Welcome to

FUNDING PRIMARY AND SECONDARY PREVENTION STRATEGIES: PART 1

THE TRAINING WILL BEGIN SHORTLY

While you're waiting...

Icebreaker Question (answer in the chat)

What are your favorite backyard barbecue dishes?

Survey & Certificate of Completion

Available following the training.

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Before We Begin...

DURING

Access the presentation slides and resource sheet now! The links can be found in the chat.

This presentation is being recorded.

DURING

Review interactive features for today's session. Locate the controls on the toolbar at the bottom of your screen.

AFTER

Complete the survey at the end of this webinar to receive your Certificate of Attendance.

A follow-up email will be sent to all participants within 2 days.

Hi, We're CalTrin!

CALTRIN
California Training Institute

Who we are

- The California Training Institute
- Funded by the State of California, Dept. of Social Services, Office of Child Abuse Prevention (OCAP) to support child abuse prevention through professional development and extended learning opportunities.
- Designed for staff of family strengthening and child abuse prevention organizations in California, including FRCs, CAPCs, CBOs, and other child and family serving systems.

What we offer

- Live webinars & small group training
- Virtual, self-paced courses
- Job aids & other resources

This training was made possible with funding from the California Department of Social Services, Office of Child Abuse Prevention. Any opinions, findings, conclusions, and/or recommendations expressed are those of the CEBC /CalTrin and do not necessarily reflect the views of the California Department of Social Services.

THE CHILD, FAMILY, AND COMMUNITY WELL-BEING LEARNING SERIES

THE CHILD, FAMILY, AND COMMUNITY
WELL-BEING LEARNING SERIES

TODAY'S TOPIC:

FUNDING PRIMARY AND SECONDARY PREVENTION STRATEGIES: PART 1

OUR INTENTION FOR THE LEARNING SERIES

- Create opportunities for Collaborative Counties to learn from subject matter experts and to engage one another about how to create a prevention infrastructure with shared responsibility and accountability among cross-sector partners, including the challenges and complexities of implementing / operationalizing their Comprehensive Prevention Plans
- Strengthen cross-sector relationships by learning together between County child welfare, juvenile justice and behavioral health, education, community-based service providers, family resource centers, local Child Abuse Prevention Council, tribal partners, and parents/youth with lived experience.
- Position Counties' to better examine and build their capacity and ability to effectively partner and engage with parents and youth with lived experience.
- Support Counties in measuring and decreasing racial disproportionality.
- Anchor service delivery systems in primary prevention and extend "downstream" from there, prioritizing resources in the most "upstream" way possible

TODAY'S GOALS

- Have a conversation about design and application of funding strategies to maximize CPP planning and implementation process.
- Establish connection between effective, sustainable CPP funding, parallel prevention opportunities, and the System of Care as the structure to hold those opportunities.
- Deepen awareness of critical Behavioral Health funding opportunities and reforms that will lead to CPP and related successes.
- Set the stage for a follow up panel presentation on these critical concepts and strategies.

THE CHILD, FAMILY, AND COMMUNITY WELL-BEING LEARNING SERIES

OUR PRESENTERS

ALEX BRISCOE
Principal, California Children's Trust

RICHARD KNECHT, MS
Integrated Services Advisor, CDSS

Moderated By:

KHUSH COOPER, MSW, PhD
President & CEO, Implematix
Adjunct Professor, UCLA

SUSTAINING PREVENTION & COMMUNITY SUPPORTS

A POINT OF DEPARTURE…

- Poverty, racism and systemic absence of access to supports and care are key drivers to entry into all government “systems”, including Child Welfare.
- Although California has made progress in the last two decades, Medicaid is both an essential and under leveraged financing strategy for child welfare system involvement.
- In order for Medicaid to play this role, it must be reimagined and transformed, to let go its over-medicalization of what are otherwise basic needs.
- In order for Child Welfare to play a full role in prevention, it must let go of its policing frame and embrace a new place as a community-based intervention.

THE ADAPTIVE DILEMMA

- FFPSA, FFPS & the CPP provide extraordinary opportunity to transform Child and Family Services in partnership with the MediCal Mental Health Delivery System in California.
  - Application of Federal Resources “pre-foster care”
  - Installation of Evidenced Based Practices
  - Align System of Care partners and deepen AB 2083 impacts via Prevention and Diversion
- FFPSA has many goals, and CPP design and execution is inherently complex, in part due to its technical aspects, but also because it requires interagency partnership that is historically not present.

THE ADAPTIVE DILEMMA

FFPSA has complexities, some of which are not fully understood or have articulated solutions yet…

- Payer of Last Resort Guidance
- EBP Fidelity
- State Block Grant use
- CARES Information/Care Management system not ready
- Parallel Upstream Reforms competition/opportunity:
  - California Youth Behavioral Health Initiative
  - CalAIM
  - Community Schools
  - Other School Medicaid Opportunities
  - Managed Care Role

THE LARGER ECO SYSTEM OF PREVENTION OPPORTUNITY

- SB 75 – Medi-Cal for Students Workgroup
- SB 823 - Probation Realignment
- Lanterman Act Provisional Eligibility Ages 3 and 4
- Children and Youth Behavioral Health Initiative (CYBHI)
- California Advancing and Innovating Medi-Cal (CalAIM)
- Family First Prevention Services Act (FFPSA)
- Multi-Tiered System of Supports
- Mental Health Services Act Tri-Annual Planning
- Juvenile Justice Crime Prevention/Youth Offender Block Grants
- School Behavioral Health Incentive Programs (BHI)
- Community Schools Partnership Program

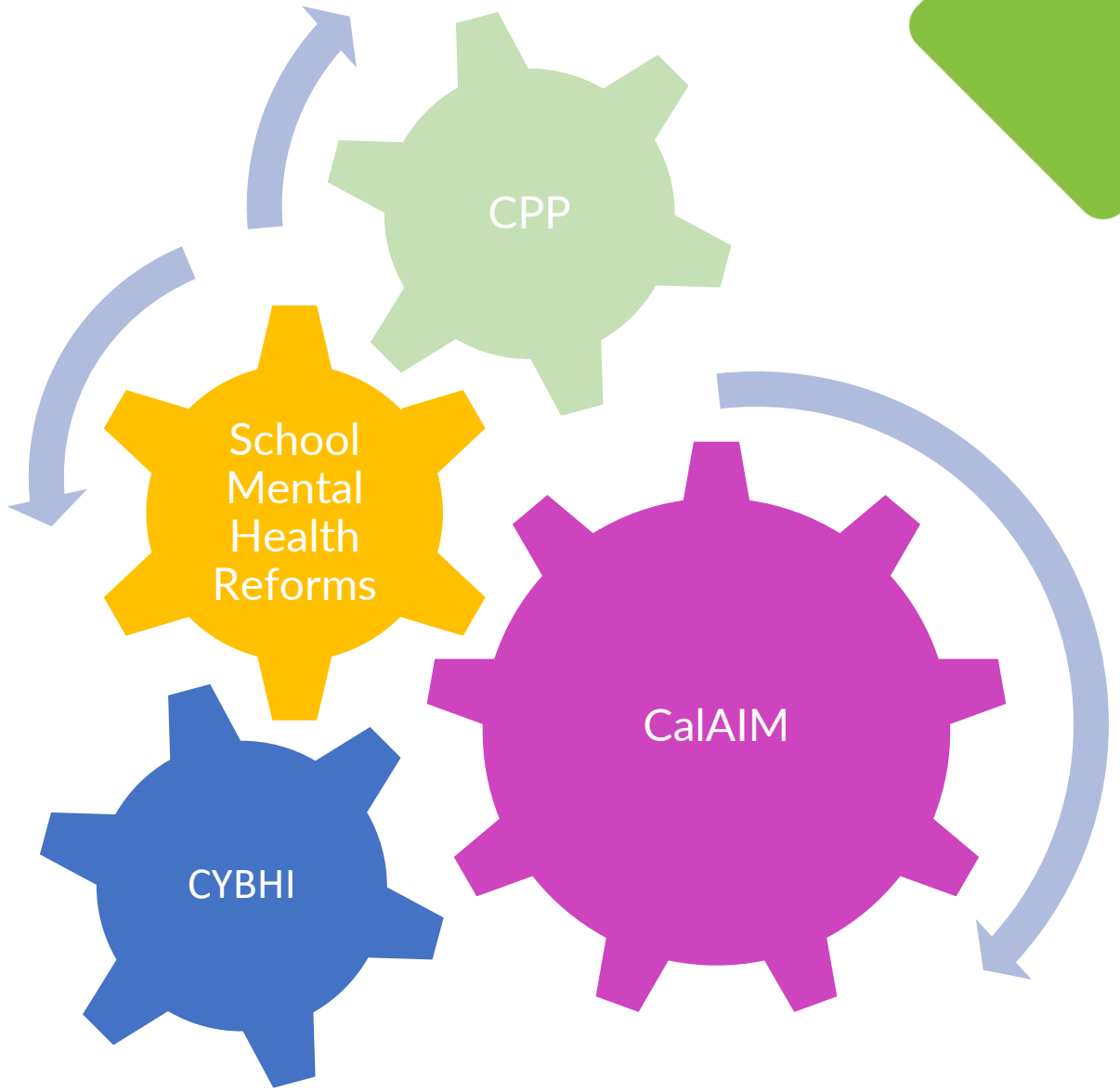
FFPSA BRINGS ABOUT OPPORTUNITIES FOR RESOURCE SHARING

- FFPSA provides 50% federal match on eligible expenditures.
- FFPSA (IV-E) allocations are the “payer of last resort”. Other Federal revenues, when appropriate, must be spent first.
- Child Welfare, Probation Agencies and County Behavioral Health Agency are expected to identify braiding strategies. Other partner agencies share generic resources via care coordination.
- Interagency Leadership Teams and fiscal managers are highly interdependent to establish coordination, planning and budgeting.

CRITICAL FFPSA/CPP AWARENESS

- Preventing entry to foster care has not historically been, nor can it be the primary responsibility of the child welfare system.
- While CA's Child Welfare and Youth Justice/Correction partners have demonstrated remarkable adaptive capacity in the last 30 years, most of the tools to keep children safe, at home, in community, in school, and out of justice involvement…are in other partner's budgets and purviews!
- Increasing numbers of children and youth in and around CWS, are going to be getting care via Managed Care Organizations, and in most cases, the MCO's and CWS/Probation systems don't know much about each other.
- More services is rarely better….Wholeness and integration of those services is what increases access, coordination and sustainability of programming!

The numerous “cogs” in prevention systems are increasingly outside the CWS/Justice System…



MANY FISCAL/PROGRAM "COGS" NOW FOUND IN SCHOOL SYSTEMS

Multi Tiered Systems of Support

- Tiered Framework (P, S, T) providing potentially broad spectrum of early social/emotional supports and services

Wellness Centers

- On-campus space for supports, services, early intervention and referral engagement

Community Schools

- Integrated Support Services
- Family and Community Engagement
- Extended Learning Time

Local Control Accountability Plans

- Foster youth and Tribal Youth focused
- Ongoing allocations
- Parallel Plan Review Cycles to CPP

California Children and Youth Behavioral Health Initiative

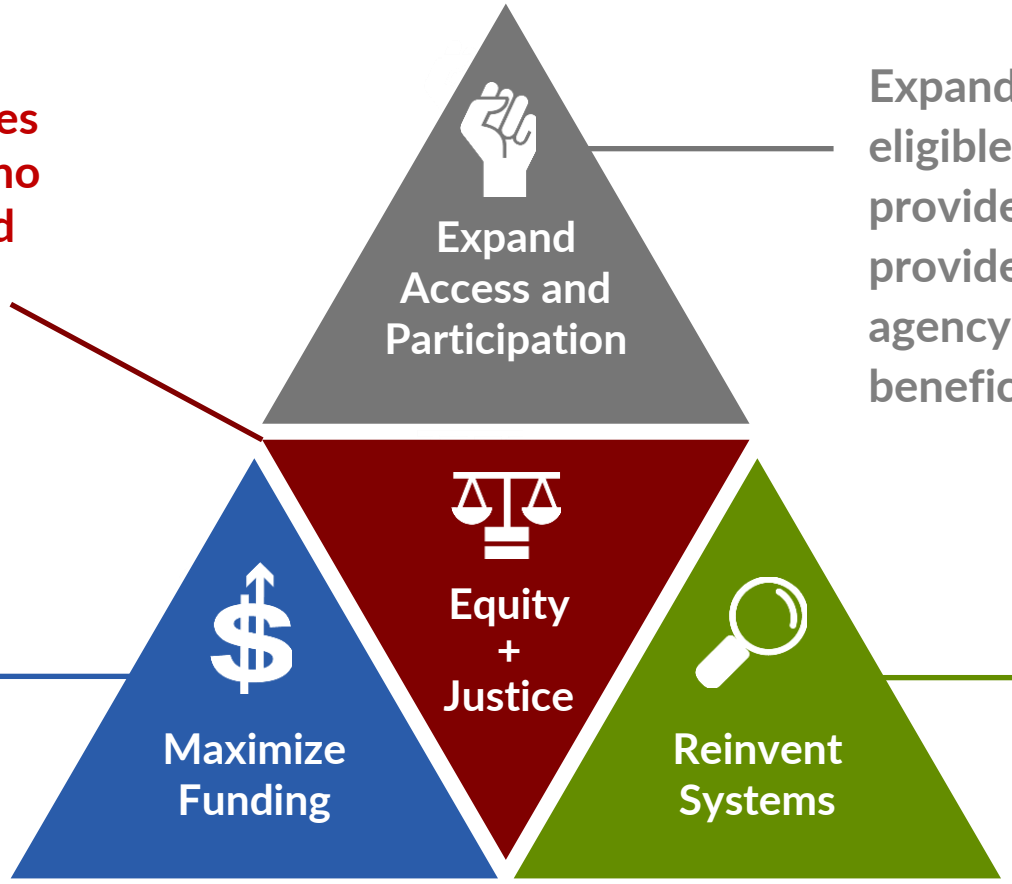
Student Behavioral Health Incentive Program

- Managed Care Incentives

Navigating An Unprecedented Reform Landscape

THIS IS CCT'S FRAMEWORK FOR SOLUTIONS

Shifting agency (who does the work) and power (who gets paid to do it) in child serving systems



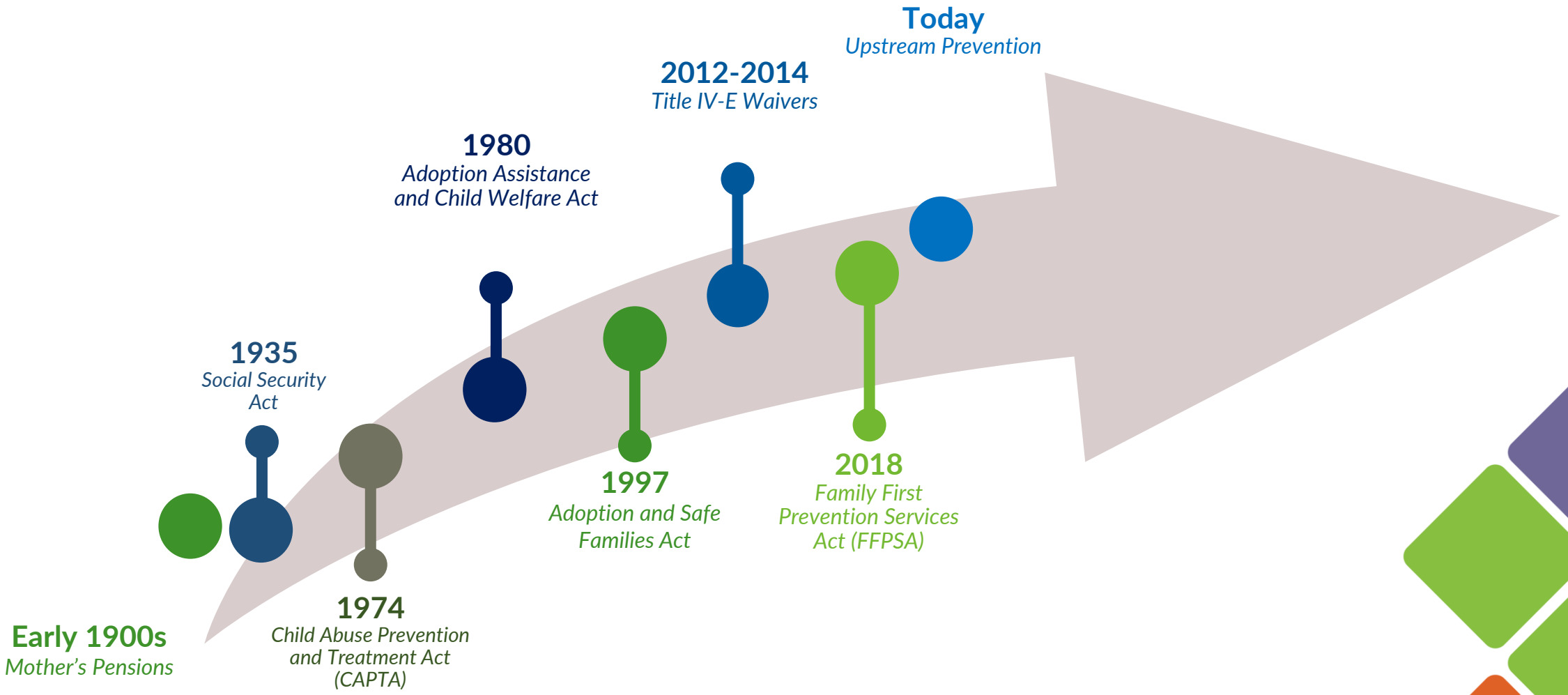
Expand who is eligible, who can provide care, what is provided, and the agency of the beneficiary

Increase state and county spending, and fully claim the federal match

Increase transparency and accountability

CHILD WELFARE THROUGH THE DECADES: SELECT POLICIES

CHAPIN HALL



CHILD WELFARE THROUGH THE DECADES: SELECT POLICIES

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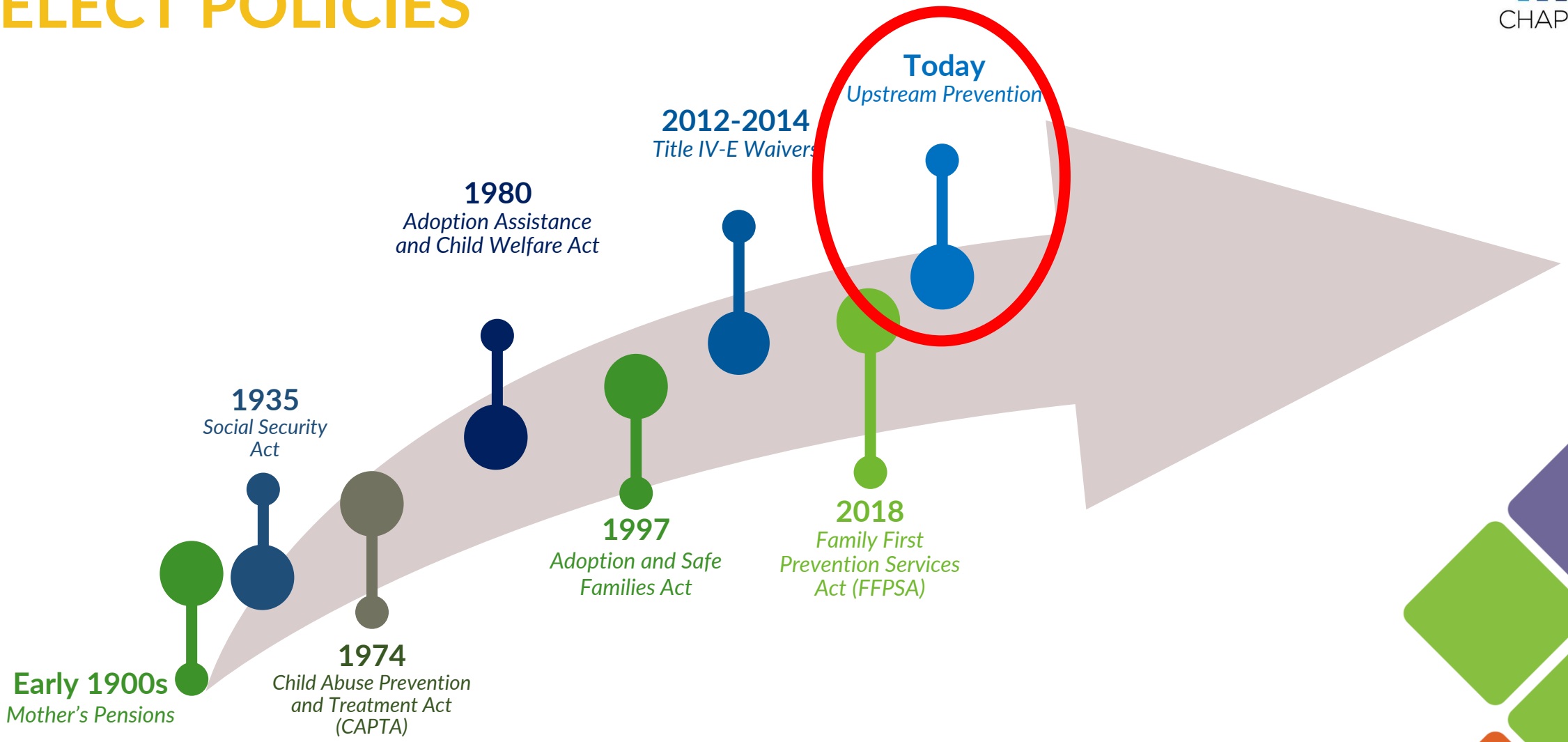


MEDICAID & CHILD WELFARE IMPACT AREAS

Upstream prevention

Provide children, youth, and families in the community with access to services and supports to meet emerging needs.

Intensive evidence-based services

Provide children, youth, and families in the community with access to services and supports to meet emerging needs living in the community.

Tailored services for children in foster care

Proactively address trauma and mental & behavioral health challenges for children and youth in foster care.

SDOH: A MEDICAID & CHILD WELFARE INTERSECTION

Many of the same factors prevent both maltreatment and poor health outcomes: SDOH

Child welfare seeks upstream prevention strategies & funds—while Medicaid increasingly addresses SDOH.

MEDICAID & PREVENTION: AN OPPORTUNITY FOR STATES TO GRASP

- Federal policy creates latent opportunities that states can leverage and shape.
- Why has state Medicaid innovation been slow?
  - Culture of medical model
  - Traditional barriers between health and human services
  - State budget limitations—despite evidence of long term savings

Helpful Guidance on Leveraging Medicaid
Addressing SDOH: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf
Behavioral health services for children & youth: https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf

AS WE DESIGN UPSTREAM PREVENTION STRATEGIES , HOW CAN WE REACH FAMILIES NOT INVOLVED WITH CHILD WELFARE?

States can do these things to leverage Medicaid as a primary prevention strategy:

- Mandate SDOH screening tools
- Offer fiscal incentives for social care
- Service director & closed loop referral platform
- Expand provider class
- Eliminate diagnosis as treatment requirement
- Expand access points to non-clinical settings

WHAT TO TRACK IN AN UNPRECEDENTED REFORM LANDSCAPE

1. **Remove diagnosis** as a requirement for treatment (expand Medical Necessity Criteria in context of EPSDT and ACES)
2. **Reform Medicaid** by claiming against exisiting expenditures in child serving systems and expanding the role of MCP's
3. **Center schools and Primary Care** as healing and anti-racist centers of support
4. **Expand Eligible Provider Classes** to address workforce shortages, build culturally concordant workforce, and honor the widsom and intelligence of lived experience
5. **Focus on Benefit Design in Managed Care Organizations to develop scaleable reimbursement for Family Therapy and Dyadic Models** in Pediatric Primary Care.
6. **Focus on Care Coordination models** to bring culturally concordant non-clinical staff and providers into health system networks.
7. **Develop social model, cascading mentorship, and mutual aid** strategies as essential social capital building strategies in Medicaid.

Read and share our policy briefs

cachildrenstrust.org

Join our Coalition

@CAChildrenTrust

Sign up for the CCT Newsletter

TAKE AWAYS:

- BIG CHANGES ARE HERE… AND MORE ARE COMING SOON.
- KNOW THE MANY FACES OF MEDI-CAL AND HOW THEY CAN BE INTEGRATED TO SUSTAIN YOUR WORK—UNDERSTAND THE CENTRICITY OF MANAGED CARE PLANS
- TRACK NEW AND EMERGING BENEFIT DESIGN AND CONSTRUCTION IN MEDICAL-INCLUDING FUNDAMENTAL REFORMS TO MEDICAL NECESSITY
- MINE THE NEW PROVIDER TYPE OPPORTUNITIES
- MINE FOR CPE!! LIMITING FACTOR FOR FFPSA AND MHPS IS ACCESS TO NON-FEDERAL DOLLARS

SUSTAINABILITY DISTILLED:

HEALTH PLANS ARE THE CENTER

BEHAVIORAL HEALTH IS CHANGING

MEDI-CAL WILL PAY FOR THINGS IT DIDN'T PAY FOR BEFORE

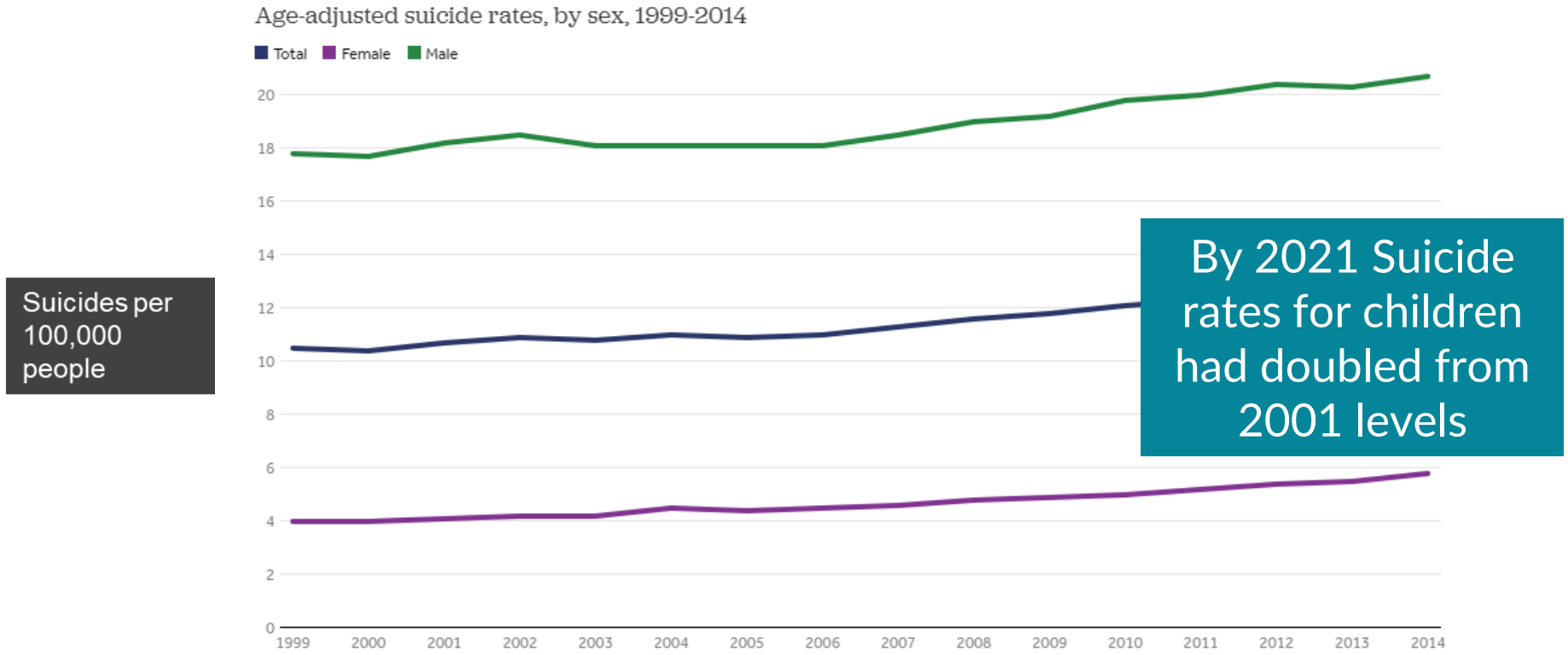
MEDI-CAL WILL PAY FOR NEW TYPES OF PROVIDERS

California Children's Trust

BEHAVIORAL HEALTH IS THE FUNDAMENTAL DRIVER OF MORBIDITY FOR 10- TO 24-YEAR-OLDS

Homicide, suicide, and unintentional injury (mostly car-related) are the three leading causes of death for youth ages 10-24.

In the last 10 years, suicide has leap-frogged cancer and unintentional injury and become the second leading cause of death for youth and young adults.



By 2021 Suicide rates for children had doubled from 2001 levels

Suicide Data is Striking

After almost steadily declining between 1986 and 1999, the national suicide rate increased a startling 24% between 1999 and 2014, with a 2% increase per year beginning in 2006.

The suicide rate for young women ages 10-14 increased the most in that time, jumping 200% from 0.5 suicides per 100,000 to 1.5 suicides per 100,000.

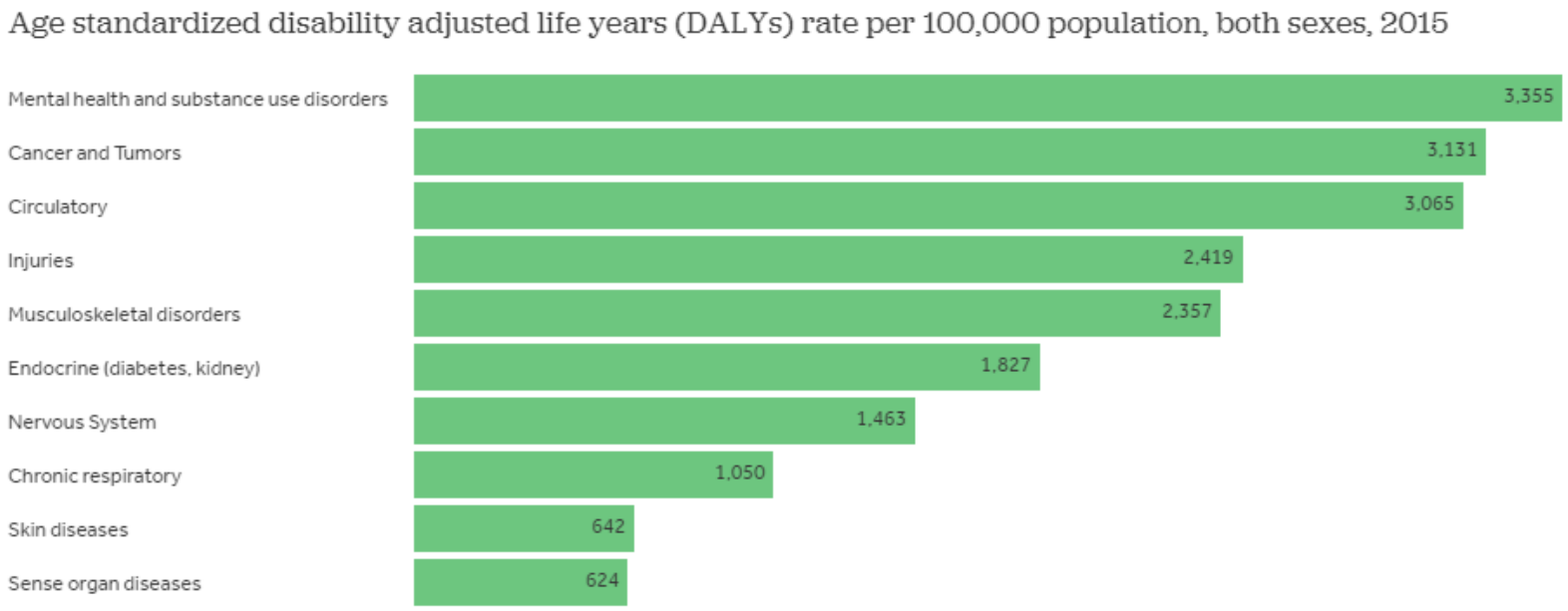
And it's not just suicide rates…

There have been striking increases in both self-reported need (surveys) and demonstrated acuity (diagnosis and utilization of crisis and inpatient services) over the last 10 years of available data.

Overall All Cause children's hospitalizations are not increasing. **The primary drivers of increases in hospitalizations among youth and young adults are behavioral health conditions.**

https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-prevalence-mental-illness-among-adults-relatively-stable

MENTAL HEALTH AND SUBSTANCE USE DISORDERS ARE THE LEADING CAUSES OF DISEASE BURDEN IN THE US

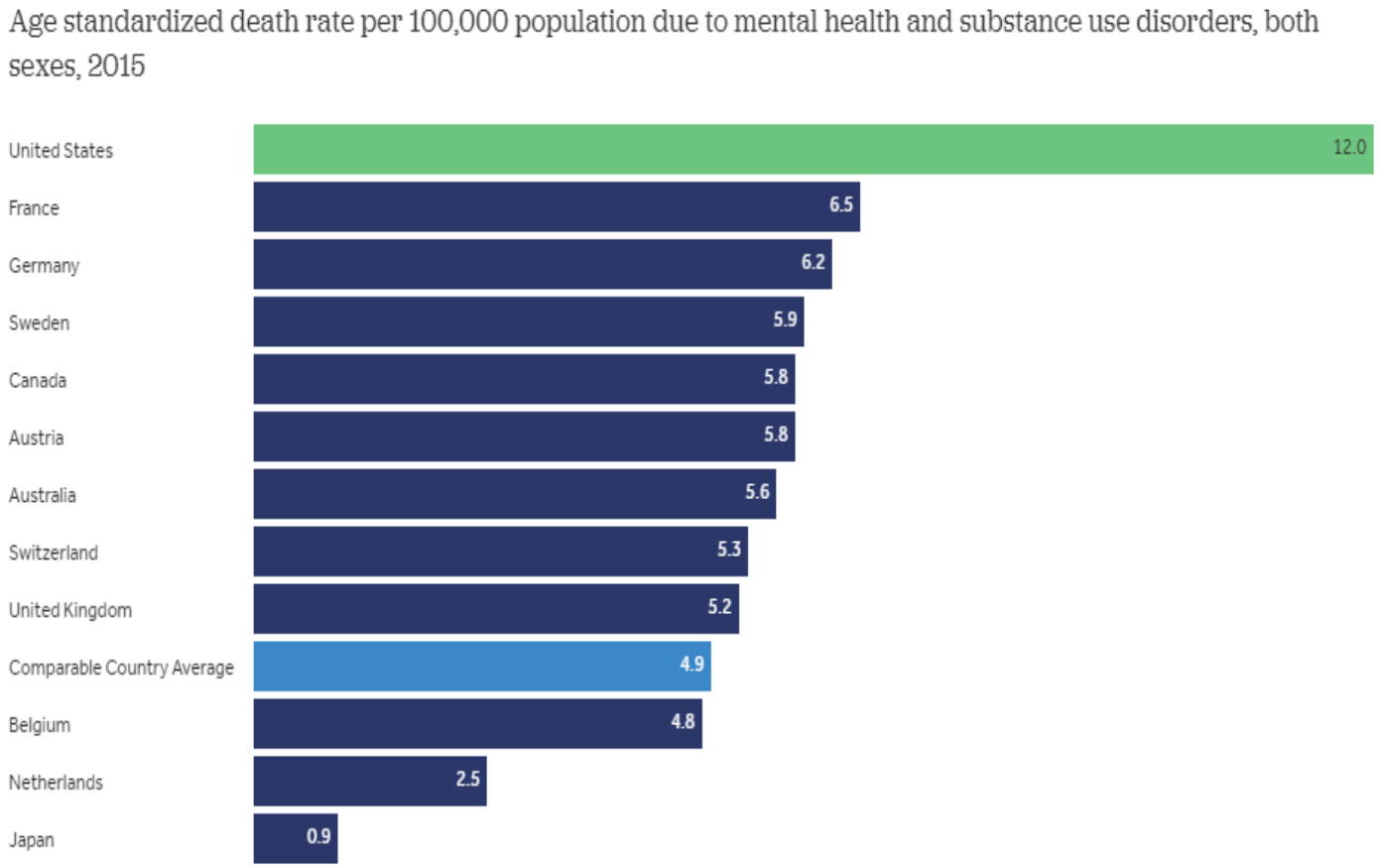


DALY, or the Disability-Adjusted Life-Year, is a metric that combines the burden of mortality and morbidity (non-fatal health problems) into a single number. One DALY can be thought of as one lost year of "healthy" life.

DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences: **DALY = YLL + YLD**

https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-prevalence-mental-illness-among-adults-relatively-stable

AMONG COMPARABLE COUNTRIES, THE U.S. HAS THE HIGHEST RATE OF DEATH FROM MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS



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THERE IS A CRISIS IN YOUNG PEOPLE'S MENTAL HEALTH

Consider the facts before COVID-19:

▲ 104%

Increase in inpatient visits for suicide, suicidal ideation, and self injury
for children ages 1-17 years old, and 151% increase for children ages 10-14

▲ 50%

Increase in mental health hospital days
for children between 2006 and 2014

▲ 61%

Increase in the rate of self-reported mental health needs
since 2005

44th ▼

California ranks low in the country for
providing access to behavioral, social, and development services and screenings

IMPACT OF COVID: WHAT WE FEARED IS COMING TO PASS…

ED VISITS

Beginning in April 2020, the proportion of children's mental health-related ED visits among all pediatric ED visits increased and remained elevated through October

24/31%

Compared with 2019, the proportion of mental health related visits for children aged 5 to 11 and 12 to 17 years increased approximately 24% and 31% respectively

25%

One in for young adults between the ages of 18 and 24 say they've considered suicide because of the pandemic, according to new CDC data that paints a big picture of the nation's mental health during the crisis

RADY CHILDREN'S HOSPITAL IN SAN DIEGO:

Between FY2011 and FY2019, annual behavioral health volume has increased

1746%

From 163 visits to 3,009 visits in 8 years

Comparatively, total Emergency Department visits has grown 23% during this same time period

PAYMENT AND DELIVERY SYSTEM REFORM IS ESSENTIAL:

- Approximately 75% of mental illness manifests between the ages of 10 and 24. Since adolescents have the lowest rate of primary care utilization of any demographic group, it makes early warning signs difficult to detect.
- Provider shortages at the Primary Care Physicians and mental health practitioner level compound the challenge.
- Diagnosis-driven models are only appropriate for some. Early identification and payor agnostic models are essential to systems change

How did we get here?

We have no common framework for defining and understanding behavioral health among and between public systems and clinical care providers.

Our public systems are deeply fragmented and under-resourced. Commercial payers have not effectively partnered with safety net systems.

A lack of clarity over whether mental health is an essential benefit or a public utility prevents commercial payers from fully engaging and cost shifts to public systems

Our definition of medical necessity is outdated and inconsistent with emerging trends and evidence regarding the impact of trauma and adversity on social and emotional health.

The field is young. Many clinical modalities with widespread application are less than 20 years old.

THERE IS REAL OPPORTUNITY TO ADDRESS A CRISIS IN THE LIVES AND EXPERIENCE OF CHILDREN AND FAMILIES:

Public opinion and policymaker agendas are aligned

Political Will: State and Federal administration have established a focus on child and family well-being driven by covid, the youth mental health crisis that preceded it, and decades of evidence from the SDOH movement.

Community Support: Half (52%) of all Californians addressing mental health needs as "extremely important" and list it among the most important issues for the state to address.

Emerging Consensus and Consciousness: Of the impact of adversity, structural racism, and the pandemic on the social and emotional health of children and families.

A Reform Landscape with Unprecedented Level of Investment (10 + Billion) and a shifting payor landscape

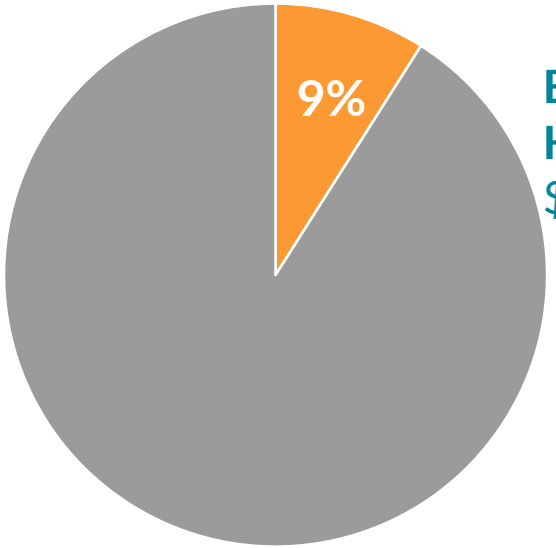
TO TAKE ADVANTAGE OF THIS MOMENT PROVIDERS WILL NEED TO:

- Develop new and expanded partnerships with Managed Care Plans (Commercial and MediCal)
- Embrace the critical need to reform our financing and delivery models so that they are team based, healing, and relationship centered.
- Focus on building a health care system for people by people (new provider types and community networks)
- Adopt a paradigm shift that reimagines mental health as a support for healthy development, not a response to pathology.

MEDICAID BY THE NUMBERS

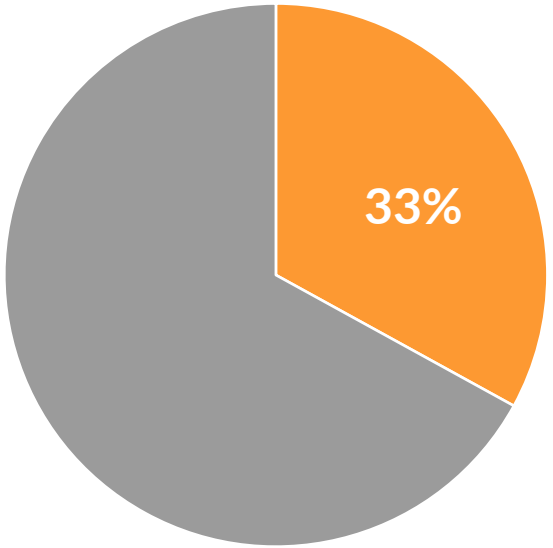
1/3 of Californians are covered by Medi-Cal (California's version of MEDICAID), which underinvests in their mental and behavioral health.

Total Dollars: $105.2 Billion



BEHAVIORAL HEALTH: $12 BILLION

Total Californians: 39 Million



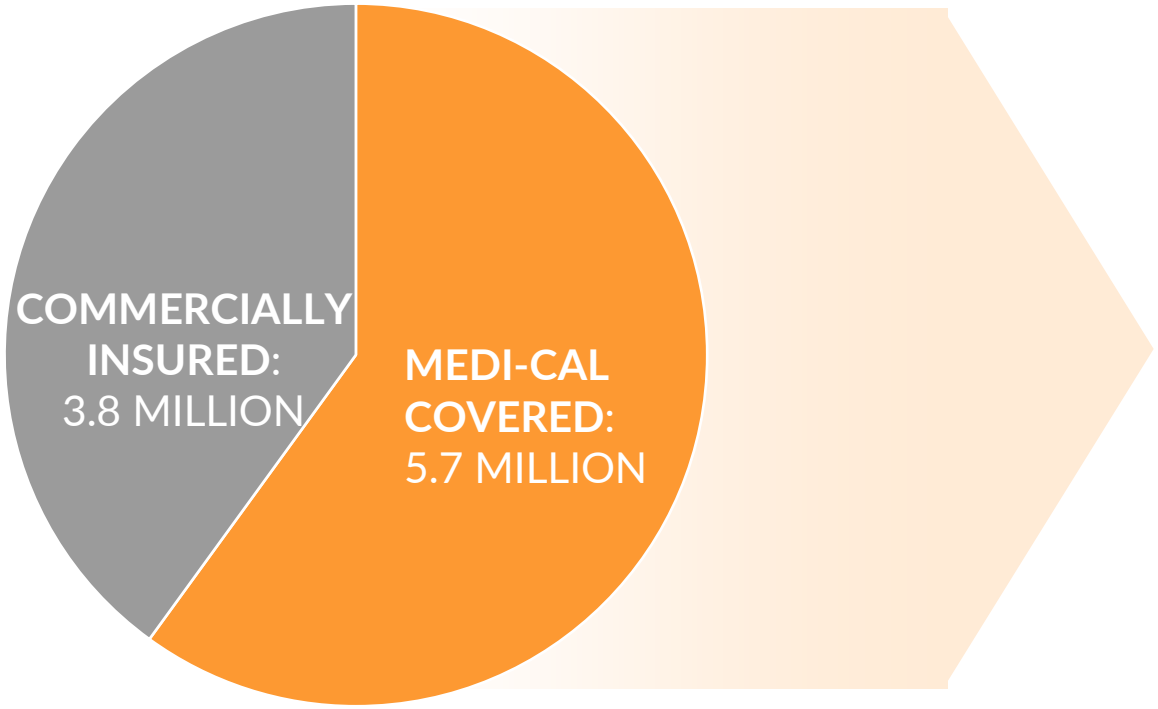
MEDI-CAL COVERED: 13 MILLION

More than 50% of all births in CA are covered by MediCal

MEDICAID BY THE NUMBERS – CALIFORNIA'S KIDS

Almost 6 out of 10 children are covered by Medi-Cal

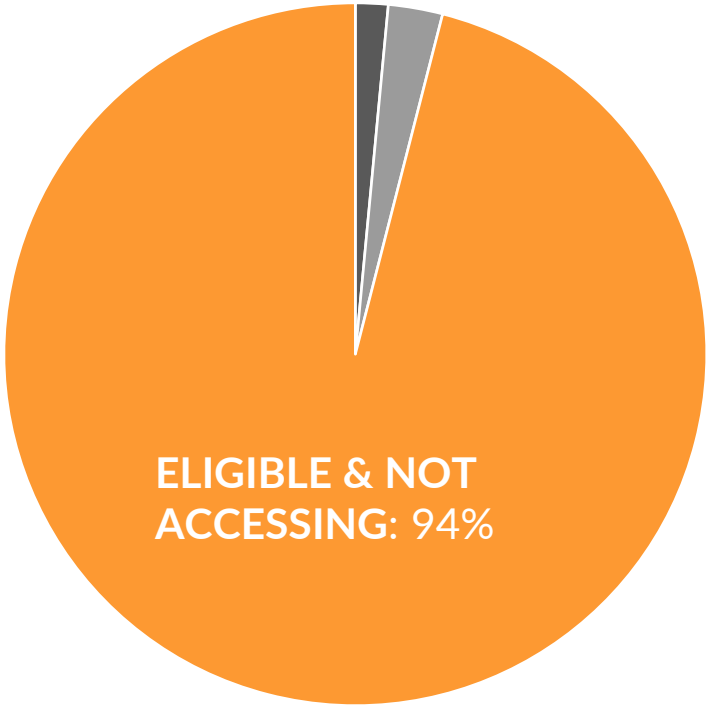
Total California Children: 9.5 Million



Mental Health

MCO Total Served Annually: 210,000 Kids

MHP Total Served Annually: 252,409 Kids



DRAMATIC UNDER-INVESTMENT IN CHILDREN

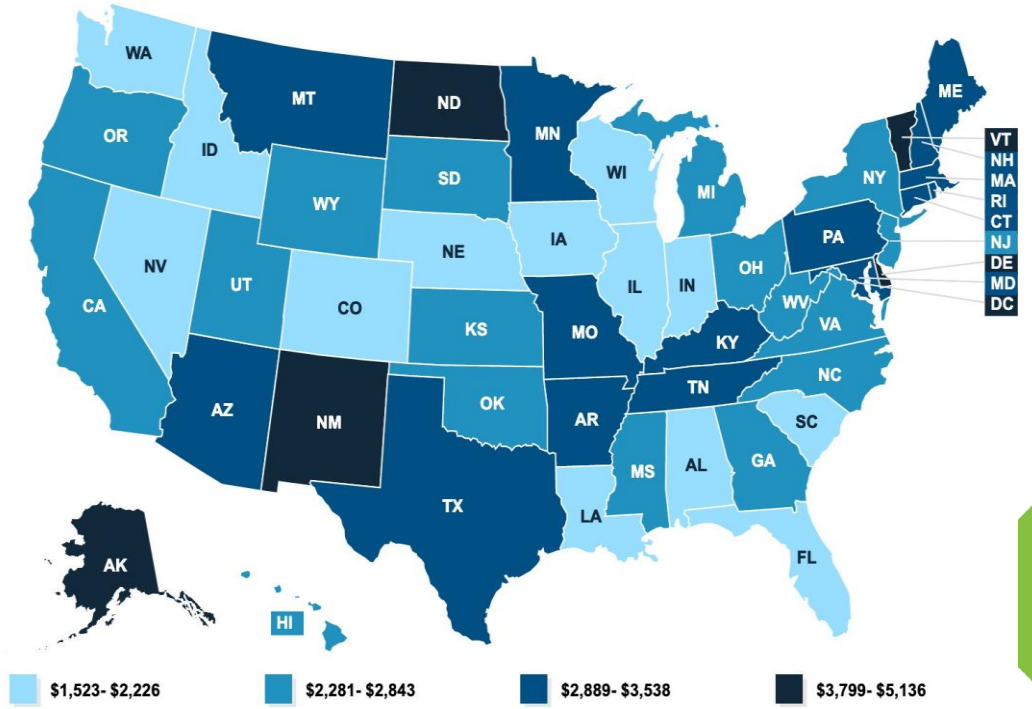
California is in the bottom 1/3 nationally for health spending at $2,500 per child enrollee.

Children represent **42% of enrollees** but only **14% of all expenditures**.

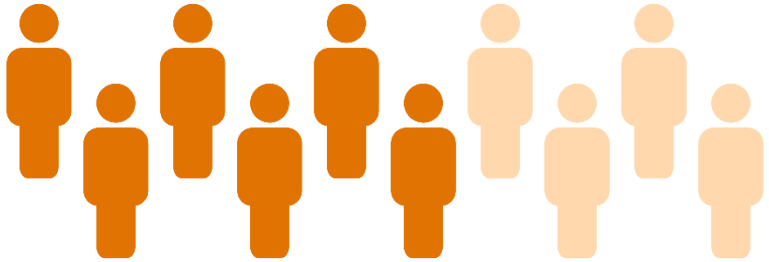
California ranks **44th in the nation of** in access to needed mental health care for children (38th overall).

California operates the largest MediCaid Program in the nation—**April 2019 Audit exposed** significant underperformance under the EPSDT Mandate and Bright Futures Guidelines.

Medicaid Spending per Child
FY 2014



AND ALTHOUGH ELIGIBILITY FOR HEALTH SERVICES HAS INCREASED….



Almost 60% of California's Children are now covered by Medi-Cal and the EPSDT entitlement (a 30% increase over last seven years)

Everyone under 21 living in a family that makes less than 266% FPL qualifies for MediCal (138% for Adults)

Everyone under 25 and over 50 regadless of immigration status are now eligible (26-50's coming in 2023)

Mental Health Access Remains Low:

Less than 6% of all children access any care at all. Less than 3% are in ongoing care.

THE "PRICE" IS HIGHER FOR BLACK AND BROWN CHILDREN

Many receive the wrong services at the wrong time…in restrictive or punitive settings.

81%

81% of children on medicaid are **children of color.**

2X

The **suicide rate for black children**, ages 5-12, is 2x that of their white peers.

70%

70% **of youth in California's juvenile justice system have unmet behavioral health needs**, and youth of color are dramatically over-represented.

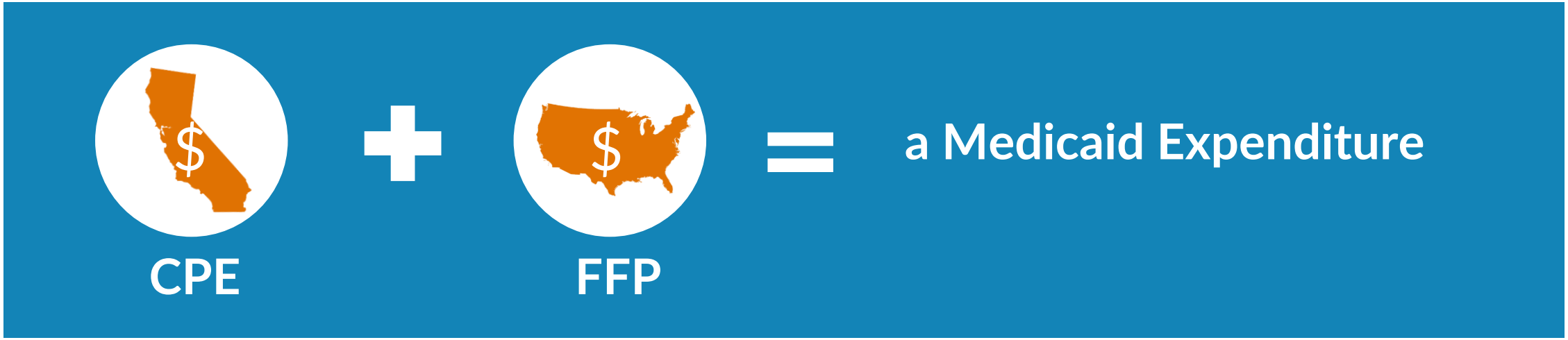
Making Healing Centered Practices a reality isn't simply a matter of tweaking access or programs…

It requires acknowledgment of how racism and poverty impact the social and emotional health of children and families

THE ARCHITECTURE OF MEDI-CAL

How it works and who pays for what

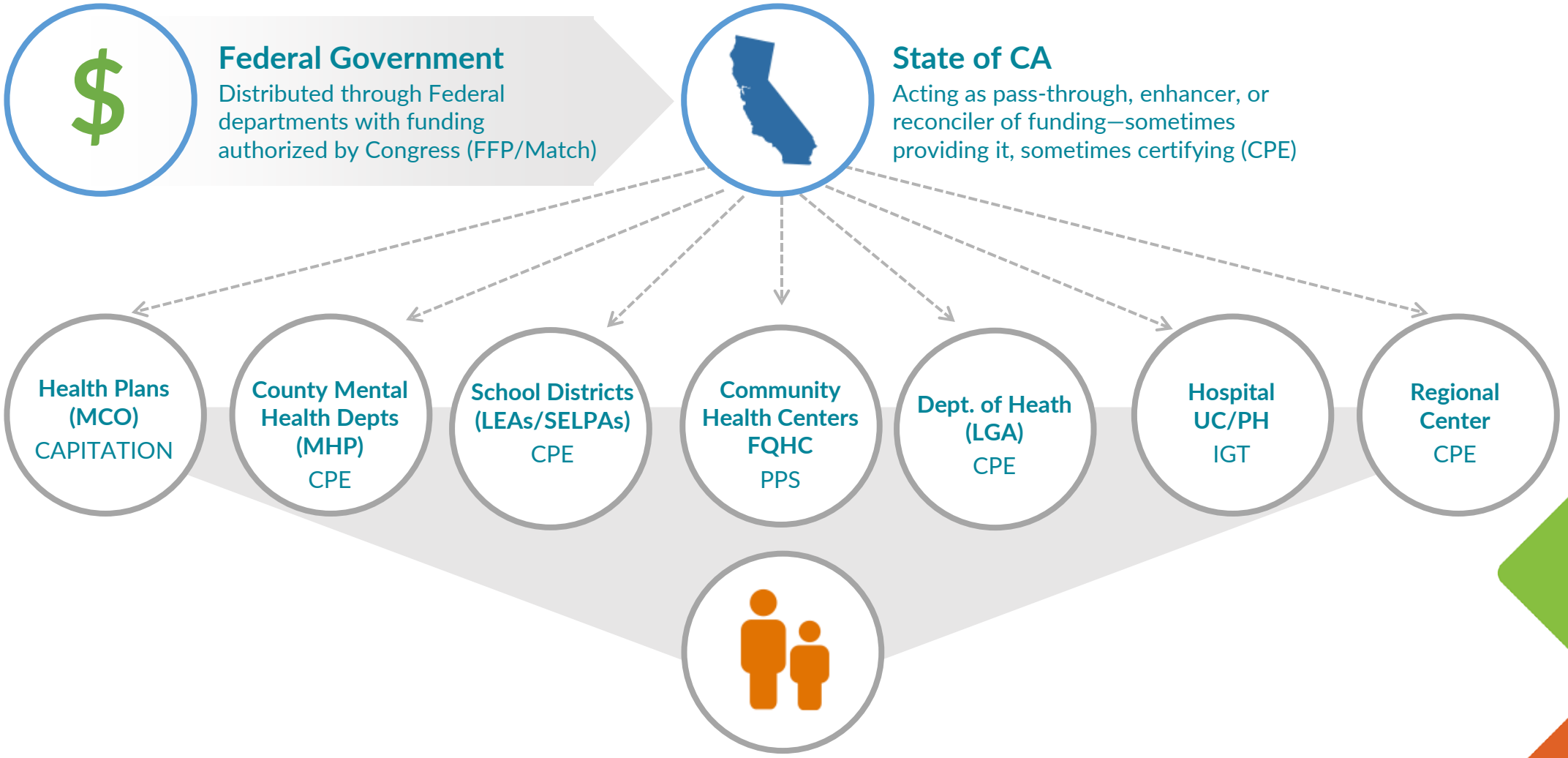
THE FEDERAL MATCH IS GUARANTEED:



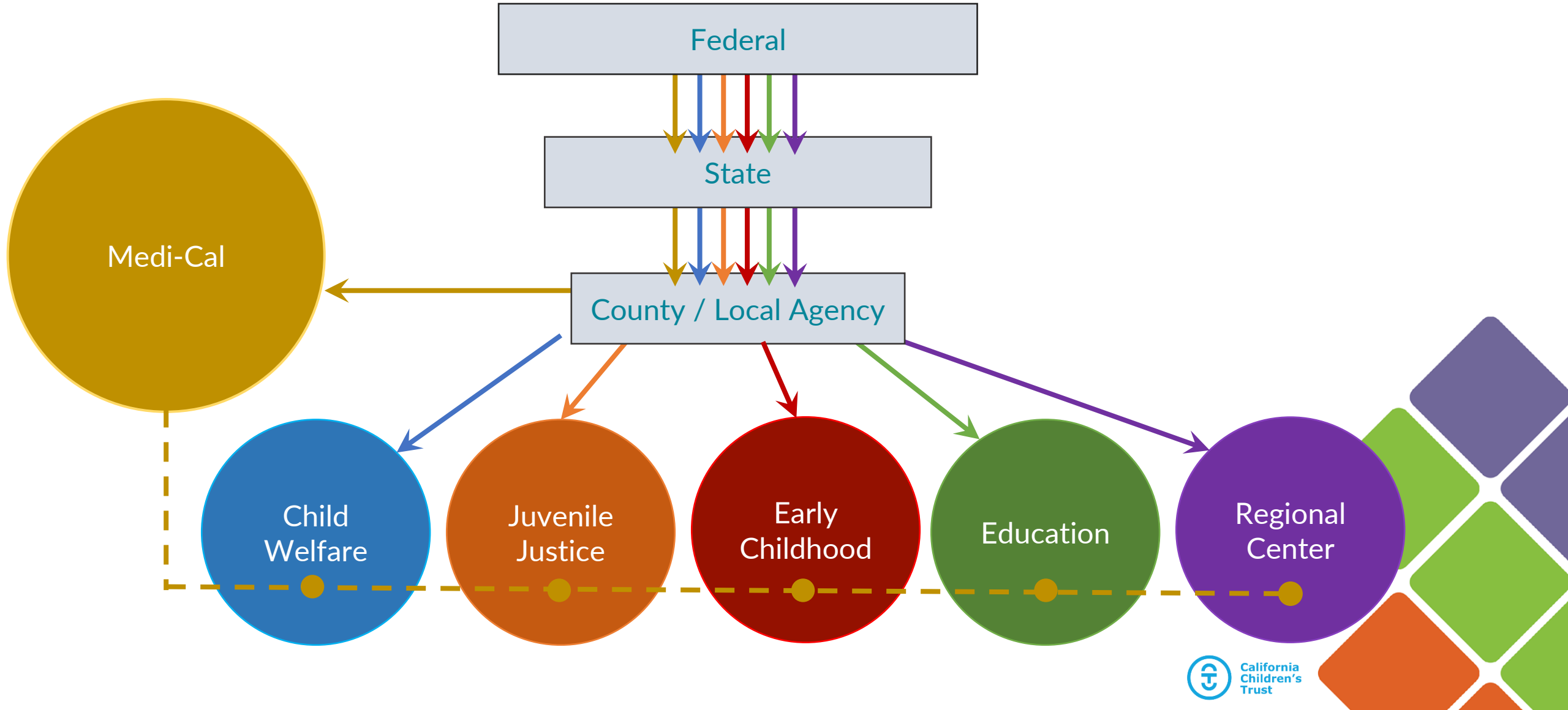
Certified Public Expenditure (CPE) = A governmental entity, including a governmental provider (e.g., county hospital, local education agency) incurs an expenditure eligible for FFP under the state's approved Medicaid state plan (DHCS definition).

Federal Financial Participation (FFP) = The federal share of Medicaid dollars when all state and federal requirements are met.

THE MEDICAID MAP: WHO PAYS FOR FEDERALLY ENTITLED SERVICES TO CHILDREN AND FAMILIES



MEDICAID AS THE TIE THAT BINDS FRAGMENTED SYSTEMS



California Children's Trust

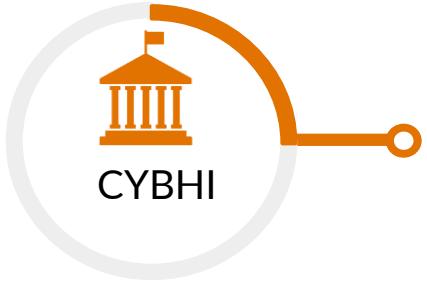
DO WE?

Have the will and skill to build new team-based models of care that that integrate payors across fragmented safety net systems?

MEDI-CAL AND CALIFORNIA'S UNPRECEDENTED REFORM LANDSCAPE

AN UNPRECEDENTED INVESTMENT:

FUNDING OPPORTUNITIES FOR NEW NETWORKS OF CARE



- Managed Care Plans and Schools/SBHIP ($400 million)
- School Competitive Grants Program ($550 million)
- MHSA SSA funding ($250 million)
- Workforce including BH Coaches ($800 million)
- BH Virtual Platform: ($750 million)
- Expanding Evidence Based Programs ($429 million)
- DYADIC Benefit ($800 Million)
- Universal Feel Schedule: (TBD)

CalAIM: $4.5 billion ($3.1 billion in 22-23 year)

- Population Health Management
- Universal Eligibility for System Involved Children to SMHS
- Enhanced Care Management (ECM)
- Community Supports (CS)
- PATH
  - IPP (incentive payment program)
  - CITED (capacity building for providers)
  - Regional Collaboratives and TA (upcoming)

- Community School Partnership Grant Program ($4 billion+)
- Expanded Learning Opportunity Grant Program ($4 billion)
- Mindfulness ($75 Million); Peer to Peer Demonstration ($10 million)
- Investments in Counselor/Social Worker pipeline
- Educator Effectiveness Grant ($1.5 billion)
- HCSB/Special Ed/Other....($1.5 billion)
- Universal TK ($176 million)
- ESSER 1, II, III ($23.4 billion)

CYBHI: $4.4 BILLION DOLLAR INITIATIVE CENTERING SCHOOLS, WORKFORCE, AND PEDIATRIC PRIMARY CARE

01 **Behavioral Health Service Virtual Platform: DHCS, $749.7 M**

02 **School-Linked Behavioral Health Services: DHCS/DMHC, $950M**

03 Develop and Expand Age-Appropriate, Evidence-Based Behavioral Health Programs: Agency/DHCS, $429M

04 Building Continuum of Care Infrastructure: DHCS, $310M

05 **Plan Offered Behavioral Health Services:** DHCS, $800M

06 **School Behavioral Health Counselor + Behavioral Health Coach Workforce:** OSHPD, $352M

07 **Broad Behavioral Health Workforce Capacity:** OSHPD, $448M

08 **Pediatric, Primary Care And Other Healthcare Providers:** DHCS, $50M

09 **Comprehensive And Culturally And Linguistically Proficient Public Education And Change Campaign:** CDPH + OSG, $100M

10 **Oversight, Coordination, Convening, And Evaluation:** DHCS, $70M

California Children's Trust

SCHOOLS CAN (and must) BE ESSENTIAL ACTORS IN OUR RESPONSE:

Schools are and have been ground zero for the youth mental health crisis, and our collective failure at supporting them has contributed to the marginalization of black and brown children (80% of children on Medi-Cal are children of color.) MediCal covers more than half of all children in California but MCOs have struggled to invest strategically or effectively in Children's Behavioral Health. Children represent 42% of all Medi-Cal Enrollees—but less than 14% of all expenditures.

The Health Care System Needs Schools: Children ages 8-18 have the lowest rate of primary care utilization of any demographic in Medi-Cal—and 75% of mental illness manifests in adolescence. Not only are schools essential actors in a reformed mental health system that overtly addresses healing, justice, and structural racism, but they are also essential service settings for children with clinical needs.

The Finances Align: Schools have what the publicly funded Medicaid system needs 1) access to kids 2) braided funding opportunities, and 3) Concensus on Framework (MTSS) and Mechanism (COST)

EXPANDING PROVIDER CLASS:

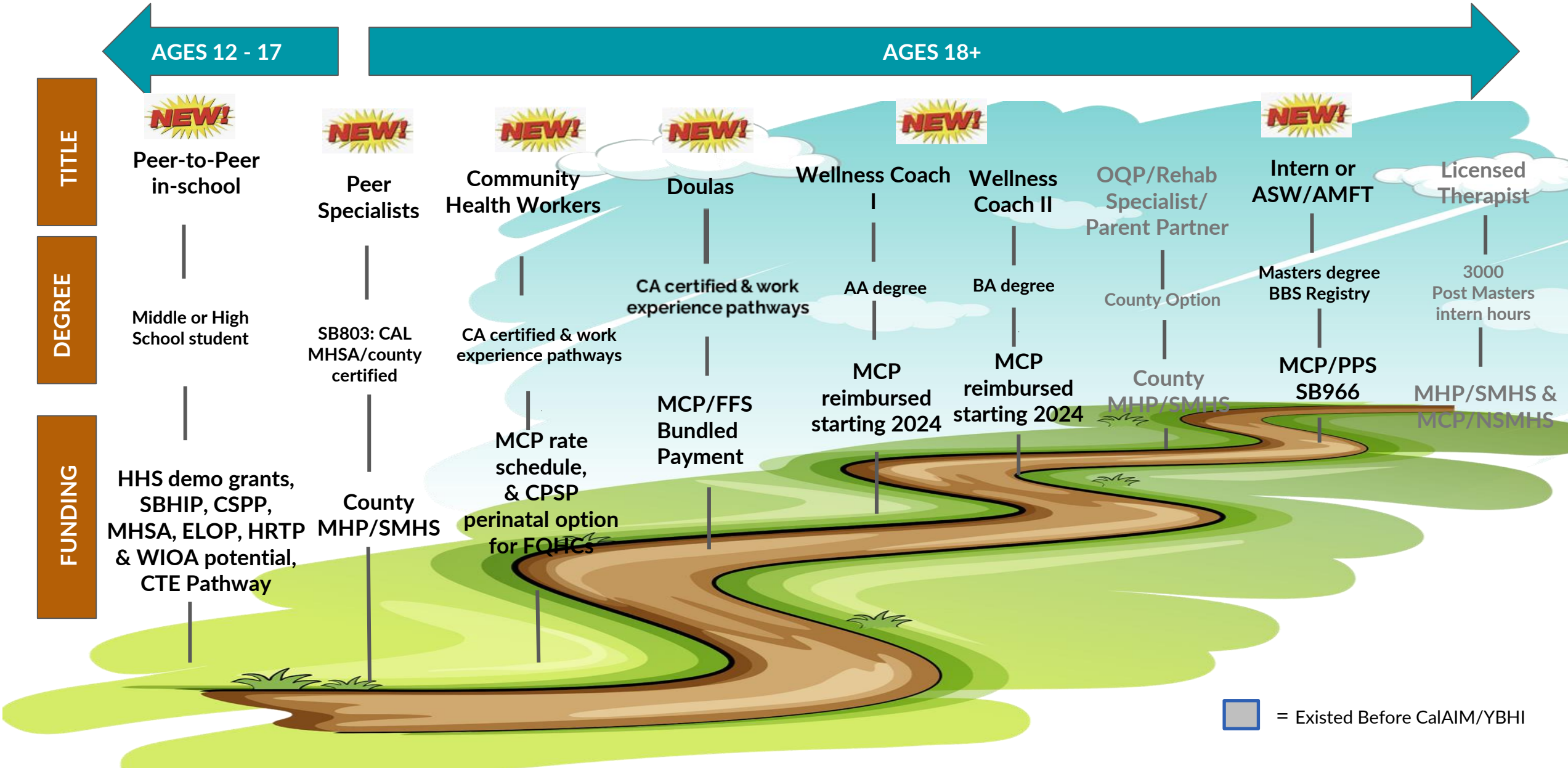
DOULAS, CHWS, PEERS, AND BH COACHES

Provider Expansion Guidelines

Scope	What can the provider do, in what setting, under what supervision and articulation, and what codes will they bill? Are community defined and culturally concordant practices specifically named and included?
Credentialing	Who is responsible for curriculum development, certifying the content and quality of the training, defining the core competencies, and certifying attainment?
Paneling	How does the new class sign-up with the payor? What is the required process and documentation?
Payor	Who pays claims—the Managed Care Organization or Mental Health Plan? Under what authority and what process?
Rates	What is the time, frequency, duration, and reimbursement level of all eligible services? Does it reflect a living wage?

NEW Medi-Cal Reimbursable Career Pathways to Support ACEs Networks of Care

Leveraging and Integrating The Wisdom and Experience of Culturally Concordant Providers

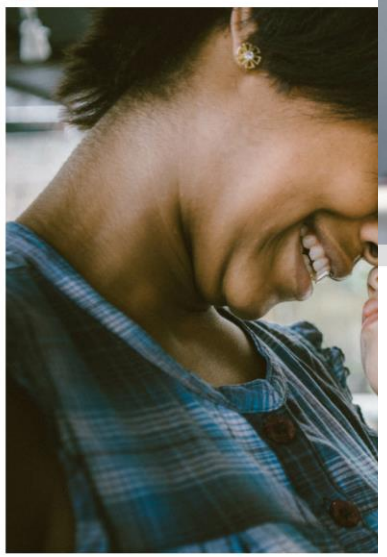


REFORMING MEDICAL NECESSITY AND EXPANDING ACCESS TO INTEGRATED BEHAVIORAL HEALTH

THE REMOVAL OF DIAGNOSIS AS A PRE-REQUISITE FOR CARE AND THE NEW FAMILY THERAPY AND DYADIC BENEFITS:

New California pr
health coverage p
front and center

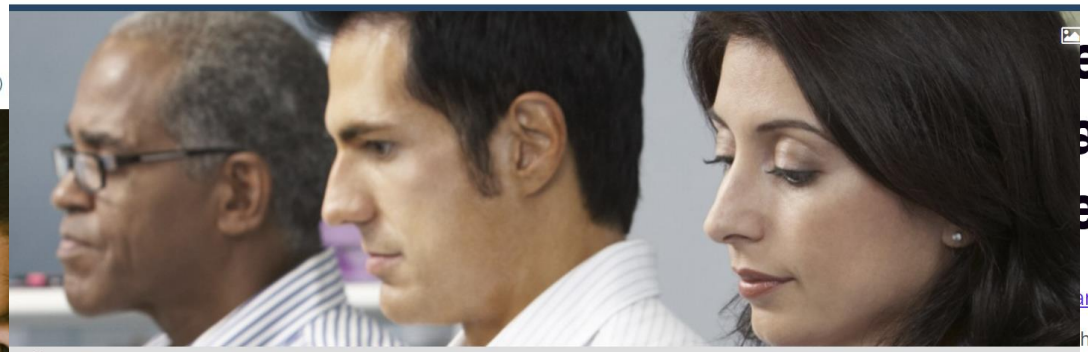
LAURIE UDESKY (PACES CONNECTION STAFF)



CLASP
The Center for Law and Social Policy

Search CLASP.org

ABOUT ISSUES RESOURCES EXPERTS BLOG DONATE



Home

SHARE

California's Medicaid Family Therapy Benefit Reimagines Medical Necessity

Innovations in Youth Mental Health

By Nia West-Bey

HEALTH AND MENTAL HEALTH

Children, Youth & Families
Young Adult Behavioral Health
Youth and Young Adults

Blog Post
May 31, 2022

In 2022, we have seen growing attention on the youth mental health crisis in this country. The U.S. Surgeon General's office issued an unprecedented advisory about the critical state of youth mental health. In response, the Biden Administration released a comprehensive plan and budget proposal. Young people—particularly young people of color and those living in poverty—were

Babies Don't Go to the Doctor By Themselves:

Innovating a Dyadic Behavioral Health Payment Model to Serve the Youngest Primary Care Patients and Their Families

AUTHORS

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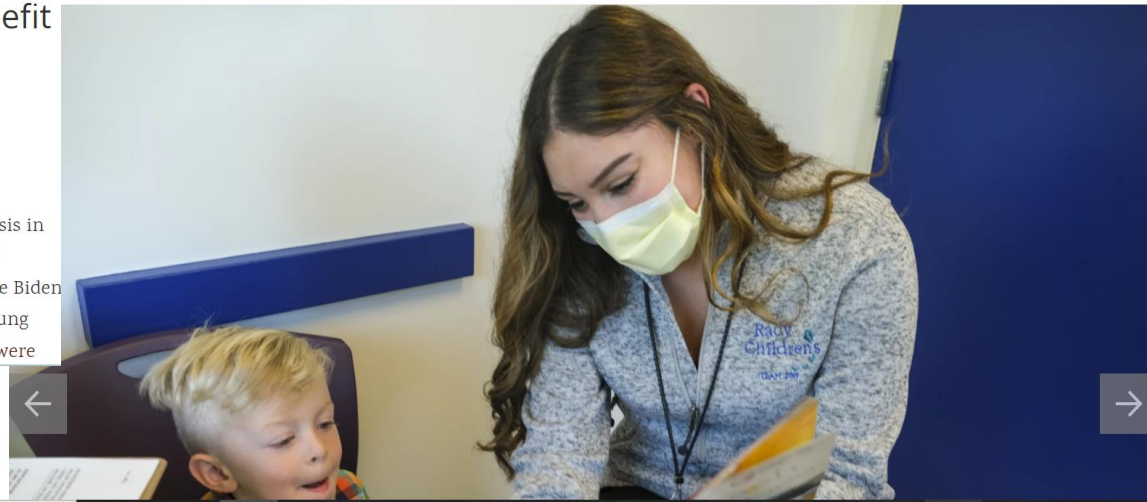
Proposal Summary

- A statewide demonstration project to align reimbursement with clinical best practices in early childhood mental health
- Essential support for proven dyadic models
- Improving health outcomes for young children and their caregivers
- Pioneering clinical best practices to inform state-level guidance
- Demonstrating partnership with safety-net clinical leadership

eed Parenting Help? Therapy? Food? alifornia Pediatrician Offices May Soon e Able to Help

ariana Dale

hed Nov 16, 2021 1:19 PM



Zuckerberg San Francisco General

UCSF

CARE COORDINATION AND COMMUNITY NETWORKS:

Enhanced Care Management:

Provision of care management for certain "Populations of Focus" (POF) focused on addressing clinical and non clinical needs in non clinical settings.

The Children and Youth ECM Populations of Focus going live statewide on July 1, 2023, which include:

1. Children and Youth Experiencing Homelessness
2. Children and Youth At Risk for Avoidable Hospital or Emergency Department (ED) Utilization (Formerly "High Utilizers")
3. Children and Youth with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
4. Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition
5. Children and Youth Involved in Child Welfare
6. Children and Youth with Intellectual or Developmental Disabilities
7. Children and Youth who are Pregnant and Postpartum At Risk for Adverse Perinatal Outcomes

Community Supports:

14 Cost effective alternative to meet health related needs by addressing the SDOH. 67% of MCO's intend to offer all 14.

Percentage of MCPs Operating in Each County Planning to Offer Each Community Support by 2024

Pre-Approved Services	% of MCPs
1. Housing Transition/Navigation	98%
2. Housing Deposits	92%
3. Housing Tenancy & Sustaining Services	98%
4. Short-Term Post-Hospitalization Housing	90%
5. Recuperative Care (Medical Respite)	94%
6. Respite Services	86%
7. Day Habilitation Programs	69%
8. Nursing Facility Transition/Diversion	71%
9. Community Transition Services/Nursing Facility Transition to a Home	71%
10. Personal Care and Homemaker Services	86%
11. Environmental Accessibility Adaptations	75%
12. Medically-Supportive Food/Meals/Medically Tailored Meals	95%
13. Sobering Centers	74%
14. Asthma Remediation	73%

CAPACITY BUILDING RESOURCES FOR CALAIM:

PATH: DHCS Implementation Funds for ECM/CS

Incentive Payment Program (funding for plans to build networks)

MCPs can distribute IPP funds across their ECM and Community Support provider networks

CITED CBO Capacity Building Grants (funding to providers)

Funding to develop and expand ECM and Community Support capacity and infrastructure

TA Market Place and Regional Collaboratives (upcoming)

A hub to provide resources and individualized technical assistance to local providers.

DHCS GRANT PROGRAMS TO TRACK

Practice Transformation Grants

Evidence Based Practice Grants

Community Schools Partnership Program

BH Workforce and Infrastructure Grants

SUSTAINABILITY CONSIDERATIONS FOR BUILDING AN ECO SYSTEM ACROSS PAYORS AND SYSTEMS:

Match what you are trying to do to the reform landscape:

- NSMHS
- ECM and CS
- Expanded Provider Classes
- CPT CODE CONVERSION AND CPE TO IGT

FFPSA

- Prevention Plans
- EBPs

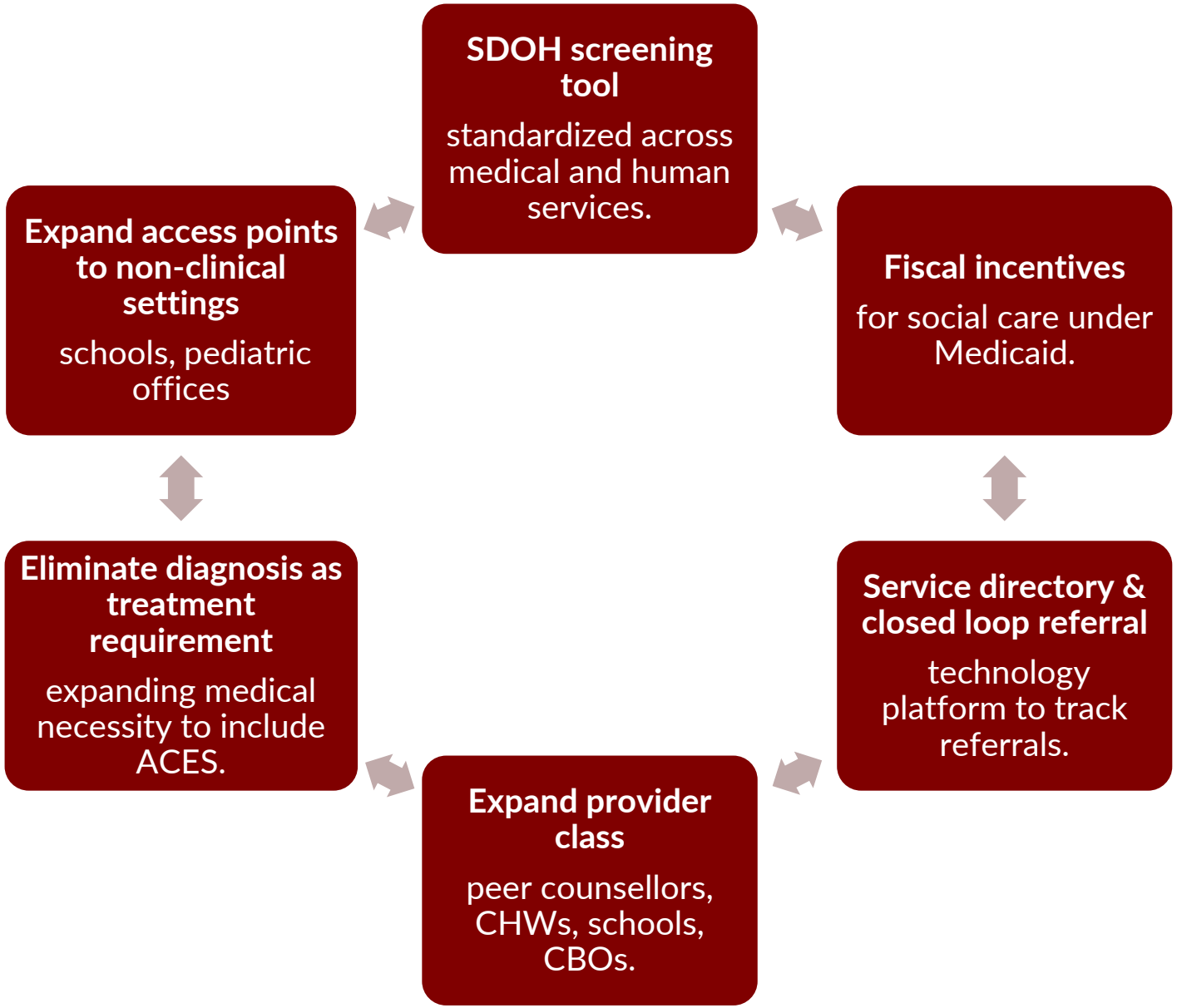
FFP generation in partnership with County MH:

- Crisis Services Benefit
- MediCal Administrative Claiming

Engage in direct relationships with MCPs (co construct and learn with them) in particular your MMCP.

HOW TO REACH FAMILIES UPSTREAM WITH MEDICAID

Key strategies



TAKE AWAYS:

- BIG CHANGES ARE HERE… AND MORE ARE COMING SOON.
- KNOW THE MANY FACES OF MEDI-CAL AND HOW THEY CAN BE INTEGRATED TO SUSTAIN YOUR WORK—UNDERSTAND THE CENTRICITY OF MANAGED CARE PLANS
- TRACK NEW AND EMERGING BENEFIT DESIGN AND CONSTRUCTION IN MEDICAL-INCLUDING FUNDAMENTAL REFORMS TO MEDICAL NECESSITY
- MINE THE NEW PROVIDER TYPE OPPORTUNITIES
- MINE FOR CPE!! LIMITING FACTOR FOR FFPSA AND MHPS IS ACCESS TO NON-FEDERAL DOLLARS

SUSTAINABILITY DISTILLED:

HEALTH PLANS ARE THE CENTER

BEHAVIORAL HEALTH IS CHANGING

MEDI-CAL WILL PAY FOR THINGS IT DIDN'T PAY FOR BEFORE

MEDI-CAL WILL PAY FOR NEW TYPES OF PROVIDERS

California Children's Trust

PARTNERSHIP IS CRITICAL TO LEVERAGE THESE FUNDING OPPORTUNITIES

AB 2083 CHILDREN'S SYSTEM OF CARE

- Requires an MOU by and between five agencies serving children and youth.
- While focused on Foster Youth, any legitimate System of Care applies to youth in and at risk of all partner agency services.
- Tribal Role required as of 2023, via AB 153.
- Rooted in Wraparound research and outcomes, which confirm need for multi-agency integration for most youth in care, and the families that support them.
- Thirty-five years of national outcomes research.

FFPSA AND SYSTEM OF CARE CONNECTIONS

- The System of Care (and its Interagency Leadership Team) provides a foundation for the required planning for, alignment and management of the CPP and it's FFPSA associated dollars.
- Behavioral Health, Child Welfare and Probation are principal partners, and Regional Centers, Tribes, schools and other departments benefit by reduced service demand and increased capacity for community-based and prevention-focused services.
- Community impact includes a significant reduction of secondary trauma, avoidance of "system entry".

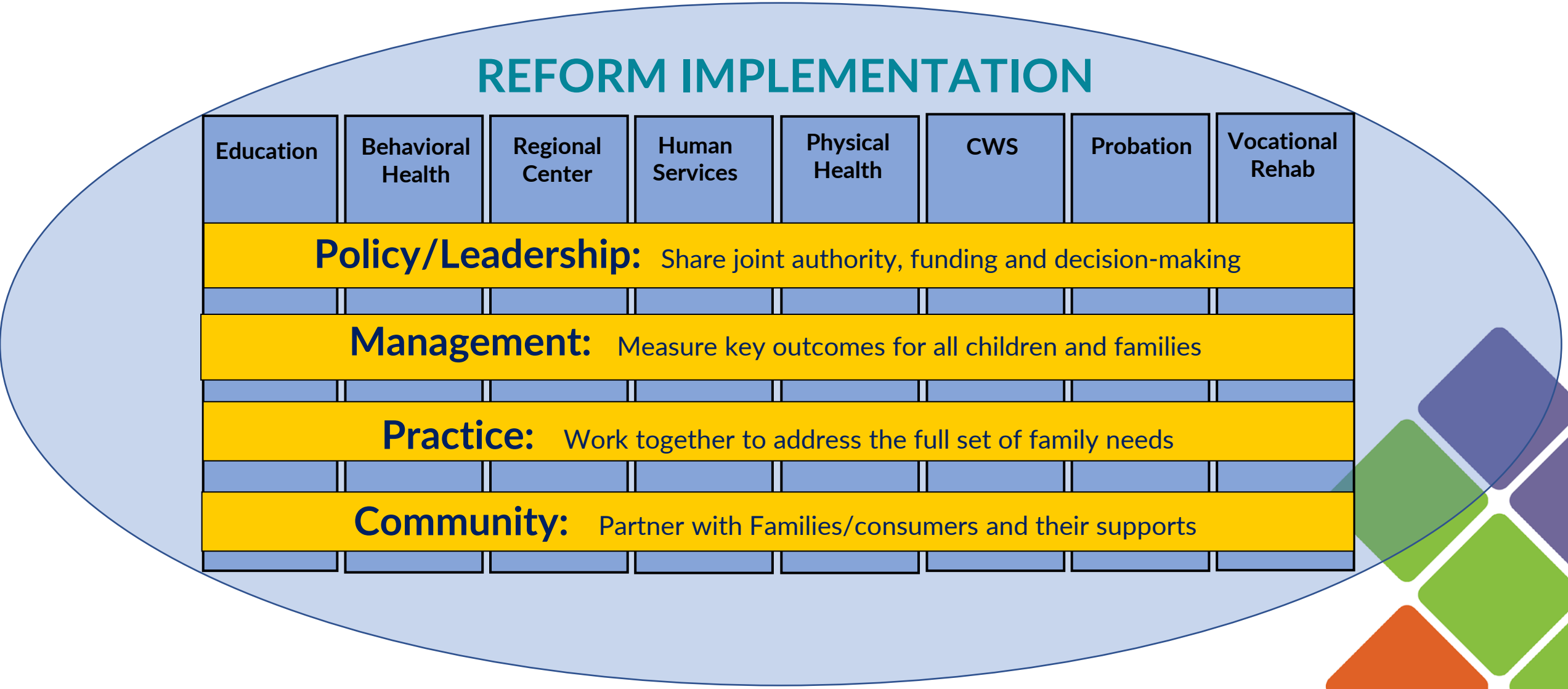
CRITICAL AWARENESS FOR INTEGRATED PREVENTION

- AB 2083 is not an initiative. It is an interagency structure intended to guide and support partners in their collective use of a coordinated network of programs and resources.
- The System of Care Memorandum of Understanding (MOU), together with implementation of the state's *Integrated Core Practice Model* provide both structure and process for effective reform and program implementation.
- A well supported collective effort with a strong "backbone" organization ensures an effective reform.
  - Use the ILT agenda to consistently discuss reforms.
  - Connect fiscal and program managers for shared planning and reporting.
- A System of Care's ultimate return on investment is best measured in how it supports social determinants of health and wellness, and how it prevents further trauma and system involvement.

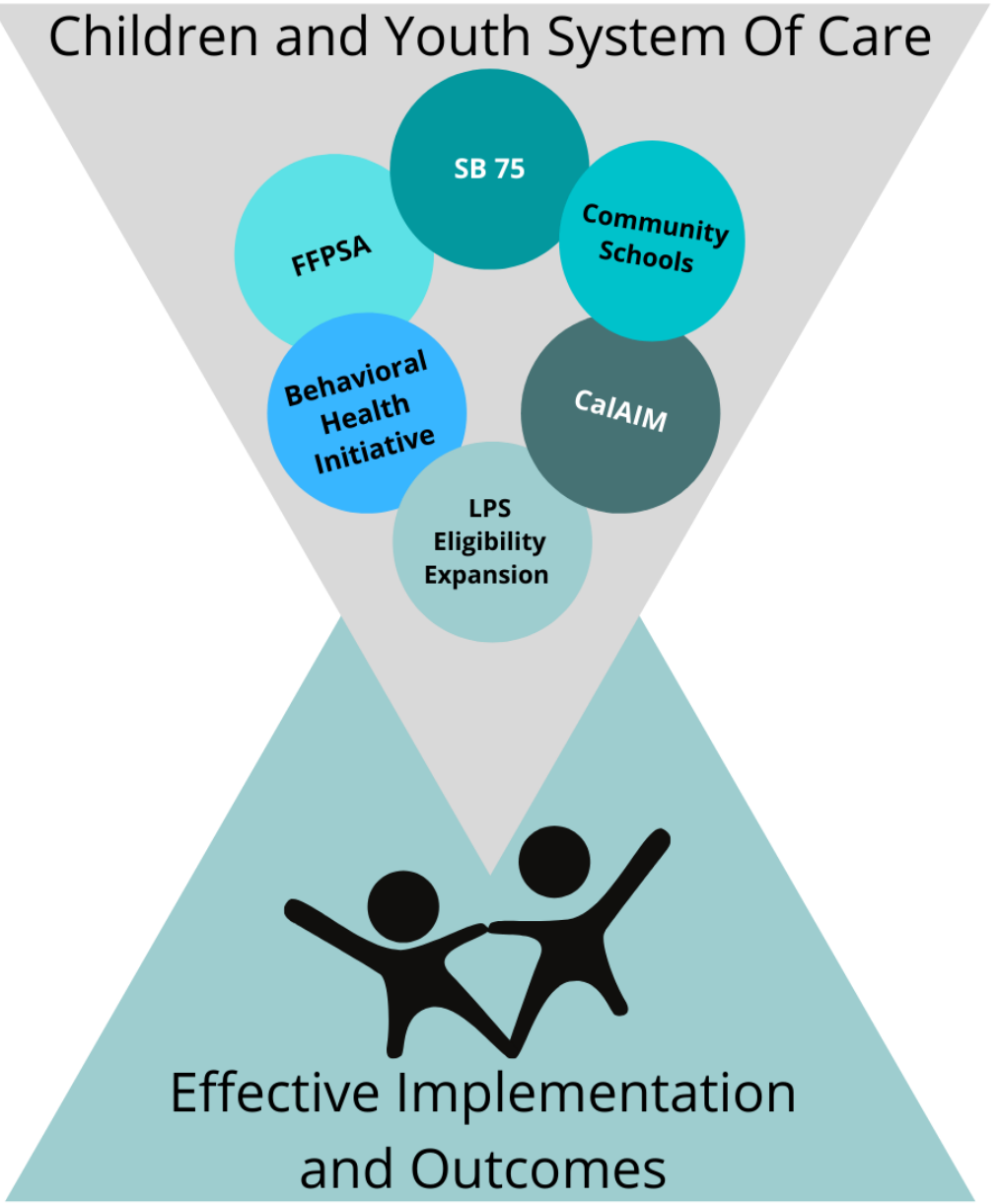
AB 2083 CHILDREN'S SYSTEM OF CARE DIFFERS FROM OTHER INITIATIVES AND INVESTMENTS

- The System of Care's unique Interagency Leadership Team structure and the local System of Care defined governance process forms a venue and vehicle in which all youth and student serving initiatives can be coordinated, collaboratively developed, and implemented.
- Vision, structure and function
- The MOU provides a structured relationship between organizations, agencies, and Tribes for the wellness and health of youth and families within their shared jurisdiction.
- The MOU typically addresses specific functional elements of collaboration which include, but are not limited to, cross system leadership, data sharing and maximizing all available funding and resources (local, state and federal).

IMPLEMENTATION OF PROGRAMS AND SERVICES REQUIRES CONNECTING ON MULTIPLE LEVELS



SYSTEM OF CARE EFFECTIVE IMPLEMENTATION AND OUTCOMES



WHY SYSTEM OF CARE BASED REFORM IS NEEDED

- Agencies often don't share youth or student enrollment or entry data, and therefore struggle to identify shared youth, so delivery of new or expanded services narrowly targets a small "at-risk" or eligible cohort.
- State and Federal initial investments are maximized and sustained when fiscal resources are matched or primary funding is leveraged across local agencies.
- Local partners and Tribes should have access to one another's outcome data, as the return on investment of these types of reforms are often found in each other's performance data (ex. fewer CPS referrals due to effective First Five parent supports).

CPP AND SYSTEM OF CARE (AB 2083) IMPLEMENTATION FACTORS ARE IDENTICAL

- Pathways to Care
- Range of Effective Services and Supports
- Population Description
- Values and Principles
- Theory of Change
- *Implementation Plan*
- Performance Measurement
- Financing Structures and Strategies
- Provider Network
- Provider Accountability
- Family Choice
- Collaboration and Family Voice
- Governance
- Transformational Leadership

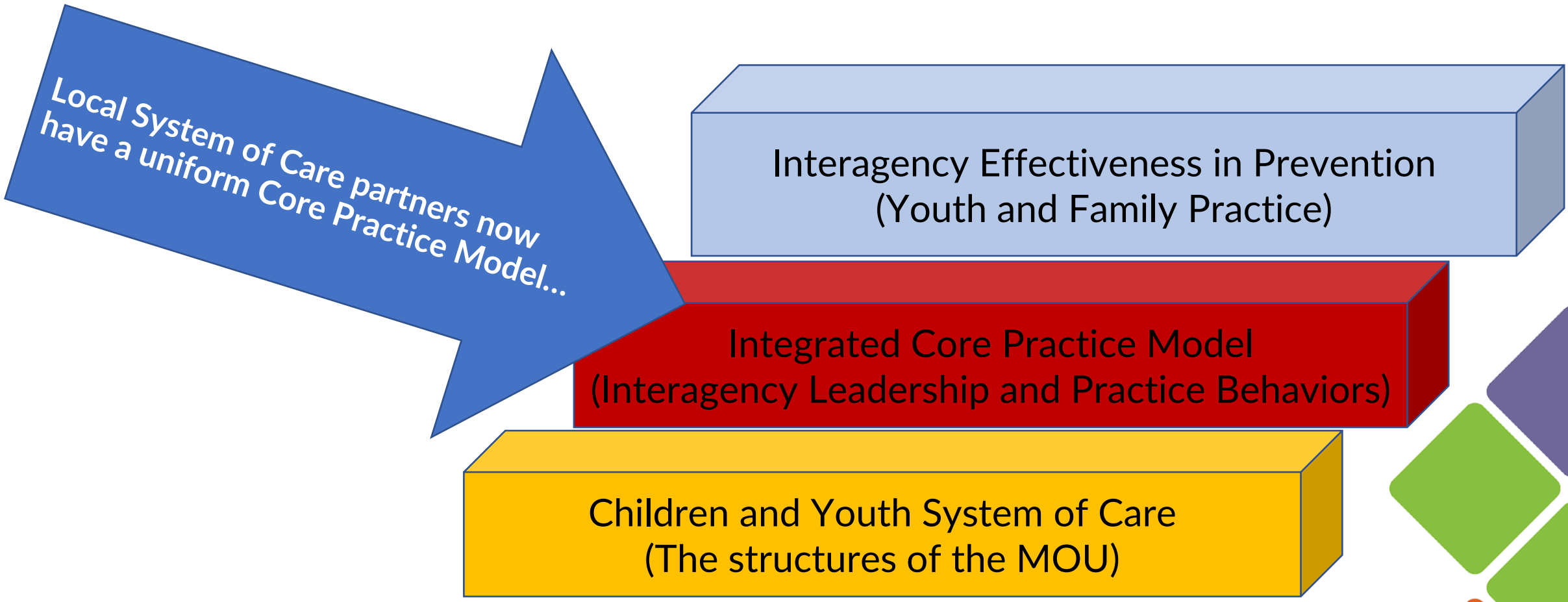
Univ. Of South Florida, 2005

FFPS GOALS ARE NEARLY IDENTICAL TO CHILDREN AND YOUTH SYSTEM OF CARE OUTCOMES

- Decreased school suspensions/expulsions; measurable increase in school attendance and graduation rates.
- Decreased behavioral and emotional problems, rates of suicide and substance abuse or misuse.
- Reduced caregiver strain and improved family functioning.
- An expanded array of home- and community-based services, individualization of services, and increased use of evidence-based practices.
- A significant decrease in Inpatient Mental Health service demand.
- Decreased rates of citation, arrest and incarceration.

Return on Investment in Systems of Care:

https://gucchd.georgetown.edu/products/Return_onInvestment_inSOCsReport6-15-14.pdf


Local System of Care partners now have a uniform Core Practice Model…
Interagency Effectiveness in Prevention (Youth and Family Practice)
Integrated Core Practice Model (Interagency Leadership and Practice Behaviors)
Children and Youth System of Care (The structures of the MOU)

WHEN VISION IS ABSENT & BLENDING AND SHARING IS SKIPPED

- Departments and agencies remain on the “Grant Treadmill”
- System learning is stymied (no longitudinal outcome data)
- No True Implementation (Usually takes 5+ years)
- Job/Position Turnover
- Community Partners remain vulnerable and often under-funded
- Inequity and disproportionality are perpetuated

AN EARLY LOOK (MICROCOSM) AT FISCAL FRAMING IN APPROVED CPP PLANS

- In some cases, good detailed analysis about the sources of prevention funding are present. However,
- There is very little concrete, detailed language about which existing sources of prevention revenues are or will be leveraged.
- Most plans mention “building capacity” of “Planning for sustainability” as ongoing processes. Some plans have nice articulation of the various streams available, but not details about how those streams will flow together sustainably.

FINAL TAKEAWAYS

- More Prevention alone will not have substantive impact or will be time-limited.
- Connecting partners, agencies and systems into true whole child and family-centered approaches will lead to effectiveness of service and efficiency and sustainability of funding/programming.
- Parallel opportunities are only known and discoverable when you're all at the table...including MCO's!
- Because much of the secondary trauma to families occurs as a result of system involvement, addressing disproportionality, equity and access issues demands that we do the pre-work of integrating delivery systems!

QUESTIONS & DISCUSSION

Thanks for joining us!

WHAT'S NEXT?

- Survey and certificate in the chat now
- Register for *Funding Primary and Secondary Prevention Strategies: Part 2*
- Recording and resources available within two days
- Watch your inbox for the next issue of *CalTrin Connect*

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