *Administration Division – Personnel Services*	5.0	$256,092
Developmental Services *Administration Division – Personnel Services Section and Labor Relations Section in addition to the Personnel Sections for the Developmental Centers*	161.0	$7,538,722

Health Services *Administration Division – Office of Recruitment and the Personnel Management Branch*		74.8		$3,331,035
HHS Agency Data Center *Administrative Services Division, Human Resources Branch*		16.0		$747,964
Mental Health *Administrative Services – Human Resources, Labor Relations and Personnel, and Personnel for the State Hospitals*		115.6		$5,336,658
Rehabilitation *Administrative Services Division – Personnel Services Section and Labor Relations Office*		38.0		$1,764,030
Social Services *Human Resources Management Division less the Civil Rights Bureau, the Office of Deaf Access and the Office of Services to the Blind*		82.7		$4,174,472
	Total	**526.4**	Subtotal	$24,879,391
			+Benefits (26%)	$6,468,642
			Total	**$31,348,033**

Medi-Cal

Department	**Employees**	**Personnel Costs**
Aging *Long Term Care/Aging Services Division – Medi-Cal Services*	37.0	$1,998,539
Health Services *Medi-Cal Managed Care Division, Medi-Cal Operations Division, Medi-Cal Policy Division, and the Payments Systems Division – Medi-Cal Dental Services Branch, Office of Medi-Cal Payment Systems, Medi-Cal Dental Services Branch, and Office of Medi-Cal Procurement*	1183.8	$66,625,878
Medical Assistance Commission	22.4	$1,696,426
Mental Health *Program Compliance – Medi-Cal Oversight North & South and Administrative Services – Medi-Cal Liaison*	26.0	$1,518,944
Total	**1269.2**	Subtotal $71,839,787
		+Benefits (26%) $18,678,345
		Total **$90,518,132**

Note: Benefits calculated as 26 percent of subtotals. See Department of Finance Budget Letter 03-23, August 1, 2003. "2003-04 Personal Services Reduction Plans." Miscellaneous Tier 2 percentage was used.

Appendix E

Licensing and Certification Duplication Among Departments

The following table shows duplication in the licensing and certification units of health and human service departments. This is not a comprehensive list.

Responsible Entity & Facility Type	*Licensure*	*Certification*
Departments of Aging, Health Services and Social Services		
Adult Day Health Care Center*	X	
Department of Aging		
Adult Day Health Care Center*		X (Title 19 only)
Department of Alcohol & Drug		
Driving-Under-the-Influence Program	X	
Narcotic Treatment Program	X	
Residential Drug Free	X	X
Department of Health Services		
Acute Psychiatric Hospital	X	X
Alternative Birthing Center	X	
Ambulatory Surgical Center	X	
Chemical Dependency Recovery Hospital	X	
Chronic Dialysis Clinic	X	
Community Care Clinic	X	
Comprehensive Outpatient Rehab Facility		X
Congregate Living Health Facility	X	
Correctional Treatment Center	X	
End Stage Renal Dialysis Clinic		X
Free Clinic	X	X (Title 19 only)
General Acute Care Hospital	X	X
Home Health Agency	X	
Hospice	X	X
Intermediate Care Facility (ICF)	X	
ICF/Developmentally Disabled Facility	X	X (Title 19 only)
ICF/DD-Nursing Facility	X	X (Title 19 only)
ICF/DD-Habilitative Facility	X	X (Title 19 only)
ICF for the Mentally Retarded		X
Outpatient Physical Therapy/Speech	X	X (Title 18 only)
Psychiatric Health Facility*	X	
Psychiatric Health Facility*		X (Title 18 only)
Psychology Clinic	X	X (Title 19 only)
Referral Agency	X	
Skilled Nursing Facility/Nursing Facility	X	X
State Hospital	X	X
Surgical Clinic	X	X (Title 19 only)

Department of Social Services		
Adoption Agency	X	
Adult Day Care Facility	X	
Adult Day Support Center	X	
Adult Residential Facility	X	
Community Residential Treatment Center*	X	
Continuing Care Retirement Community	X	
Foster Family Agency	X	
Foster Family Home	X	
Group Home	X	
Large Family Child Care Home	X	
Residential Care Facility for the Chronically Ill	X	
Residential Care Facility for the Elderly	X	
Small Family Home	X	
Small Family Child Care Home	X	
Social Rehabilitation Facility	X	
Transitional Placement Program	X	
Foster Family Agencies (not DSS)		
Certified Family Home		X
Department of Mental Health		
Community Residential Treatment Center*		X
Mental Health Rehabilitation Center	X	

* Licensing/certification responsibility rests with two or more departments concurrently.

Appendix F

Major Health & Human Service Data Systems

A preliminary review of state health and human service departments identified 63 data systems in development or being used to perform program operations, compile data and to meet reporting and analysis requirements. Most of the systems identified in this review were automation-based systems. Others involved survey instruments, paper reports, fax or e-mail reports, or were a combination of manual and automated processes. Department names and abbreviations are listed in the charts at the end of this appendix.

Automation-based Systems

1. **ALIRTS – Automated Licensing Information and Report Tracking System.** OSHPD system used by health facilities to report health care utilization data annually to the State.
2. **CADDIS – California Developmental Disabilities Information System.** Database of DDS clients and client service information used for case management and to meet reporting requirements.
3. **CADDS – California Alcohol and Drug Data System.** Used by county agencies to collect and report information about clients of publicly funded drug and alcohol treatment to ADP.
4. **CCSAS – California Child Support Automation System.** New system being developed by DCSS to administer the statewide child support program and enforce support payments.
5. **CDS – Common Dataset.** CDA system under development that will consolidate and upgrade client tracking and funding databases into a single database warehouse for improved program reporting.
6. **CEMSIS – California Emergency Medical System Information System.** A database of patient care statistics compiled by EMSA from data supplied by local agencies.
7. **CMIPS – Case Management Information and Payroll System.** DSS system that supports county eligibility determinations, service authorizations and payments for In-Home Supportive Services.
8. **CMS-NET.** DHS Children's Medical Services client tracking and authorization system used by counties.
9. **CSI – Client and Services Information System.** DMH system used to capture patient services and care data from counties.
10. **CWS/CMS – Child Welfare Services/Case Management System.** DSS case management system for administering and delivering child welfare services provided by counties.
11. **EBT – Electronic Benefit Transfer.** DSS system used to provide Food Stamps and CalWORKs benefits through ATM and retail point-of-sale terminals.
12. **ECD – Enforcement Caseload Database.** EMSA system used to identify cases, assignments, status and other information related to paramedic enforcement activity.
13. **EDS – Electronic Data System.** DHS system used to process Medi-Cal provider care information.
14. **EMS Plan Information.** Database of contacts, demographics and numbers and types of EMS support components compiled by EMSA from local emergency medical services' plans.
15. **EMT Training Program.** EMSA's database of emergency technician training programs in the State.
16. **FCS – Field Computer System.** DOR system used to administer client case services and meet State and federal reporting requirements.
17. **Health-e-App.** MRMIB/DHS electronic application for Healthy Families or Medi-Cal enrollment.
18. **HICAP – Health Insurance Counseling and Advocacy Program.** Database compiled by CDA from paper reports submitted by program contractors.

19. **IDB – Integrated Database.** DCSS reporting system and database used by local child support agencies to send data to other agencies for child support collection and enforcement activities.

20. **Infonet DMC – Infonet Drug Medi-Cal.** ADP system used by community-based service providers to make Drug Medi-Cal claims electronically to the State.

21. **IPC – Inpatient Consolidated Paid Claims.** System used to report county authorized mental health services to DMH that are billed for through the DHS Medi-Cal fiscal intermediary system.

22. **ISIS – Integrated Statewide Information System.** DHS system used by local agencies to enroll and report on participants in the Women, Infants and Children Supplemental Nutrition program.

23. **MCH-BUDGET – Maternal & Child Health Budget.** DHS system used by counties for program reporting, budgeting and federal financial participation invoicing.

24. **MEDS – Medi-Cal Eligibility Data System.** DHS database of CalWORKs, Foster Care, Food Stamp, Refugee Assistance and County Medical Services beneficiary information reported by counties.

25. **MIRCal – Medical Information Reporting for California.** OSHPD reporting system used by health care providers to supply patient data to the State.

26. **MIS/DSS – Management Information System / Decision Support System.** DHS system used to compile and report Medi-Cal data for State management and policy assessment purposes.

27. **NAPIS/OCA – National Aging Programs Information System/Older Californians Act.** System used to collect and report CDA program client service data and update national database.

28. **NORS – National Ombudsman Reporting System.** System used to collect and report data on CDA ombudsman program activity and update national database.

29. **OTIS – Online Tobacco Information System.** DHS system used by counties to collect and report budget and cost data regarding tobacco use prevention activities.

30. **PARC – Programs Audits Reporting Contracts.** Contract management and database system used by CSD to compile and manage contract information for Community Service Block Grant, Low-Income Home Energy Assistance, Energy Weatherization, Naturalization, and Mentoring programs.

31. **PEDS – Proposition 10 Evaluation Data System.** Web-based CCFC system used to collect and evaluate data on State and county Prop.10 funded programs.

32. **PRISM – Pre-Statewide Interim Systems Management.** Interim DCSS systems used for data collection and support of State and local child support activities pending completion of the California Child Support Automation System (CCSAS) currently in development.

33. **RASSCLE – Response and Surveillance System for Childhood Lead Exposures.** DHS reporting system used by counties to report lead poisoning case information to the State.

34. **SAWS – Statewide Automated Welfare System.** DSS system used by counties for enrollment, benefit determination and case management. It is used to share Medi-Cal, CalWORKs, Food Stamp, Foster Care, Refugee Assistance, and County Medical Services data with the State and other counties.

35. **SD/MC – Short-Doyle/Medi-Cal Approved Claims.** DMH system used by county mental health programs to send Medi-Cal reimbursement claims to the State for mental health services.

36. **SFIS – Statewide Fingerprint Imaging System.** DSS system used at the county level to verify beneficiary identity and prevent fraud.

37. **SMUD – Sacramento Municipal Utility District.** Energy assistance rate program database of eligible SMUD clients reported to CSD.

38. **VCS – Verification Certification System.** CSD system used to compile client eligibility and payment information provided by local home energy assistance and weatherization programs.

39. **Vital Records.** Automated DHS systems used to compile and report county vital statistic data.

Other Systems

1. **BEP – Business Enterprise Program.** Used by DOR to administer the Business Enterprise program and evaluate vendor performance to satisfy State and federal program reporting needs.
2. **CalOMS – California Outcomes Measurement System.** ADP uses this system to compile local alcohol and drug program client outcome data and make assessments.
3. **CDER – Client Development Evaluation Report.** Diagnostic and evaluation system used by centers to help developmental service clients and to report program data to DDS.
4. **CHIS – California Health Interview Survey.** Survey of California households regarding health and access to health systems. Survey data is used by CCFC to evaluate statewide and local service needs.
5. **CMF – Client Master File.** DDS system used to compile client demographic data.
6. **CR – Cost and Financial Reporting System.** Annual report to DMH required from entities providing community mental health services.
7. **CRA/VAP – Clients Rights Advocacy and Volunteer Advocacy Project.** Client issues, allegations, concerns and complaint data compiled and used by SCDD for program evaluations.
8. **CSS – Consumer Satisfaction Survey.** Survey of DOR service consumers measuring satisfaction with department policies, procedures, outcomes and quality of services.
9. **DATAR – Drug and Alcohol Treatment Access Report.** Used by local agencies to report to ADP information on waiting lists for client treatment.
10. **ELI – Evaluation Local Initiatives.** DHS system used by counties to collect and report data on AIDS prevention activities.
11. **GI – Grantee Information.** SCDD system for client service and outcome grant compliance reporting.
12. **HCS – Habilitation Client System.** Used by DOR to manage developmentally disabled case services.
13. **IDR – Involuntary Detention Reporting.** Quarterly reports required by DMH from providers on number of clients provided involuntary mental health treatment.
14. **IMD – Institutions for Mental Disease Reporting.** DMH system used to collect and track patient care costs for patients in IMDs.
15. **Lodestar.** Used by counties to track and report adolescent and family program client data to DHS.
16. **LQAI – Life Quality Assessment Information.** Survey data on individuals with developmental disabilities compiled for SCDD assessments of needs and services.
17. **PADS – Prevention Activities Data System.** ADP system used to collect data from local agencies on prevention activities.
18. **PLP – Paramedic Licensing Program.** EMSA system used for licensing paramedics and providing data on paramedic licenses to local EMS agencies.
19. **PODS – Performance Outcome Data System.** DMH system used to collect and store survey data on mental health client satisfaction with local service and care.
20. **SACPA – Substance Abuse and Crime Prevention Act.** ADP system used by local agencies to report Proposition 36 program compliance data and satisfy State program reporting requirements.
21. **SCE – Senior Community Employment.** U.S. Dept. of Labor prescribed system used by CDA to satisfy reporting requirements under the Older Americans Act.
22. **SNAP – Statewide Needs Assessment Project.** As part of the assessment, DOR conducts a triennial survey of rehabilitation client satisfaction with services provided through department programs.
23. **TBS – Therapeutic Behavior Services.** Court ordered DMH reporting system used to collect data from health care providers on therapeutic behavior services provided to youth.
24. **Trauma Centers.** EMSA system used to map and report data on classification levels and locations for local trauma centers.

Health & Human Services Data Systems

	Departments																
Data Collection & Reporting	**DCSS**	**DHS**	**DSS**	**DMH**	**ADP**	**OSHPD**	**EMSA**	**SCDD**	**CDA**	**HHSDC**	**CCFC**	**CMAC**	**DDS**	**CSD**	**DOR**	**MRMIB**	**County**
ALIRTS						X											X
BEP															X		X
CADDIS										X			X				X
CADDS					X												X
CALOMS					X												X
CCSAS	X	X	X														X
CDER								X					X				X
CDS									X								X
CEMSIS							X										X
CHIS											X						
CMF								X					X				X
CMIPS			X							X							X
CMS Net		X															X
CR				X													X
CRA/VAP								X									X
CSI				X													X
CSS															X		X
CWS/CMS			X							X							X
DATAR					X												X
EBT			X							X							X
ECD							X										
EDS		X															X
ELI		X															X
EMS Plan							X										
EMT Training							X										
FCS															X		X
GI								X									X
HCS															X		X
HEALTH-E-APP		X														X	X
HICAP									X								X
IDB	X																X

Department Abbreviations

ADP – Department of Alcohol & Drug Programs

CCFC – CA Children & Families Commission

HHSDC – Health & Human Services Data Center

MRMIB – Managed Risk Medical Insurance Board

CDA – CA Department of Aging

DCSS – Department of Child Support Services

CMAC – CA Medical Assistance Commission

OSHPD – Office Statewide Health Planning & Development

DDS – Department of Developmental Services

County – Local public and private agencies

DHS – Department of Health Services

CSD – Community Services & Development

SCDD – State Council on Developmental Disabilities

DMH – Department of Mental Health

DOR – Department of Rehabilitation

DSS – Department of Social Services

EMSA – Emergency Medical Services Authority

Health & Human Services Data Systems

	Departments																
Data Collection & Reporting	**DCSS**	**DHS**	**DSS**	**DMH**	**ADP**	**OSHPD**	**EMSA**	**SCDD**	**CDA**	**HHSDC**	**CCFC**	**CMAC**	**DDS**	**CSD**	**DOR**	**MRMIB**	**County**
IDR				X													X
IMD				X													X
Infonet DMC					X												X
IPC				X													X
ISIS		X															X
Lodestar		X															X
LQAI								X									X
MCH-BUDGET		X															X
MEDS		X	X	X	X					X						X	X
MIRCal						X											X
MIS/DSS		X		X								X					
NAPIS/OCA									X								X
NORS									X								X
OTIS		X															X
PADS					X												X
PARC														X			X
PEDS											X						X
PLP							X										
PODS				X													X
PRISM	X																X
RASSCLE		X															X
SACPA					X												X
SAWS	X	X	X							X							X
SCE									X								X
SD/MC				X													X
SFIS			X							X							X
SMUD														X			X
SNAP															X		X
Trauma Centers							X										
TBS				X													X
VCS														X			X
VITAL REC.		X															X

Department Abbreviations

ADP – Department of Alcohol & Drug Programs

CCFC – CA Children & Families Commission

CDA – CA Department of Aging

CMAC – CA Medical Assistance Commission

County – Local public and private agencies

CSD – Community Services & Development

DCSS – Department of Child Support Services

DDS – Department of Developmental Services

DHS – Department of Health Services

DMH – Department of Mental Health

DOR – Department of Rehabilitation

DSS – Department of Social Services

EMSA – Emergency Medical Services Authority

HHSDC – Health & Human Services Data Center

MRMIB – Managed Risk Medical Insurance Board

OSHPD – Office Statewide Health Planning & Development

SCDD – State Council on Developmental Disabilities

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