

Transforming Together:

Ecosystem of Care Implementation Guide



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About This Guide

This Ecosystem of Care Implementation Guide was developed to assist California counties and communities in realizing a more united whole child Ecosystem by, for and with the children, youth and families they serve and support. This Guide is a companion to [California's Children and Youth Behavioral Health Ecosystem Working Paper](#) ("EcoPaper"), commissioned by the [California Health and Human Services \(CalHHS\)](#) Agency and developed by [Breaking Barriers](#). Developed with input from across California, the EcoPaper set forth the vision, rationale, and necessary components of a reimagined behavioral health whole child Ecosystem. This Guide is designed to implement those recommendations.

Where the EcoPaper explains what must change and why, this Implementation Guide focuses on how to transform systems. It translates the EcoPaper's recommendations into practical steps counties and communities can take, uniting existing initiatives and efforts to create a holistic approach to serving youth and families to maximize sustainable whole child impact.

Federal shifts and reductions in funding create new pressures on local systems and underscore why integration is no longer optional but necessary. Counties that coordinate across agencies can do more with existing resources, make services and supports more transparent and navigable, and thus improve outcomes for children and youth. Building from the EcoPaper, this Guide demonstrates how to turn those pressures into opportunities for sustainable system change.

From 2024 to 2026, a group of leaders from education, behavioral health, public health and other agencies came together to begin to pilot cross-agency coordination and collaboration as part of the [Transforming Together \(T²\)](#) Initiative. This initiative supported leaders in four (4) California counties to evolve disconnected and duplicative programs and services—that were never designed to work together—into a coordinated and comprehensive, whole child **Ecosystem of Care**.

Funded by [California's Children and Youth Behavioral Health Initiative \(CYBHI\)](#) in coordination with [California Community Schools Partnership Program \(CCSPP\)](#), and led by the [San Bernardino County Superintendent of Schools](#), T² worked to help integrate California's current System of Care, CCSPP and CYBHI work into a broader vision and structure for realizing a whole child Ecosystem in every California county.

Through this work, T² has helped counties unite education, health, social services, and other child-serving organizations into a coordinated, integrated network. By complementing and aligning to other state initiatives, T² has worked with counties to ensure maximization of resources and create the conditions where child and youth social, emotional, physical, and cognitive needs can be holistically met.

This Guide builds on the [CYBHI Youth at the Center Report](#), and the [California's Children and Youth Behavioral Health Ecosystem Working Paper](#), and draws on the experience of the T² demonstration counties and the Collaborative Leadership Working Group members to provide practical guidance for putting the EcoPaper recommendations into action. The term "Ecosystem" reflects the interconnected web of children, youth, families, education, health, social service, juvenile justice and other child-serving partners working together in shared structures to realize more transparent, accessible, comprehensive, equitable and effective services and supports for all children and youth.

Why Systems Integration Matters

California is already investing in powerful initiatives such as Community Schools, the Children and Youth Behavioral Health Initiative, and the System of Care framework, among others. Each is designed to expand opportunities and improve outcomes for children, youth, and families.

But if pursued in isolation, even the strongest initiatives risk becoming siloed, duplicative, or having limited impact. Transforming Together unites these efforts into one coordinated Ecosystem.

By aligning initiatives under a shared vision, counties can:

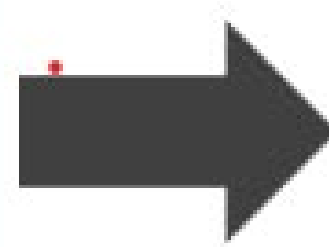
- Break down silos between agencies and programs.
- Maximize the impact of available resources.
- Ensure that children and families experience holistic, whole child and whole family support.

The starting point is clear: California cannot achieve better outcomes for children and youth if essential services remain fragmented. The EcoPaper highlighted the risks of siloed programs; this Guide shows the path forward. **The diagram below illustrates this fundamental shift—from individual, disconnected services toward an integrated Ecosystem of Care.**

Moving from Siloed to Integrated Services



Individual and fragmented agencies often operate in scarcity of resources; many initiatives focus on the same students and youth.



Integrated systems are whole systems, and whole systems are healing systems!

breaking
barriers
THE POWER OF ONE

The Whole Child: A Shared Definition to Inform Collective Impact

Research and practice underscore that child development depends on a mix of health, safety, engagement, and support. These factors are interconnected and interdependent: children's brains and bodies develop in context, shaped by the people, places, and experiences around them.

Agencies often address these factors separately, guided by their specific missions, mandates, and expertise. This specialization is a strength—schools, health providers, social services, and others each bring essential knowledge and focus to the children and families they serve. The challenge arises when these areas of expertise operate in isolation, leaving families to navigate disjointed or even conflicting supports.

As part of the counties' system change efforts, T² encourages leaders to adopt a whole child definition that elevates the comprehensive needs of individuals being served. Prioritizing the whole child—meaning **the full range of social, emotional, physical and cognitive needs and assets of children and youth**—emphasizes how coordinated systems, and not siloed services, contribute to an individual's health, learning and wellbeing.

This whole child definition creates a common language for agencies with different missions. Many frameworks already reflect these principles; Transforming Together proposes a focus on the whole **child** for clarity across agencies with complementary but different missions.

Learn more about the research informing the Transforming Together whole child definition and its components here: [Whole Child Circles and Graphics](#).

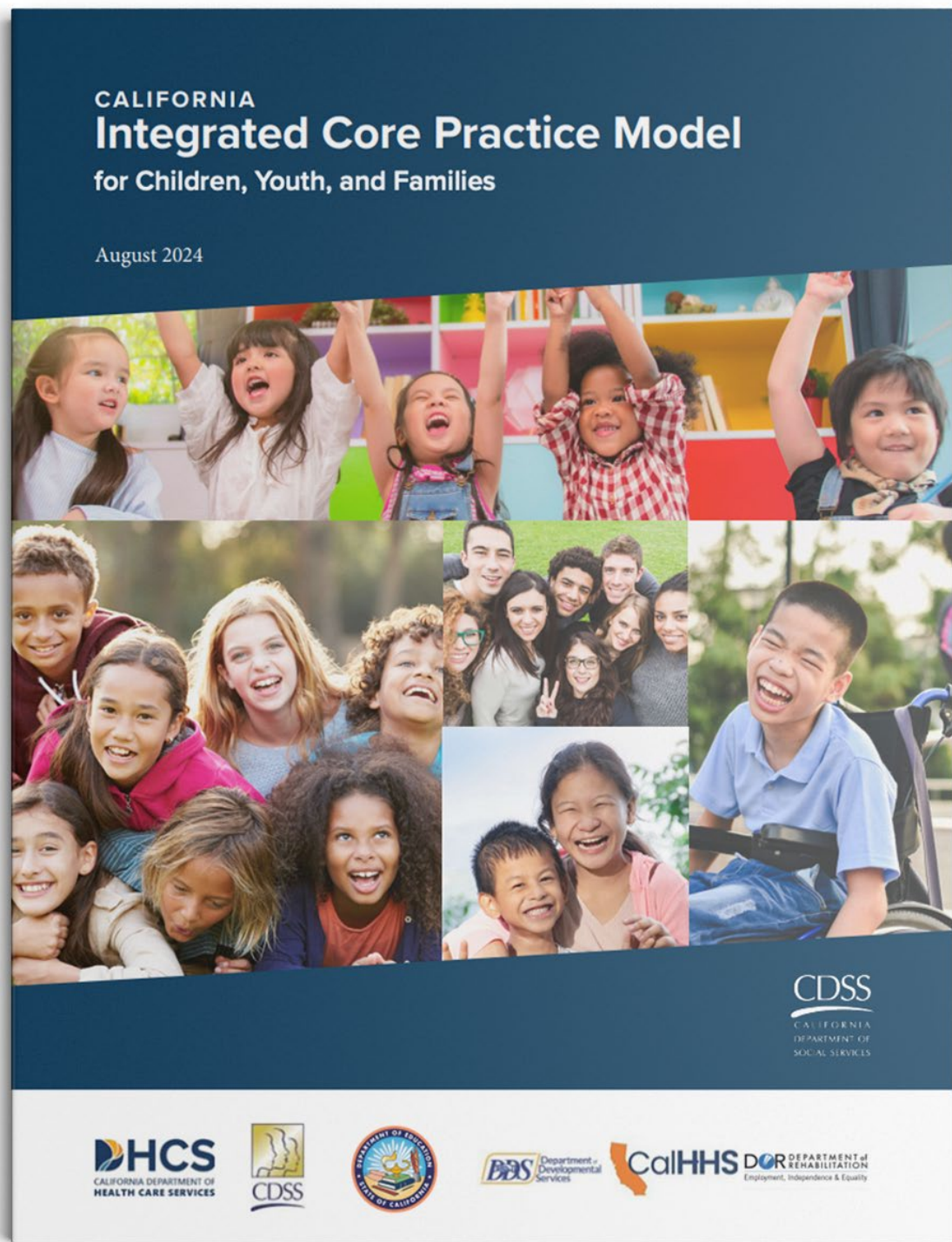
Neuroscience and Practice Inform a Whole Child Definition

Transforming Together's whole child definition draws on neuroscience and decades of research in education, health, and human services.

Neuroscience shows that child development is dynamic: cognitive, emotional, physical, and social capacities grow through constant interaction with environments and relationships. These research findings reinforce what educators, health providers, and families have long understood: while a single influence can spark change, lasting success comes from many factors working together.

The whole child definition also reflects principles embedded in established frameworks such as California's Integrated Support Systems (see, for example, page 13 of the [Integrated Core Practice Model Guide](#)), Systems of Care, and Community Schools.

By clarifying the common ground among these approaches, Transforming Together's definition supports consistent communication between agencies, community partners, and families—and helps align collective goals for children and youth.



Across education, human services, and health systems, a whole child approach emphasizes a shared set of principles that influence how care is delivered, as summarized in the table below:

Whole Child/ICPM Principle

Young people's well-being and development is impacted by the context in which they live.

Integrated Core Practice Model (ICPM) Principle: Community-Based

Cross-Sector Application

Health professionals, human service staff and educators who follow a whole child approach understand that individuals do not exist in a vacuum. They learn, grow and develop in families, communities and societies with varied cultural, environmental, economic and systemic factors. In the health field, for example, practitioners and policymakers take into account the **social determinants of health** (healthcare access and quality, education access and quality, social and community context, economic stability, and neighborhood and built environment) when considering the supports a person might need to reach their optimal health outcomes. Similarly, educators with a whole child approach take the time to understand students' and their families' context beyond the school walls in order to help them build on assets and overcome challenges.

Development involves the interaction between social, emotional, cognitive and physical conditions.

ICPM Principle: Developmentally Appropriate

Staff in the education, health and human services fields share a common understanding that within an individual their well-being (or lack of well-being) in one area has ripple effects across their development overall. For example, a young person who is experiencing high levels of emotional distress will likely struggle to focus in school, impacting their cognitive development. This emotional distress may also undermine their physical well-being and even their ability to maintain positive social connections.

Each individual is on their own unique developmental pathway.

ICPM Principle: Individualized

Within a whole child approach, people who work with children and youth understand that each individual has a unique set of developmental assets and challenges. There is no "average" student, patient or client, rather each individual is growing and learning on their own trajectory that requires supports and scaffolds at different times and in different ways. [Reference: Todd Rose, **The Myth of Average**].

Youth voice is critical.

ICPM Principle: Voice and Choice

Staff in the health, human service and education fields understand the importance of listening to their patients'/clients'/students' perspectives so that they can fully understand the context they are experiencing, the full range of their well-being, and their unique assets and challenges.

Focusing on assets and aspirations, rather than trauma and deficits, creates opportunities for growth.

ICPM Principle: Strength-Based

Practitioners and policymakers taking a whole child approach understand that no one is defined by the worst thing that ever happened to them. [Reference: Shawn Ginwright, **Healing Centered Engagement**] Rather, human beings are impacted by an array of experiences, relationships and environments that can be leveraged to support their healthy development across their entire lifetime.

Research on Working Together for Whole Child Success

T² builds on a strong body of research showing that coordinated, cross-system action achieves results that no single program or agency can deliver on its own. In particular, the initiative draws on frameworks such as Collective Impact, System of Care, and Community Schools—approaches many California communities are already using to inform their change efforts.

The Case for Change

Recent data underscore the urgency:

Youth suicide rates increased 62% from 2007 through 2021, with disproportionate impacts on youth of color and LGBTQ+ youth¹.

Chronic absenteeism surged to over 25% statewide during and after the COVID-19 pandemic².

Behavioral health service requests for children and youth have outpaced the workforce, with some counties reporting waitlists of months.

These findings align with the EcoPaper's analysis of California's state, which documents record-high rates of youth mental health needs, rising absenteeism, and months-long service waitlists across the state (EcoPaper, pp. 6–11).

Without system change, no single agency can solve these challenges. Fragmented services, siloed funding, and disconnected decision-making leave youth and families struggling to navigate complex systems. A countywide Ecosystem of Care provides the structure to align resources, strengthen the workforce, and improve long-term outcomes for children and youth in the ways they need and want.

Moving from Siloed to Strategic

Meeting today's challenges requires attention to the whole child—the social, emotional, physical, and cognitive needs that are inseparable in a young person's life. At the same time, it is important to recognize the value of specialization: education, health, social services, justice, and other child-serving systems each bring essential expertise. A school counselor, a pediatrician, or a probation officer must focus on their primary role, just as an oncologist's priority is to deliver the right chemotherapy.

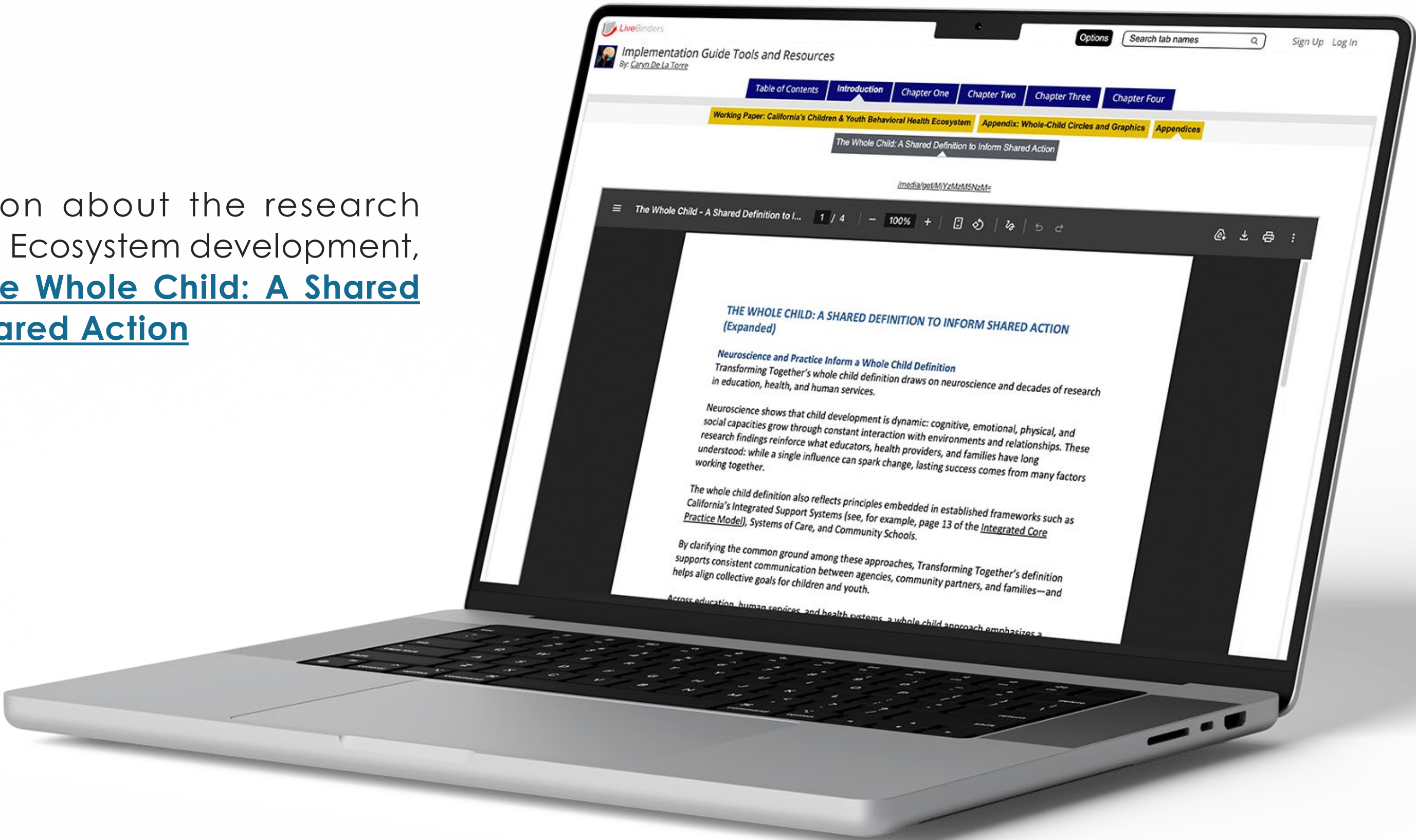
The challenge arises when these systems operate in isolation. When agencies focus only on their piece without coordination, families experience disconnected or even contradictory services. The opportunity is to preserve the strengths of each field while weaving them together into an Ecosystem where strategies are coordinated, data is shared, and funding is aligned.

In such an approach, families encounter supports that feel seamless. Educators can address the root causes of absenteeism with help from health and social services. Mental health providers can anticipate and respond to needs earlier. Agency leaders can fill critical workforce gaps together. And most importantly, children and youth can access care and opportunities that reflect their full humanity rather than fragmented parts of their identity.

Below is a graphic which illustrates the vision, structure and function T² is working to realize in an Ecosystem of Care across every California county and community.

 Vision, mindset and culture	 Structure, organization and resources	 Function, process and outcomes
✓ Clear shared vision by, for and with children and families ✓ Communities and families empowered as partners to elevate their interests ✓ Commitment to address root issues of structural inequity	✓ Integrated approach to child wellbeing and alignment across the ecosystem ✓ Capacity building, technical support, and research agenda for initiating and building local ecosystems of care ✓ Larger, culturally responsive and congruent behavioral health workforce	✓ Community-defined shared outcomes, accountability and continuous improvement ✓ Data and info sharing processes and tools ✓ Effective approaches to integrated funding to maximize impact ✓ Coordinated care navigation for youth, students and families

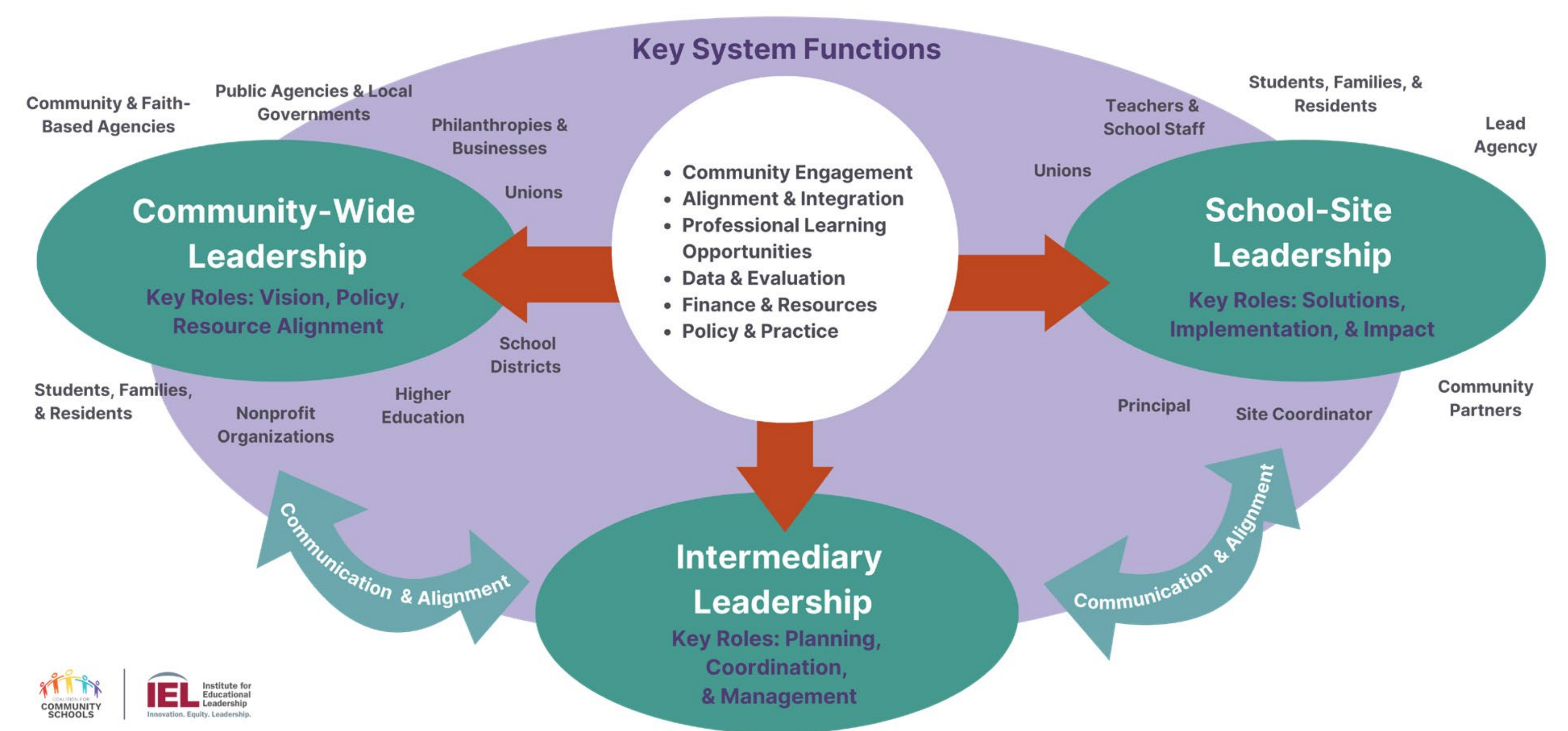
For further information about the research supporting whole child Ecosystem development, see this document: [The Whole Child: A Shared Definition to Inform Shared Action](#)



California Policy Momentum

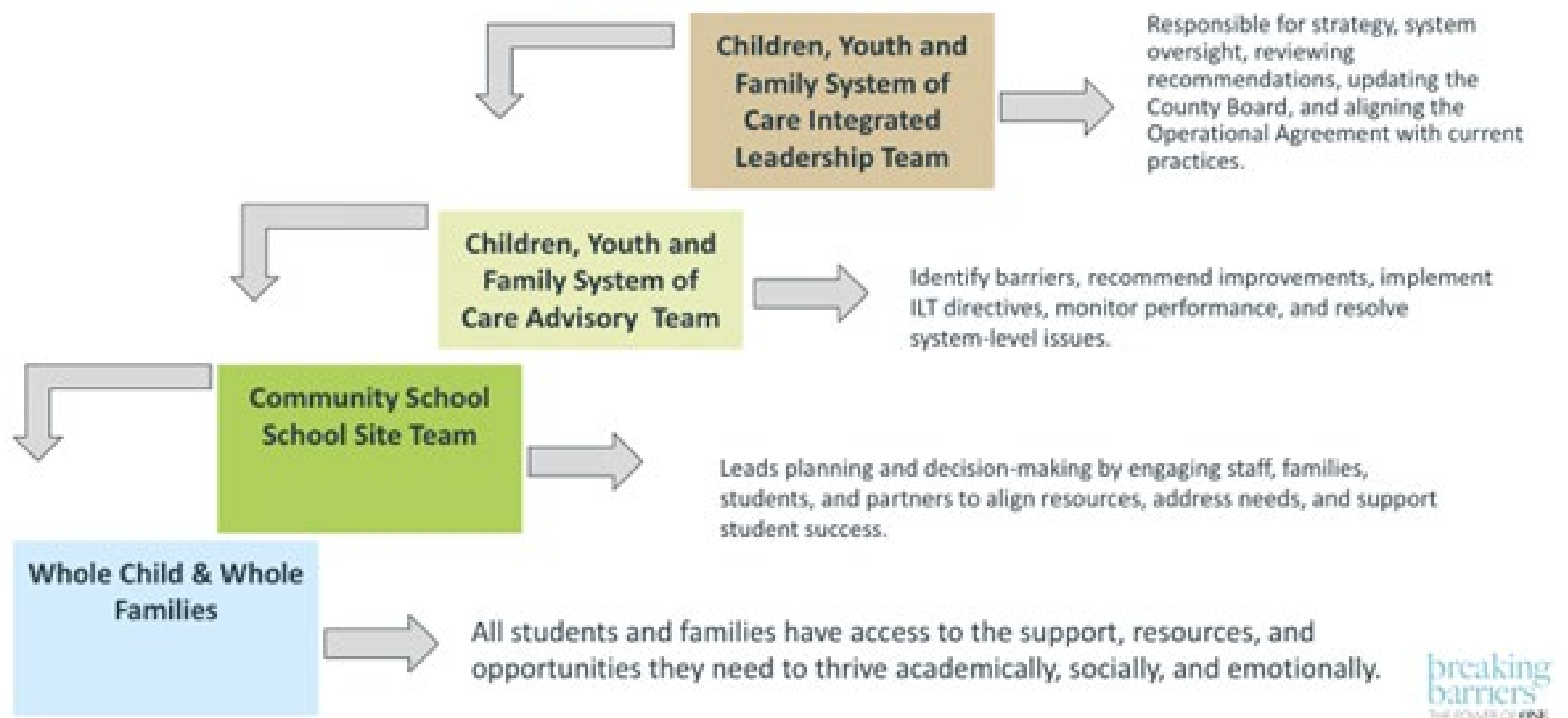
Importantly, state policy already points counties in this direction. The Local Control Funding Formula (LCFF) for schools, the Children and Youth Behavioral Health Initiative (CYBHI), the California Community Schools Partnership Program (CCSPP), California Advancing and Innovating Medi-Cal (CalAIM), and AB 2083’s Interagency System of Care requirements all set expectations for shared responsibility for whole child outcomes across communities, education, health, juvenile justice, human services and other child serving organizations. These policies each have elements that encourage (and in some cases, require) integrated systems approaches. The current work in education systems to scale Community Schools—a California priority—should both provoke and inform county plans for collaboration. All county leaders who help manage programs and services for child and family wellbeing, and not just education leaders, can use these resources and ideas across systems. This combined investment and structure of Community Schools supports accelerated integration.

Below is a graphic for the Collaborative Leadership Structure for Community Schools:



Both AB 2083 System of Care and the CA Community Schools Partnership Program seek to develop the same Ecosystem: cascading interagency and community leadership structures to improve outcomes for the children and youth of California, including a county-community leadership team, an intermediary implementation leadership structure-team and a site-level leadership structure-team that together unite communities and agencies in shared leadership, shared goals, shared accountability processes, shared financing, shared information and shared care. Similarly, CYBHI seeks to transform and reimagine the way California supports children, youth and families by centering the needs of young people and uniting the agencies and organizations that serve them. Together, these bodies of work form the Ecosystem of Care that T² is advancing through this Guide, establishing the conditions for California’s children, youth, families, and those that support them to thrive.

An Ecosystem of Care: Cascading System Supports (Conceptual)



County Spotlight

Building Access Through Trust and Integration (Fresno County)

Fresno County Superintendent of School's (FCSS) journey toward an Ecosystem of Care began with a stark reality: rural communities on the county's west side had virtually no access to behavioral health services. "We knew there was a lack of services for all students," recalls Trina Frazier from the office of the Fresno County Superintendent of School. FCSS partnered with the Department of Behavioral Health to bring services directly into schools, homes, and communities—laying the foundation for trust and shared responsibility. Over time, FCSS shifted from offering only specialty mental health (Tier 3) services to offering Tier 1 and Tier 2 services, now including prevention and early intervention supports, mild mental health services with 12 wellness centers strategically placed in high need areas, and mobile therapy units serving as regional hubs. FCSS now has a full behavioral health continuum of care.

Key milestones along the way included blending funding streams, piloting billing through the statewide fee schedule, and creating a consortium with districts to close gaps for students with private insurance. "Our goal was to remove as many barriers as possible so families could have a choice where they obtain services," adds Tammy Frates from the office of the Fresno County Superintendent of School. Wellness Coaches, clinicians, and family partners now provide care through a "no wrong door" approach, ensuring families are connected to support no matter where they enter the system.

The work has not been without challenges—navigating two different systems (medical and educational) required patience, training, and new language. But FCSS is seeing results: waitlists have shortened, more youth in rural areas are accessing care, attendance has improved, and suspensions have declined.

For FCSS, the most inspiring outcome is simple: children receiving mental health services they never had before. As Trina explains, "It can change the trajectory of a student's life—teaching them how to cope with what's going on at home, so they can show up ready to learn."

Collective Impact

In 2011, Jon Kania and Mark Kramer described **Collective Impact** (see here: [Collective Impact](#)) —an emerging approach communities, frustrated with fragmented interventions, were beginning to use to advance shared, cross-organization goals and actions and better address thorny social problems.

They identified five conditions that distinguish Collective Impact initiatives:

- **Common agenda** – a shared vision for change, including a common understanding of the problem and a joint approach to solutions.
- **Shared measurement systems** – consistent data collection and use across all participants to track progress and foster accountability.
- **Mutually reinforcing activities** – coordinated, differentiated actions by each participant that support and align with the common agenda.
- **Continuous communication** – strong channels for trust-building, learning, and alignment among participants.
- **Backbone support organizations** – dedicated staff and structure to coordinate the initiative and maintain momentum.

Subsequent research confirms that Collective Impact and Systems of Care approaches deliver measurable improvements that go well beyond any single agency's efforts. For example, national evaluations of System of Care show (see here: [Expanding System of Care: Improving the Lives of Children, Youth, and Families](#)):

- **Improved child and youth well-being:** Significant decreases in depression, anxiety, aggression, and trauma symptoms, with concurrent gains in strengths and functioning at home, in school, and in the community.
- **Better education outcomes:** Increases in school attendance and grades, with reductions in suspensions and expulsions.
- **Reduced juvenile justice involvement:** Youth demonstrate lower arrest rates, fewer contacts with law enforcement, and reduced rule-breaking behaviors.
- **Stronger family outcomes:** Families report reduced caregiver strain, greater ability to manage challenging behaviors, and improved financial stability.
- **Lower use of restrictive settings:** Expanded home- and community-based services have led to reductions in costly inpatient and residential placements, allowing reinvestment of resources into more effective supports.

System of Care

The **System of Care framework** emphasizes family-driven, culturally responsive, community-based services delivered early. Beth Stroul (Georgetown University) and Robert Friedman (University of South Florida), working with the U.S. National Institute of Mental Health, developed this framework in the 1980s to better address the unmet needs of children with significant behavioral health challenges.

Federal support and strong evaluations (for example: [Issue Brief](#)) helped spread the model nationwide. Whether adopted by behavioral health, education, child welfare, or juvenile justice systems, these efforts all emphasize cross-agency coordination, individualized care plans, and strong family and youth participation (full report, here: [Return on Investment in Systems of Care](#)).

California put these principles into law through [AB 2083](#), which requires every county to establish an interagency leadership team and create a service coordination plan for foster youth with complex needs.

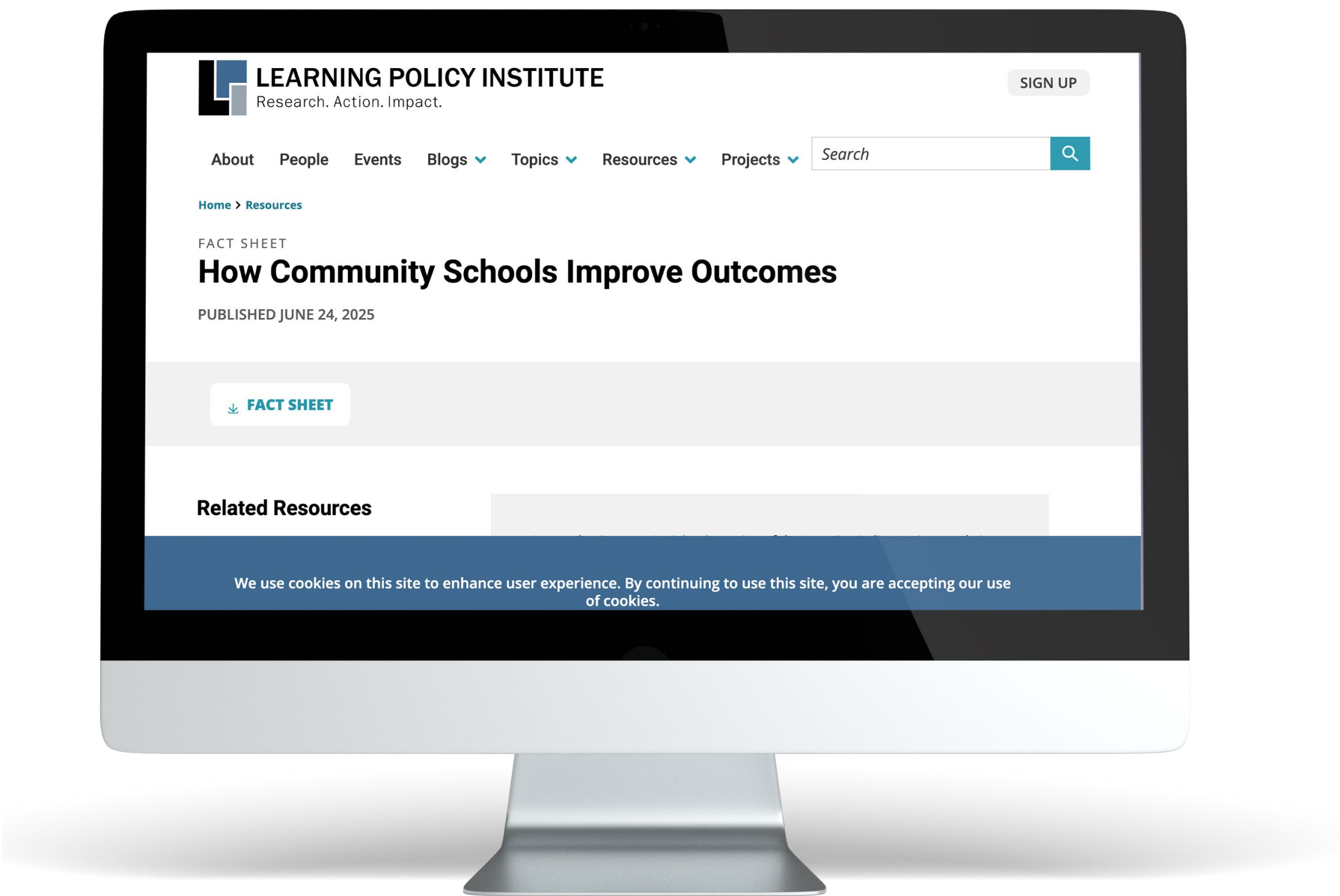
Community Schools

The **Community Schools model** rests on a simple insight: When schools address academic, social, emotional, and health needs together, they create conditions for stronger learning. This whole child approach posits schools as central to both learning and community wellbeing. Throughout the 1980s and 1990s, educators and policymakers refined the model, including distilling its core features into four key Community Schools pillars (see here: [California Community Schools Partnership Program](#)):

- Integrated student supports
- Extended learning time and opportunities
- Family and community engagement
- Collaborative leadership and practices

Evidence shows Community Schools boost achievement, attendance, and parent engagement while also improving access to health and social services, reducing disciplinary actions, and strengthening school climate (see here: [How Community Schools Improve Outcomes](#)).

Thousands of schools across the country identify as Community Schools, often by providing wraparound supports, deepening family partnerships, and creating richer learning opportunities without necessarily engaging in broader systems reform. At the same time, large-scale Community School initiatives—including California’s historic \$4+ billion investment—seek to go further by aligning district, county, and state systems to sustain and scale the model. In this sense, Community Schools can serve as both a school-level strategy and a lever for collaborative systems change.



Across these approaches, outcomes improve more consistently and at greater scale when agencies work together with fidelity to shared principles.

Using This Guide

This Guide captures the framework and implementation steps necessary to realize the recommendations of the 2023 CYBHI **Ecosystem Working Paper**. An Ecosystem of Care is more than a network, it is a living, coordinated system where schools, health providers, social services, juvenile justice, communities and other child serving agencies work seamlessly together so that any door a young person or their family walks through becomes the right door to access the care, supports, and opportunities they need to thrive.

The Guide and its resources are designed for county government and agency leaders, managers, and community partners who are:

- Participating in existing cross-agency programs, committees, or teams;
- Leading or staffing cross-agency efforts; or
- Seeking help and ideas to initiate or grow effective agency collaboration.

It provides practical resources, templates, and lessons, including how to navigate inevitable challenges, drawn from diverse counties and cities across California.

Four Chapters

The Guide offers support to counties in four chapters:

- **Building Shared Leadership**
- **Developing Shared Goals**
- **Realizing a Shared Universal Service Array and Workforce Development**
- **Sustaining an Ecosystem of Care**



Chapter 1

Shared Ecosystem Leadership



Why Shared Leadership

The first step in building an Ecosystem of Care requires securing broad, high-level county leadership commitment to this effort and keeping leaders engaged and focused on steering the change process. Without shared leadership across agencies, efforts will be fragmented and siloed, and whole child services and supports cannot be realized.

This chapter—and the entire Implementation Guide—regularly refers to a decision-making structure with two separate but intertwined tiers that county leaders can deploy to support creating and implementing a new Ecosystem of Care: an Integrated Leadership Team (ILT) and an Executive Advisory Committee (EAC).

The interagency leadership structures and functions required by [California's AB 2083 legislation on Children and Youth System of Care](#) uniquely realize the need for united leadership. The policies outlined by AB 2083 are among the state's most important efforts to improve child and family services—and provide opportunities to broaden and deepen county efforts to create a fully accessible and effective continuum of services for at-risk families and youth³. Adopted in 2018, the legislation requires each county to develop and implement a Memorandum of Understanding (MOU) outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma.

Additionally, AB 2083 mandates the creation of an Interagency Leadership Team (ILT) in each county, bound by the MOU and charged with coordinating efforts to improve youth outcomes. Although the legislation focuses on youth in the foster care system, many state and local leaders have recognized its required structures as the most accessible interagency effort available in California for connecting child and youth-serving systems more broadly. Simply put, the Interagency Leadership Team is a model for expanded work statewide. As such, many California counties have begun leveraging this leadership team structure to support the essential “vision-structure-function” demand of other systems-change work.

Ideally, a well-established Interagency Leadership Team is positioned to be a central clearinghouse for all whole child efforts within a county as it articulates an Ecosystem of Care.

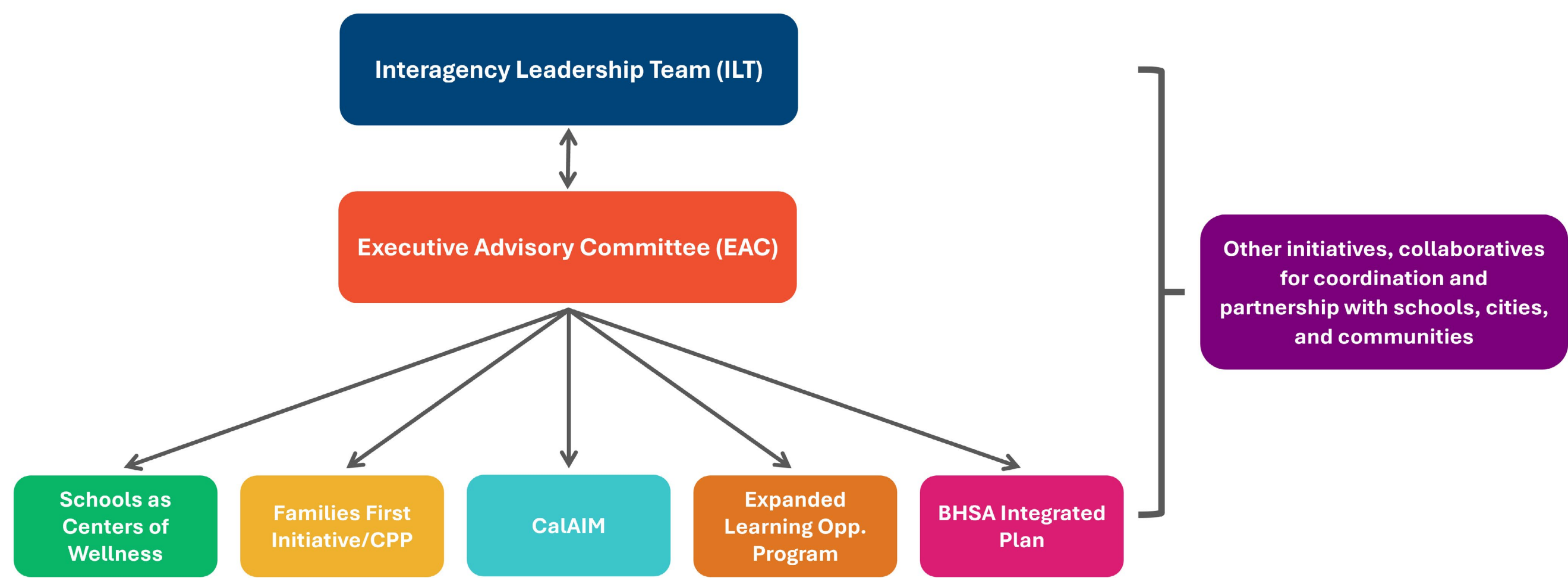
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What is Shared Leadership

This chapter provides suggested actions and tools for county teams to leverage, expand, and align the AB 2083 structure with other existing California initiatives. While AB 2083 offers a common and accessible entry point, the Interagency Leadership Team/Executive Advisory Committee (ILT/EAC) approach (described below) can also stand alone as an effective organizing structure. In either case, the goal is to help counties design and sustain an Ecosystem of Care for all children and youth. The ILT/EAC will:

- **Identify and support a two-tiered leadership structure.** Form an Interagency Leadership Team (ILT) to set vision and policy direction, and a second-tier Executive Advisory Committee (EAC) to execute and manage the cross-agency implementation and coordination.
- **Engage communities in existing cross-agency efforts.** Include youth, families, Tribal leaders, and community voices in decision-making.
- **Create a shared vision and clarify roles.** Help the ILT develop a unified, measurable vision and ensure clear roles, norms, and expectations for how agencies collaborate and make decisions.

Below is a sample graphic of California's existing AB 2083 System of Care infrastructure and efforts which, united with aligned California efforts, can be expanded to realize an Ecosystem of Care:



To learn more of each of the above programs, click below:

- [Schools as Centers of Wellness](#)
- [Family First Prevention Services \(FFPS\) Initiative](#)
- [California Advancing and Innovating Medi-Cal \(CalAIM\)](#)
- [Expanded Learning Opportunities Program](#)
- [Behavioral Health Services Act \(BHSA\) Integrated Plan](#)

Systems change requires committed and sustained leadership. Collective impact, System of Care, Community Schools, and other research-informed practice approaches provide venues where leaders of partner organizations can develop and maintain a shared vision and goals and oversee cross-agency implementation.

How the ILT and EAC Work Together

These two leadership groups play important, complementary and necessary roles:

- The **Integrated Leadership Team (ILT)**, the first tier of the shared leadership structure, includes agency directors, chiefs and superintendents, parent/youth representatives, and, ideally, community partner organizations. The AB 2083 legislation charges the ILT to establish a unified vision for the foster care system and ensure that individual agencies and community organizations collaborate to work toward this vision. Pursuing an effective Ecosystem, and any measurable return on investment, will require the county's ILT to expand its vision to begin addressing the complete spectrum of child and youth service delivery issues and processes for a far larger set of youth in any particular county.
- The **Executive Advisory Committee (EAC)**, the second tier of the shared leadership structure, includes managers, deputy directors, and/or other senior leaders of departments or agencies who share responsibility for building the new Ecosystem. The EAC executes the vision of the ILT and manages the day-to-day work and decisions about achieving the county's vision for whole child and community-centered care.

An inherent early tension in convening and recruiting an ILT, especially one focused on uniting the broader California children's systems into one integrated Ecosystem of Care, is deciding who to tap and how large to make the group. **The most critical factor in determining a leadership team's composition is to have those with decision-making authority consistently present in meetings so that trust and shared accountability are built and sustained.** But group size and representation can also either restrict or unleash the ILT's capacity to execute its vision: if too small, the body cannot represent the full scope of need or services; if too large, the team will struggle to make decisions or implement agreements.

The most critical factor in determining a leadership team's composition is to have those with decision-making authority consistently present in meetings so that trust and shared accountability are built and sustained.

In practice, most counties have found that an ILT composed of no more than six to nine members representing a diverse set of partners is most effective. Examples of members include:

The director or deputy-level staff from these agencies: Mental Health/Behavioral Health, Regional Center, Child Welfare, Juvenile Probation, and the County Office of Education.

Presiding judges: judges often bring a unique perspective to the system and a unique capacity to influence a leadership team. In moments of difficulty, having a non-county authority to mediate and interpret can bring disparate views between other partners into synchrony.

Native Tribal authorities: California's most recent System of Care design efforts (and the experience of many counties) point to Tribal leaders as essential ILT participants.

Family and youth representatives.

Leaders from other county departments and initiatives that interact with the behavioral health system, such as Human Assistance or Public Health and/or the local First 5 Commission; and youth and parents who work closely with or are part of the target population for services.

Directors and agency heads typically sit on the ILT, while deputies, assistant directors, and senior managers from the same agencies sit on the EAC. The examples below illustrate this tiered structure across systems. Counties must determine their own local membership for each.

Interagency Leadership Team	Executive Advisory Committee
Role: Establishes a unified vision for the Ecosystem of Care and ensures that individual agencies and community organizations collaborate to work toward this vision.	Role: Executes the vision of the ILT and manages the day-to-day work and decisions towards achieving the county's vision for whole child and community-centered care.
Sample Composition: AB 2083 Signatories: Agency Leads, Judge	Sample Composition: Designated Deputies, Asst Directors, Sr Managers from each partner agency
Sample roles: • Director/HHS or Social Services* • Chief Probation Officer • County Schools Superintendent • Regional Center Executive Director • Federal Tribal Representative • Parent Representatives • Youth Representatives • First 5 Director • Court/Presiding Juvenile Judge	Sample roles: • Child Welfare Director* • Public Health Director* • Behavioral Health Director* • Assistant/Deputy Chief Probation Officer • Associate Superintendent of Schools • Regional Center System of Care Manager • Children's Manager/Asst Director BHS/MHP • Federal Tribal Representative • Sr Manager, Public Health • Managed Care Plan Representative
Sample Processes & Functions: • Determining strategy and direction • Overseeing implementation and effectiveness of the system • Reviewing, assessing and responding to advisory team recommendations • Sharing updates with County Board of Supervisors • Ensuring the Operational Agreement reflects current practice	Sample Processes & Functions: • Identifying system barriers and proposing solutions • Reviewing shared practices/policies and recommending improvements • Carrying out ILT directives for addressing trends and gaps in program design • Monitoring system performance through dashboard and other measures • Working to resolve system-level issues

* Note: Roles listed are sample positions meant to illustrate levels of authority, not to imply duplication or role-splitting. Counties without a Health and Human Services Agency structure (i.e., wherein Public Health, Behavioral Health, and Child Welfare all report a single Agency Director) should adjust by placing system directors in the ILT and deputies/managers in the EAC.

Key Components of an Ecosystem of Care Leadership Structure:

Systems change requires committed and sustained leadership. Collective Impact, System of Care, Community Schools, and other research-informed practice approaches provide venues where leaders of partner organizations can develop and maintain a shared vision and goals and oversee cross-agency implementation.

Shared leadership, supported and anchored in a high-functioning leadership body, is essential for persevering through the numerous obstacles to cross-agency collaboration. Working together regularly, partners can successfully address common challenges such as:

- **Facilitating access to one another's data outcomes and outputs.** Sharing data allows partners to measure impact and streamline service delivery. One partner's programmatic or fiscal impact is often visible in the outputs or "gains" of a partner agency. Note that while many outcomes can be shared and analyzed without any legal concern, some data sharing requires complex agreements or memoranda (which is also why a designated leadership body needs to be engaged in resolving any roadblocks).
- **Identifying or redeploying financial resources** to sustain the otherwise isolated funding within any singular partner agency.
- **Tapping the wisdom and experience of peer leaders in adjacent departments within the system,** who have a view of the whole to augment or clarify county or community needs. This collective wisdom allows a leadership team to recognize and sustain its transformative role.⁴
- **Co-developing and offering a new, comprehensive array of services and supports**—allowing agencies and communities to address various needs collectively, develop the continuum of programs and services needed to keep children and youth at home, in school, and outside of youth corrections.



How to Build Shared Leadership

Strategies for Building Cross-Agency Leadership and Collaboration

In California, most policymakers and agency leaders agree that high levels of collaboration between organizations are necessary for improving systems, access to necessary services and supports, family and youth empowerment, and outcomes. However, collaboration and coordination are hard work: They require up-front time to synthesize different goals, assumptions, and approaches into a new, shared approach, and they require ongoing attention and problem-solving as new processes and activities are tested and rolled out.



Resource Spotlight

Counties can review the examples of [Successful Multi-Agency Collaborations \(CCEE ESOC Toolkit\)](#) to see how other jurisdictions have structured governance and partnerships. These case examples provide concrete illustrations of what cross-agency collaboration can look like in practice and why it is critical to access to care.

A common early question is: who convenes and sustains this work? In practice, counties have taken different approaches. Often, a “host agency” — such as the County Office of Education, the Health and Human Services Agency, or the Presiding Juvenile Judge — provides the initial spark by convening partners and coordinating early logistics. Framing this role as a host, rather than a lead, emphasizes that the host’s responsibility is to create space for collaboration, not to dominate decision-making.

Equally important is recognizing that shared ownership takes time to develop. Early on, momentum often relies on a single host agency to organize and catalyze action. But over time, as trust builds and roles clarify, the shift toward collective responsibility becomes a critical milestone in the maturation of an Ecosystem of Care. Only when ownership is genuinely shared across ILT members can the system fully realize its potential for sustained, cross-sector transformation.

Key Consideration: From Host to Shared Ownership:

- A host agency is often needed to initiate the work.
- Shared ownership across ILT members is essential for long-term sustainability.

Collaboration and coordination are hard work: They require up-front time to synthesize different goals, assumptions, and approaches into a new, shared approach, and they require ongoing attention and problem-solving as new processes and activities are tested and rolled out.

The transition from a single “spark” to collective responsibility marks an important stage in the Ecosystem’s development and this takes time.

To begin this work, agency leaders can consider the suggestions below.

1. Map and (Re)form Cross-Agency Leadership Structures

In California, local leaders are required to regularly meet as part of existing state-sponsored or state-funded efforts and initiatives to support the whole child, in addition to the explicit engagement requirements from AB 2083. Thus, in naming a leadership group to coordinate the new Ecosystem of Care being created, leaders should first identify, map and connect existing local, county, and regional interagency structures—such as Interagency Leadership Teams, Community School teams, Mental Health Commissions, or Accountable Communities for Health (ACH)—with one another and with parents and youth to form a collective and aligned organizational structure.

Specifically:

- Identify existing interagency leadership groups already working toward improved whole child and youth services. Basic functional analysis tools and shared conversations within and across agencies will identify where overlapping efforts and initiatives exist, and where and how they can be reduced and redefined to help advance the work.



Resource Spotlight

The [Existing Interagency Workgroups \(CCEE ESOC Toolkit\)](#) resource can help counties map current cross-agency teams, spot duplication, and identify opportunities to consolidate meetings into more coherent structures.

- Determine each leadership groups' purpose, scope, initial objectives, and goals.
- Identify participants for the county's ILT and EAC structure and attend to the meaningful inclusion and participation of youth, families, Tribal experts, and local organizations.
- Invite the various tables/structures, through reporting and advising to the county's ILT and/or EAC, to identify opportunities and redundancies and increase outcomes for all children and youth.
- Evaluate and address the county education office's unique ILT or EAC representation. County leaders need to adapt the scope of the existing ILT and EAC—or designate new structures—to focus on all youth, not only foster care youth. As these groups adopt and start to act on a broader vision for youth wellbeing, associate superintendents or leads from other parts of the county education agency should join to help design and sustain the work.

To effectively build a coordinated and sustainable Ecosystem of Care for all children and youth in California, local leaders can connect and align existing interagency structures rather than continue working in silos (or create new ones). This approach not only fulfills the state's legal and policy requirements but also leverages current efforts, reduces duplication, and ensures meaningful participation from families, youth, and community partners. By strategically mapping and integrating these leadership groups, counties can create a unified ILT and EAC structure that drives stronger outcomes and delivers on the promise of whole child support.



County Spotlight

Building the Blueprint - How One County Mapped its Cross-Agency Meetings (Alameda County)

When a new leadership team stepped into place at the Alameda County Office of Education (ACOE), they found themselves navigating a long list of inter-agency partnerships and meetings to which the office had previously committed. With a new superintendent, a fresh student services division, and many new leaders across divisions, the team wanted clarity about what to prioritize and what collaborative efforts were most critical. “We were really trying to understand the existing landscape around cross-agency work and meetings within the county,” recalled Chaun Powell, former Senior Chief of Student Services. “That was really the catalyst for it.”

As a first step, team members created a single spreadsheet that identified every cross-system/cross-agency meeting that they knew existed, which agencies were attending them, a description of the meeting, and which ones they believed required ACOE's presence. “We sent it out to each of our division leads that we knew led in areas connected to the system of care, or other county agencies (e.g., First 5) and had them populate the meetings they were part of,” Powell explained. “Then we still questioned if we had it all.”

To fill any gaps, Powell and her colleagues brought the draft to the county's newly formed Interagency Coordinating Council (ICC), which included leaders from probation, child welfare, social services, and First 5, as well as the county office of education. “We asked them, ‘Do we even have all the meetings here?’” Powell said. “The document evolved into a compilation of all the different cross-systems meetings happening.”

As the spreadsheet grew, so did its value. “What it is evolving into is a tool that allows us to look at efficiency and if we’re utilizing time in the best way possible,” Powell shared. The map revealed redundancies, such as multiple prevention-focused teams working in silos, often with the same attendees cycling through back-to-back meetings. “One day, I had three meetings. I walked into the first one, saw the people, then we all left early for the next meeting—and it was the same people again. Three times in a row. I thought, ‘what is going on?’” This visibility sparked important conversations about consolidation and coherence. For example, the county created a unified health steering committee after identifying duplication among health-related meetings. “We actually used that as a pilot to consolidate,” Powell said.

Despite its eventual success, the process hasn’t been without challenges. “We were all new. We didn’t even know if we were talking to the right people,” Powell admitted. Getting others to prioritize the work required explaining the “why”—a critical step she now emphasizes to others. “If I could do it again, I would make the purpose and objectives clear from the beginning and put some real timelines in place.”

Now, the spreadsheet is a living tool that continues to evolve. With regional centers and Alameda County Health recently added to the ICC, the team plans to refine the spreadsheet further. “Our next step is to explore opportunities to further simplify the structure where and if it makes sense—to combine more meetings and maximize time,” Powell said. “It’s all about creating coherence and better alignment for our systems (Big S) Ecosystem of Care.”

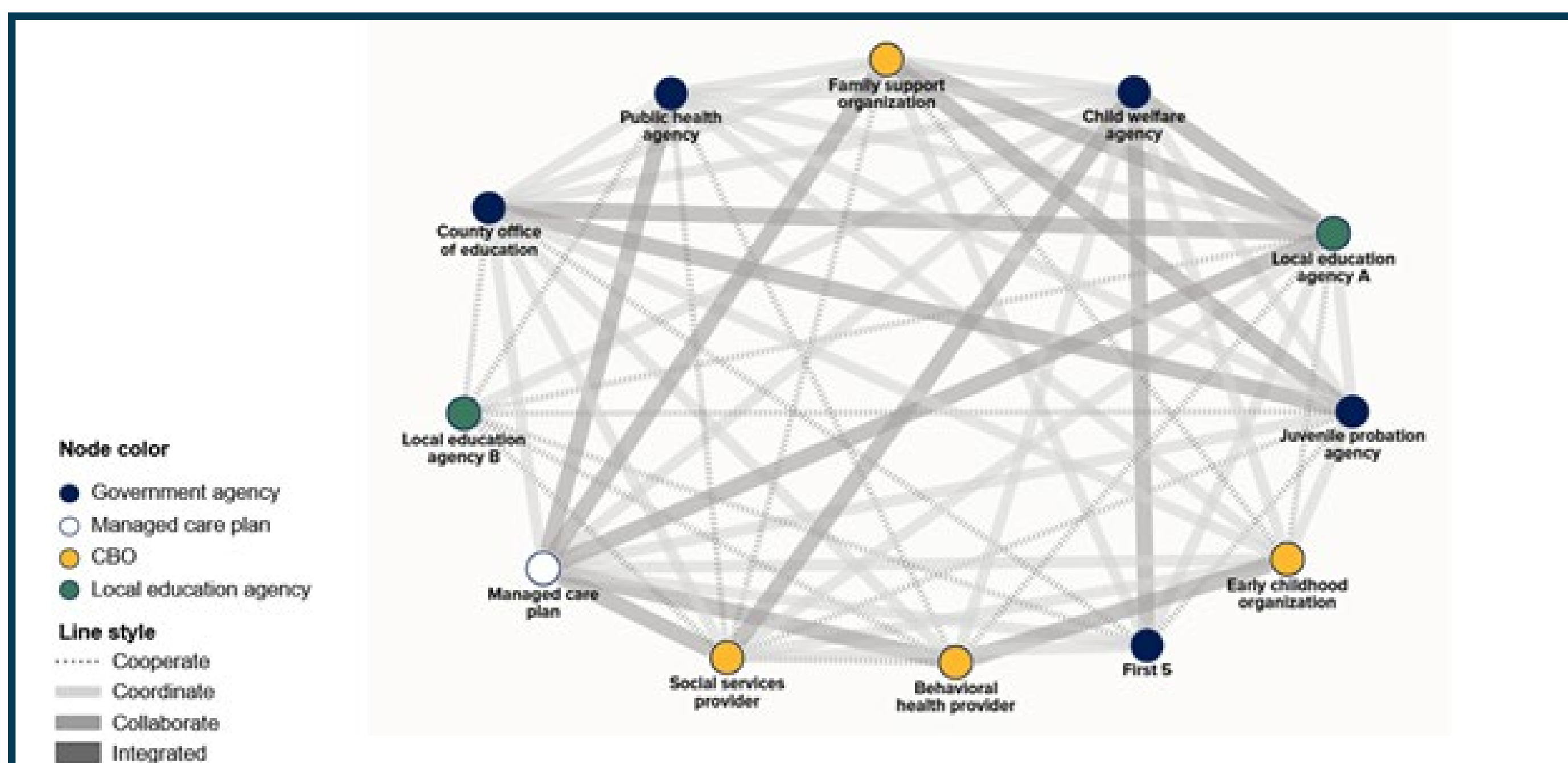
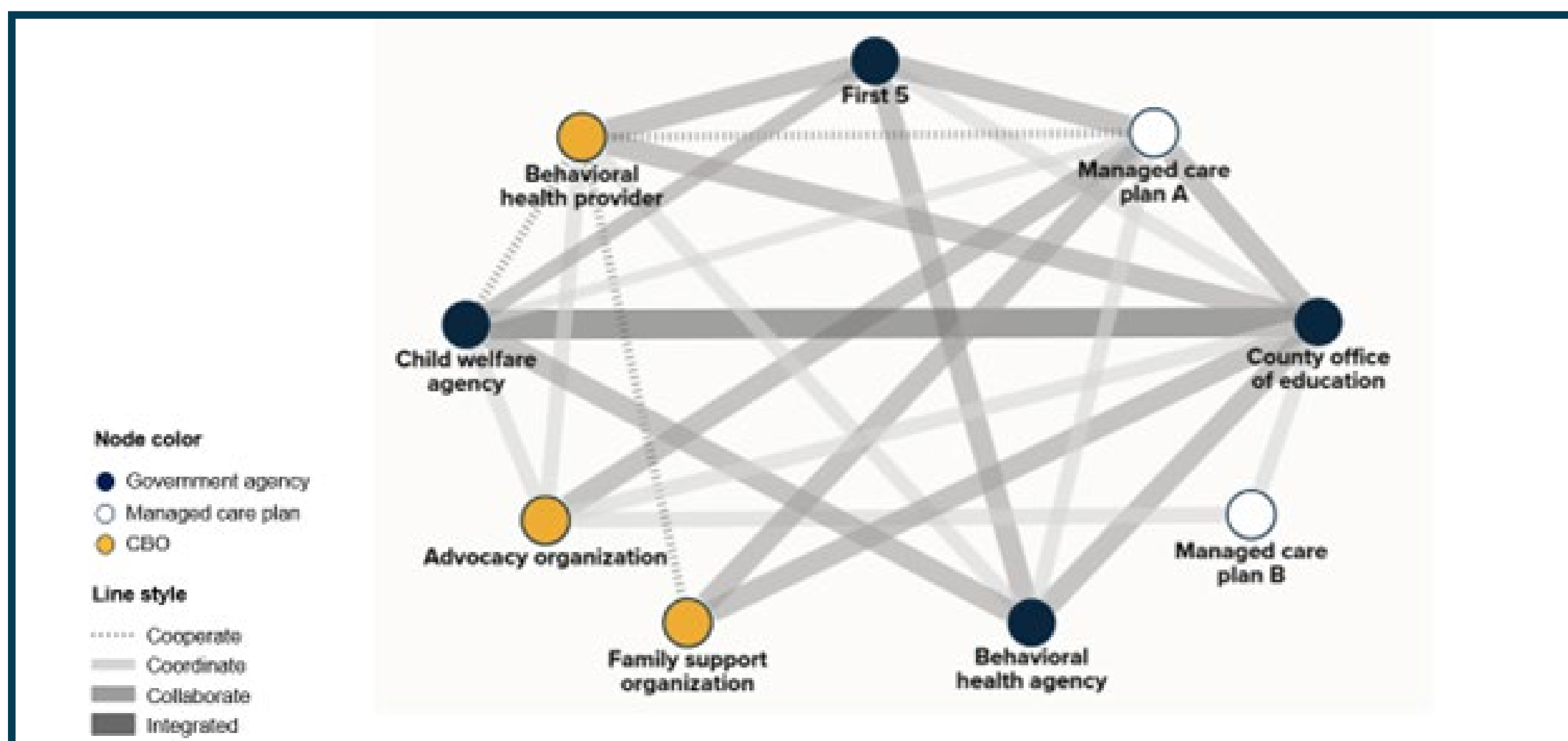


Tool Spotlight

The Network and Ecosystem Experiences Survey (NEES) is a tool developed by [Mathematica](#) and the California Health & Human Services Agency (CalHHS) under the Children and Youth Behavioral Health Initiative (CYBHI). It is designed to better understand how closely organizations within the child and youth behavioral health ecosystem connect and work together.

Through the survey, leaders from child- and youth-serving organizations rate the strength of their relationships with one another on a five-point scale, from co-exist to integrated. These ratings are used to conduct a network analysis and create a map that visually shows the connections between organizations. Lines represent relationships, and thicker, darker lines indicate stronger connections.

This analysis provides insight into how strongly organizations collaborate, coordinate, or integrate in supporting children and youth behavioral health. Although responses are subjective and typically limited to the perceptions of individuals within each entity who completed the survey, it helps start a conversation and illustrate the broader Ecosystem that underpins CYBHI in California counties, highlighting opportunities to strengthen partnerships across sectors to build a more connected Ecosystem of Care by, for and with children, youth, and families. It also enables counties approaching ILT development to map their current connections across agencies over time.



2. Build Trust and a United Mindset Through Clear Expectations

The interagency leadership structure and function—and the Ecosystem of Care it works to develop—has value and impact well beyond any single initiative and should not be contingent on or driven by individual reform or opportunity. It must be institutionalized.

Collective, cross-agency leadership facilitates individual agencies in transforming, aligning, and maximizing their deeply interdependent child, youth, and family initiatives and programs. We invite leaders to recognize that this whole child approach demands seeing and embracing every reform not as a narrow transaction or initiative between their department and the state or federal funding entity—exchanging dollars for compliance—but as an opportunity to fit the dollars into a continuum of wholeness, intentionally leveraging prior and future initiatives.

Moreover, leaders have the opportunity to recognize that vision, structures, and functions to implement systems-change are all interrelated. The ILT cannot just focus on one element alone—its vision should inform and be informed by the system's new functions; its structures should both hold and adapt in response to the vision; and its functions should be supported by and sustain the vision. The key for system leaders is to see this deep interdependence, and then patiently and persistently adapt their vision, structures and functions through ongoing quality control and improvement to realize the collective legacy they want for children, youth and families.

System partners find alignment and unity toward collective impact when they trust each other; the greater the trust, the more readily solvable challenges will be.



Tool Spotlight

The [**Activities to Establish Shared Understandings Tool \(CCEE ESOC Toolkit\)**](#) offers facilitation exercises that ILTs can use to build relational trust, identify assumptions, and establish common ground early in their collaboration.

Leaders can help build trust through the ways they themselves commit and “show up.” Invariably, the trust between professionals necessary to transform a system will demand that leaders understand that accountability and responsibility for children are essential to solving the challenges at hand. How one sees, embraces and behaves toward those in and outside one's agency has implications for system success. **Many integrative efforts collapse when leaders are unwilling to compromise, share power, or recognize the value of the work of other agencies.** Authentic alignment of vision and purpose does not occur without this transformative mindset effort.

Many integrative efforts collapse when leaders are unwilling to compromise, share power, or recognize the value of the work of other agencies. Authentic alignment of vision and purpose does not occur without this transformative mindset effort.

Specifically:

- Set the expectation that all partners commit to being responsive with their communications, attending meetings prepared, engaging during and after those meetings, and keeping their commitments.
- Identify necessary conditions for systems-change work to be successful in the county. Although public systems are often not well-funded to conduct the “pre-work” of collective effort, leaders still must invest in determining if their respective agencies are “ready” to share responsibility, risk, resources, and rewards. Each partner should conduct a readiness determination by engaging in an honest and transparent dialogue, both internal to the organization and external with partners.
- Establish a clear, shared vision and mission (and eventually goals and objectives – more on this in Chapter 2) to guide leadership team deliberations and decisions. Consistent attention to the reality that all youth within the county deserve the most robust, accessible, effective support possible and that the system partners have an aligned set of goals is critical to that end. This clarity of collective purpose, intent, and outcomes can become the organizational glue of the partnership. Vision and mission alone, absent the capacity to measure that vision and mission’s impact, is unsustainable. Broadly, AB 2083 MOUs—and the overall goals of California’s System of Care approach—are to “keep children and youth at home, in school, and out of youth justice involvement.” Every county must choose its own collective vision and mission.
- Agree to disagree. Some issues may not be solvable immediately regarding being and doing things together. At times, people must put problems aside to move on to areas of shared interest. However, it is equally critical to record those disagreements for future conversation so the team can revisit and resolve them later.
- Create healing-centered spaces with grounding exercises and community care opportunities. Establish safety protocols including community members’ right to pause conversations that become re-traumatizing.

Transforming systems to better serve children and youth requires more than structural change—it demands a united mindset of trust, shared accountability, and a willingness to lead with humility and collaboration. Without these conditions, even the best-designed partnerships fail. **When leaders commit to showing up consistently, sharing power, and aligning around a common vision for children, youth and families, they create the foundation for genuine collective impact and collective legacy for California’s young people and its future.** This mindset shift is not optional; it is the catalyst that enables agencies to move toward unified, sustainable solutions for all youth.

Including Youth, Families, and Community Experts in County Leadership Teams

California has rich resources and supports that provide an endless fount of wisdom and lived experience supporting shared leadership. Parents and youth with lived expertise can be found in all parts of the Ecosystem and may be particularly present in local community-based organizations. Many systems use titles such as Peer Navigators, Cultural Brokers, Parent Partners or Youth Advocates, and in many cases, these experts’ capacities are grounded in and supported by evidence-informed practices, such as Promotoras or Promotoras de Salud.

Authentic inclusion of parents, youth, and community experts requires attention to many factors. Research suggests that these guidelines can be helpful when forming or strengthening ILT and EAC efforts to ensure they include a broader community perspective⁵:

Including Youth, Families, and Community Experts in County Leadership Teams

- Establish shared decision-making responsibility with youth, parents, Tribal representatives, and community experts who have equal power in setting priorities and making decisions
- Identify where partners in the system are already present and meaningfully incorporate parent and youth voices regarding system quality improvement and leadership.
- Identify potential revenues to expand and fund parent and youth voices in county system leadership (See Chapter 4 for additional details about shared governance funding).
- Adapt or create job descriptions for parent and youth participation and roles. Please see here for examples of [Parent and Youth Job Descriptions](#).
- Identify potential persons with lived experience in the county/region/systems who, with proper support, might be interested and able to join the leadership team.
- Adapt agency processes to honor community communication styles and decision-making approaches. Provide training for agency staff on how to participate respectfully in community-led conversations and gatherings.
- Develop a means to collect, analyze, and act on, in an ongoing way, youth and family input about the efficacy of the county/regional Ecosystem towards identified shared goals and outcomes.⁶
- Create a consistent method to orient youth and parents as they assume responsibilities and roles in the leadership structure.
- Community voice should be present from the very start. They should be included when determining the leadership groups' purpose, scope, initial objectives, and goals.
- Ensure equitable and appropriate compensation for time, expertise and emotional labor; critically examine what the equity practice can and should look like in this compensation model.
- Ask: How do meeting formats, timing, and decision-making processes accommodate different cultural approaches, including Indigenous talking circles, African American call-and-response dialogue, and Latino plática conversation styles?



County Spotlight

Models to Include Youth and Families in Co-Design

Counties across California are experimenting with locally grounded models of family and youth co-design.

Santa Clara County operates a countywide network of Family Resource Centers that serve as neighborhood hubs for parent leadership, peer navigation and feedback loops.

Humboldt County established a Transition-Age Youth Collaboration within its Children's System of Care, ensuring families and young people co-develop strategies for prevention and early intervention.

San Bernardino County has embedded family and youth voice directly into its Interagency Leadership Team (ILT), pairing parents and young adults with agency leaders to inform policy, training, and cross-sector practice.

Including Non-Government Agencies and Community Organizations/Service Providers in County Leadership Teams

In addition to the voices and wisdom of youth and parents, the ILT and EAC should amplify their work in partnership with key contractors, community-based organizations, and other non-government agencies. Interest holders should co-design the nature and scope of the public-private partnership for a whole child system, and they can operationalize it in a few ways.



Resource Spotlight

[Examples of Successful Multi-Agency Collaborations \(CCEE ESOC Toolkit\)](#) showcases ways counties have engaged Community-Based Organizations (CBOs) and service providers as full partners in governance, offering models for shared accountability and public-private alignment.

Having non-government entities as signatories to an MOU and active in a shared leadership agreement (or potentially having voting power if that is the decision-making model) can introduce complexities that require all partners to adapt. As mentioned above, all partners in the Ecosystem must begin with a shared mindset that prioritizes improved outcomes for children, youth, and families. Individual agency and/or organization expectations or interests regarding who will do what in supporting children, youth, and families should not be primary drivers of the Ecosystem design and/or implementation.

Some ways to meaningfully achieve this desirable public-private leadership structure include:

- Incorporate CBO agency leaders as routine attendees, either as guests or participants in the work. Clarify their expected roles (and influence) early on and document these expectations in any system-wide agreement documents and in practice.
- Encourage CBO partners or contractors to submit annual or semi-annual reports to the ILT or EAC, sharing updates regarding the efficacy of programs, outcomes, impact, and community perspective.
- In larger counties, identify an informal CBO “liaison” who can attend the EAC or ILT meetings and participate and support the process. Liaison voting status should depend upon the structure of the community build.
- Establish semi-annual retreats, where the systems leaders and community partners spend time in strategy and dialogue to foster alignment and measure impact toward their shared goals, outcomes, and intentions. These longer engagements can provide rich opportunities to align visions and create shared solutions that enrich the entire Ecosystem of support.

Including Community Schools/Education Leaders on County Leadership Teams

Existing county ILT/EAC structures across California do not always include education leaders, or, if they do, these leaders do not always represent or are not fully informed about the significant change work happening in schools. This includes the California Community Schools Partnership Program (CCSPP) to expand necessary supports and services to more students. Given the strong alignment between the goals of California's CCSSP and CYBHI efforts and the importance of smartly leveraging the funding these two programs provide communities, educators must be substantively involved in county ILTs and EACs.

Ideally, System of Care partners or non-education county agency leaders take the first steps to invite and engage education and community school leaders into county Ecosystem leadership teams if the ILT or EAC does not reflect these perspectives. However, education agency leaders can also take proactive steps to become more engaged in cross-county agency deliberations and planning.

These activities could include some of the following approaches:

- County and Local Education Agency (LEA) Community Schools (CS) designers and developers/grant seekers can communicate their plans, progress, needs assessments, asset/gap analyses, and any early wins/milestones accomplished to their ILT or EAC teams. Ideally, whether official members of the ILT or not, county and district leaders should regularly present updates to system partners and request processes for ongoing sharing of information.
- LEA programs should engage County Office of Education ILT representatives to seek a seat within the System of Care planning and oversight function.
- ILT/System of Care leaders should look for funding streams already allocated to or intended to support local schools and commit to long-term sustainable streams. (Opportunities include BHSA, Juvenile Justice Crime Prevention Act (JJCPA), Medi-Cal/Short-Doyle, etc.). [See Chapter 4 for additional guidance in this area.]
- Community Schools coordinators and county Medi-Cal budget personnel can work together to identify how the CYBHI Fee Schedule Program and other Medi-Cal expansion can help strengthen and sustain CS efforts to expand behavioral health services.⁷ [See Chapter 4 for additional guidance in this area.]
- System of Care leaders should invite their other contractors to engage and be aware of opportunities within the Community Schools development, to co-locate or leverage resources within or aligned with the CS efforts in that school.

3. Update Interagency Agreements and MOUs to Reflect the New, Broader Vision for All Children and Youth

As described above, AB 2083's required inter-agency MOU and formal and informal multi-agency agreements required by other state initiatives can be adapted and expanded to reflect a county's new, broader aspiration for all children and youth in the County.

The AB 2083 interagency MOU for System of Care outlines the intent and commitments of the participating partners in improving and coordinating family and youth services. This MOU should also capture the work of the ILT and EAC specific to the county, which may include revision of, consolidation of, and/or alignment with existing interagency agreements.

In cases where an existing AB 2083 MOU is weak, underused, or overly legalistic, consider creating a new MOU. Samples and suggestions from other counties are readily available. Importantly, some form of agreement is needed to specify the shared vision partners are committing to, and to identify the key functions each partner will be pursuing. When well written, the MOU aligns vision, identifies key functions and processes, and clarifies how to administer those functions and processes jointly. Please see here for an example from Sacramento County: [Child, Youth and Family System of Care 2023-2026 Operational Agreement](#).



County Spotlight

Adapting AB 2083 in support of Whole Child/Whole Student Integration (Santa Clara County)

When Santa Clara County departments and their partners serving children, youth and families began exploring a deepening of their partnership toward a more integrated system to support children and families, they looked to the Memorandum of Understanding (MOU) and emerging Interagency Leadership process required by California's AB 2083 legislation as a model that also could help advance their overall vision for improving services for all families and youth. "We were already doing the visioning and collective work," explained Patty Ramirez, a longtime leader of the effort. "So when AB 2083 came about, it was like, yes—let's use that model to put on paper what we're already doing."

In 2008, the county's Board of Supervisors called on agencies to come together to better support children. They commissioned a new Cross Agency Service Team (CAST), a collaboration of county departments, school districts, community-based organizations (CBOs), and other partners. Together, they had sought to develop a strong partnership to serve children and families better; the work has evolved to what is now the vision of creating a "no-wrong-door" system of care. This work intentionally mirrored local schools' Multi-Tiered System of Supports (MTSS) framework and was deeply influenced by systems change thought leaders like Peter Senge. "That foundational work is what allowed us to even envision what this work could look like," Ramirez noted.

The process of expanding the AB 2083 MOU took time—nearly five years from the initial drafting to full implementation. "It has taken years to have all the agreements in place and to finalize our operational manual," Ramirez said. "Now we're in the early implementation phase of our agreements."

The MOU is held together by a shared vision, clearly defined agreements about interagency functions, and a strong commitment to collective accountability. County departments, including behavioral health, social services, probation, public health, First 5, the office of education and the San Andreas Regional Center all played key roles in its development. They were joined by parents and youth whose lived experience helped shape the work. "We even pay parents and are now working to bring in youth voice through paid internships," Ramirez shared.

However, sustaining alignment is not without its ongoing challenges. "There's this constant creative tension," Ramirez explained. "If we don't hold tightly to the vision, people fall back into their silos—especially when new policies or budget pressures emerge." To help address these tensions, the team revisits its shared logic model, holds regular retreats, and starts each agenda with a reminder of the shared goals.

Looking ahead, Santa Clara's Ecosystem continues to evolve their MOU as new partners come to the table, including managed care plans. "At first, they weren't part of the work," Ramirez said. "Now they are, and they're sharing data and identifying how we can help connect families to the services they offer."

For other counties considering a similar path, her advice is simple but powerful: "Start with trust. Build relationships. Define your vision and your terms—even if it takes six months just to agree on what 'prevention' means for example. And take the time to build your blueprint. Don't try to build the plane while it's flying."

4. Establish and Sustain Recurring System Operations and Meeting Norms

Regular meetings of key partners are essential to keep efforts on track. They provide space to recommit to a shared vision, resolve disagreements, set next steps, monitor progress, hold partners accountable, and celebrate successes. Well-planned and well-implemented meetings of the key partners and leaders in the county are an essential mechanism for keeping the work moving.



Tool Spotlight

This project and Implementation tool (see here: [Ecosystem Action Plan](#)) can be used to help assess and track progress in your integrated system transformation or Ecosystem.

The aligned Sample Action Plan below offers counties a month-by-month visual roadmap to guide meeting agendas and keep leadership teams focused on concrete steps. By linking recurring meetings to clear deliverables, the plan helps ensure discussions translate into action.

What Transformation Might Look Like: Sample Action Plan

Month 1-2 • Launch visioning process: Facilitate cross-agency workshops to define shared vision and mindset. • Begin mapping current leadership structures across systems to identify redundancies and gaps. • Assign host agency and ILT administrative coordinator.	Month 3-4 • Draft and refine shared vision and common language documents. • Conduct crosswalk of agency roles and identify overlaps for efficiency. • Hold ILT retreat to build trust and clarify expectations. • Develop recurring meeting calendar and norms for ILT and workgroups.	Month 5-6 • Update or draft interagency MOU to reflect expanded mission (e.g., AB 2083 + broader integration). • Implement staffing strategies (e.g., co-location, shared job roles) to support collaboration. • Formalize and document decision-making protocols and escalation paths.
Month 7-8 • Launch coordinated care team pilot or service mapping process across child-serving systems. • Ensure regular meetings are happening with fidelity and document key decisions. • Start development of shared indicators and data governance framework. • Determine integrated funding opportunities (Shared Financing)	Month 9-10 • Develop infrastructure for secure data sharing (with legal/data leads). • Host joint training or alignment session across agencies to reinforce culture and collaboration. • Identify Key Performance Indicators and begin data collection and small-scale feedback loops (e.g., focus groups, case reviews) • Act on leveraging opportunities for leveraged or braided funding.	Month 11-12 • Hold systemwide learning session to reflect on early data and identify successes and adjustments. • Revise MOUs or operations as needed based on lessons learned. • Document year-one achievements and priorities for year two. • Celebrate and recognize agency contributions to integration.

Although not glamorous, how meetings of county leaders and partners work in practice—and what happens before and after meetings—is essential to achieving any success.

Specifically:

- Commit to frequent meetings—ideally monthly—for both the ILT and EAC. With the many commitments and busy calendars of leaders, it may be tempting to suggest that county ILT and EAC groups can meet just quarterly or even semi-annually. However, cross-agency collaboration experience in California and other states indicates that more regular and consistent meetings are a hallmark of successful systems-change efforts. This guidance is invaluable during the early months (or years) of design and implementation, when teams are working out key issues (and disagreements). If ILT members cannot meet every month, the EAC team must be empowered and supported to take on more responsibility (and decision-making) for transforming the system.
- Call meetings by the right name. Name the meetings in ways that support the “wholeness” they are cultivating, as well as the connection of the system. Use nomenclature that supports the focus on creating a fully connected Ecosystem of Care, such as “Children and Youth Ecosystem of Care ILT” or “Children and Youth Ecosystem of Care EAC,” rather than “AB 2083 meeting” or “ILT meeting,” which can create confusion and lack of clarity on calendars.
- Follow-up and follow-through. County leaders should ensure meeting routines (and responsibilities) support consistent and timely follow-up with minutes, lists of key decisions or next steps, and other reminders after meetings, as well as timely agenda creation and distribution before meetings.

Effective meetings are not just logistical necessities, they are the engine that drives sustained, coordinated systems change. When held regularly and designed intentionally, meetings help build momentum, foster accountability, resolve conflict, and reinforce shared purpose. Without consistent, well-structured engagement, even the most ambitious plans stall. Leaders who prioritize meaningful meeting practices—before, during, and after—create the conditions for trust, clarity, and collective action, ensuring that the Ecosystem of Care for children and youth continues to evolve and deliver real outcomes.

5. Use Staffing Strategies to Reinforce Ecosystem’s Collaboration

How agencies delegate and deploy managers and staff to support the ILT, EAC, and cross-agency decisions is an opportunity to strengthen collaboration.

Specifically:

- Adapt or create roles/job descriptions for the ILT and EAC leadership team—clearly outlining the overall functions of the ILT and EAC, as well as the roles of each member. Designate the roles of lead participants, backup participants and any other key leaders who are not regularly part of the ILT or EAC.
- Share recruitment, training, coaching, and supervision of staff. For example, ILTs in some California counties share hiring, recruitment, and orientation of key staff, even agreeing to form hiring panels for managers and directors from different agencies to inform each other’s recruitment efforts and ensure alignment with the overall, cross-agency vision for change.
- Co-locate teams. When county staff from different departments are co-located or work closely with one another, decisions, supervision, and cross-team training can be both cost-effective and contribute to ensuring seamless and shared outcomes. Co-locating staff in cross-functional units and working teams has a powerful impact on how team members see and embrace their shared obligations for children and youth, breaking down informational and organizational bureaucracies that impede the effectiveness or timeliness of care.

6. Pay Attention to Administrative Support

How counties staff and support their ILTs and EACs directly impacts the success of cross-agency collaboration. Thoughtful delegation, co-location, shared hiring practices, and aligned training are not just administrative choices, they are strategic actions that build trust, reinforce shared accountability, and bring the vision of a unified system of care to life. Even well-intentioned efforts can falter without the right people in the right roles, equipped with a shared mindset and common tools. Effective staffing is the infrastructure that sustains momentum, breaks down silos, and ensures children and families receive timely, coordinated support.

- Identify support persons who understand the county's overall goals for change and coordination, possess the perspective and skills to interface with other busy administrative leads/contacts of ILT and EAC members, and can take responsibility for maintaining a shared set of files. These roles can be rotated or shared by all partners.
- To help further supporting cutting through any perceived silos, cross-train and orient support staff to the vision of the leadership team. For example, some counties have created [System of Care Desk Guides](#) for their key support staff.
- Identifying capable administrative and operational support professionals to provide meeting support and informational linkages between ILT partner agencies is critical to ongoing success. Consistent and regular agenda creation, calendaring of meetings, capturing of minutes, and follow-up tasks of the partners or meeting attendees are significant to establishing an "identity" for the system.
- Do not rotate support responsibility too frequently. Understanding the landscape and the intent of the collective effort is complicated. However, when changes are needed, current or outgoing staff should orient the new team members, ideally overlap responsibilities for two or three months, and ensure the roles and responsibilities of all involved staff are well-documented.

In addition to the suggested steps and considerations above, all of which offer ideas for how ILT and EAC teams come together, county leaders also play critical roles in sustaining momentum. The change required "to ensure youth and families can find support when, where and in the way they need it most" will take time, sustained effort, and goodwill.

7. Commit to Shared Data, Measurement, and Evaluation

System transformation efforts risk becoming directionless and unsustainable without a commitment to data, shared measurement, and continuous evaluation. Establishing common outcomes, aligning policies, and openly sharing information across agencies are essential steps toward building a more coordinated, equitable, and effective Ecosystem of Care. These practices not only improve services and reduce strain on families and staff, they also create a feedback loop that drives smarter decisions and stronger accountability.

Celebrating and communicating early wins reinforces momentum and builds public and political will. In short, data isn't just about tracking progress, it's about making progress possible.

- Evaluate key existing policy and practice documents across all partner agencies to identify potential system-wide policies. This review effectively cultivates uniform practices across the system (e.g., how to conduct assessments, facilitate client-level team meetings, share training and onboarding of staff, etc.). Doing so also reduces strain on staff and families and has demonstrated a significant return on the investment for partners.⁸
- Identify shared measures of impact. Creating a set of outcomes is critical to integrated service success. Identifying and quantifying the outcomes or impacts of the collective work from the start is a powerful and necessary way to sustain the effort and address equity and inclusion that is often otherwise conceptual. See Chapter 2 for more details.

- Determine the universal array of services and support the county/region to make smart decisions to coordinate care and align resources to offer and decide how to make them accessible to children and youth. This survey of services and supports can be accomplished by mapping, conducting a functional inventory of programs and services, and collectively reviewing the outcomes of those services. See Chapter 3 for greater detail.
- Share information and data. ILT and EAC meetings are key venues for identifying agreements and differences and putting them into writing. This practice ensures that individuals share and exchange information in ways that protect privacy and support care coordination and timely access to services. See Chapters 2 and 4 for more detail.
- Celebrate and broadcast success. Reinforcing early positive outcomes is an effective way to gain traction as part of the difficult work of transforming government programs and services. Even the small, early successes of beginning a conversation or establishing agreements are something to acknowledge. Use local communication vehicles to let commissions, boards of supervisors, and other parallel decision-makers know of your emerging successes. The moment early practice-level impact is visible, communicate that impact to the broader local field of constituents in and around the Ecosystem of Care.



Tool Spotlight

[Spreadsheet of Goals, Proposed Actions, and Metrics \(CCEE ESOC Toolkit\)](#) gives counties a structure to document shared commitments, clarify agency responsibilities, and track goal progress over time. It serves as a foundation for building strong MOUs.



Resource Spotlight

[Sacramento County's AB 2083 MOU \(Sample\)](#)

Sacramento County's 2023–2026 Operational Agreement shows how agencies can move from frameworks to practice. It offers a clear model of:

- **Shared vision and mission** (see Introduction: Purpose, Vision, Mission, Principles).
- **Two-tiered governance** (see Part One: Interagency Leadership Team and Advisory Body).
- **Concrete implementation mechanisms** (see Part Three: Information & Data Sharing and Part Seven: Alignment and Coordination of Services).

Readers can reference these sections to see how Sacramento made abstract commitments operational, with clear roles, decision-making processes, and accountability systems across agencies.

[Creative Metrics for Measuring Difficult-to-Quantify Goals \(CCEE ESOC Toolkit\)](#) Sacramento's MOU includes measurable outcomes, but many essential results (like trust, equity, and culture change) require broader metrics. This resource helps counties understand how to capture those dimensions so agreements stay grounded in impact, not just compliance.

8. Make Essential Decisions to Coordinate Care and Align Resources

Coordinated care and aligned resources are critical to ensuring youth and families receive the right support at the right time. When agencies make decisions together—about services, placements, and funding—they maximize impact, reduce duplication, and create a more responsive and efficient Ecosystem of Care. See Chapters 2 through 4 for more information.

- Evaluate opportunities to expand the use of and enhance the critical state-required Interagency Placement Committee process and care coordination function, in addition to other cross system teamwork, such as Coordination of Services Teams (COST) and Individualized Education Program (IEP) teams. Create a pathway for a group of interagency managers to collectively review a youth's and family's needs and identify resources to keep that young person out of institutional care at the EAC and school site level. This information should be gathered regarding individual cases and shared with the ILT so the entire Ecosystem of Care is consistently learning about barriers children are facing and determining how to break those barriers. See Chapter 2 (needs assessment) and Chapter 3 (universal array and care coordination).
 - Agree to leverage and coordinate revenues and funding streams. In high-trust partnerships, departmental resources become the collaborative's resources. Decisions around using new monies, discretionary grant dollars, or when revenues are sparse or in decline, can and should be made in collaboration with partner agencies. See Chapter 4 for examples of revenue sharing and collaborative resourcing.
 - Determine pathways and interagency structures to resolve any lack of clarity across agencies regarding roles and responsibilities for children, youth and families.
-



Chapter 2

Shared Ecosystem Goals



Why Shared Goals

Chapter 1 describes how county leaders, when they set a new vision and commit to creating a new Ecosystem of Care, build structures to facilitate their cross-agency coordination and decision-making.

Setting a shared vision for delivering child and family services differently is just the beginning. For a vision to lead to change, it must be coupled with a clear articulation of priorities and concrete goals to measure progress. In addition, implementation is more successful when communities being served help co-create these priorities and goals—thus helping to ensure any new system reflects what is most needed and is achieving the goals that matter to those being served.

Outcomes that are shaped and informed by cross agency and community commitment can lead to stronger measurement of impact across systems. Many agencies in California track similar outcomes—such as school readiness, family stability, and youth well-being—but they do so in isolation and with different approaches. When agencies come together to develop shared goals and align their data, they can better understand how their efforts overlap, reinforce one another, and contribute to shared efforts.

In one California county, for example, data from different agencies illuminated the finding that children at risk of entering the foster care system were more successful when enrolled in alternative, community pathways, such as those funded under the Family First Prevention Services Act (FFPSA). The goal of FFPSA is for fewer children to enter foster care. County leaders hypothesized that these pathways programs, which provide support services to families before a child enters kindergarten, are effective at helping children become “school-ready” and more successful learners—and, as a result, they chose to expand investments in similar community programs.

Similarly, in comparing and analyzing data from multiple systems and agencies, a different California county’s Interagency Leadership Team learned schools offering intensive mental health services had significantly fewer students who entered or re-entered the foster care system.

Cross-agency data have also shown that young children whose families received help through a Community School program were less likely to enter the child welfare system. These insights only became clear when partners took time to compare their data and outcomes across agencies.



County Spotlight

Building a Shared Data Dashboard (Sacramento County)

Sacramento County has made data the cornerstone of its system-of-care transformation. Starting with its AB 2083 Interagency Leadership Team (ILT), county leaders committed to prevention and early intervention and to holding themselves collectively accountable. As of summer 2025, they are in the final stages of developing a cross-agency performance dashboard that links outcomes and program measures across child welfare, behavioral health, probation, Regional Centers, education, public health, and other system-of-care partners.

Data experts and the county’s Child, Youth and Family System of Care Advisory Team have worked together to identify measures that not only reflect each agency’s work but also reveal how their efforts connect. Semi-annual reports to the ILT help leaders highlight trends, adjust practice, and allow partners to make decisions together. The dashboard intentionally informs both policy and frontline action.

In parallel, Sacramento’s [Public Health GIS Suicide Prevention Dashboard](#) provides a powerful, complementary example of data integration. Developed with stakeholder input and grounded in public health, the GIS dashboard visualizes suicide trends and risk factors geographically, allowing agencies and community partners to align prevention efforts in real time. Together, these initiatives illustrate how shared data infrastructure can strengthen cross-system accountability and accelerate learning across the county’s Ecosystem of Care.

Community-based organizations also can play a key role in contributing their insights—they often have trusted relationships, local data, and insights that public systems can learn from.



Tool Spotlight

Setting Concrete Goals and Measuring Success (CCEE ESOC Toolkit)

Shared goals lead to:

■ **Increased political credibility and support**

When agencies work together and show how their programs contribute to shared outcomes—and can achieve a better “return on investment” than prior, siloed efforts—they gain credibility with boards, commissions, and elected officials. For example, a health services department leader who can say, “Our investment not only helped us meet our goals, but also improved school outcomes and reduced foster care entries,” sends a powerful message about impact and efficiency. Boards are more likely to support funding when they see coordination and shared success across agencies.

■ **Stronger positioning for grants and external funding**

Funders—both public and private—want to invest in efforts that show collaboration, impact, and clear return on investment. When counties can tell a unified story, backed by shared data and outcomes, they become stronger candidates for funding.

■ **Less duplication and administrative burden**

Some agencies have robust means and capacity for tracking outcomes and improving services; others have more limited staff and systems. By aligning outcomes and creating joint dashboards or data reports across all agencies, counties can reduce duplicated work (refer to Sacramento County vignette in Chapter 1), identify gaps, and better support agencies with fewer resources. This approach helps everyone spend more time improving services and less time on paperwork.

■ **Clearer, more consistent communication with the community**

When partners agree on key metrics they are tracking and why, their messages to the public become clearer and more trustworthy. Communities, elected officials, and local stakeholders are more likely to engage when they hear consistent, coherent, and transparent updates about outcomes.

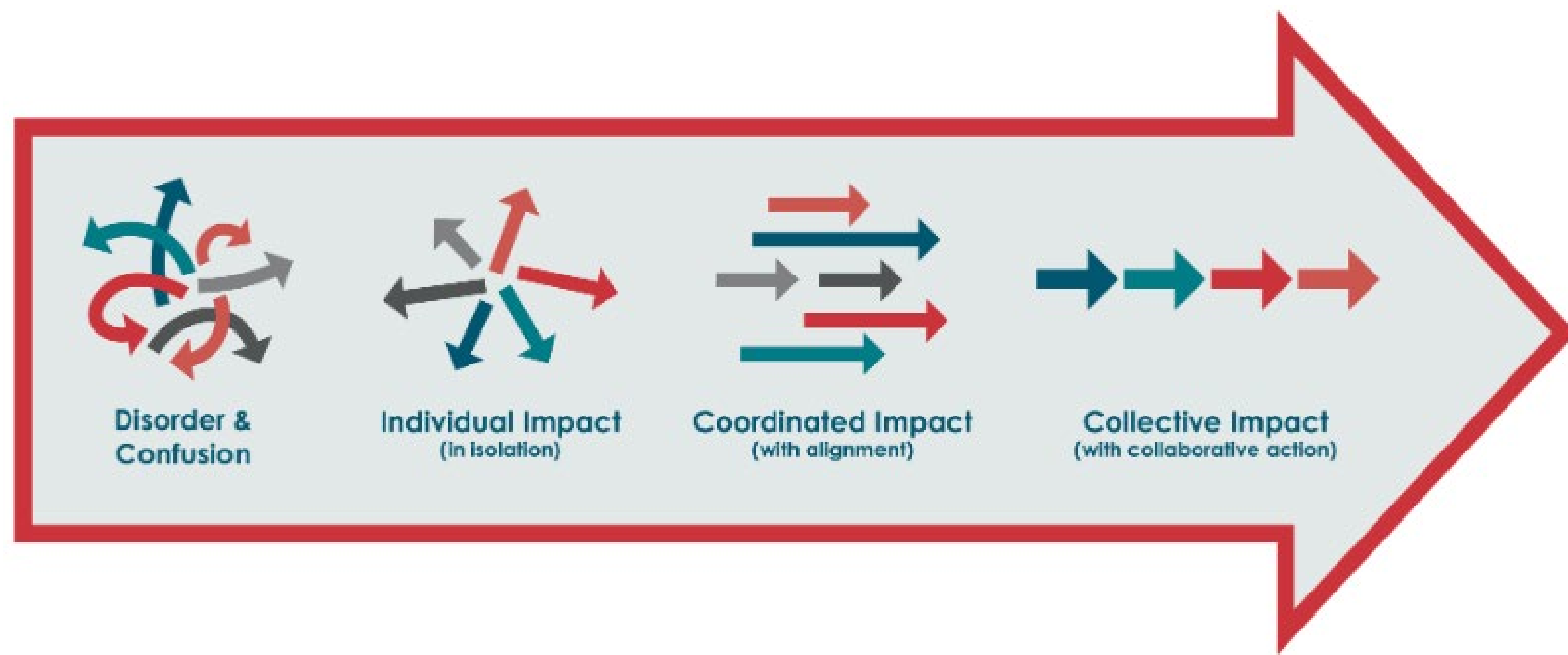
■ **More meaningful engagement with youth and families**

It is not easy for government agencies to involve youth, parents, and caregivers in government planning efforts. However, by looking for creative avenues and working hard to craft shared outcomes, the county’s ILT can cultivate deeper and more authentic engagement. When community members help shape how success is defined, the work becomes more relevant and accountable. Listening to lived experience—and incorporating that knowledge into decision-making—is a powerful way to correct past harms and create a new approach to service delivery that better meets families’ needs.

What Are Shared Goals

While most government leaders routinely consult with community members, set goals, measure impact, and use data and information to inform improvements and establish accountability within their own agencies, doing so as part of a cross-agency and community structure is inherently more challenging, complicated and necessary. This is why building an Ecosystem with intentionality and mutual agreements is so important. Each agency understands its constituency and will likely discover that they are the same consumers.

Today, many government-sponsored child, youth, and family services in California use a variety of approaches to try and identify community and population needs, including even using nearly identical community assessments. The result: The efforts of many agencies to identify community needs are often redundant and inefficient; indeed, families and youth often are asked to share and re-share the same information and background with each new agency from which they seek support.



Ecosystem building unites agencies and communities so that meaningful shared goals can be identified, realized and evaluated collectively, efficiently, and impactfully. This holds all systems and community partners jointly accountable to shared transparent goals that can continually and effectively determine progress for children and youth towards the outcomes they want for themselves, and we want for them.

How to Build Shared Goals

Creating a new Ecosystem of Care and working to better coordinate county services and collaborate across different county agencies and communities towards united goals and outcomes is an opportunity to do better.

Here are the steps toward developing shared goals:

1. Analyze Macrodata to Develop One Shared Dashboard

One first step for county interagency leadership teams is to take stock of the “macrodata” they can access from across all agency partners. Aggregated and de-identified information—or “macrodata”—is often built from microdata (personally identifiable data or information), but used at the system level. County leaders rely on this type of information to understand community needs, evaluate services, guide investments, and meet state and federal reporting requirements. Macrodata is information about service utilization, service or population gaps, trends, overall outcomes, etc. With macrodata from multiple agencies, leaders can ask:

- What data do various state and county agencies, including education agencies, already collect about our target populations?
- Looking across all these data comprehensively, what do they suggest about needs and gaps? In particular, by looking at data from different agencies about the same populations or measuring similar outcomes at the same time, do any patterns or new insights emerge?
- What do non-government partners—and the children, youth, and families they engage with and serve—identify as the biggest challenges in their communities?
- How can all collaborating partners best measure, assess, monitor, and account for meeting these priorities?

One of the biggest barriers to local government agencies sharing data with each other has been a widespread perception that most data are too sensitive to share, even when it has been stripped of personal identifiers and is being used for big-picture planning. These concerns have led to delays, missed opportunities, and the repeated creation of new processes to solve the same problem: How can we use data to improve outcomes across systems?

In some cases, state requirements already expect agencies to compare their outcome data with other agencies. These existing processes can be creatively expanded. Some opportunities include:

- The **Mental Health Plan's External Quality Review (EQRO)** process requires participation from multiple systems, including child welfare and juvenile justice. When done well, it includes youth and parent input and reveals how investments in one area (such as mental health) affect others (such as child welfare).
- Similarly, the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) processes encourage departments to align timelines, questions, and findings—giving a fuller picture of what communities need (see here: [CDPH letter](#) and here: [Community Planning for Health Assessment](#)). These processes now connect closely with the Managed Care Plan (MCP) Population Needs Assessment (PNA) and related state efforts to integrate CHA, CHIP, and PNA findings into a unified BHSA Integrated Plan framework, ensuring that local priorities and statewide planning are informed by consistent, population-level data (see [Department of Health Care Services Population Health Management](#)).
- California now has a unique opportunity, within its Behavioral Health Services Act (BHSA) Integrated Plan requirements, to establish an Ecosystem-wide reporting process that parallels local design objectives. While the reporting obligation for this data is the responsibility of the county BHS or MHP, the outcome measures included span a broad spectrum of partner objectives. The [Behavioral Health Outcomes, Accountability, and Transparency Reports \(BHOATR\)](#) could essentially serve as a universal outcomes frame for any county.



Resource Spotlight

The [Existing Needs Assessment Tools and Data Resources \(CCEE ESOC Toolkit\)](#) provides counties with a catalog of common data sources and assessments already in use, reducing duplication and helping leadership teams leverage what's available before commissioning new studies.

2. Integrate Both Qualitative and Quantitative Data

Aim to incorporate both qualitative and quantitative data in identifying community needs and shared outcomes. This can be in the form of interviews, focus groups, listening sessions, etc.



Resource Spotlight

The [Summary of Interviews \(CCEE ESOC Toolkit\)](#) captures insights from partner agencies and community members, offering counties a structured method to compare stakeholder perspectives with quantitative data.

The [CYBHI County Case Studies](#) provide detailed examples of how local leadership teams are advancing system-of-care integration through shared governance, data alignment, and cross-sector collaboration across seventeen California counties. From a data perspective, each case offers quantitative insights about a given county's demographics, behavioral health outcomes, and resources compared to statewide averages. Each report also describes the working relationship of county agencies with one another through quantitative and qualitative means. With detailed references for each data source, these reports offer practical replicable models of shared dashboards and metrics for consideration. Making the most of system macrodata sometimes requires input from advisors with experience in system design, data strategy, and technology. These experts can help county leaders and agency staff navigate the inevitable challenges that come from aligning efforts and synthesizing data.

3. Ensure Community Voice

Another key first step to setting priorities and goals is committing to examine agency-collected data, discuss implications and possible priorities, and find solutions in collaboration with community members. In particular, county leaders should invite to the table those who have been harmed in the past by prior efforts or requirements, in order to minimize new harm going forward. Data can help guide this process—when reviewed collectively across systems, it can reveal patterns of inequity, identify systemic barriers, and illuminate where policies or practices may have caused or perpetuated harm. By leveraging shared data responsibly, counties can strengthen trust and ensure that future decisions are grounded in transparency and accountability (see here: [Data Exchange Framework](#)). County leaders can invite more authentic involvement in these ways:

- Invite and support historically underserved communities to identify actions necessary to create an Ecosystem that earns trust (and recognizes any mistakes and harmful programs, policies, or practices).
- Seek out accessible forums (traditional and non-traditional) and safe spaces that foster the conditions that allow for authentic community feedback to occur.
- Commit to co-create shared goals that can become transparent metrics for success, tracked through a local dashboard that is accessible and understandable to all.

Key Component: Co-Created Outcome Measures

Engaging those with lived experience and other community interest-holders is already an expectation for California agencies serving children, youth and families. To ensure goals and outcome measures are reflective of the needs of the communities they serve, pay attention to engaging community members in all parts of Ecosystem building work including co-creating outcome measures. Public agencies have often struggled to build consistent, meaningful relationships with historically underserved communities, and involve them in shared, authentic decision-making.⁹ Reasons include:

- **Historical mistrust and harm:** Many communities—particularly Black, Indigenous, and other communities of color (BIPOC)—have experienced decades of systemic exclusion, surveillance, and harm at the hands of public institutions. This legacy of inequity and broken promises fosters deep mistrust, making it difficult for agencies to engage residents who have little reason to believe their voices will be heard or valued.
- **One-sided engagement practices:** Agencies often rely on transactional or tokenistic outreach methods, such as town halls or surveys, that solicit input without redistributing decision-making power. These methods may check a box but don't reflect the kind of relationship-building or shared governance that communities seek. Without clear roles, follow-through, or accountability, community members may feel their participation is performative or inconsequential.
- **Structural and cultural barriers:** Engagement efforts are frequently designed around agency convenience rather than community access. Meetings are scheduled during working hours, materials are only in English, and expectations for participation often ignore real constraints such as transportation, childcare, or digital access. In addition, agencies may lack staff who reflect the communities they serve, limiting cultural competence and trust.
- **Limited internal capacity and skills:** Public agencies are rarely structured or resourced to support deep, sustained community engagement. Staff may lack training in participatory practices or may not have the time, tools, or authority to meaningfully involve families and community leaders in planning and decision-making. Engagement is often siloed rather than integrated into the agency's core functions.
- **Power imbalances remain unaddressed:** Even when agencies invite communities to the table, they may fail to examine or shift the underlying power dynamics. Authentic shared decision-making requires not just inviting input, but actively sharing authority, ceding control, and valuing lived experience alongside professional expertise. Without intentional power-sharing, engagement efforts can reinforce rather than repair inequities.

When counties center community voices—especially from historically underserved groups—in their needs assessment and priority-setting processes, they gain clearer goals, more durable support, and stronger results.



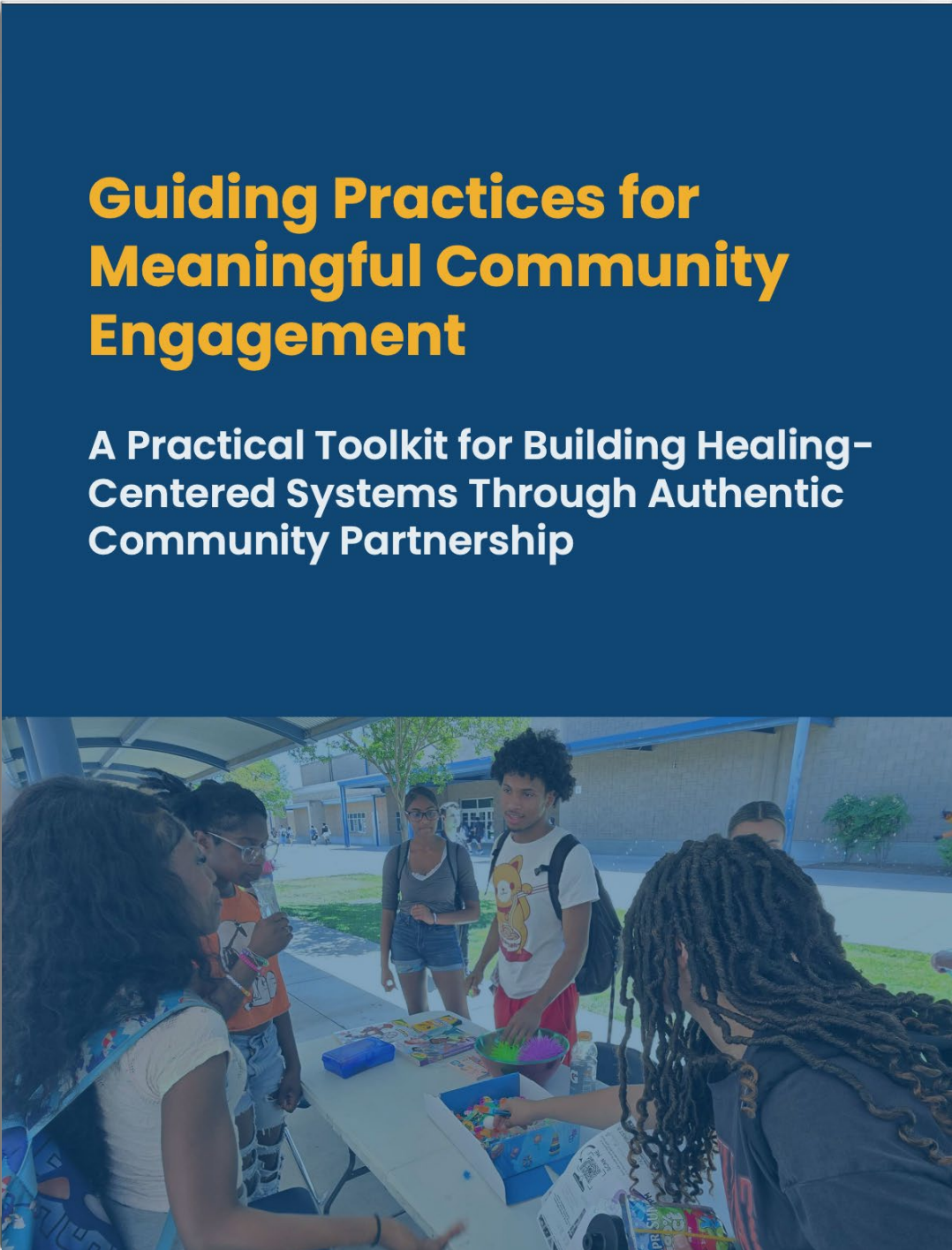
Resource Spotlight

The [Guiding Practices for Meaningful Community Engagement Toolkit](#) is designed for government program managers, policymakers, and service providers who want to move beyond traditional community engagement toward genuine partnership. It draws from the 12 Calls-to-Action from the Youth at the Center Report, and insights gathered from communities across California.

The [Examples of Community Need, Mission Statements & Evidence \(CCEE ESOC Toolkit\)](#) shows how other communities have elevated lived experience into formal mission statements, offering models counties can adapt to codify power distribution meaningfully.

The [Examples of Community Need, Goals, and Metrics \(CCEE ESOC Toolkit\)](#) provides concrete outcome frameworks counties can use to align community defined metrics across systems and reduce duplication.

The [Activities to Establish Shared Understandings \(CCEE ESOC Toolkit\)](#) provides exercises counties can use to ensure youth and families co-design goals and norms with system partners, reinforcing shared ownership of decisions.



Examples of Community Need/Problem, Goals, and Metrics			
Community Need/Problem	Evidence	Mission/Vision	Metrics
High rates of foster youth and homeless families.	The number of children in foster care has increased 20% in the last 3 years; 75% of children removed from the home are Hispanic or Filipino but only 30% of allegations involve Hispanic or Filipino families; the number of families identified as McKinney-Vento eligible has increased by 15% since 2020; the percent of incarcerated adults with children has	The Bay County Integrated System of Care Workgroup seeks to increase collaboration between child-serving agencies to improve access to housing, supports, and services for families with children in our county.	Short term 1. Increase access to diversion programs for individuals with children. 2. Increase availability of parenting classes and anger management groups. 3. Add disproportionality and cultural sensitivity to annual mandatory reporter trainings. 4. Increase access to apprenticeships for teen parents. Long term 5. Increase options and intake points for families with children at risk of experiencing homelessness. 6. Reduce number of children removed from
			• # of arrests v. incarceration • # of drug arrests v. incarceration • Proportionality of child welfare referrals by race and ethnicity • # of families referred for support services v. removal from home • # of families completing the housing intake form • # of families who return to homelessness • Amount of funding spent on homelessness prevention v. housing for homeless families • Amount of funding spent on drug diversion programs • # of families qualifying for Head Start or preschool based on homelessness • # of families identified as homeless by county v. schools • # of apprenticeship partners

EcoSystems of Care Toolkit	
Examples of Community Need, Mission Statements & Evidence	
Specific Community Need or Problem	
Community Need: High rates of foster youth and homeless families.	
Evidence: the number of children in foster care has increased 20% in the last 3 years; the number of families identified as McKinney-Vento eligible has increased by 15% since 2020; the percent of incarcerated adults with children has increased 20% since 2018	
Mission Statement: The Bay County Integrated System of Care Workgroup seeks to increase collaboration between child-serving agencies to improve access to housing, supports, and services for families with children in our county.	
Community Need: Children and pregnant women's usage of preventative health services are low creating a downstream impact on adult health and cost of care.	
Evidence: Brilliant Beginnings screenings are completed at a rate that is 15% lower than the state average (or lower than goal set in managed care plan's improvement plan); the percentage of adults requiring SMHS services has increased by 30% in the last decade; health plans have increased rates 10% more than the state average over the last 2 years.	
Mission Statement: Agencies in the Augusta County Children and Youth System of Care Workgroup work collaboratively to identify and address barriers preventing children and families from accessing health and community services.	
Community Need: High rates of gang membership and gang-related violence.	
Evidence: Arrests of gang-affiliated members has increased by 30% in the last 5 years; gun-related deaths (exclusive of domestic abuse) in the county have increased by 15% since 2021; high school students' participation in afterschool programs has decreased every year over the last decade; CHKS reports an increased rate of drug use among youth in the last 5 years.	
Mission Statement: The Canary County System of Care Workgroup strives to improve the safety and health of our community through effective collaboration and communication between local agencies.	

EcoSystems of Care Toolkit	
Activities to Establish Shared Understandings	
The following is a summary of activities shared by EcoSystem of Care (ESC) members that can be utilized to help create shared understandings and comradery between members.	
- Allocate the first few meetings to each agency providing a 20 minute presentation on their roles and responsibilities OR start every meeting with a 20 minute presentation from a different agency about what they do. When all agencies have presented, have each agency present on their roles again utilizing a new format to demonstrate how they interact with children and families. - Create an example scenario of a child and family and have each agency explain how they would interact with that child/family and the services they would provide. Ask them to explain both the prevention services they offer (like screening and assessment) and the intervention services they provide when an issue has been identified. - Ask each member to do a presentation on a 'day in the life' of a staff member at their agency in which they describe what a typical day looks like as a social worker, school counselor, behavioral health manager, etc. This helps humanize the role members play in serving youth and contextualizes their experiences. - Engage in an exercise to identify overlap in the populations that each agency serves. Create 5 to 10 short descriptions of various youth with moderate to acute needs and ask each agency to describe how they interact with youth with those characteristics and what their responsibilities to them would be. For example, "Amy has physical impairments that prevent her from holding a pencil, feeding herself, and completing certain tactile functions. What services might your agency provide Amy?" - Create an activity to show how each agency contributes to the ESC mission or different focus populations/problems. For example, if a focus population is youth experiencing homelessness, participants might map their agency's services, prevention programs, or policy work that contributes to positive outcomes for that population - directly or indirectly. Repeating the activity should reinforce the notion that all agencies have something to contribute for any focal population as all systems and issues are interrelated. The ideal is that every agency and agency's representative can see their work as relevant to the ESC. - Create an activity to push members of the workgroup to adopt a prevention mindset rather than a reaction mindset. Draft a scenario in which there are multiple points at which intervention or additional services could have been provided and were not, which then caused the child's situation to worsen. Ask workgroup members to identify the points at which prevention services should have been provided, describe the services, and hypothesize about how they would have changed the child's outcome. Here's one example: https://drive.google.com/file/d/1Nlyce8WKp89-W2C3uRgd1a5SpkRGu-8P/view?usp=drive_link	



District Spotlight

Tapping Parent and Youth Perspective Creatively and Comprehensively

One rural school district in California demonstrated what is possible when leaders think creatively and comprehensively about learning from and getting advice from parents, youth and community members.

With community partners, the district deliberately organized and aligned various surveys and feedback sessions to happen within the same springtime period, so results from these data sources could be readily compared side-by-side and inform decision-making. Feedback sources coordinated by the district included a special telephone survey of district families, school-based focus groups with students and with parents, and the California Healthy Kids Survey (administered to students aged 10 and older).

One helpful finding from all these data: School leaders learned that families deeply appreciated the district's family connection center (the center was created to be a single, centralized hub where district families can easily find and access a range of supports, information, and services). According to the surveys and focus groups, parents praised the warm, respectful atmosphere at the center, including simple gestures by staff such as being greeted by name or feeling heard.

At the same time, by being able to consider all this data side-by-side, leaders also saw clear themes where the district could do better or consider different approaches. These challenges included:

- Inconsistent communication undermined trust.** Both parents and students emphasized the need for more reliable, timely, and two-way communication. Parents want regular check-ins and mandatory spring conferences, while students value everyday gestures—like being greeted or checked in on—which strengthen their sense of belonging.
- Discipline practices perceived as unfair.** Across all groups, there were strong concerns about inconsistent enforcement of rules, especially for students with staff or athletic ties—which they said undermined both trust and school climate. Students and parents called for clear, consistent, and equitable consequences.
- Some engagements hampered by lack of relationships.** Parents said they are more likely to engage—and students more likely to thrive—when they feel known and supported. Personalized outreach (e.g., positive calls home, teacher invitations to events) and teacher behaviors that show care were repeatedly cited as motivators for participation and academic effort.
- Barriers to participation need structural solutions.** Time, childcare, and transportation remain major barriers to parent involvement. Suggestions included increasing advance notice for events, improving clarity about event content, and expanding access to family transportation or online engagement options.
- Students concerned about safety and supervision.** Many students reported bullying, fights, and widespread vaping—especially in unsupervised areas like bathrooms. They called for improved adult monitoring, better vape detection, and clearer consequences to reduce unsafe behaviors.
- More emotional and academic support needed.** Students expressed a clear desire for anger management tools, supportive adult spaces, and help catching up academically when they fall behind. They want support that is proactive, not punitive, and tailored to their emotional and learning needs.



Resource Spotlight

Conceptualized and refined by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the International Association for Public Participation (IAP2) and many others, the **Family Engagement Continuum offers a practical framework for government leaders to understand options for and strengthen involvement.** (Here is a step-by-step resource: [Mapping the Family-Engagement Continuum](#))

This progression mirrors key ideas from [Christine Ortiz Guzman's work in equityXdesign](#), which emphasizes that process matters as much as outcomes, and that power should be intentionally shifted toward those most impacted by a system. In both the Family Engagement Continuum and in Ortiz Guzman's conceptions, the goal is not simply to “engage” families, but to create conditions in which they are recognized as leaders, co-designers, and essential stewards of change. However, it is important to note that some community members do not want to be involved in systems-level decision making. Most people simply want to live their lives, care for their children, and want to be able to rely on systems to operate in a user-friendly manner that allows them to have the most control possible over their life circumstances. Systems must work effectively for all community members regardless of their engagement preference. California's Children and Youth System of Care approach under AB 2083 adapts this Family Engagement Continuum to institutionalize family and youth participation across governance and planning structures. The California Health and Human Services Agency asks counties to ensure families, peer supporters, Tribal representatives, and youth are engaged at all levels—shaping policies, coordinating services, and deciding on outcomes.

For government leaders and cross-agency teams like an Integrated Leadership Team, these frameworks offer a roadmap for building trust, sharing power, and designing systems that reflect the knowledge and priorities of the communities they serve.

The five levels of the Family Engagement Continuum include:

- Awareness & Information Sharing** (Passive Engagement)

 - **Concept:** Families are informed about services, policies, and opportunities but are not actively involved in shaping them.
 - **Goal:** Ensure families are aware of their rights, resources, and system functions.
 - **Examples:** Websites, brochures, newsletters, automated calls, and social media updates.
- Consultation & Input** (Advisory Role)

 - **Concept:** Families are asked for feedback to improve services and policies, but do not have direct influence over decisions.
 - **Goal:** Gather lived experience to inform planning and enhance program relevance.
 - **Examples:** Surveys, town halls, listening sessions, focus groups, and parent/youth advisory councils.
- Partnership & Collaboration** (Active Engagement)

 - **Concept:** Families work alongside professionals in planning, implementation, and decision-making.
 - **Goal:** Ensure family perspectives shape how services are designed and delivered.
 - **Examples:** Family representatives on planning committees, participation in case planning meetings, co-design of programs or supports.
- Shared Leadership & Decision-Making** (Empowered Involvement)

 - **Concept:** Families take on formal leadership roles within governance, policy development, and system oversight.
 - **Goal:** Embed family voice within institutional decision-making structures.
 - **Examples:** Family members as voting board members, peer navigators, co-chairs of committees, or parent/youth co-facilitators.
- Family-Driven Systems** (Transformational Engagement)

 - **Concept:** Families lead the design, implementation, and evaluation of services and policies, with systems accountable to them.
 - **Goal:** Shift power dynamics so that families drive decision-making at all levels.
 - **Examples:** Family-run organizations, parent-led training for providers, youth-led advocacy coalitions, or family-directed care models.



Resource Spotlight

The [Examples of Integrated Systems Activities \(CCEE ESOC Toolkit\)](#) provides practical illustrations of how counties have operationalized family partnership at each level of the continuum, offering examples to adapt locally.



County Spotlight

Student Wellness Advisory Groups (Santa Clara County)

When the Santa Clara County Office of Education launched Student Wellness Advisory Groups (SWAG), the goal was clear: center youth voice in shaping wellness supports. Rather than designing services for students, county leaders created space for young people to lead. Starting with just six students, SWAG members were trained in civic engagement and supported by adult allies to form their own subcommittees. They advised on wellness center design—literally rearranging spaces into welcoming circles—and organized campaigns like “Hecka-Well Day,” which grew into a countywide wellness week.

Over time, SWAG scaled from a small advisory group to a movement, with over 100 wellness centers influenced by student input. Structures for continuity, such as including middle schoolers and creating “shadow” roles, helped sustain youth leadership as students graduated. Families were also engaged, building advocacy skills alongside their children. By treating youth as partners—equipping them with resources, leadership opportunities, and a seat at interagency tables—SWAG not only reshaped local services but also modeled how student voice can drive systemic change.

Key Component: Compensating Parents and Youth

In recent years, there has been a growing shift toward compensating parents who participate in government-sponsored advisory committees—not just as a gesture of goodwill, but as a matter of equity and effectiveness. While many agencies have long acknowledged the importance of parent perspectives in shaping public systems, the practice of unpaid participation often has placed undue burden on families, especially those with limited income or inflexible work schedules.

While local jurisdictions may have resource constraints, particularly in a challenging funding and budgetary landscape, compensation can help remove barriers that families face and support more consistent, representative, and meaningful engagement. At the same time, agencies operate within a constrained fiscal environment, often balancing rising service demands, workforce shortages, and competing program priorities. Acknowledging these realities underscores the need for sustainable, equity-driven funding strategies, those that make it possible to compensate families fairly while maintaining program viability and long-term impact.

Paying parents acknowledges the real cost of participation—whether it’s taking time off work, arranging child care, or navigating transportation. Without compensation, these costs can exclude the very families whose perspectives are most critical to informing equitable policies and services. In contrast, offering payment levels the playing field, allowing families from a broader range of backgrounds to take part and stay involved over time.

Compensation also strengthens the quality and sustainability of parent participation—when parents are compensated for their time and expertise, they are better able to prepare, contribute actively, and remain engaged over time. This in turn develops deeper relationships, more informed feedback loops, and ultimately more responsive decision-making by agencies. Moreover, valuing parent expertise alongside professional or technical expertise helps shift power dynamics in a way that builds trust and shared accountability.

Some helpful resources county leaders can use to make the case for compensation of parent involvement and to determine when, how and how much to compensate include:

- [Engaging Community Members: A Guide to Equitable Compensation](#) (prepared by the Center for Health Care Strategies)
 - [Parent Compensation Tools website](#) (prepared by the National Health Council)
 - [Evaluating Incentive Strategies on Parental Engagement](#) (prepared by the National Library of Medicine)
-

4. Carefully Define Measures of Progress

When government, community, caregivers, and those who use health and education services work together to identify shared outcomes and metrics, true needs can become better reflected in the priorities of a new Ecosystem of Care.

In addition, community voices can point out when certain aspects or elements of what is measured have little actual meaning to those being served. For example, utilization metrics or service penetration data don't inform the actual effectiveness of a service and are of minimal use in discussions with most audiences.

The starting point for identifying shared outcomes and measures should be the common vision that describes the change and impact desired in the community.³ This is the visioning referred to in Chapter 1.

Next, **partners can use their shared vision to identify and recognize which goals and outcomes will support their desired reality for family and youth wellbeing.** For example, a vision of “keeping children and youth at home” could be measured by permanency or entry into the child welfare system, or by students in school who are homeless or placed out of home due to special education needs. Partners can decide which of these measures—or both, or others—best reflect the change they hope to see (and the data they have ready access to).

Remembering that local systems already assess many things, the “what” to measure could include:

- Mental health and emotional wellbeing: Reduced rates of youth mental health challenges, including suicidality and externalizing behaviors; increased access to mental health resources; increased positive coping skills.
- Education and academic success: Improved academic performance; increased graduation rates; increased enrollment in college and career programs; reduction in school absenteeism.
- Physical health and safety: Reduced rates of substance use and abuse; increased physical activity and access to recreational programs; safe and clean environments.
- Youth engagement: Increased youth involvement in community decision-making; volunteerism.
- Social connectedness and support networks: Stronger peer relationships; stronger positive social interactions; increased mentorship; increased family engagement.
- Economic opportunity and workforce opportunities: Increased access to and/or completion of financial literacy education; increased access to and participation in internship opportunities; increased employment rates.
- Cultural and identity development: Increased offerings for and participation in culturally-specific programming and networks; increased number of programs that advance or address issues of racial equity and justice.
- Crime prevention and juvenile justice reform: Reduced involvement in the juvenile justice system; increased participation in restorative justice programs; reduced juvenile justice referrals from education, foster care, and other systems.



Resource Spotlight

[Creative Metrics for Measuring Difficult-to-Quantify Goals \(CCEE ESOC Toolkit\)](#) Many essential results (like trust, equity, and culture change) require broader metrics. This tool helps counties capture those dimensions so agreements stay grounded in impact, not just compliance.

In addition, make time for the group to orient and educate one another to each department's related processes. Do not expect that the similar use of terms always means the same thing to each agency. Common understanding and a shared vocabulary come from sharing in a detailed way what different indicators mean, how they are used, and where they fit in the larger determination of community need.

Finally, engage state authorities to inform them that— in pursuit of better alignment and coordination—local departments will be conducting their needs determination in a broader and more concurrent manner. In addition, invite or require the ad hoc team to report regularly to the ILT, with status updates and requests for information, support, or clarity from the ILT or partners.



County Spotlight

Shared Dashboard

Located in the heart of California's Central Valley, this County is home to approximately 1.6 million residents and one of the state's most diverse populations, with no single ethnic majority. To support a shared vision for children, youth, and families, County partners developed a cross-system dashboard through a collaborative process to identify key indicators, define shared measures, and organize data into unified scorecards.

Identifying Relevant Indicators and Measures

The County, in partnership with [a contracted support team](#), identified a core set of indicators aligned with shared outcomes across systems, drawing from existing data sources and stakeholder input.

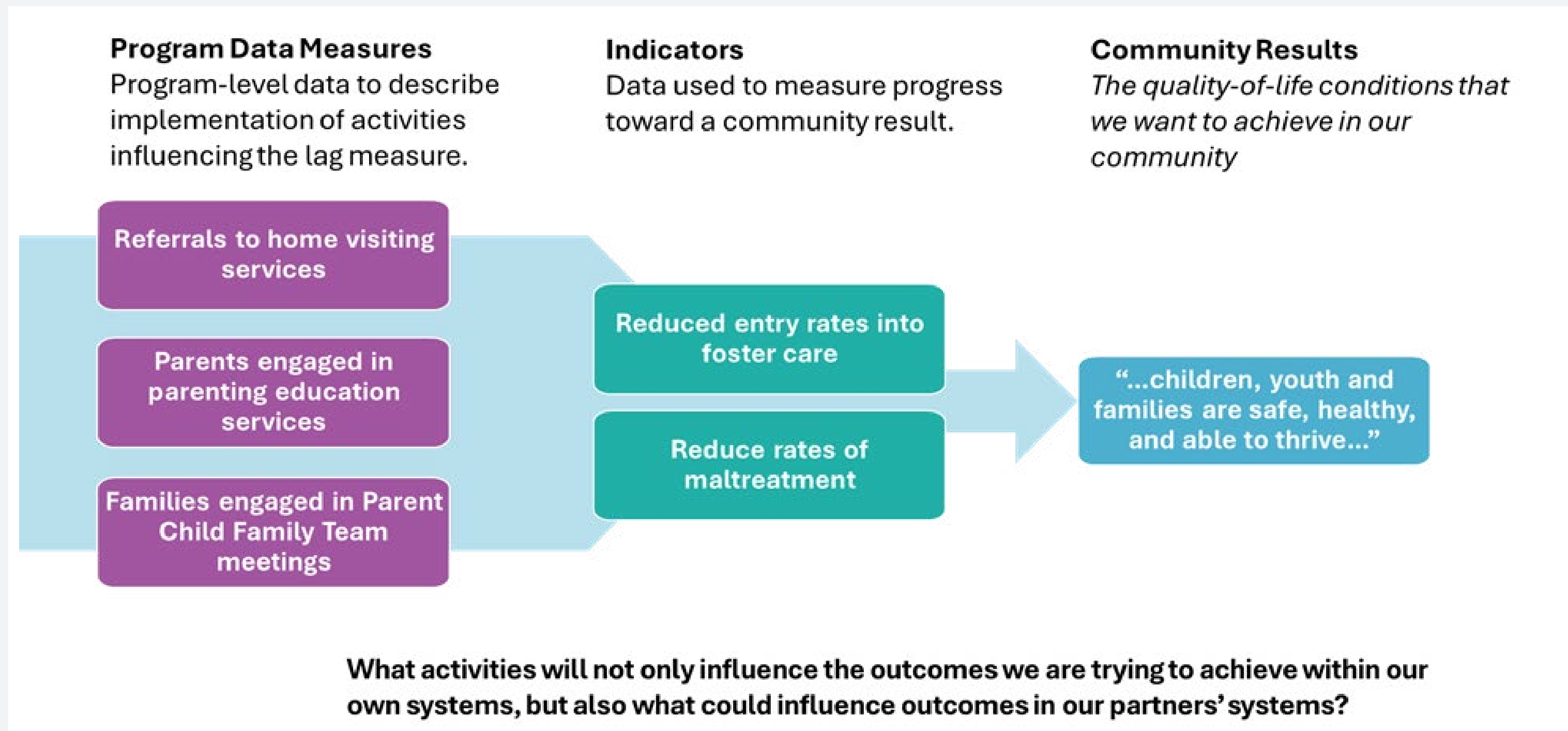




County Spotlight

Defining Shared Measures

Cross-agency partners worked to define a common set of measures, establishing shared definitions and ensuring consistency in how progress is tracked and reported.



Organizing Data into a Scorecard

These measures were then organized into a streamlined scorecard structure, allowing partners to view performance across result areas in a clear, actionable format. Please find a sample scorecard below:

All Children are Healthy Scorecard

[Matrix Identifying Measures Reflecting Cross-Systems Collaboration](#)

All Children are Healthy

	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
All Children are Healthy				
Rate of child abuse and neglect homicides per 100,000 children aged 0-5	FY4 2022	2.9	→ 1	45%
Rate of child abuse and neglect homicides per 100,000 children aged 0-17	FY4 2022	1.0	→ 1	-9%
Rate of infant deaths per 1,000 Black/African American children aged 0-1 due to "preventable" causes	FY4 2022	7.7	→ 1	38%

Department of Child, Family, and Adult Services

	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
All Children are Healthy: DCFAS Program Measures				
% of youth with mental health screening within 45 days of case opening	FY1 2026	30.0%	→ 2	-24%
% of youth with mental health screening within 45 days of case opening (court)	FY1 2026	25.6%	→ 1	-39%
% of youth with mental health screening within 45 days of case opening (voluntary)	FY1 2026	35.0%	→ 2	0%
% of youth who were connected to Behavioral Health Services within 60 days of entering foster care	FY4 2025	31.9%	→ 3	-17%

Public Health

	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
All Children are Healthy: Public Health Program Measures				
# of mothers with a positive Perinatal Mood and Anxiety Disorder (PMAD) screening	FY2 2026	62	→ 1	195%
# of mothers with a positive Perinatal Mood and Anxiety Disorder who were referred to behavioral health services (including GMCs and Behavioral Health Services/BHS)	FY2 2026	19	→ 4	90%
# of mothers with a positive Perinatal Mood and Anxiety Disorder who were referred and successfully engaged with behavioral health services (including GMCs and Behavioral Health Services/BHS)	FY2 2026	17	→ 1	-19%
# of families participating in home visiting and culturally specialized programs, including Black Infant Health program, African American Perinatal Health program, Community Nursing, and Nurse Family Partnership	FY2 2026	453	→ 1	27%
# of individuals referred to behavioral health services (including GMCs and Behavioral Health Services/BHS)	FY2 2026	81	→ 1	-26%
# of referred individuals successfully engaged with behavioral health services (including GMCs and Behavioral Health Services/BHS)	FY2 2026	36	→ 1	71%
# of individuals referred to Alta California Regional Center	FY2 2026	59	→ 2	392%
# of referred individuals successfully engaged with Alta California Regional Center	FY2 2026	44	→ 2	1367%

The final product is a shared scorecard that integrates data across systems, supports continuous quality improvement, and provides a transparent view of collective impact.

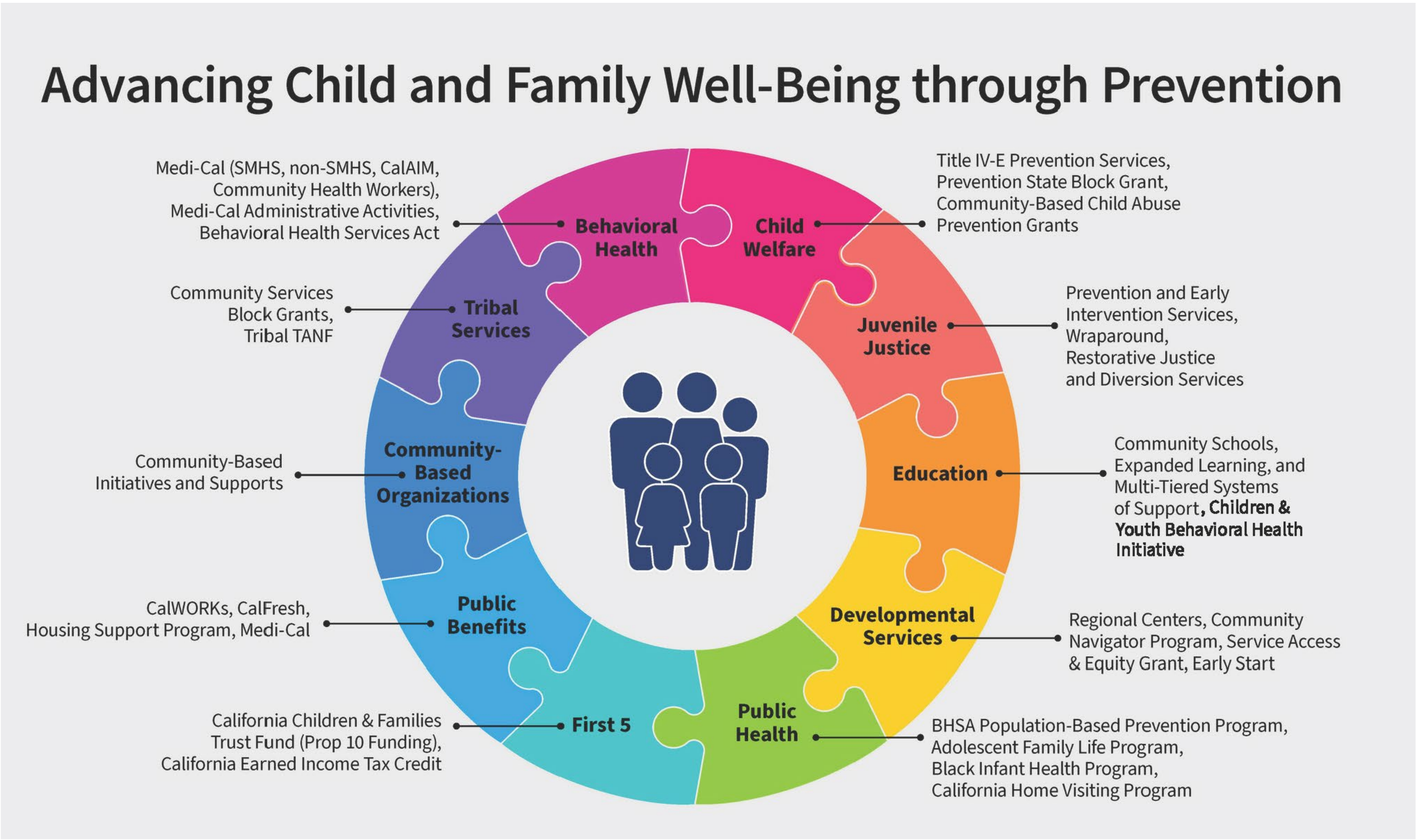
Chapter 3

Realizing a Shared Universal Service Array and Workforce Development

This chapter moves from shared leadership structures, vision and goals to implementation by outlining how counties can organize, align, and deliver services and supports across agencies through realization of a universal array of services and shared workforce development efforts. While a System of Care refers to the coordinated delivery of programs and supports within and across individual agencies to support individual populations, the Ecosystem of Care represents the broader, integrated network of systems and relationships that realizes and sustains those services and supports by, for and with all children and youth of a county and community. This “universal array” is the connective structure that translates this vision into practice—providing a common way to understand how supports are structured, delivered, and connected so that every child and family experiences a seamless Ecosystem of Care rather than fragmented inaccessible service silos.

The universal array is not a new tool or program; it is a conceptual and structural framework that operationalizes California’s Ecosystem of Care—the collective, cross-agency environment and workforce necessary to support children, youth, and families and best empower them to achieve their goals and access what they need when they need it. Grounded in the tenets of the [EcoPaper](#) and expanded through the implementation architecture described in Chapters 1 and 2—such as AB 2083 MOUs, Interagency Leadership Teams (ILTs), Executive Advisory Committees (EACs), and the referenced implementation tools—the universal array provides a unifying frame to organize these efforts.

The universal array is grounded in a simple but transformative idea: no single system can meet the full range of needs experienced by children, youth, and families. Lasting well-being is achieved when prevention efforts are coordinated across agencies and sectors, leveraging the strengths, resources, and expertise of an entire community. The graphic below illustrates the interconnected systems and investments that contribute to a prevention-focused Ecosystem of Care and highlights why a shared framework is necessary to align these efforts into a cohesive whole.



Why Develop a Universal Array Framework

Each system, including education, behavioral health, social services, probation, public health, early childhood, and others, has its own array of services that its system is responsible for, aware of, and often, but not always, conceptualized by tiers (universal, targeted, intensive). The universal array offers a shared conceptual map for seeing these tiers in relation to one another, helping partners identify where efforts overlap, where gaps exist, and where integration of services and supports can produce greater impact. This then allows agencies to maximize utilization of their available resources and align workforce efforts where supports are most needed.

By synthesizing these arrays, counties can begin to see the various systems as an Ecosystem, understanding not just what services exist, but how they connect. Implementation of this framework requires coordination structures (such as Integrated Leadership Teams (ILTs) and Executive Advisory Committees (EACs)), cross-agency planning tools (like the Key Roles in the Ecosystem Tool, Child and Family Policy Institute of California (CFPIC) Coordination Tool, and Integrated Core Practice Model), and data-informed decision-making processes that ensure services are accessible, equitable, complementary, and responsive to local needs. These tools can be referenced in the How section of this chapter.

This alignment is not only a best practice; it is now an expectation embedded in California's evolving behavioral health policy infrastructure. Under the Behavioral Health Services Act (BHSA), county behavioral health plans must develop an Integrated Plan¹⁰ that explicitly supports their Ecosystem's universal array of services - including education. This requirement reinforces the need for behavioral health systems to articulate how their tiered supports (universal, targeted, and intensive) integrate within the broader cross-system array—ensuring a “no wrong door” approach to prevention, early intervention, and recovery.

While the universal array provides a conceptual map for aligning systems, its true power lies in how it is practiced.

The framework depends on the connective tissue that binds agencies, teams, and practitioners together in shared accountability for children, youth, and families. Structures such as ILTs and EACs, along with their shared goals, help test, strengthen, and sustain how coordination functions in real time—and the benefit of it.

Each staff member they encounter should know how to guide them to the next point of support, ensuring needs are met efficiently and without duplication. In addition, family and community needs often recur in an Ecosystem working to serve and support them. As such, defining those recurring presentations allows counties to continually build structures and processes to best ensure the necessary universal array is available, accessible, transparent and effective for them across all available resources.

To realize this level of coherence, senior leaders must invest in training, development, and Ecosystem development and maintenance. This means identifying where gaps exist in practice, ensuring a baseline level of shared understanding across agencies, and supporting staff to steward a “universal array mindset.” The goal is to move beyond a siloed table or chart of services toward a continuously improving Ecosystem of practice—one in which collaboration, learning, and leadership sustain the promise of a truly accessible and effective universal array.

A living universal array can be tested through a simple thought experiment: if a family were to walk through one door, would their experience be seamless? Would there be a tapestry they can access that is navigable and understandable in the front, while the strands and knots form a complex web of supports behind?

Integration Strengthens Outcomes

Integration does not require agencies to take on each other's responsibilities. Instead, it establishes a shared infrastructure, through Interagency Leadership Teams (ILTs), Executive Advisory Committees (EACs), and other cross-sector collaboratives—that enables each partner to contribute its expertise toward a single, coordinated experience for children, youth, and families.

When a young person enters any “door” of the Ecosystem, whether through education, social services, behavioral health, housing, or probation, they should be met by a coordinated system that recognizes their needs, understands which partner is best positioned to meet them, and ensures smooth navigation of services and supports across agencies. In this model, the burden of coordination shifts from the family to the system itself, which is designed to be responsive, efficient, and equitable. SAMHSA and Casey Family Programs have shown that such cross-system alignment and shared accountability lead to improved access, efficiency, and outcomes, reducing duplication, emergency placements, and out-of-home care. Similarly, as mentioned in Chapter 1, California’s expansive CYBHI and Community Schools initiatives, along with others, underscore that a unified, whole-system approach is essential to achieving equitable outcomes and reimagined care coordination.

By organizing supports through a universal array of services, counties can transform existing programs into a shared service Ecosystem, one that aligns distinct agency functions into a coherent whole. The universal array does not replace programs; it connects them into a shared framework for aligning, mapping, connecting, and deepening them across systems. Research on Community Schools offers further validation for this approach: large-scale evaluations, such as RAND’s analysis of New York City’s Community Schools Initiative, demonstrate measurable improvements in attendance, on-time grade progression, and graduation rates, along with stronger family engagement and school climate.¹¹

This alignment enables agencies to:

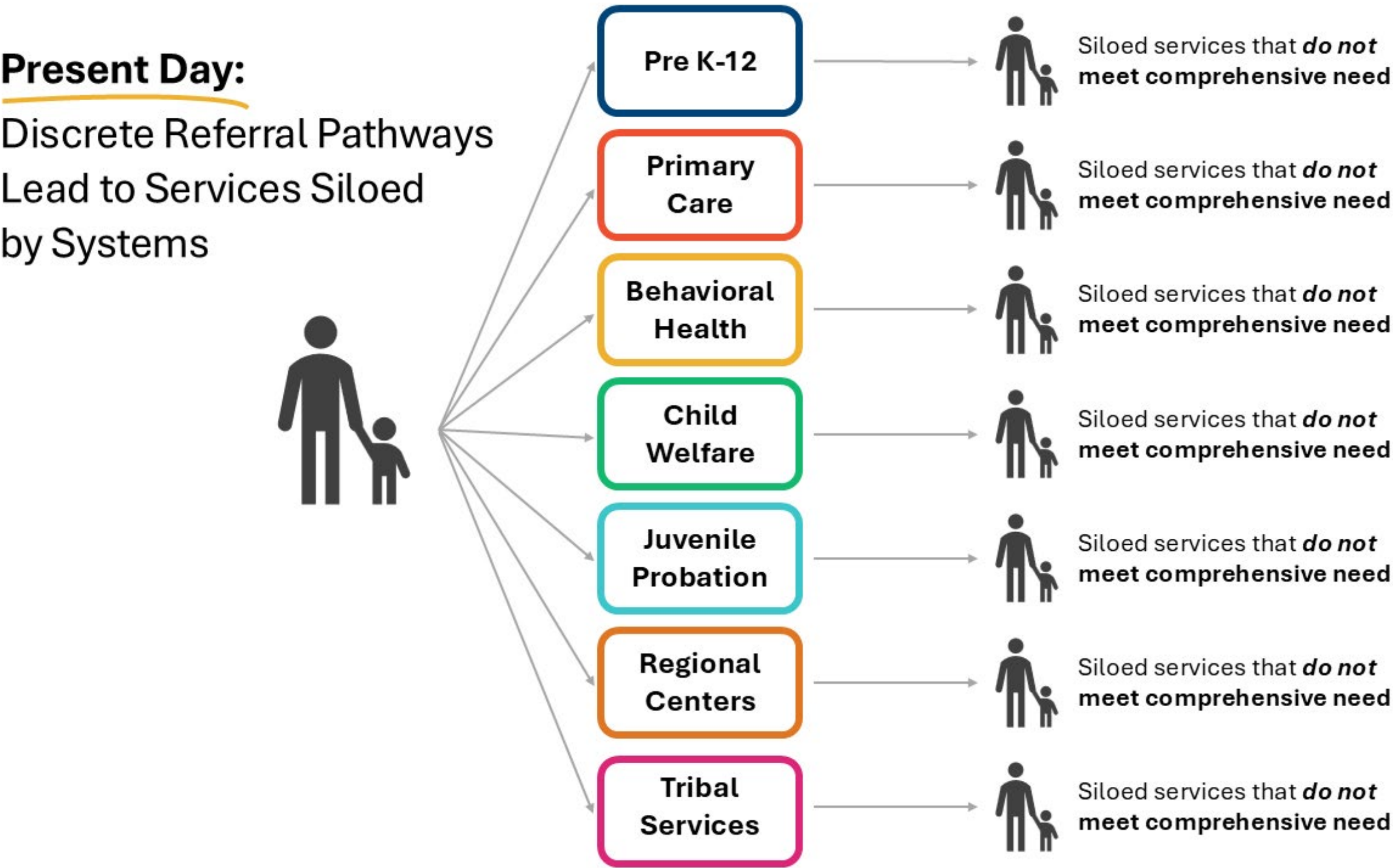
- Identify where their tiers of service overlap or leave gaps.
- Coordinate resources across education, health, behavioral health, human services, Tribal partners, and other partners.
- Establish referral pathways and feedback loops to track outcomes across the Ecosystem.

Ultimately, a universal array of services becomes stronger through integration and shared ownership, allowing every agency to operate within its core strengths while collectively ensuring that children and families receive the right supports—no matter where they enter the Ecosystem.

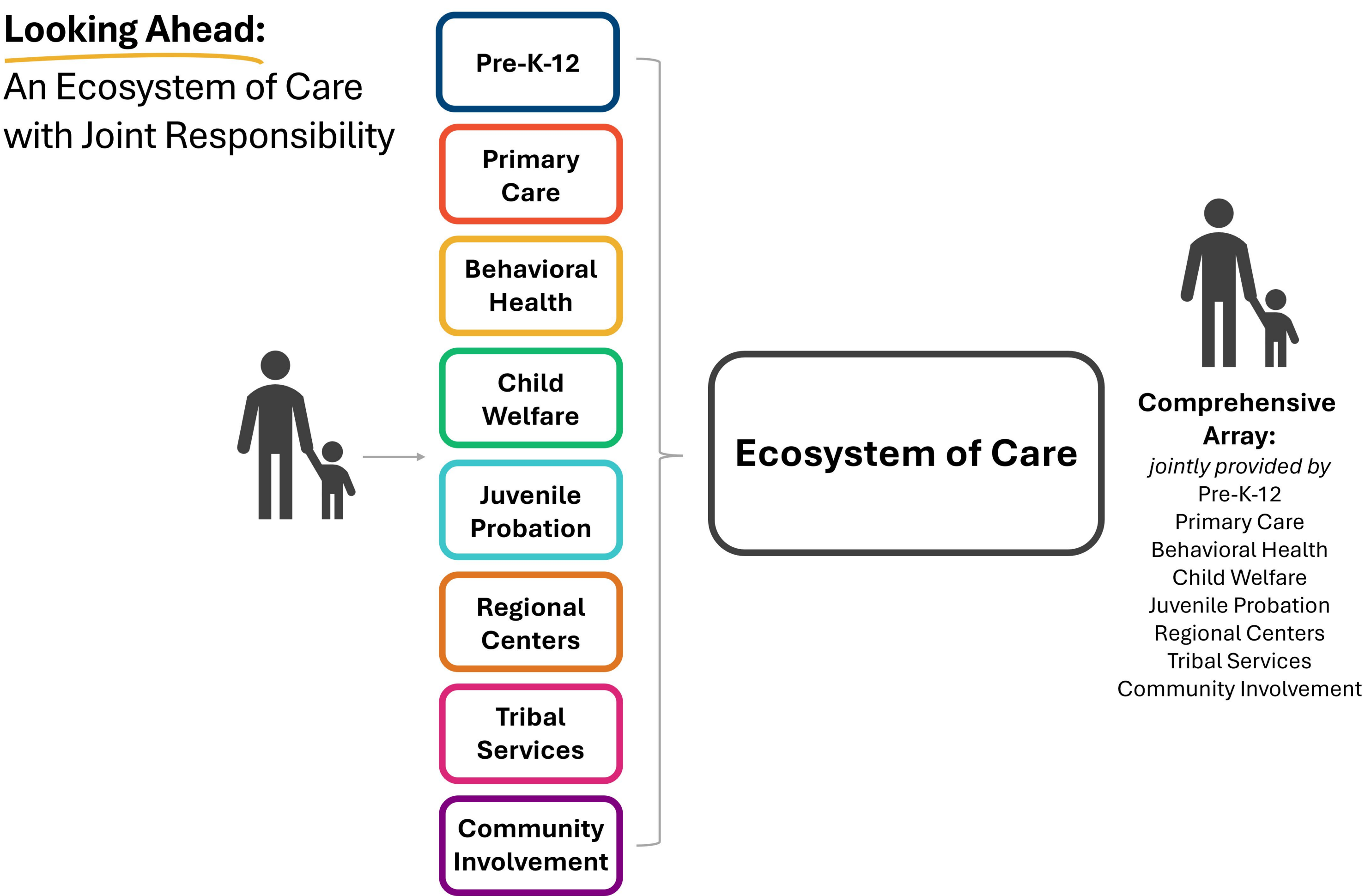
This vision of an integrated Ecosystem is best understood through the lived experience of families navigating care. By intentionally aligning referral pathways, communication protocols, and shared accountability mechanisms, counties can ensure that families are met not with isolated programs, but with a coordinated Ecosystem of Care. The following graphics illustrate this shift: from a present-day landscape of fragmented service pathways to an integrated system that functions as one coherent continuum.

Referral Pathways Solidify the Ecosystem for Families in Need

The below graphic illustrates how the system operates today for an overwhelming number of students, children and youth:



Families are then referred into care arrays provided by each distinctive care system. These routinely fail to meet the comprehensive, cross-system needs of families or maximize utilization of available resources.



The necessity for this comprehensive array of services and supports leads system partners to a shared agreement about what is most needed from the public-facing systems—including CYBHI, Community Schools, and other child- and family-serving entities. This agreement, often codified within an expanded AB 2083 Memorandum of Understanding (MOU), should include a structured process for identifying where gaps exist within and across care continuums, and for aligning system partners to fill those gaps. Importantly, this process is most effective when it operates through whole-system fidelity mechanisms such as ILTs, EACs, and other cross-agency collaboratives that are designed to coordinate decision-making and accountability across systems. These structures ensure that every agency's tiered services are not only mapped, but actively connected, reducing duplication, strengthening referrals, and closing access gaps in real time.

Any universal array of services must function as a living, adaptive framework, one that evolves as community needs, research, and practice advance. The effectiveness of an integrated Ecosystem depends on its capacity to listen and respond: to analyze outcomes, incorporate local feedback, and adjust services based on emerging best practices.

As emphasized in Chapter 1, the sustainability and legitimacy of a county's Ecosystem of Care depend on shared leadership, including meaningful community participation, not as a one-time consultation, but as an embedded governance condition. Through structures such as the ILT and EAC, counties can institutionalize a continuous learning cycle in which youth, families, and community partners co-define what is working, identify persistent barriers, and guide the refinement of supports across all tiers. This iterative process not only strengthens the alignment between agencies but also deepens community ownership of the system itself, ensuring that services remain relevant, equitable, and sustainable over time.

What Is a Universal Array Framework

A universal array is typically structured into a three-tiered framework, mirroring evidence-based systems such as Multi-Tiered Systems of Support (MTSS)¹², public health models, and trauma-informed care approaches. Like MTSS, a universal array of services relies on early identification, coordinated intervention, and continuous progress monitoring across systems to ensure that no child falls through service gaps. This model makes services more navigable, allows for clear identification of levels of need, and supports phased implementation across counties. In parallel, transparent referral pathways and local interagency structures support access and coordination.

MTSS integrates academic, behavioral, and social-emotional supports within a unified system designed to serve the whole child. Its five essential domains, leadership, integrated supports, family and community engagement, and inclusive policy and practice, mirror the interagency collaboration required for an effective Ecosystem of Care.

To bring this vision into practical reality, multi-agency partnerships must carefully map the necessary intersections and interdependencies of each system's services and supports. For example, with respect to child welfare intersections, local partnerships should develop practice cross-agency protocols that inform how Child and Family Teaming (CFT), Child and Adolescent Needs and Strength (CANS) assessments and wraparound practices will feed into the universal array or MTSS.

Additionally, from a system design standpoint, these same multi-agency partnerships can utilize available data such as matching CANS data with service utilization data to map the intersections and gaps of the local service networks. California's implementation of the Foster Care Tiered Rate Structure (TRS) presents a timely opportunity to use these tools to implement the Wraparound Immediate Needs (WIN) program in a manner that aligns with the universal array and MTSS. In addition, the California Community Schools development and education's [Strengthening Coherence Across Initiatives](#) work provide similar aligned pathways to identify services and supports for children and youth in MTSS structures. Uniting these efforts should result in multi-agency teams working in close partnership in the development of local solicitations, contract design, network selection, staffing and workforce training, even when implementation falls largely within the scope of one particular system or department.

The California Multi-Tiered System of Support (MTSS) Framework offers a useful reference point for how counties might conceptualize a universal array of services.

Like the universal array, MTSS emphasizes that outcomes improve when agencies align structures, share data, and coordinate supports around a common framework. By applying similar principles at the county and cross-agency level, leaders can ensure that every child and family experience seamless, coordinated, and tiered supports across the full continuum of care.

From MTSS to a Universal Array: A Shared Framework for Integrated Systems

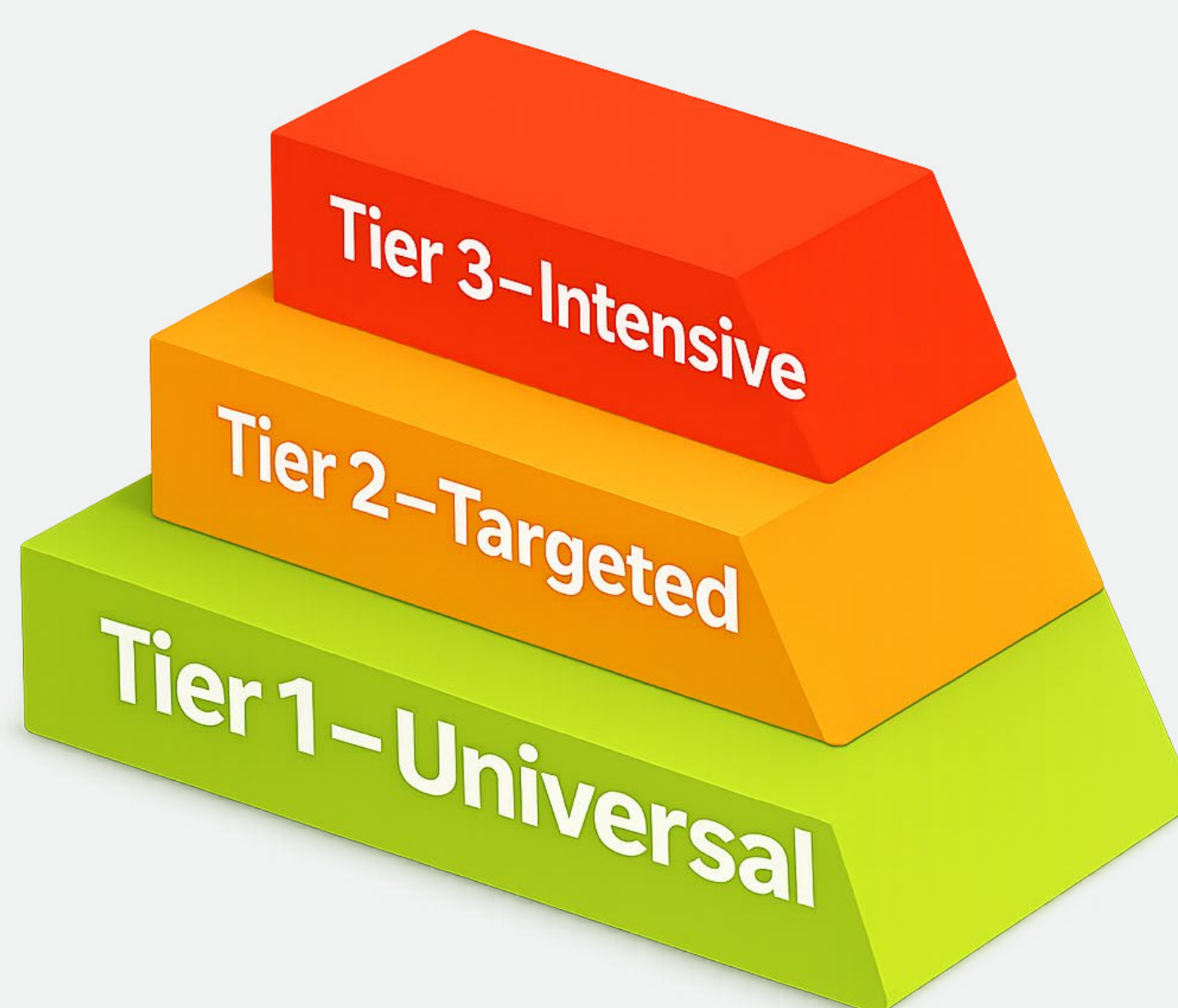
The MTSS framework provides a foundational structure for organizing a universal array of services, one that is adaptive, layered, and responsive to the evolving needs of children, youth, and families. Within an integrated Ecosystem of Care, this three-tiered structure translates across agencies, enabling partners in education, behavioral health, social services, probation, Tribal partners, and community-based organizations to identify how their respective service arrays align within shared levels of prevention, early intervention, and intensive support.

Each tier builds upon the last, ensuring a continuum that connects prevention to intervention and intervention to sustained recovery and resilience. When operating effectively through interagency coordination, these tiers become a shared organizing logic for how counties can deliver equitable, seamless services that respond proportionally to need.

- **Tier 1** ensures wellness and prevention support and services are available universally to all, fostering conditions for thriving before crises emerge.
- **Tier 2** focuses on targeted early intervention for individuals or families showing elevated risk factors, providing timely and proportionate responses to prevent escalation.
- **Tier 3** delivers intensive, individualized services through coordinated, multi-agency care teams, ensuring the most vulnerable children and youth receive sustained, wraparound support.

This tiered framework enables systems to not only identify where supports exist, but also where gaps, redundancies, or inequities may persist across the continuum. In this way, the universal array becomes a practical roadmap—helping counties align resources, strengthen referral pathways, and ensure that every child, youth, and family can access the right level of care at the right time.

While the three-tiered framework provides a common organizing structure across agencies, it is important to recognize that tier definitions and terminology vary by system. Despite these differences, the underlying principle remains consistent: aligning each agency's continuum of care within a shared framework enables coordinated access, reduces redundancy, increases resource utilization, and strengthens cross-system integration.





County Spotlight

Strengthening the Universal Tier 1 Foundation (San Bernardino County)

In San Bernardino County, the San Bernardino County Superintendent of Schools (SBCSS) and the Department of Public Health, through Community Vital Signs (Vital Signs), are advancing collaboration across a universal array of supports to strengthen the Tier 1 foundation within a Multi-Tiered System of Supports framework. Grounded in the Social Determinants of Health and aligned with the Countywide Vision's Wellness Element, this partnership intentionally connects education and public health systems to address the conditions that influence student well-being. Within the county's five-year action plan, Behavioral Health has been identified as a top priority, and SBCSS serves as the champion for a strategy focused on expanding and strengthening school-based health and wellness centers, both mobile and site-based, as universal access points for mental health services, substance use screening and referrals, and oral health prevention.

Through this collaboration, SBCSS and San Bernardino County Public Health are aligning language, data, and infrastructure to reinforce a cohesive Tier 1 system. Partners developed shared definitions for school-based health centers and school-based wellness centers to ensure consistent understanding across agencies and districts. They are also finalizing a baseline assessment to measure partner awareness and readiness, along with a comprehensive countywide map of school-based resources to identify gaps, reduce duplication, and guide strategic expansion. By strengthening shared understanding and coordinated planning at the universal level, SBCSS and Public Health are building an integrated prevention-focused Ecosystem that supports seamless connections to more targeted interventions when needed.

Core Components of the Tiered Universal Array

Clarifying the Tiered Universal Array Framework

The Tiered Universal Array organizes supports into three levels (Universal, Targeted, and Intensive) so that every partner in a children's Ecosystem of Care has a shared language for describing what services are provided, for whom, and for what purpose. While schools often use similar tiered frameworks - such as MTSS, or Positive Behavioral Interventions and Supports (PBIS) - this schema expands the concept beyond education so that behavioral health, child welfare, probation, public health, and community-based partners can align their understanding of need and service intensity.

- Universal Supports:** Services and conditions that promote wellness, prevent problems before they arise, and build protective factors for all children, youth, and families. These supports are accessible regardless of identity, diagnosis, insurance status, or system involvement.
- Targeted Supports:** Additional, time-limited supports for children, youth, or families who are experiencing emerging challenges or are at increased risk of harm. These services aim to address needs early and prevent escalation to more intensive intervention.
- Intensive Supports:** High-intensity, specialized interventions for children, youth, or families experiencing significant, persistent, or complex needs. These supports may involve multiple agencies, deeper coordination structures, and individualized service planning.

This tiered framing provides a common vocabulary across agencies and builds coherence in how partners identify needs, allocate resources, and design integrated pathways to care. It also allows counties to identify gaps which can then be filled through shared workforce expansion efforts.



County Spotlight

Expanding Prevention Capacity so that Licensed Clinicians can focus on Youth with Higher Needs (Alameda County)

Between 2023 and 2024, Alameda County began addressing persistent behavioral health workforce shortages by intentionally expanding its prevention and early intervention workforce, enabling licensed clinicians to focus more fully on youth with complex needs. Through early implementation of California's Children and Youth Behavioral Health Initiative (CYBHI), the county aligned multiple workstreams to strengthen a universal array of services across education, health, and community settings.

A central strategy was Alameda County's early adoption of Certified Wellness Coaches (CWCs), a new behavioral health professional role created under CYBHI. Using CWC Employer Support Grant funding, the Alameda County Office of Education (ACOE) supported LEAs across the county to begin integrating CWCs into school-based and school-linked care teams during the 2024 pilot phase. CWCs are positioned to deliver wellness promotion, screening, care coordination, and mild to moderate behavioral health supports, functions that are essential to prevention but have historically drawn licensed clinicians away from higher-acuity clinical care.

This workforce expansion was paired with targeted infrastructure investments to ensure sustainability. Through coordinated implementation of the CYBHI Fee Schedule Program, Student Behavioral Health Incentive Program (SBHIP), and School-Linked Partnership and Capacity Grants, ACOE worked closely with the county behavioral health department and managed care plans to reduce administrative burden for schools. These efforts are linked with ongoing work to develop a centralized claims submission process, acquire and customize an electronic health record system, and build a consolidated data warehouse to streamline data sharing across LEAs.

As these systems came online in 2024, county and education leaders recognized that expanding reimbursable, prevention-oriented roles, such as CWCs, could rebalance the workforce. By ensuring that CWCs can deliver reimbursable services for students with mild to moderate needs, licensed clinicians are increasingly able to focus on students requiring specialty mental health care. This approach strengthens the universal array by broadening access to prevention, addressing needs earlier, and reserving intensive services for youth with the highest levels of need.

Overall, Alameda County's early CYBHI implementation, with parallel efforts to support a larger effort to align workforce development, financing mechanisms, and cross-agency infrastructure through the county's Interagency Coordinating Council and Interagency Leadership Teams, is supporting a prevention-forward, sustainable wellness ecosystem, advancing a true "no wrong door" experience for children, youth, and families.

Tier 1: Universal Supports – Promoting Wellness and Preventing Harm

Tier 1 refers to services and supports that are proactively designed to promote child and family well-being, prevent problems before they arise, and build the protective factors that foster resilience. These supports are universally accessible, meaning every child and family—regardless of identity, existing diagnosis, or level of system involvement—should benefit from them.

Schools and communities are the primary delivery platforms for these services, serving as accessible, trusted environments for early identification and prevention. This alignment reflects the California Community Schools model¹³, which positions schools as integrated hubs that connect children, families, and caregivers to a coordinated continuum of wellness supports. Through cross-sector collaboration with behavioral health, social services, and community-based organizations, schools help ensure that prevention and early intervention efforts reach families where they already are.

By investing heavily in Tier 1 infrastructure, counties lay the groundwork for equitable access and early intervention. These supports reduce downstream demand on more costly, intensive interventions and strengthen school-community partnerships.

Examples of Tier 1 Supports:

- School- and community-based wellness promotion (e.g., social-emotional learning, nutrition, mental health education delivered through schools, CBOs, faith-based and neighborhood organizations)
- Community schools and CBO-led integrated support teams (e.g., school-community partnerships coordinating universal health, behavioral, and social supports)
- Family education and engagement (e.g., access to Family Resource Centers, parenting classes, abuse prevention resources, literacy initiatives, peer-led supports, often hosted by CBOs, First 5 programs, and Child Abuse Prevention Councils)
- Universal developmental, behavioral, and trauma-informed screening (e.g., conducted across schools, early learning settings, regional centers, and community-based access points)
- School climate and community safety initiatives (e.g., PBIS, restorative practices, and conflict resolution and healing circles)
- Enrichment and connection opportunities in community settings (e.g., arts, clubs, sports, and culturally responsive youth programs led by CBOs)
- Universal learning and navigation supports across systems (e.g., classroom instruction, family resource centers, and community-based referral pathways)



County Spotlight

Extending the Universal Array Through Mobile and School-Linked Workforce Models (Fresno County)

Fresno County identified significant access gaps for youth in rural and remote communities, driven by geographic distance, transportation barriers, and behavioral health workforce shortages. Through CYBHI implementation, the County expanded its workforce by investing in mobile and school-linked staffing models that extend services beyond traditional clinic-based settings.

To address persistent access challenges, Fresno County focused on expanding and redeploying its behavioral health workforce to better reach rural youth. Fresno County Superintendent of Schools hired additional staff to support SBHIP-funded school wellness centers and mobile mental health vans, enabling providers to deliver services directly in schools and communities rather than relying solely on fixed-site clinics.

Schools became a central access point for this expanded workforce. By placing staff in school-linked settings, Fresno County strengthened early identification, referral pathways, and coordination with educators and families. Delivering services in familiar environments reduced stigma, minimized missed instructional time, and supported prevention and early intervention efforts.

Mobile mental health vans further increased the reach and flexibility of Fresno County's workforce. Staff assigned to mobile units were able to serve multiple rural communities, overcoming transportation barriers and expanding access for youth who previously had limited or no local services. This model allowed Fresno County to respond more effectively to emerging needs across a large geographic region.

By aligning workforce expansion with CYBHI goals, Fresno County built a more flexible and sustainable service delivery model. Investments in school-linked and mobile staff reduced dependence on fixed-site providers and strengthened cross-sector collaboration between behavioral health, education, and community partners. As a result, Fresno County improved access to behavioral health supports for rural youth while advancing a more equitable and responsive Ecosystem of Care.

Tier 2: Targeted Supports – Early Response for Emerging Needs

Tier 2 addresses emerging risks or signs of need in children, youth, or families who are not fully meeting developmental, academic, social, physical or behavioral benchmarks, despite access to universal supports. These supports are more targeted and often time-bound, responding to specific issues such as trauma exposure, anxiety, grief, academic challenges, or family instability. Tier 2 supports may be school-based or community-based and typically involve short-term intervention with coordinated follow-up.

Tier 2 plays a critical role in buffering youth from escalating challenges and keeping them at home, in school and community and outside of justice involvement. They support an intentional connection to prosocial and positive environments. It also reinforces the principle of "no wrong door," enabling access regardless of entry point (e.g., school, healthcare, family resource centers, child welfare).

Tier 2 services are also where systems must intentionally design for equity, ensuring that interventions are culturally responsive, linguistically accessible, and inclusive of the diverse experiences and strengths of children and families. Applying these design principles allows agencies to proactively identify and engage youth and families who might otherwise face barriers to access or timely support.

Examples of Tier 2 services include:

- Brief therapeutic services (e.g., group therapy for grief, stress, anxiety)
- Alternative or Differential Response in Child Welfare
- Behavioral coaching, peer mentorship, and targeted social-emotional groups
- Stabilization support (e.g., short-term housing, food, transportation, technology access)
- Crisis de-escalation support and family mediation
- Parent education or coaching
- Targeted academic interventions
- Early intervention services
- Individualized Education Plans (IEPs), 504 Plans, Individual Program Plans (IPPs), and Family Service Plans; ranging from Tier 2 to Tier 3 depending on intensity and coordination needs

Tier 3: Intensive and Integrated Services – Coordinated Care for Complex Needs

Tier 3 services encompass high-intensity, individualized supports for children and families with significant needs. These youth typically require intensive cross-agency collaboration to design and deliver integrated care plans. Services in this tier are deeply relational, trauma-responsive, and frequently longer-term in nature.

Examples of Tier 3 services include:

- Comprehensive Wraparound supports with a dedicated, cross-agency care team
- Individualized Education Plans (IEPs), and Family Service Plans
- CalAIM Enhanced Care Management (ECM) for children and youth with complex needs
- Full-service partnerships and specialty mental health services via BHSA
- Evidence-based therapeutic interventions (e.g., TBS, Functional Family Therapy, Multisystemic Therapy)
- Mobile crisis response and psychiatric stabilization services
- Regional Center services (e.g., Early Start, respite, intensive case management, developmental disability supports)

- Integrated supports for justice-involved youth (e.g., probation-involved youth receiving coordinated behavioral health, education, and family services)
- Integrated care for youth in foster care and crossover systems (e.g., child welfare, probation, behavioral health)

Sample Countywide Tiered Universal Array — Illustrative, Not Exhaustive

The table below provides a non-exhaustive illustration of how a county's tiered universal array might be organized across agencies and systems. It is intended to show one possible way of mapping shared accountability and aligned services across the three tiers, rather than to prescribe a fixed or comprehensive model.

Tier 1: Universal Supports

Agency / Lead System	Example Programs & Services	Primary Focus / Function
County Offices of Education / School Districts	• School wellness programs (Social and Emotional Learning, nutrition, health ed.) PBIS and restorative practices • Family engagement and literacy programs • Academic enrichment and tutoring supports aligned to whole child wellness goals • Career exploration, college readiness, and early workforce development initiatives integrated into classroom and community-based learning	Promote whole child wellness, belonging, and prevention of risk; create safe, inclusive school climates, particularly of vulnerable populations (e.g., justice involved, trafficked, expelled, parenting teens, newcomer, etc.)
Public Health Department	• Immunization campaigns • Nutrition and physical activity initiatives • Youth tobacco and vaping prevention	Population-level prevention and community health promotion
Libraries & Parks Departments	• Summer reading and youth recreation • Arts and civic engagement programs	Accessible community spaces for positive youth development

Tier 2: Targeted Support

Agency / Lead System	Example Programs & Services	Primary Focus / Function
Behavioral Health	- School-based and community-based therapy groups (grief, anxiety, trauma, early substance use) - Navigator and case management support - Family mediation and crisis de-escalation	Early identification and short-term intervention to address emerging mental health and substance use needs
Child Welfare	- Differential Response / Family Resource Centers - Parent coaching and stabilization supports (housing, food)	Family strengthening and risk mitigation to prevent system entry
Community-Based Organizations (CBOs)	- Mentorship programs - Culturally-specific support groups	Responsive, identity-affirming, time-limited supports for youth and families

Tier 3: Intensive & Integrated Services

Agency / Lead System	Example Programs & Services	Primary Focus / Function
Behavioral Health / Social Services	- Full-Service Partnerships (BHSA) - Mobile crisis response - Evidence-based therapies (TBS, FFT, MST), as directed by the Integrated Practice Child and Adolescent Needs and Strengths (IP-CANS) Tool, where relevant	Cross-agency coordinated care for youth with complex needs
Education Systems: LEA / Special Education Local Plan Areas (SELPA)	- IEPs, Family Service Plans - Intensive special education supports	Individualized academic and behavioral interventions
Probation / Child Welfare / Health Care	- Wraparound teams with dedicated care coordinators - Integrated support for foster/probation youth - Psychiatric stabilization or residential services	Multi-system alignment and sustained care for high-acuity youth and families
Regional Center	- Early Start services - Respite and in-home supports - Intensive case management - Specialized developmental disability supports, as directed by the Individual Program Plan, where relevant.	Specialized, long-term developmental disability services and intensive coordination for children and youth with complex needs

The above table illustrates how a Three-Tiered Integrated Service Array functions when roles and responsibilities across agencies are clearly defined and coordinated. It highlights the shared purpose of partner agencies in delivering individualized, cross-system care for youth with complex needs. Together, these efforts exemplify the universal array in practice.

Clarifying Note on Tiering

The tiers in this framework describe types and intensity of services—not categories of youth. Children, youth, and families may access supports across multiple tiers simultaneously, depending on their needs, strengths, and circumstances. The universal array is designed to be additive and flexible, allowing Tier 1, Tier 2, and Tier 3 services to operate in parallel rather than as a linear progression.

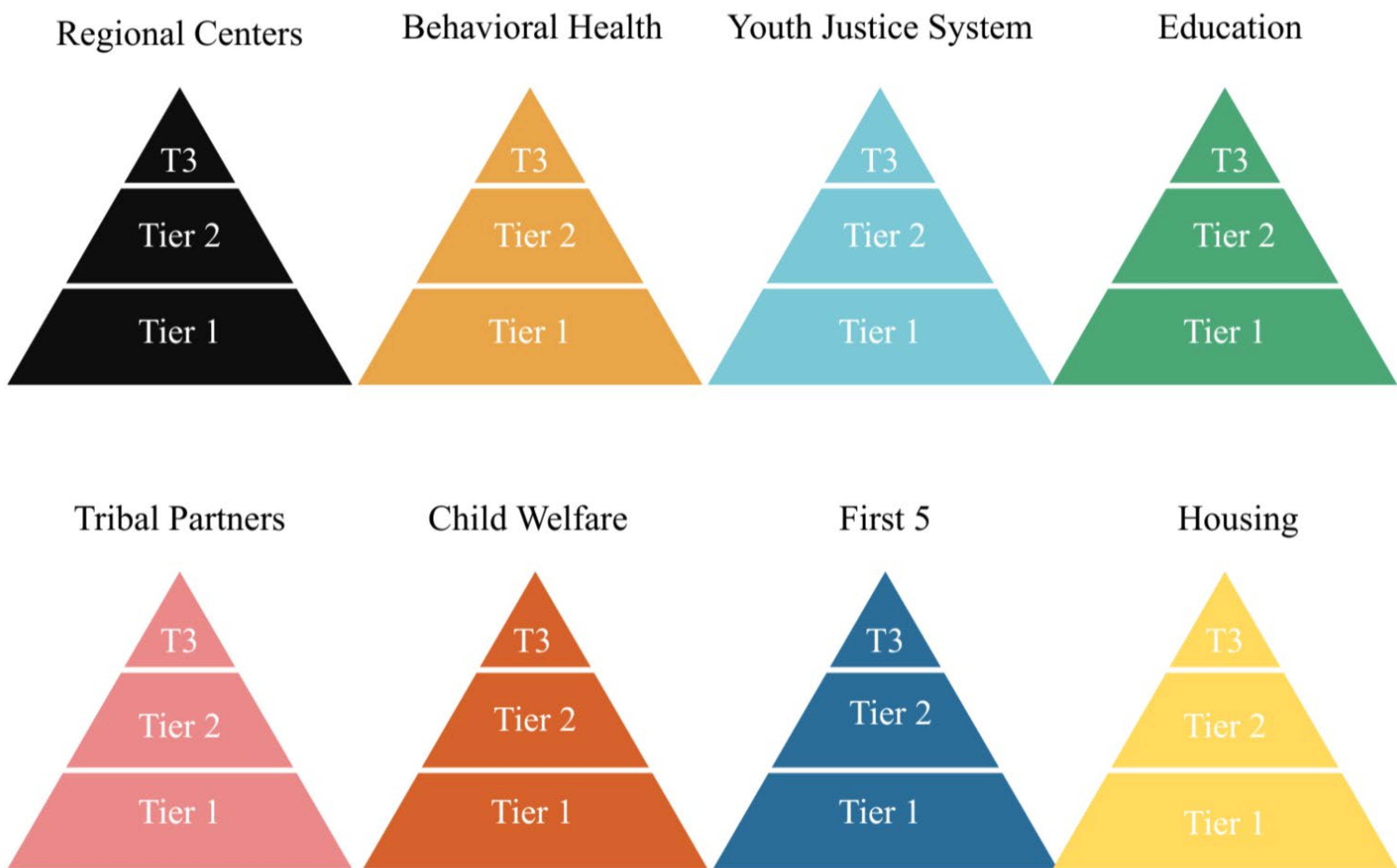
Example: A youth may participate in Tier 1 enrichment and school-based supports while also receiving Tier 2 behavioral health services at the same time.

From Parallel Systems to a Shared Universal Array

The graphic below illustrates the shift from individual, siloed systems, each with its own tiers of service, to a shared, integrated framework that unites partners across the Ecosystem of Care.

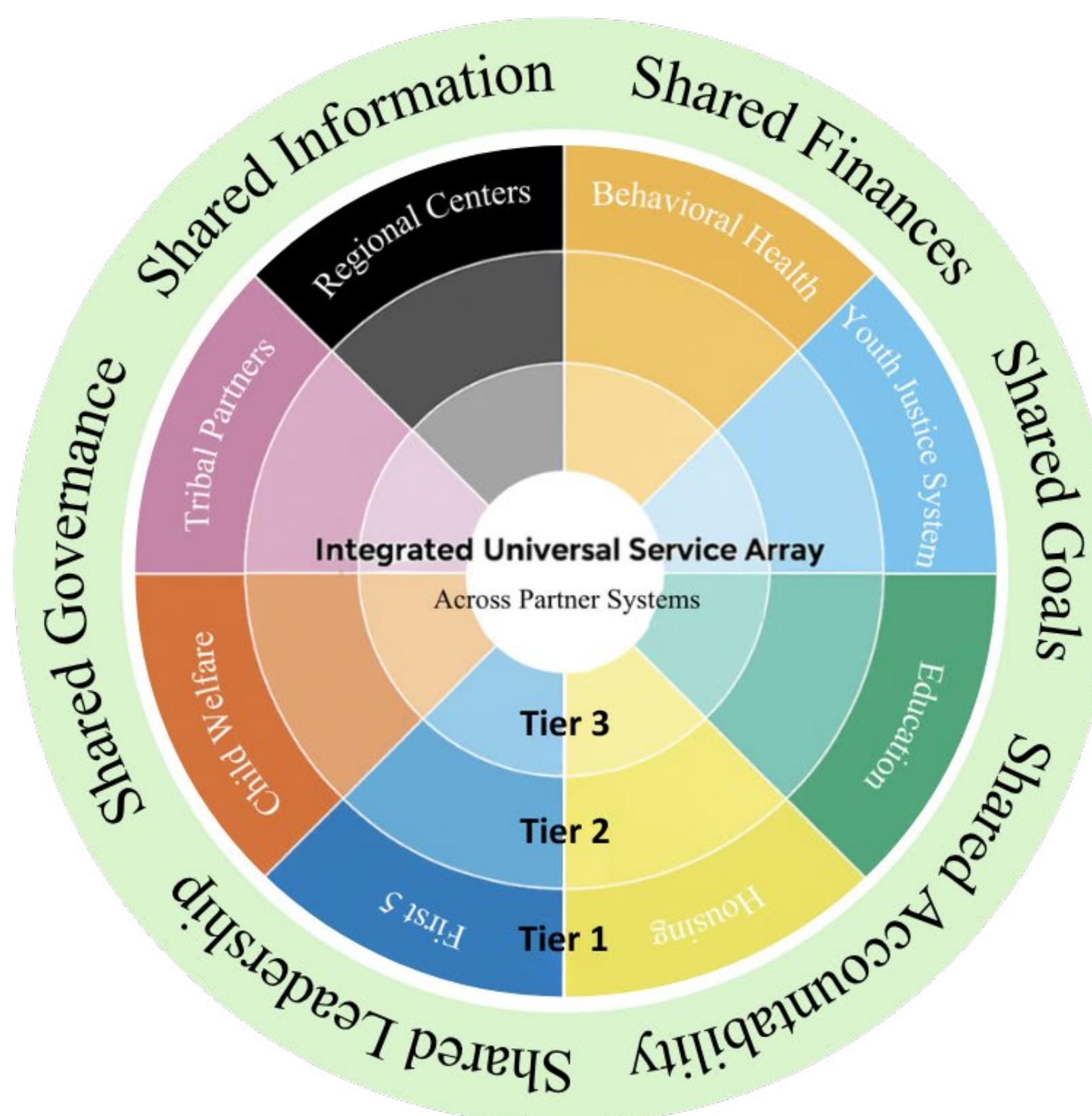
In the first model, each agency operates its own array, often with overlapping goals but disconnected infrastructure, eligibility criteria, and data systems. The second model demonstrates the intent of a Universal Array Mindset and implementation design: a single, coordinated framework where all partner systems align their tiered supports (universal, targeted, and intensive) around shared values, goals, and access points.

– From This (illustrative, not exhaustive) –



In the second model, agencies have organized their tiered services and supports and then united them in one transparent Universal Array, where universal, targeted and intensive supports across agencies are transparent.

– To This (illustrative, not exhaustive) –



Building the Connective Tissue: Stewarding a Living Universal Array

To reemphasize, the universal array should not be viewed as a static framework or set of programs but as a dynamic Ecosystem of practice that evolves through training, collaboration, and continuous improvement. It requires that staff across agencies share a baseline understanding of the tiered model and are supported by leadership to identify and address gaps in coordination and access.

Strategies of focus:

ILT and EAC Structures: Act as the primary cross-agency convening bodies that test the “one door” experience, ensuring that every pathway into the system yields a seamless, coordinated response and committing to a shared vision for ALL children in a county, region and/or community.

Leadership Investment: Senior leaders identify where the universal array is strong or weak, resource training accordingly, and track progress toward a minimally viable “baseline of practice.”

Cycle of Continuous Improvement: Teams test and refine protocols through real case walk-throughs (“if we entered through one door...”), learning where handoffs break down and how to improve.

The Workforce Dimension

Integration depends on more than service alignment—it requires a workforce capable of working across systems. California’s recent policy and funding investments, including the Medi-Cal Peer Support Specialist Certification¹⁴, Certified Wellness Coach model¹⁵, and CYBHI Broad Behavioral Health Workforce Capacity¹⁶, reflect the state’s recognition that coordination and effective supports for our children and youth requires new roles and redefined competencies (see here for more details on roles and services that have been added through these initiatives: [California's Workforce Expansion and Ecosystem Roles](#)).

The implementation of a universal array, therefore, includes the parallel work of expanding and supporting an integrated workforce to provide those identified services and supports:

- Building interdisciplinary teams that bridge health, education, social services, justice, Tribal organizations, and others to steward, provide and evaluate a Universal Array.
- Recruiting and sustaining community-informed professionals—peer specialists, family navigators, cultural brokers, and allied health workers.
- Ensuring ILTs and EACs include workforce planning and cross-training as part of their ongoing improvement cycles and priorities.

The universal array is only as strong as the people and teams who steward it. ILTs and EACs align agencies around a shared, “one door” experience, while senior leaders invest in training and protocols so that any staff member can guide a family seamlessly to the right tier of support. Counties should stand up a minimally viable universal array practice, baseline training, clear handoffs, and feedback loops, then iterate through continuous improvement.

How to Build a Universal Array Framework

Across systems, the “How” of universal array realization and implementation is expressed through aligning services and supports and then identifying standing coordination structures that enable children, youth, families and those who serve and support them to access the services and supports available to them in a county and community. These are the avenues by which the universal array is transparent and accessible across agencies and communities.

In education, the care navigation pathways include mechanisms such as Coordinated Outreach and Support Teams (COST) and School Attendance Review Boards (SARB), which bring partners together to align supports around youth and families. Comparable structures exist across health, behavioral health, and justice systems—including multidisciplinary case conferences, individual family team meetings, clinical rounding, and cross-agency case review forums—that serve the same function: translating shared responsibility into coordinated action for accessibility and efficacy.

These structures differ in form across sectors, but they perform the same core role: acting as coordination hubs where systems test the “no wrong door” experience in practice.

Below are steps to approach the work:

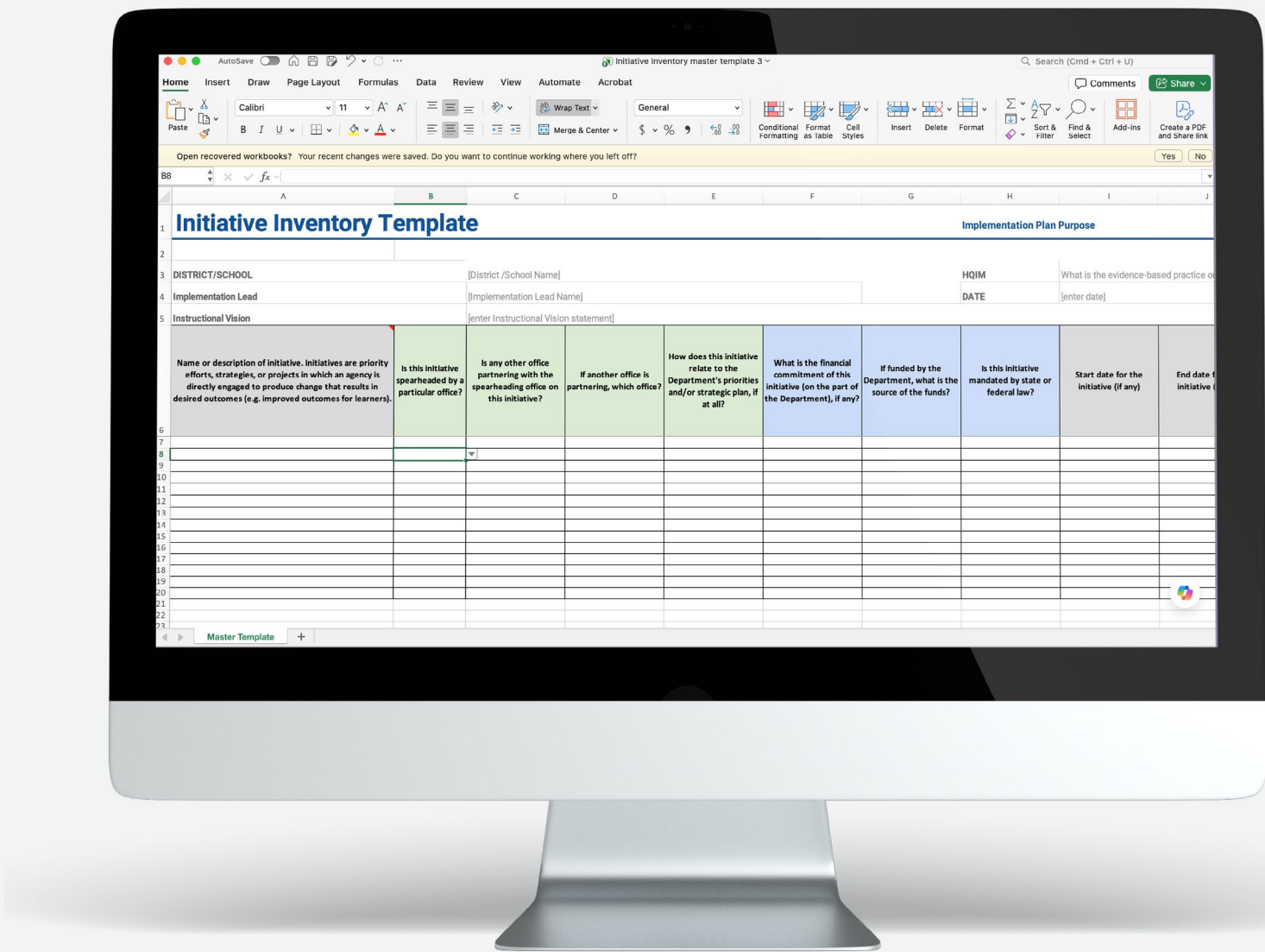
1. Operationalize the Universal Array Through Initiative and/or Support Inventories

A living universal array relies on people—staff who understand how their roles and supports connect and align across systems and tiers to create a seamless, “no wrong door” experience for children, youth, and families. Integrated Leadership Teams (ILTs) and Executive Advisory Committees (EACs) are the convening bodies that commit to identifying a universal array and then translating it from theory to coordinated practice. This universal array includes children and youth with private and commercial insurance, as many Tier 1 and Tier 2 supports—such as prevention, school-based services, navigation, and community programs—are not dependent on insurance coverage and are accessible across systems.



Tool Spotlight

The [Initiative Inventory Mapping Tool](#) helps counties translate the universal array from concept into coordinated practice by providing a structured way to document, organize and align initiatives, programs, and workforce roles across systems. Designed for use by ILTs, EACs, and cross-sector partners, this tool supports the realization of a shared understanding of the resources of the Ecosystem of Care and helps identify opportunities for stronger alignment. When used as part of ongoing implementation and continuous improvement cycles, this tool helps counties map services across tiers, clarify agency roles and responsibilities, identify gaps or duplication in the array, and align workforce investments with system priorities. Rather than serving as a static inventory, the Initiative Inventory tool can be used to strengthen identification, planning and coordination of a universal array. A screenshot of this tool is below:



In addition to the Initiative Inventory, the Workforce table below provides a non-exhaustive sample of roles that commonly anchor each tier of the universal array. This can be mapped as part of an Initiative Inventory and is intended as a planning and diagnostic tool—not a prescriptive list—to help ILTs and EACs visualize how their workforce, partners, and investments align with the tiered structure and how they can build the connective tissue necessary for an integrated, continuously improving system. In each Ecosystem, the tiers will look different and decisions will be made where to map available and necessary services and supports in tiers that make sense for the county/community. The important function of the work, however, is a shared effort to identify, understand and make accessible the resources available in a tiered Ecosystem and clarify the roles of providers across agencies who are providing that array.

Sample Roles by Tier — Illustrative, Not Exhaustive

Tier 1: Universal Supports

Core Roles	Primary Responsibilities & Functions	ILT/EAC Stewardship Actions
Community Health Workers (CHWs) / Promotoras, school wellness coordinators, nurses, Certified Wellness Coaches, counselors, family engagement specialists, recreation and library staff, community-based organization outreach workers, youth development staff, and family resource center coordinators	Promote wellness, prevention, and belonging through education, outreach, enrichment, and environmental supports. Identify early risk signs and connect families to Tier 2.	Ensure cross-training in referral pathways; coordinate communication materials; align calendars and outreach across agencies; monitor reach and participation data.

Tier 2: Targeted Supports

Core Roles	Primary Responsibilities & Functions	ILT/EAC Stewardship Actions
Peer Support Specialists, case managers, navigators, school psychologists, social workers, mental health clinicians, family liaisons, targeted group facilitators, CBO case managers, community-based counselors, peer mentors, and family support specialists	Provide short-term, skill-building, or stabilization supports; connect families to appropriate Tier 3 services when necessary.	Review caseload capacity and referral timeliness; identify where resource strain affects responsiveness; organize joint supervision or peer-learning sessions across agencies.

Tier 3: Intensive & Integrated Services

Core Roles	Primary Responsibilities & Functions	ILT/EAC Stewardship Actions
Licensed clinicians, Full-Service Partnership teams, probation and child-welfare care coordinators, SELPA specialists, mobile crisis teams, CBO clinical providers, intensive case management teams, housing stabilization partners, and reentry or permanency support providers	Deliver individualized, cross-system care plans; ensure stabilization, safety, and long-term supports for youth with complex needs.	Conduct periodic “case-mapping” reviews to test coordination; assess shared outcomes; flag workforce shortages requiring system-level solutions or cross-agency resource sharing.

All Tiers (Cross-cutting)

Core Roles	Primary Responsibilities & Functions	ILT/EAC Stewardship Actions
Program managers, ILT/EAC members, data and quality improvement leads, training and development staff, CBO program directors, backbone organization staff, and cross-agency conveners	Provide supervision, data analysis, training, and continuous improvement oversight to sustain alignment and accountability across tiers.	Maintain the universal array map; facilitate regular workforce gap analyses; guide improvement cycles; ensure onboarding and training reinforce universal array principles.

Tools such as the [Key Ecosystem Roles Map](#) and local initiative inventories can visually depict who provides services across agencies, what those services are, and how services align across tiers. This step ensures the universal array is grounded in local context and builds on what already exists.

ILTs and EACs can return to an initiative inventory and related tables quarterly or semi-annually as part of their agenda cycle—testing whether each tier functions effectively, where coverage gaps exist, and what professional development or funding realignments are required. Over time, this becomes a practice of stewardship: not merely managing programs, but actively tending to the health, coherence, and resilience of the countywide universal array. It is also necessary and useful as additional initiatives and policies are passed at the state level for implementation in counties. See Continuous Quality Improvement in Chapter 4.

2. Operationalize the Universal Array through an Accessibility Tool

As a county articulates a shared, integrated universal service array—clarifying roles, access points, and tiered supports across systems—the next step is translating that framework into day-to-day practice. Doing so requires tools that help partners see the full landscape of services, understand who is best positioned to respond to different needs, and coordinate action across systems in real time. This can be done through technologies which make services and supports across agencies transparent and clear for care navigators, parents, youth, and others who support them.



Tool Spotlight

The [System of Care Coordination Tool](#), developed by the [Child and Family Policy Institute of California \(CFPIC\)](#), offers a practical example of how technology can be used to operationalize a universal array. The tool enables counties and their partners to visualize and analyze the full range of services available to children, youth, and families across child welfare, behavioral health, education, probation, regional centers, and community-based organizations—anchoring coordination in a shared understanding of the Ecosystem of Care.

What distinguishes this approach is its focus on supporting those best situated to identify needs and facilitate access. Rather than functioning as a static directory, the tool is designed for use by care navigators, frontline teams, and cross-system leaders operating at the intersection of service delivery and lived experience. Within the governance structures outlined in Chapter 1—such as Interagency Leadership Teams (ILTs), Executive Advisory Committees (EACs), and other cross-agency collaboratives—the tool supports aligned decision-making, resource coordination, shared data use, and commitment to getting children and youth the resources they need when they need them.

When paired with a clearly defined universal array, tools like CFPIC’s help translate governance into practice. Counties can use shared data to identify gaps, clarify referral pathways, and determine which roles or partners are best positioned to respond—ensuring that services are connected intentionally rather than accessed in isolation. In this way, technology reinforces, rather than replaces, human-centered coordination and care navigation.

Ultimately, this example illustrates how a universal array becomes actionable when governance, workforce roles, and shared infrastructure are aligned. By first defining the array and then embedding it within tools designed for coordination and navigation, counties can move from conceptual frameworks and isolated service delivery systems to integrated practice—supporting a more effective, responsive, equitable, and “no wrong door” experience for children, youth, and families.

3. Identify Cross Agency and Community Teams for Care Navigation

The workforce and leadership structures that sustain a universal array, outlined above, represent the need for an Ecosystem stewardship practice. To translate that practice into sustainable Ecosystem design, counties must also attend to the operational backbone of the universal array: the data, infrastructure, and processes that make alignment possible. The following steps outline how ILTs and EACs can move from array alignment to practical ongoing implementation, ensuring that the universal array functions as an integrated and continuously improving Ecosystem.

This process is jointly stewarded by the Interagency Leadership Team (ILT), Executive Advisory Committee (EAC), and supporting cross-system teams such as Interagency Placement Committees, COST teams, family planning teams, Community Schools implementation teams, and others. **Coordination and accountability occur through ongoing teaming and the elevation of access or program issues to the ILT/EAC when systemic resolution is required.**

As such, counties and communities must identify who these care navigation teams and individuals are and ensure they have access to universal array information and feedback loops to ILTs and EACs to ensure implementation pathways are working on the ground, and children and youth are receiving access to the most robust and effective cross agency and community services and supports possible.



County Spotlight

Building a Tiered Ecosystem of Support (Imperial County)

Imperial County, youth-serving agencies are working together to build a shared, tiered system of support that meets children, youth, and families where they are. Education, behavioral health, public health, child welfare, managed care, the Regional Center, the Sheriff's Office, Probation, the Native community, and community-based partners have aligned their efforts around a common understanding of prevention, early intervention, and more intensive supports.

At the universal level, the ILT is working to coordinate Tier 1 supports that promote student well-being across school and community settings, focusing on prevention, positive school climate, and family engagement. When early concerns arise, partners use shared referral pathways and coordinated Tier 2 supports to ensure children and youth receive timely, appropriate services without duplication or delay. For youth with more complex needs, agencies collaborate at Tier 3 to align intensive, individualized supports, ensuring care is coordinated across systems and responsive to the whole child and family.

4. Implement, Expand, and Integrate Workforce

- Launch or enhance programs within each tier of the array on an ongoing-basis, embedding family and youth navigators, cross-sector case managers, and team-based coordination practices.
- Implementation can begin with high-leverage programs that already connect multiple systems, such as Full Service Partnerships, School-Based Wellness Centers, Community Schools, and Family Resource Centers, while building toward full integration over time. Training and coaching across agencies would benefit from reinforced shared planning, cultural humility, and trauma-informed practice.
- In addition, workforce development efforts can be targeted to expansion of necessary services and supports at targeted levels.

5. Monitor and Adapt

Use data to track impact, address disparities, and refine the universal array. This includes analyzing service access, outcomes, and satisfaction across tiers; identifying where inequities persist; and integrating lessons learned back into ILT/EAC planning. When done well, this creates a feedback loop that keeps the universal array responsive, equitable, and locally owned.



County Spotlight

Creating Shared Billing and Administrative Workforce Roles to Sustain School-Based Services (Yolo County)

Yolo County identified limited administrative and billing capacity as a key barrier to sustaining school-based behavioral health services across multiple Local Education Agencies (LEAs). Through the Children and Youth Behavioral Health Initiative (CYBHI) and the Behavioral Health Student Services Act (BHSSA) implementation, the County used these funding sources to expand its workforce by funding shared administrative and billing roles through Child Welfare, Behavioral Health, the County Office of Education, and community-based agencies that support service delivery, reimbursement, and sustainability.

As school-based behavioral health services expanded across Yolo County, Child Welfare, Behavioral Health, and County/District Education partners recognized that clinical staffing alone was not sufficient to sustain services over time. LEAs and community partners faced challenges related to Medi-Cal billing, documentation, and administrative workload—often limiting their ability to fully implement or maintain services. In response, Yolo County prioritized workforce expansion in non-clinical, systems-support roles that are essential to long-term sustainability.

Using CYBHI and BHSSA, Yolo County funded shared administrative and billing staff - from Child Welfare, Behavioral Health, and County/District Education - who support multiple LEAs. These roles were designed to reduce duplication, increase efficiency, and provide consistent expertise in billing processes, compliance requirements, and service coordination. By centralizing these functions, the County strengthened the operational backbone of school-based services while allowing clinical and school staff to focus on direct support for students.

The shared workforce model also improved access by enabling more LEAs to participate in school-based behavioral health partnerships, regardless of their individual administrative capacity. Smaller or rural districts, in particular, benefited from shared billing and administrative support that would have been difficult to sustain independently. This approach supported more equitable participation across the County's education Ecosystem.

Through cross-agency collaboration and a commitment to shared infrastructure, Yolo County used workforce expansion to address a critical but often overlooked gap in service delivery. By investing in administrative and billing roles alongside clinical capacity, the County strengthened the sustainability of school-based behavioral health services and advanced CYBHI's goals of access, coordination, and long-term system transformation.



Chapter 4

Sustaining an Ecosystem of Care



From Designing to Sustaining the Ecosystem

Looking Back: How We Got Here

This chapter focuses on how counties sustain an Ecosystem of Care after the necessary foundational structures are in place. Earlier chapters addressed shared leadership, shared goals, universal array of services and workforce development. Chapter 4 turns to the operating practices that keep those critical structures, processes and functions continuously effective over time: integrated financing, continuous quality improvement, community-defined information sharing, and reciprocal accountability.

Sustainability is not simply finding a replacement grant or preserving every program. It is the disciplined work of aligning public resources, data, decision-making, and accountability so that the Ecosystem can adapt, improve, and continue serving children, youth, and families most effectively. Drawing on recommendations of the [Ecosystem Paper](#), framed by the structure of Interagency Leadership Teams (ILTs), Executive Advisory Committees (EACs), shared vision, shared goals, and a universal array of services, integrated funding and sustainability practices enable an Ecosystem of Care to continue to improve and thrive.¹⁷ The necessary habits of continuous improvement, information sharing, and reciprocal accountability serve as constant checks for alignment and change, ensuring the Ecosystem of Care consistently moves forward.

The monetary resources that convert to tangible resources we see in our Ecosystem—people, physical space, data/technology, and time—have a higher likelihood of being maintained if they:

- Reinforce a shared leadership structure, vision and a concrete set of shared goals advancing whole child outcomes, not just program compliance. (Chapter 1)
- Directly support the ongoing, living Ecosystem function of a universal array that has a stable revenue stream underpinning Tier 1 prevention and school/community hubs and reliable funding, people, and data to ensure Tier 2 and 3 are coordinated (Chapters 2 and 3).¹⁸
- Buy the time and space for professionals to engage in continuous feedback from children, youth, and families that drives iterative quality improvement.¹⁹ (Chapter 4)

It is these behaviors that give way to a sustainable change driver – shared culture and function within and between public institutions, youth and families, and community-based providers.

Why Plan for Sustainability

Sustainable funding offers comfort of both safety and longevity. Still, achieving sustainability for child-serving programs or services has at times proved elusive, particularly for innovative programs.²⁰

There are countless examples of public programs that follow a predictable cycle: pilot of an intervention, one-time funding to scale the practice, then a funding cliff that results in capacity dissipating from that local community.²¹ This, as well as other structural limitations, leads to treating programs and practices as separate and distinct. System leaders often approach sustainability in ways that disconnect financial decision-making from its programmatic impacts and any kind of shared leadership structure. These factors lead to the child-serving system being unable to effectively access and leverage one-time investments and ongoing investments, resulting in under-utilization of funding, perceived scarcity, and the prioritization of cost control over service and support provision.

Without sustainability practices being more frequently used by county and local leaders, those who must contend with these challenges are the very people intended to be served in the first place: California's children, youth, and families, as well as the dedicated, frontline public servants supporting them. If we are unable to develop the shared leadership, goals, and approaches to finance, data sharing and sustainability highlighted throughout this Guide, we will continue this cycle of being driven by siloed funding streams and operational design, rather than deliberately and collectively sharing the responsibility for children and youth across California.

Principles that Guide Sustainability Practice

As several of California's most recent grant-based investments in youth behavioral health begin to sunset, the call for simply more resources to sustain various programs, initiatives, and embedded services becomes louder. That notwithstanding, there are also newly developed ongoing funding resources that can be accessed such as the CYBHI Fee Schedule program, Certified Wellness Coaches, and new types of services under CalAIM, among others, that are beginning to expand the workforce and increase the role of non-traditional behavioral health care providers.

To leverage grant programs and ongoing funding sources and better serve young people, consider the following core principles:

-  **Public resource leverage strategy.** Treat all public funds (education, behavioral health, healthcare, child welfare, juvenile justice, and early learning) as one portfolio to be aligned, not isolated pots to defend. Several examples in TK-12 education, early childhood education, behavioral health, and collective impact demonstrate the power of this mindset.²² The strategy can be applied in three situations: (i) pursuing new revenue, (ii) repurposing existing revenue, and (iii) maximizing under-utilized sources.
-  **A public dollar is everyone's dollar.** Driven by public institutional boundaries of law, money, and organizational charts, it is easy to fall into the belief that the monetary resources underwriting that institution are isolated from others. Treating public taxpayer dollars as though they are controlled in isolation from other public goods is a common but unfortunate mistake. Instead, we are stewards and guides entrusted to optimize the use of that investment both within and across public-serving institutions. This mindset gives rise to practical tools that allow ILT/EAC and service teams to collect, map, and formalize what everyone has, agree on how best to deploy those resources, and then formalize them in agreements, contracts, and other financing mechanisms.
-  **Continuous improvement, information sharing, and reciprocal accountability are the fuel to the engine of integrated financing and effective shared care and support for children, youth and families.** Each of these sustainability practices plays a crucial role in reinforcing why system integration is essential and creates a broad consensus on how limited public resources will be used to accomplish those aims.

By following these principles, as counties put in place their integrated systems, the likelihood of maintaining the most impactful and valuable supports in California communities increases.

Four Core Interdependent Sustainability Practices

This chapter is organized around four core sustainability practices:

-  1. Integrated Financing
-  2. Continuous Quality Improvement
-  3. Community-Defined Data Ethics and Information Sharing
-  4. Reciprocal Accountability

Each practice is presented through a Why/What/How sequence, with examples and tools. This section provides a high-level description of each of the four sustainability practices that reinforce the components laid out in the previous three chapters. Counties can sustain an Ecosystem of Care by embedding four core practices into their operations:

Core Practice 1: Integrated Financing

Cross-agency practices and agreements that blend, braid, and coordinate public and private funding sources toward shared outcomes across education, behavioral health, healthcare, child welfare, developmental services, juvenile justice, and other local partners.

Core Practice 2: Continuous Quality Improvement

A structured, ongoing cycle of inquiry in which children, youth, families, and caregivers help define “quality,” interpret cross-agency data, test changes in practice, and use evidence to adjust policies, workflows, and resource allocations at front-line, program, and system levels information.

Core Practice 3: Community-Defined Data Ethics and Sharing

Practices, agreements, and infrastructure through which communities most impacted by public systems help decide what data are collected on an ongoing basis, how information flows between agencies, and how stories and numbers are interpreted and used—within clear legal and ethical guardrails.

Core Practice 4: Reciprocal Accountability

Cross-agency outcomes, indicators, and dashboards that make visible how partners are performing on an ongoing basis by, with and for one another and for communities —supporting mutual accountability between systems and the public, and between funders and front-line partners.

Using a Self-Assessment Tool to Identify Assets and Weaknesses

Just as the leadership teams work together in building shared goals and understanding the universal service array, the team should work together and complete a self-assessment that allows the ILT/EAC to understand where they are relative to these sustainability practices.



Resource Spotlight

[Self-Assessment Tool](#) (This is an Excel version of the tool. Linked here is another version of the same tool in Word document format: [Sustainability Practice Self-Assessment Tool 2](#))

Core Practice 1: Integrated Financing

Why Integrated Financing

In the public social service sector, we are charged with providing and improving high-quality, timely services to those who need them most with a given set of resources. Chapters 1, 2 and 3 identified several factors that have influenced the ability of county leaders to sustain high-quality, impactful services over time, including the one-time nature of certain funding sources on the backdrop of volatile economic circumstances, large volumes of programs initiated at the same time, long-standing accounting rules that challenge steps to integration, and incentives that drive public servants away from these sustainability practices. These factors lead to: 1) focusing on siloed processes for system navigation (rather than serving the whole child), 2) ineffective resource allocation within and across agencies, 3) a scarcity mindset, and 4) workload and administrative burdens of managing many separate funding sources per initiative.

The practice of integrated financing offers not only a pathway to rewiring these behaviors for county and local agency staff but also demonstrates that, when implemented, positive change results. In Massachusetts, the Children's Behavioral Health Initiative, emphasizing integrated financing, helped to drive a 32% decrease in hospitalization and a 40% decrease in member inpatient expenditures. In Maine, overall mental health expenditures decreased by 28% after implementing shared tools, standardized practices, and continuous quality improvement processes that supported integrated financing.²³ Universal array practice, baseline training, clear handoffs, and feedback loops, then iterate through continuous improvement.



What is Integrated Financing

Integrated financing is defined as cross-agency practices and agreements that blend, braid, and coordinate multiple public and private funding sources toward shared outcomes so that dollars support children, youth, and families when and how they need it across education, behavioral health, healthcare, child welfare, justice, managed care plans, and developmental services.

To achieve integrated financing, county ILT/EACs and support teams must address decision-makers' mindset, funding processes within and between organizations, and resource allocation tools in decision-making.

Each of these is briefly reviewed in the table below, identifying each element, the current response, and what the response must evolve to in the future.

Element	Current	Future
Decision- makers mindset	What grant can we get to do this?	What resources do we need and how do we align them?
Funding processes within and across organizations	This is how much money we have left, can this help with our work together?	Let's all come together before our budget development processes start. How can we configure our resources to reach our collective goals?
Resource allocation tools in decision-making	This is how we have used this funding source in our organization. Do you have a financial report from your organization showing something similar?	Let's develop a single financial reporting format for the resources we are each contributing to this effort. What does this show us about our total, available resources?

In addressing each of these elements, county leaders can use the tools and their associated actions below to make progress in moving from the “Current” to the “Future” column.

How to Accomplish Integrated Financing

First, each organization at the table must provide at least one programmatic lead and one financial lead for planning and ongoing committee work. Second, a larger group of individuals will need to meet regularly to discuss key agreements, including the needs of the youth served, assessment results, programmatic requirements, and process improvements (see Chapters 1, 2 and 3 regarding shared leadership, goals and universal array structures, processes and functions). The sum of this is a service outline that articulates the specific programmatic design and, therefore, resource needs. It is from these merged data sets that the finance lead is not only aware of upcoming shifts but also is informed early enough to make necessary shifts in resource allocation.

With these two elements in place, an ILT can follow the steps below. Note that these are not necessarily linear in their action. In some circumstances, teams may have to revisit previous assumptions based on future step outcomes, e.g., a revenue source is not available at the volume anticipated.

1. Agree Upon Resourcing Design Rules and Know Each Other’s Sector Funding Drivers

In this step, there are two primary elements: consensus on resourcing design rules and understanding other sector funding drivers.

Develop shared funding and resource allocation goals

This step sets norms for how ILT team members make decisions about funding and resource allocations. Below are a few examples of design rules:

- Funding investments will prioritize Tier 1 and 2 prevention activities, e.g., funding mix will be split approximately 70% to Tier 1 and 2 and 30% to Tier 3, etc.
- Our goal over the next two years is to protect relational roles in our systems, e.g., peer advocates, navigators, community school coordinators, etc.
- Access to and use of one-time funding for our system will be judicious, generally funding infrastructure and capacity-building activities so we do not create future-year funding liability.
- Team members will share data and analysis with group members before scheduled meetings to use the in-person time for engagement and iterating towards decision-making.²⁴



County Spotlight

Longstanding Model of Integrated Systems and Braided Funding (Placer County)

Placer County has more than 30 years of experience building an integrated system of care for children, youth, and families. This long-standing collaboration brings together key child- and family-serving partners, including Child Welfare, Behavioral Health, Probation, Public Health, Education, the Courts, and community-based youth and family agencies.

This cross-system work has historically been chaired by the Presiding Superior Court Judge and is intentionally designed to integrate decision-making, service delivery, teaming structures, and financing. As former Presiding Judge Richard Couzens famously stated, “Put your money on the table and your hands behind your back.” This principle underscored a shared commitment to public stewardship—recognizing that public dollars do not belong to any single agency but instead must be leveraged collaboratively in service of the public good.

Guided by this philosophy, Placer County has implemented numerous examples of cross-system collaboration and braided funding, including:

- Leveraging partnerships between Children’s System of Care and Education to utilize Title IV-E funding in support of foster youth
 - Accomplished by utilizing an MOU between County Social Services and County Office of Education; Title IV allows for leveraging funding for Administrative Activities
- Braiding staffing and funding across agencies, including Probation and Behavioral Health, to operate short-term residential programs for non-adjudicated youth
- Coordinating cross-agency funding and resources, including Law Enforcement, to prevent the exploitation of children
 - Accomplished by utilizing funding from the Juvenile Justice Crime Prevention Act (JJCPA); Probation, through a collaborative committee, could use funds to prevent the entry or escalation of youth further into the justice system
- Supporting countywide suicide prevention training initiatives
- Advancing school climate efforts, including Positive Behavioral Interventions and Supports (PBIS) and the Interconnected Systems Framework (ISF)
 - Placer County Behavioral Health, through community engagement process, used funds from California’s Mental Health Services Act to fund suicide prevention activities
- Supporting multiple levels of interagency teaming and integrated referral pathways
 - Placer County Office of Education fully participated in the intake process through child welfare, child and family team meetings, integrated system of care “ongoing” teams, and a process of the Systems Management Team, a strength-based decision-making process to support children with the most intensive needs
- Implementing staff co-location and shared infrastructure to improve coordination and access
 - Staff in Placer County are integrated into ongoing services teams with child welfare, behavioral health, probation, lived experience and public health

These examples represent only a portion of Placer County’s historical braided-funding strategies. While funding streams and policy environments may shift over time, the foundational commitment remains constant: Placer County continues to prioritize innovative, collaborative approaches to aligning and leveraging resources—placing dollars at the center of a shared system of support for all children and families in the County.

Know the Funding Incentives of Partners

Each public service sector has unique characteristics associated with the form and function of the federal and state governments' allocation of monetary resources to counties and local communities. Teams should begin by discussing funding incentives directly with one another across agencies, using the high-level descriptions as considerations during conversations.

For example, teams might begin with some of the general funding and resourcing characteristics of their sectors and the opportunities and constraints that they are under. The [Characteristics and Sources of Public Funding Allocations](#) resource provides an overview, while the resource spotlighted below offers further detail, including a list of current ongoing and one-time (available for the next 2 years) funding sources. Understanding at a broad level, the mix of funding and other resources that can be leveraged through partnership between county behavioral health, regional centers, managed care plans, county child welfare, probation, public education, and court systems will strengthen the capacity of the ILT and its implementing staff and structures to take steps toward integrated financing.



Resource Spotlight

[Integrated Care Characteristics and Sources of Public Funding](#)

2. Build an Ecosystem Revenue Map Linked to Sustainable Strategies

The second step is to identify and discuss the incentives that drive decisions in each public agency. As a start, the finance leads from each sector will need to compile information about their funding arrangements. This will inform an Ecosystem financial map, which parallels the activities in Chapter 1, on mapping existing leadership tables, and in Chapter 3, on mapping existing services to realign them to a universal array.

Once all the information is compiled into a single source, such as an Excel spreadsheet, each agency's finance lead, in consultation with the programmatic lead, will need to identify how much funding might be available for the joint activities.

With identified individuals in place, the second action is to determine specifically what will be sustained and for how long. This is also an opportunity to identify the existing funding streams and how their resources contribute to these joint strategies. This sets up a conversation to discuss current programs and services that a new design might replace. This analysis can be aligned with the universal array initiative and funding stream mapping in Chapter 3. While the data does not necessarily have to be a fully complete list, it should consist of significant sources of funding support.

It is important to ensure there is a designation on both the program and financial sides to indicate whether it is one-time or ongoing. Not capturing this appropriately likely leads to poor financing assumptions and can cause challenges in the future.

3. Co-Design a Work Plan for Sustainability

Building on the previous chapters herein, county leaders and system teams should co-design a logic model that includes the following components to link the activities to explicit action towards sustainability:

- Overall timeline: Identifies the beginning and end calendar dates
- Proposed tasks: Those that support the actions identified previously
- Task deadlines: Within the overall timeline, dates that identify the due date for the deliverable
- Responsible individual: That further specifies the responsible person, as well as support, and who they are accountable to
- Expected output: In advance of reaching an anticipated outcome/impact, we will need to measure outputs
- Success Indicator and Metric: To capture data that can be used in Plan-Do-Study-Act (PDSA) cycles

The last action in this step is to build cost assumptions for each strategy. This provides insight into what is being funded and how it connects to other integration strategies.

4. Design and Document Revenue Allocations to Strategies

The approach to assigning available revenue to the costs of agreed upon strategies involves both the science of understanding restrictions (if any) on contributed revenue and the art of putting together multiple revenue streams to support strategies and their associated costs. This involves primarily three tasks to accomplish this step:

- Identify the working relationships of those funded staff in the ILT and EAC's strategies relative to partner organizations. Fund staff across agencies where possible with shared reporting responsibilities. Consider optimizing the use of their time: individual, group, client-facing.
- Identify the limitations and potential opportunities to braid or blend funding, and apply these to decisions to support strategies. Allocation methodology:
 - ☐ Start with the most restricted resources first to fund common aims
 - ☐ Contracted support should be directly tied to an individual in the ILT/EAC with a 'finger on the pulse' of the organization

Analyze the spending rules under federal and state resources; often there is more flexibility than first presented

- Employ multi-source revenue allocation techniques that best fit the needs identified.
 - ☐ **Braiding:** Multiple funding streams support a single program or initiative, but each retains its identity in the books. You track which costs are charged to which source, even if front-line staff experience "one program."
 - ☐ **Blending/pooling:** Dollars from multiple sources are commingled into a single pot that funds services, and you no longer track every individual expenditure back to its source. Accurate blending generally requires explicit legal authority because you're giving up source-level identity.

Especially where federal or state grants are involved, most “integrated finance” ends up in the **braiding** bucket where:

- Each government records its own **revenues and expenditures** by funding source,
- Intergovernmental flows follow GASB’s **exchange vs non-exchange** rules
- The integrated picture is created through **coding, internal reporting, and cross-entity schedules**, not by collapsing entities in the audited financials.

Pooling can occur—but usually within a single reporting entity (e.g., a county special revenue fund) or within a legally separate joint powers authority (JPA) that has its own component-unit financial statements.



County Spotlight

Building Integrated Systems Through Community-Centered Partnerships (Humboldt County)

Humboldt County has a long history of advancing integrated, community-centered approaches to serving children, youth, and families—rooted in collaboration across behavioral health, education, child welfare, public health, juvenile justice, Tribal partners, and community-based organizations. In a rural and geographically diverse county, integration has been driven not only by policy, but by necessity: systems working together to ensure access, continuity, and culturally responsive supports.

At the heart of Humboldt County’s approach is a commitment to shared responsibility and relationship-based systems building. Cross-agency partnerships have focused on aligning service delivery, strengthening care coordination, and braiding funding to support children and families with complex needs—particularly those impacted by trauma, foster care involvement, justice system contact, housing instability, and behavioral health challenges.

One prominent example of integrated work is the County’s Humboldt Bridges to Wellness (HBTW) initiatives, which bring together education, behavioral health, social services, and community partners to support youth and families experiencing significant barriers to stability and engagement. Through HBTW and related efforts, Humboldt County has emphasized coordinated case management, warm handoffs across systems, and shared accountability for outcomes—often blending education, mental health, and social service resources to reduce fragmentation and improve access. This funding integration was accomplished by using the Mental Health Services Act, now the Behavioral Health Services Act, to fund staff in schools working with children, and through integrated teaming, leveraged this funding to support staff who provided intensive cross-systems support. Today this might look like California’s Community Schools Partnership Program.

While the specific programs and funding streams have evolved over time, Humboldt County’s core approach remains consistent: systems come together around shared goals, shared populations, and shared responsibility for outcomes. Financing is viewed as a flexible tool to support integrated practice—not as an end in itself, but as a means to strengthen collaboration and improve the lives of children, youth, and families.

As Humboldt County continues to build and refine its integrated system—through CYBHI, school-based partnerships, and broader System of Care efforts—it does so on a foundation of cross-agency trust, community partnership, and a demonstrated willingness to align resources in service of the whole child. This reflects their efforts to identify resource allocations and blend and braid them based on what is currently available to support the key agreed upon needs of children and youth.

5. Formalize Integrated Financing in Legal Agreements with Partners

To formalize arrangements contemplated in Steps 1-4, consider embedding shared financing responsibilities in the AB 2083 MOU and related MOUs (e.g., with managed care plans, COEs, CBOs). Include: shared priorities and populations of focus, revenue-sharing or reinvestment rules (e.g., local wraparound trust funds, Medi-Cal savings reinvestment), and/or dispute-resolution, and adaptation processes when state or federal rules change.²⁵

6. Build Long-Range Forecasts Including Agreed Upon Joint Pursuits

This step helps partner agencies look past the current budget cycle and make shared, practical decisions about how the system will stay stable over the next 3–5 years. The goal is not a perfect prediction but rather a set of reasonable scenarios that let leaders agree on (1) what they will protect, (2) what they will change, and (3) what they will pursue together so the system doesn't drift back to “business as usual” when revenue tightens.

Start with a 3–5-year forecast model everyone can see

Use a long-term financial modeling tool that can show multi-year projections and assumptions in plain language (for example, municipal forecast models or financial sustainability tools commonly used in public-sector planning). Build one shared “baseline” forecast that includes:

- Expected revenue by major source (state, federal, county, grants, fee-for-service)
- Known cost drivers (placements, hospital/crisis utilization, staffing, contracted services)
- Planned initiatives already in motion (e.g., school-linked behavioral health expansions, implementation timelines)

Keep the model simple enough that partners can understand what changes the forecast (utilization, rates, match requirements, workforce costs), not just the final numbers.

Use the PRL framework to structure joint decisions

A helpful way to organize cross-agency planning is **PRL: Pursue, Repurpose, Leverage**. This makes conversations concrete and keeps partners from staying stuck in “we need more money.”

P — Pursue new revenue streams (bring new dollars into the Ecosystem)

Identify realistic new or expanded funding sources and assign owners for each pursuit. Examples in California may include new state/federal initiatives, wellness funds, Children and Youth Behavioral Health Initiative (CYBHI) opportunities (including school-linked financing approaches), and newer behavioral health funding structures (e.g., BHSa-related changes where applicable).

R — Repurpose existing resources (shift dollars toward what works)

Look for spending that can be redirected away from high-cost institutional or crisis responses and toward community-based supports. This often includes a planned reduction in reliance on high-cost placements by strengthening alternatives (care coordination, in-home supports, wraparound, family partner/youth peer supports, crisis stabilization, and school-linked services). Repurposing is where the biggest long-term system change often happens—but it requires agreement across agencies on what will replace the high-cost pattern.

L — Leverage and maximize what you already qualify for (draw down the full match and optimize block grants)

This includes “maximization” work such as:

- Medicaid/Medi-Cal claiming strategies (e.g., Medi-Cal Administrative Activities, CalAIM Enhanced Care Management, and Community Supports where eligible)²⁶
- Title IV-E and FFPSA claiming optimization (for eligible child welfare prevention-related)
- Juvenile justice and behavioral health claiming and braiding approaches²⁷
- Federal block grant optimization and “maximum revenue drawdown” planning

Build three scenarios and decide what changes in each

Create three revenue scenarios across the 3–5-year horizon:

- Stable: revenues hold roughly steady (minor growth or inflation adjustments)
- Moderate decline: meaningful reductions or one-time funds ending
- Severe decline: major funding shock (state reductions, federal changes, utilization spikes, or workforce cost inflation)

Set “rules of thumb” to protect core whole child functions

Practitioners benefit when leadership makes the tradeoffs predictable. Establish simple rules such as:

- Protect **core whole child roles** that hold the system together (care coordination, family/youth partners, shared screening/assessment pathways, cross-agency problem-solving routines).
- Protect **Tier 1 and Tier 2** supports (prevention, early intervention, school-linked supports) as long as possible, because these reduce later crisis and placement costs.
- If cuts are necessary, avoid making many small, incremental reductions that seem minor on their own but collectively undermine the system’s overarching fiscal and programmatic priorities; instead, reduce the specific drivers that push youth into higher-cost pathways.

Align financing mechanisms so agencies can move together

Long-range forecasts only help if partners can actually act on them. Identify and strengthen mechanisms such as aligning budgeting protocols across agencies, performance-based funding approaches, philanthropic partnerships, and state-level innovative financing approaches when available.

Core Practice 2: Continuous Quality Improvement (CQI)

Why CQI

Sustained, cross-agency, youth-and-family-centered continuous quality improvement (CQI)—embedded in real governance and learning routines—is the key discipline that keeps integrated systems from slipping back into fragmented, crisis-driven “business as usual” and instead shifts resources toward prevention and family-centered support.

What is CQI

CQI is the routine that keeps the Ecosystem of Care aligned with its whole child vision as conditions change. It helps partners ask: What is working? What is not working? What are youth and families experiencing? What needs to change in practice, policy, staffing, or funding?

CQI in this Guide has five core elements:

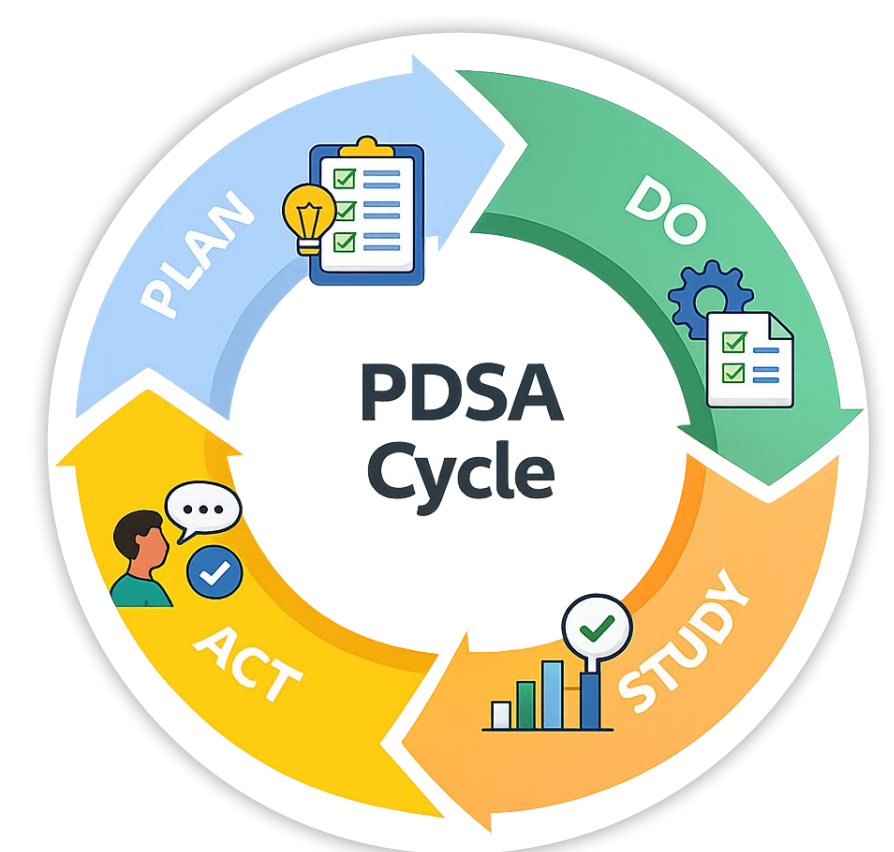
1. Starts with lived experience. The entry point is “What is it like to walk through one door?”—not “What does our data system already collect?” Youth and family stories shape the questions you ask.

2. Uses shared data and outcomes (Chapter 2). CQI builds directly on the macrodata, shared outcomes, and dashboards that ILTs/EACs defined in Chapter 2. You are not inventing new indicators for every project; you are reusing and refining the shared ones.

3. Driven by rapid learning cycles

Using Plan–Do–Study–Act (PDSA):

- Plan: define the problem, prediction, and design ways to test change.
- Do: try the change for a short period or in a limited setting.
- Study: review what happened using both data and stories.
- Act: adopt, adapt, or abandon; decide what to try next.



4. Aligned across system levels

- Front-line: care teams, school sites, Community Schools, mobile crisis teams.
- Program: departments or initiatives (e.g., wraparound, diversion, Community Schools).
- System: ILTs looking at the universal array across the county or region.

5. Is framework-agnostic but disciplined. You can use improvement science, implementation science, LEAN/ Six Sigma, Total Quality Management, Baldrige, or a blend of these (see [The Families of CQI Frameworks](#)). The key is not which process you pick, but whether you run disciplined cycles that change practice and resource allocation.

How to Establish CQI

Below is the broad outline of steps that can be taken by leadership towards co-designing a CQI approach.

1. Co-Define “Quality” with Youth and Families

The goal here is to build a shared, local definition of what sustainable “good” looks like across the Ecosystem, and is co-defined with youth and families. Ensuring that their input is prioritized in the local definition of quality is essential to creating a responsive and effective CQI process.

Don’t aim for a perfect rubric. Aim for something “good enough to disagree with.” You can refine it after one or two CQI cycles, based on what you learn.

2. Establish Feedback and Learning Routines

An important reminder is that these steps and protocols apply to the ILT/EAC-level of the Ecosystem. As outlined in Chapters 1 and 2, there will be teams that operate underneath that should adopt CQI review procedures that are connected to the overarching goals and outcomes of your Ecosystem. In this way, these other teams are nested within the decisions, actions, resource allocations, and progress made by the ILT or EAC.

It is important to choose a manageable tempo for members of the CQI team, and identify a focus area(s) in order to not have everyone feeling overwhelmed with information. The team will want to decide what feedback is gathered and reviewed.

3. Link CQI Directly to Budget and Workforce Decisions

Connecting the dots between CQI, budget, and workforce decisions helps cross-agency partners maintain alignment that impacts the whole Ecosystem of Care. Both the beauty and the challenge of identifying shared CQI metrics also means that when one agency is under significant financial strain, partner agencies can come together and problem-solve how the agreed upon essential services can be maintained.

Make at least one of the three decisions in each cycle explicitly cross-agency (e.g., “probation fund a family partner role”). This keeps everyone honest about the “integrated” part of integrated CQI.

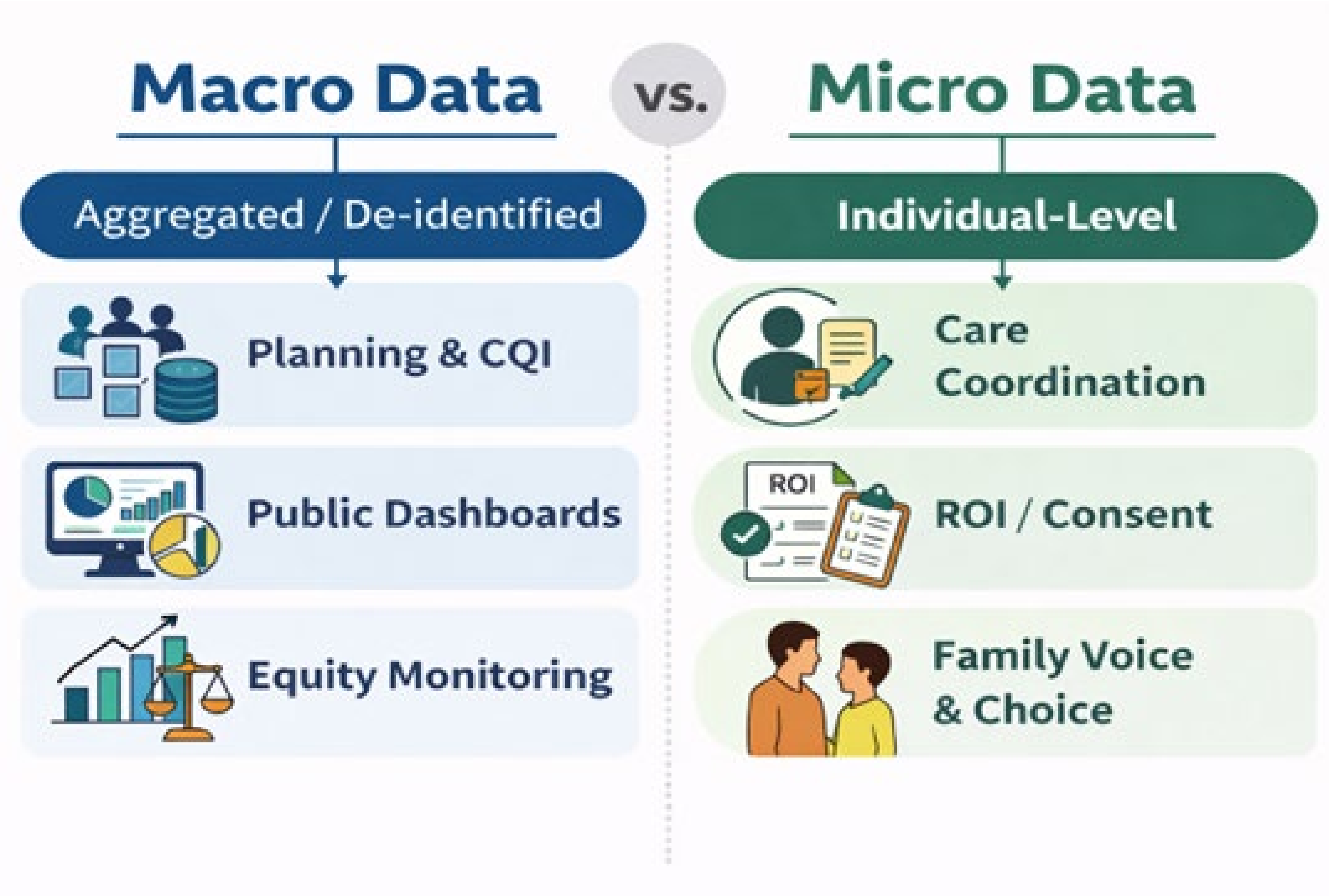
4. Make CQI Visible and Safe

Create a culture of learning throughout the Ecosystem of Care, utilizing the CQI process to improve practices and outcomes. When used as a tool for blame or finger-pointing, it results in broken trust among partners and among those providing the services. Co-creating CQI metrics with parents and youth, and ensuring that these metrics are reviewed with them as well as with all partner organizations, will strengthen the trust across the system and among community members.

Core Practice 3: Community-Defined Data Ethics and Information Sharing

Chapter 2 of this Guide has distinguished between two related but different types of information sharing. **Macrodata sharing** refers to aggregated, de-identified data used across systems for planning, accountability, and continuous quality improvement. **Microdata sharing** refers to person- or family-level information shared with clear privacy safeguards to coordinate care, reduce duplication, and ensure services follow the child or youth - a one child one plan approach.

Both are necessary in a thriving Ecosystem of Care, but they operate under different ethical expectations, legal frameworks, and governance structures.



Why Do Ethics and Equity Matter for Data

Whether data is being aggregated or shared on a macro or micro level, data is not neutral. In an Ecosystem of Care, data is a form of **power** and **relationship**.

Used well, data helps partners see inequities, coordinate care, and hold systems accountable to children, youth, and families.

For many communities who have been marginalized, including: Black, Indigenous, and other people of color; people with disabilities; LGBTQ+ youth; immigrants; and youth involved in child welfare or juvenile justice—the historical impact of data gathering is deeply mixed.

It is not surprising that families approach new dashboards and data projects with skepticism. At the same time, California's legal and policy landscape makes clear that responsible and beneficial information sharing is both possible and necessary with children, youth and families at the core.

■ **AB 2083 Systems of Care MOUs, Health Insurance Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act (FERPA), and ICPM** all emphasize sharing information as needed to coordinate care while protecting privacy.

■ **Chapter 2** of this Guide shows how **macrodata**—aggregated, de-identified data—can and should be shared across education, behavioral health, health, child welfare, juvenile justice, and others for goal setting, planning and continuous improvement. This type of sharing is distinct from **microdata sharing**, which involves individual-level coordination and requires consent, clear purpose limitations, and stronger privacy guardrails.

Another practical barrier is fragmented case plans and systems. When each program has its own case management tool and assessment, it becomes nearly impossible to see the full picture for any one young person. A more integrated, community-defined approach to information sharing is key to changing this. Some leaders refer to this as a “one child, one plan” approach: a way of organizing information so that funding and services follow the person, not the program—within clear, community-approved rules and strong privacy protections.

What Do Community-Defined Data Practices Look Like

Community-Defined Data Practices can be defined as infrastructure through which communities most impacted by public systems help decide what data are collected, how information flows between agencies, and how stories and numbers are interpreted and used—within clear legal and ethical guardrails.

In practice, community-defined information sharing means:

■ **Those most affected are decision-makers**, not just respondents. Youth, caregivers, Tribes, and community organizations help set priorities and standards.

■ **Shared data governance**: youth, caregivers, Tribal representatives, CBO partners, and front-line staff are at the table when decisions are made about what gets measured, how data will be used, how findings will be shared, and how harms will be addressed if data are misused. (See Chapter 2 for more information on this.)

■ **Shared standards for data use**, rooted in principles such as do no harm, reciprocity (data should return value to the communities that generate it), transparency, cultural humility and strengths-orientation. (See Chapter 2 for more information on this.)

These practices align with ICPM and whole child approaches: they treat data as one more way to honor youth and family voice, context, and strengths.

How to Build Community-Defined Data Ethics and Information Sharing

As is outlined in Chapter 2, the engagement of parents and youth as decision-makers is critical to an Ecosystem of Care's success in meeting the needs of the community. Just like engagement in creating metrics to be measured and being participants at every level of the system, ensuring that data and information sharing approaches include the lived experience of youth and parents is equally important.

Some of the steps toward building these practices include:

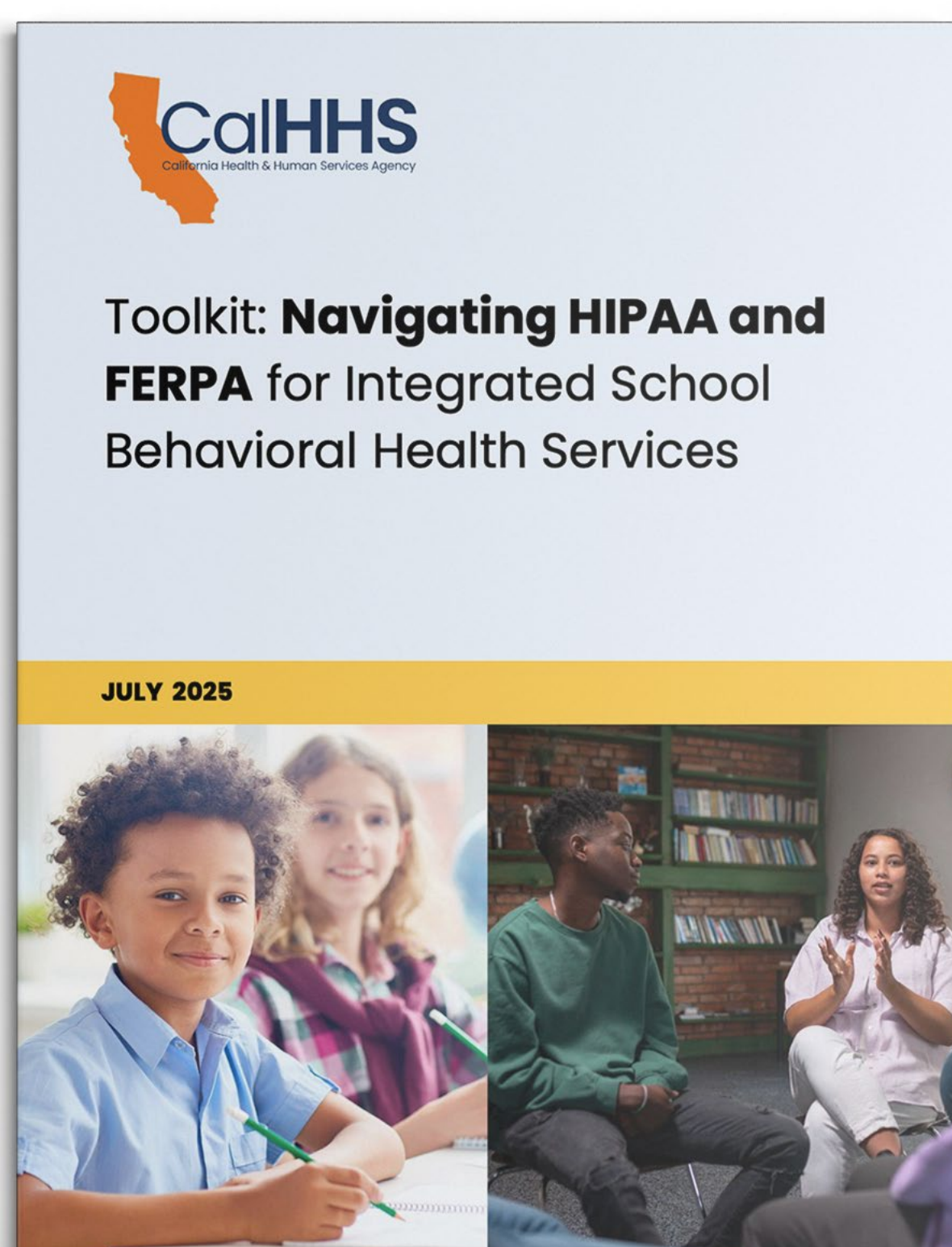
1. Complete a charter outlining how macro and micro data will be handled.
2. Simplify and standardize macro and micro information-sharing.
3. Implement privacy respecting data infrastructure for all data sharing.
4. Build community data practices. These practices align with ICPM and whole child approaches: they treat data as one more way to honor youth and family voice, context, and strengths.

As outlined in Chapter 2, pay youth and family charter members for their time, expertise, and emotional labor as consultants - not “volunteers.” Equitable and appropriate compensation is part of ethical practice; it signals that lived experience is valued on par with professional expertise.



Tool Spotlight

One helpful resource for health-education care coordination and identified individual case information sharing is CalHHS's Toolkit: [Navigating HIPAA and FERPA for Integrated School Behavioral Health Services](#). This is a tool that can also be utilized to see how community stories can be used to define, simplify, standardize and train on individual case information sharing across counties and communities. This is hard work and it takes time, but once completed, counties can build sustainable, transparent, community defined, clear individual case information sharing practice models.





County Spotlight

System of Care Information and Data Sharing (Tuolumne County)

As part of their AB 2083 System of Care design and implementation, Tuolumne County's Interagency Leadership Team identified a desire to ensure a more timely and seamless sharing of youth and family specific information by and between system partners. As required by AB 2083, the County's MOU had made commitments to address this practice problem. AB 2083 partners include Central Valley Regional Center, County Probation, Child Welfare, Behavioral Health, and Office of Education.

In 2022, the Interagency Leadership Team identified a shared desire to create and utilize a universal Release of Information (ROI) form in the hopes of supporting a consistent and timely case coordination and management function. The ILT charged its Advisory Team with exploring and creating the tool.

The Advisory Team dedicated portions of their monthly meetings to exploring needs and expectations of stakeholders and developing an effective strategy to engage local schools and community partners in the creation of the ROI. Examples of other universal ROI forms provided context to how the universal ROI might support overall objectives - speeding referral processing, reducing wait times for care entry, and reducing staff duress associated with delayed ROI processes.

A prototype was developed with the Advisory Team with additional input from the Behavioral Health Services Division. Their parallel work on an enhanced ROI form – designed to meet the higher standards required within the substance use disorder and mental health systems – helped inform the final prototype. The ROI was reviewed over an eight-month period and began beta testing in fall 2024. The testing phase included engagement with local schools to ensure that local education staff could also effectively use the form.

Beta testing and minor revisions were completed, and an accompanying policy was created as an addendum to the 2083 MOU, and to accompany staff training.

As a result of this cross-agency ROI development and realization, Education, Behavioral Health, Probation, Regional Center, and Child Welfare team members will be able to share case information about individual children and youth to more effectively and efficiently support them, including care coordination for them and their families.

Strengthening School–Behavioral Health Partnerships Through Shared Data and Closed-Loop Referrals Vignette (Yolo County)

In Yolo County, leaders across the County Office of Education, school districts, child welfare and behavioral health are taking important steps to strengthen coordination between schools and community behavioral health providers. Recognizing that referrals alone do not guarantee access to care, Yolo County is building a closed-loop referral process that helps ensure students and families are successfully connected to services—and that schools and county partners can learn from the outcomes of those referrals over time.

Through a partnership between the Yolo County Office of Education and Health and Human Services, the County is piloting a new approach that allows schools to refer students to behavioral health supports in the community in real time and receive visibility into service outcomes, helping partners across systems better understand needs, service utilization, and impact across schools and districts.

The pilot district, Washington Unified, is helping demonstrate what this kind of integration can look like in practice. By pairing referral and outcomes data, the County is strengthening its ability to meet grant reporting requirements while also building a more meaningful feedback loop for continuous improvement. County and district leaders can begin to answer key questions that are often difficult to track across systems: Are students receiving services in a timely way? Are youth returning for the same concern after services end?

To support this work, Yolo County is leveraging P-CIS platform to implement standardized referral templates and build dashboards and reports that provide actionable insight across agencies. Planned integrations with systems such as Aries and Netsmart Avatar would help connect existing behavioral health infrastructure with school-linked referral and outcome tracking, strengthening the foundation for long-term cross-sector collaboration.

Core Practice 4: Reciprocal Accountability

Why and What of Reciprocal Accountability

Just as shared goals require that local partners work closely together to agree on their goals, and the measures of those goals, reciprocal accountability can be defined as supporting mutual accountability between systems and the public, and between funders and front-line partners, rather than top-down compliance only. Reciprocal accountability is focused on ensuring that broader community goals are attended to, such as young people feeling safe, connected and hopeful, and that inequities are being addressed through decisions at the system level. When public agencies hold each other accountable, and the community can also hold them accountable, there is deeper integration and movement towards a transparent and effective whole child approach.

This requires cross-agency outcomes and indicators—not just program-specific metrics—and you need to be willing to adjust funding, policy, and practice when the picture isn't good. (See Chapter 2 regarding community dashboard development.)

How to Build Reciprocal Accountability

Internal vs. Public Dashboards

Reciprocal accountability needs two kinds of dashboards:

- **Internal dashboards** – used inside ILTs and program teams to learn quickly, test changes, and adjust resources (internal accountability).
- **Public dashboards** – used with boards, community members, and youth/family partners to share progress, gaps, and commitments (external accountability).

They can draw from the same data, but the **audience, level of detail, and tone** are different.

Use internal dashboards as learning tools first; external accountability will be stronger, not weaker, when people trust the internal process.

Practice Examples

- **Behavioral health:** State [EPSDT](#) and [CYBHI](#) dashboards, alongside managed care partner data, show access and outcomes by county, allowing local teams to compare themselves to peers and identify gaps.
- **Education & Community Schools:** [PACE/LPI](#) document districts that track academics alongside climate, engagement, and family partnership metrics.
- **Child welfare & wraparound:** Counties use [System of Care](#) or [wraparound](#) dashboards to track placement stability, bed-day reductions, and family-reported satisfaction across agencies.
- **Juvenile justice:** Some states publish dashboards that show recidivism, diversion, and education [outcomes for justice-involved youth](#), disaggregated and sometimes linked (at least at the macro level) to mental health and school engagement.

Building on the work of shared goals in Chapter 2, follow the below steps to create practices around reciprocal accountability:

1. Co-Select a Few High-Value Indicators

Choose a small set of metrics that actually matter to young people, families, and partners—and that you’re willing to act on. Then consider four filters:

- 1. **Relevance** – Does it connect to a key whole-child or system goal?
- 2. **Cross-agency value** – Does it matter to more than one agency?
- 3. **Equity insight** – Can it be disaggregated meaningfully?
- 4. **Actionability** – If this indicator got worse, would we know what to try next?



Tool Spotlight

[Setting Concrete Goals and Measuring Success \(CCEE ESOC Toolkit\)](#) is a tool referenced in Chapter 2 that helps define goals and metrics. This can again be used in reciprocal accountability practices to identify those goals you wish to revisit.

Use internal dashboards as learning tools first; external accountability will be stronger, not weaker, when people trust the internal process.

2. Build Feedback Processes

Build transparent, non-retaliatory and consistent avenues for discussion and means of input with internal leadership teams, as well as community partners, parents and youth regarding chosen reciprocal accountability metrics and whether the metrics are achieving determined goals, as well as whether they are improving mutual accountability (co-design, co-evaluation, and co-implementation) of the Ecosystem.

3. Refine and Adapt

Based upon gathered reciprocal accountability metric feedback, refine the structures, processes and functions of the Ecosystem to respond and improve (e.g. training, resource allocation, other.)

Sustainability is Not Optional

Sustainability is not a single funding stream, dashboard, or a policy agreement. It is a disciplined way of operating together over time.

Through the four interdependent core practices outlined in this chapter—Integrated Financing, Continuous Quality Improvement, Community-Defined Information Sharing, and Reciprocal Accountability—ILTs and EACs move beyond realizing Ecosystem of Care governance and implementation structures, processes and functions into sustaining and stewarding it. These sustainability practices align resources with whole child goals, connect stories with data, make tradeoffs visible, and ensure that improvement is continuous rather than episodic for children, youth, families and those supporting them.

Counties will approach this work differently. Context, history, and local relationships matter. But the underlying principles remain constant:

- Public dollars are stewarded collectively, not defended in isolation.
- Quality is defined with children, youth, and families—not for them.
- Data is a tool for learning and equity—not surveillance or compliance alone.
- Accountability flows in all directions—across agencies, to communities, and back to one another.
- Success of our young people is our collective responsibility, our economic and workforce imperative, and our future.

As county leaders advance their implementation efforts to develop a whole child Ecosystem of Care, the invitation is not to implement everything at once, but to establish steady routines: shared budget conversations, recurring CQI cycles, community data dialogues, and dashboard-informed governance. Over time, these routines become embedded, operational norms and culture which, more than any single grant or agreement, are what sustain an Ecosystem of Care.

The tools and appendices throughout this Guide are designed to support that shift—from isolated initiatives to integrated infrastructure; from short-term funding to long-term stewardship; from fragmented accountability to shared responsibility for whole child outcomes and the future of California.

The work of sustainability is, ultimately, the work of honoring our shared commitment: that every child, youth, and family experiences a system that is coherent, responsive, effective, and worthy of their trust.

Closing

The Time is Now to Build an Ecosystem of Care

The integration work to realize an Ecosystem of Care across every county in California is about making access easier and more effective for children, youth, families and those who serve them every day. When systems are fragmented, professionals spend more time navigating barriers than meeting needs: a school counselor scrambling to find mental health support, a probation officer unsure who else is helping the same young person at the same time, a pediatrician without insight into a child's housing instability. By contrast, when systems integrate for collective impact, each agency can focus on its strengths—and not try to do it all. Communities that have embraced collective impact approaches have seen graduation rates rise, kindergarten readiness increase, teen pregnancy fall, and chronic homelessness drop. The message is clear: integration doesn't just create better systems and maximize utilization of our resources, it helps every professional do their job better and makes life measurably better for kids, families, our workforce, the economy and our future.

A thriving Ecosystem of Care is not built once. It is maintained through intentional alignment, protected through collective decision-making, and strengthened each time partners choose integration over isolation. And, only by uniting our collective efforts can California realize the full promise of each initiative, achieve lasting transformation across systems, and the future we want for our children, youth, families and great state.

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A Note to Readers

This Implementation Guide reflects the collective expertise, experiences, and thoughtful contributions of the many individuals and organizations acknowledged here. It was developed with the shared goal of supporting collaboration, strengthening implementation, and advancing better outcomes for children, youth, and families across California. We hope it serves as a practical resource that can be adapted to meet the unique needs of local communities.

Because every jurisdiction, organization, and circumstance is different, this Guide is intended to provide general information and implementation considerations rather than legal advice. Nothing contained herein should be construed as legal advice or a definitive interpretation of federal, state, or local law, regulation, or policy. Readers are encouraged to consult their own legal counsel and appropriate state and local agencies regarding questions about legal or regulatory requirements or the application of this information to specific situations.

Examples, templates, sample language, and implementation tools included throughout this Guide are provided for illustrative purposes and should be reviewed and adapted, as appropriate, to align with applicable laws, local policies, and organizational practices.

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Glossary

Term	Definition/Description
504 Plan	A formal accommodation plan under Section 504 of the Rehabilitation Act of 1973 that ensures students with disabilities have equal access to education through specific supports and modifications in the general education classroom, who might not qualify for special education services under IDEA
AB 2083	System of Care: Requires each county to develop and implement a Memorandum of Understanding (MOU) outlining roles and responsibilities of local entities that serve children and youth in foster care who have experienced severe trauma in order to unify supports
ACH	Accountable Communities for Health, a vehicle for cross-sector collaboration on community health issues
ALN	Assistance Listing Number
BH	Behavioral Health
BHOATR	Behavioral Health Outcomes, Accountability, and Transparency Reports
BHS	Behavioral Health Services
BHSA	Behavioral Health Services Act
BHSSA	Behavioral Health Student Services Act
BIPOC	Black and Indigenous People of Color
CalAIM	California Advancing and Innovating Medi-Cal
CalHHS	California Health and Human Services Agency
California's CalAIM Justice-Involved Reentry Initiative	A component of CalAIM that allows individuals who are incarcerated or otherwise justice-involved to receive targeted Medi-Cal services prior to release
California's Integrated Support Systems	Statewide framework that aligns education, health and human services to provide coordinated, whole child supports within schools and communities
CalWORKS	Public assistance program that provides cash aid and services to eligible families that have a child(ren) in the home
CANS	Child and Adolescent Needs and Strengths Assessment
CAPTA	Child Abuse Prevention and Treatment Act

Term	Definition/Description
CAST	Cross Agency Service Team
CBCAP	Community-Based Child Abuse Prevention program
CBO	Community-based organization
CCSPP	California Community Schools Partnership Program
CDPH	California Department of Public Health
CFDA	Catalog of Federal Domestic Assistance
CFPIC	Child and Family Policy Institute of California
CFT	Child and Family Teaming
CHA	Community Health Assessment
Children, youth and families	Meant to be inclusive of all those served and eligible to be served by the child and youth behavioral health ecosystem, including their families, caregivers and supportive network
CHIP	Community Health Improvement Plan
Chronic absenteeism	A measure of student attendance defined as missing 10% or more of school days, excused or unexcused, over a given period
CHW	Community Health Worker
COE	County Office of Education
Collective impact	A collaborative framework in which cross-sector organizations and community members work together around a shared agenda and common goals to address complex social challenges more effectively than any single organization could alone
Community Schools	A “whole child” school improvement strategy where the district and school work closely with teachers, students, families, and partners
Continuum of Care	The entire range of behavioral health supports, ranging from promotion and prevention to treatment and recovery
COST	Coordinated Outreach and Support Teams
CQI	Continuous Quality Improvement
Cultural Brokers	Trusted individuals who help bridge cultural, linguistic and systemic gaps between families and service providers
CW or CWS	Child Welfare or Child Welfare Services

Term	Definition/Description
CWC	Certified Wellness Coach
CYBHI	Children and Youth Behavioral Health Initiative
DHCS	Department of Health Care Services
EAC	Executive Advisory Committee
ECM	Enhanced Care Management
Ecosystem of Care	A living, coordinated network in which schools, health providers, social services, juvenile justice, communities, and other child-serving agencies and community partners work seamlessly together so that any door a young person or their family walks through becomes the right door to access the care, supports, and opportunities they need to thrive
Economies of scale	Cost advantages that enterprises obtain due to their scale of operation, and are typically measured by the amount of output produced per unit of time
ELOP	Expanded Learning Opportunities Program
EPSDT	Early and Periodic Screening, Diagnostic and Treatment – Medicaid benefit for children and youth under age 21 that ensures access to comprehensive preventive, diagnostic and treatment services
EQRO	External Quality Review Organization
ERMHS	Educationally Related Mental Health Services
ERP	Enterprise Resource Planning
Fee Schedule	A standardized list of predetermined rates that establishes the maximum amounts reimbursed for specific services provided by healthcare or behavioral health providers, used by government programs, insurers, and agencies to ensure consistency in billing and reimbursement across providers and settings
FERPA	Federal Educational Rights and Privacy Act
FFPSA	Family First Prevention Services Act
FFT	Functional Family Therapy
First 5 Commission	Public agencies established under Proposition 10 that invest in programs and systems supporting the healthy development of children ages 0-5
FSP	Full Service Partnership

Term	Definition/Description
FTE	Full-time Equivalent
GASB	General Accounting Standards Board
HBTW	Humboldt Bridges to Wellness
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IAP2	International Association for Public Participation
ICC	Interagency Coordinating Council
ICPM	Integrated Core Practice Model
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Plan
ILT	Interagency Leadership Team
IP-CANS	Integrated Practice Child and Adolescent Needs and Strengths
IPC	Interagency Placement Committee
IPP	Individual Program Plan
ISF	Interconnected Systems Framework
JJCPA	Juvenile Justice Crime Prevention Act
JPA	Joint Powers Authority
K-12	Kindergarten through 12th grade
LCFF	Local Control Funding Formula
LEA	Local Education Agency
LEA-BOP	Local Education Agency Medi-Cal Billing Option Program
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, and all other sexual orientations, gender identities, and gender expressions
LPI	Learning Policy Institute

Term	Definition/Description
Macrodata	Population- or systems-level data that reflects broad trends, patterns, and outcomes across a community, county, or region; in the context of integrated systems of care, macrodata is used to identify disparities, track progress toward shared goals, and inform cross-agency planning and resource allocation
MCP	Managed Care Plan
Medi-Cal	California's Medicaid program
MH	Mental Health
MHP	Mental Health Plan
MHSA	Mental Health Services Act
Microdata	Individual- or case-level data that captures specific information about a single child, youth, family, or service interaction; in the context of integrated systems of care, microdata is used to inform individualized care planning, track progress across services, and ensure that supports are tailored to each young person's unique needs and circumstances
MOU	Memorandum of Understanding
MST	Multisystemic Therapy
MTSS	Multi-Tiered Systems of Support
NEES	Network and Ecosystem Experiences Survey
No wrong door	Philosophy that individuals should be seamlessly connected to needed services regardless of their entry point to the system
PACE	Policy Analysis for California Education
Parent Partners	Individuals with lived experience navigating child-serving systems who are employed or engaged to support and advocate for other families
PBIS	Positive Behavioral Interventions and Supports
P-CIS	Person-Centered Intelligence Solutions
PDSA	Plan-Do-Study-Act
Peer Navigators	Individuals with lived experience, often as former system participants or caregivers, who provide guidance and support to help youth and families navigate complex service systems
PEI	Prevention and Early Intervention

Term	Definition/Description
PNA	Population Needs Assessment
PRL	Purpose, Repurpose, Leverage
Promotoras	Trusted community health workers, often from the communities they serve, who provide culturally and linguistically responsive outreach and education, and support families across a range of areas
Promotoras de Salud	Community health workers who provide health education, prevention and linkage to healthcare services
RAND	The RAND Corporation is a nonprofit research organization that conducts policy analysis and research across areas including health, education, public safety, and social services
Regional Center	Network of nonprofit agencies contracted by the California Department of Developmental Services that coordinate and provide services for individuals with developmental disabilities
ROI	Release of Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SARB	School Attendance Review Boards
SBHIP	Student Behavioral Health Incentive Program
SDOH	Social Determinants of Health
SEL	Social Emotional Learning
SELPA	Special Education Local Plan Area
Short-Doyle	A California state program that funds county-administered mental health services for Medi-Cal eligible individuals, including children and youth, and establishes the framework through which counties deliver and receive reimbursement for publicly funded behavioral health services
SMAA	School-Based Medi-Cal Administrative Activities program
SOC	System of Care
Social connectedness	A sense of belonging to a group, family, or community
SOW	Statement of Work
SWAG	Student Wellness Advisory Groups

Term	Definition/Description
T²	Transforming Together
TBS	Therapeutic Behavior Services
Tier 1	The foundational level of a three-tiered service framework focused on universal wellness and prevention, where the supports and services are available to all children, youth, and families - regardless of risk level - and are designed to foster conditions for thriving before crises emerge
Tier 2	The second level of a three-tiered service framework focused on targeted early intervention for individuals or families showing elevated risk factors, providing timely, proportionate responses designed to prevent escalation to more intensive levels of need
Tier 3	The most intensive level of a three-tiered service framework, delivering individualized services through coordinated, multi-agency care teams and designed for the most vulnerable children and youth, ensuring they receive sustained, wraparound support that addresses complex, interconnected needs
TQM	Total Quality Management
TRS	Tiered Rate Structure
Universal array	Describes the universe of available services and supports for children and youth
Wellness Coach	Trained paraprofessional who provides prevention and early intervention supports to children and youth, often in school or community settings
Whole child	A framework that recognizes the full range of social, emotional, physical, and cognitive needs and assets of children and youth as interconnected and inseparable, and recognizes that lasting well-being requires coordinated supports across education, health, human services, and other child-serving systems that are developmentally appropriate, individualized, strength-based, and shaped by youth and family voice
WIN	Wraparound Immediate Needs program
Youth Advocates	Young people, often with lived experience in child-serving systems, who support and represent the perspectives of other youth in services, planning and decision-making

Endnotes

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³A summary of the AB 2083 legislation goals, requirements and content—prepared by the California Health and Human Services and California Department of Education in September 2021—is available [online](#)

⁴<https://www.c4cw.org/>

⁵Barbara J. Friesen, Nancy M. Koroloff, Janet S. Walker, and Harold E. Briggs, 2011 or Osher, Osher and Blau, 2008.

⁶When considering how to capture student data, this resource may be useful: <https://www.cde.ca.gov/ls/he/at/chks.asp>. When searching for tools to assist in building caregiver engagement, the following may be of use - <https://www.ed.gov/about/ed-initiatives/raise-bar/raise-bar-resources-parents-and-families>

⁷For more information on accessing Medi-Cal to meet the social, emotional and mental health needs of students in schools, see <https://cachildrenstrust.org/wp-content/uploads/2020/08/cct-practicalguide-final-v2.pdf> . For a general information on Medi-Cal, see https://cachildrenstrust.org/wp-content/uploads/2020/06/cct_medi-cal_onepager.pdf

⁸<https://nwi.pdx.edu/pdf/ReturnonInvestmentinSOCsReport6-15-14.pdf>

⁹In recent years, many communities have begun exploring new approaches to creating government programs—or crafting solutions for particular service delivery problems or gaps—by evolving the concept of who should be “designers” and “experts.” Instead of relying mainly on traditional experts or agency leaders with certain academic credentials or job titles to make decisions—about problems that largely they don't experience themselves, for communities that largely they do not live in themselves—these new efforts seek to prioritize the insights of people most proximate to the problem. This approach calls for government agencies to spend more time identifying and working with those who are experiencing the problem to be solved and centering those individuals in the process of decision-making. For more information on this approach, see for example this interview between Harvard Business School's Race, Gender and Equity Program and Christina Marie Ortiz Guzman of Equity Meets Design: <https://www.hbs.edu/race-gender-equity/projects/just-digital-future/Pages/video.aspx?item=christine-ortiz>

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¹⁴<https://www.capeercertification.org/certification/>

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²⁷[Casey Family Programs](#), SOC Strategy Brief.