

*Welcome to*

**THE TRAINING WILL BEGIN SHORTLY**

*While you're waiting...*

**FUNDING PRIMARY AND SECONDARY PREVENTION STRATEGIES: PART 1**

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**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	DURING	AFTER
 Access the presentation slides and resource sheet now! The links can be found in the chat.	 Review interactive features for today's session. Locate the controls on the toolbar at the bottom of your screen.	 Complete the survey at the end of this webinar to receive your Certificate of Attendance.
 This presentation is being recorded.		 A follow-up email will be sent to all participants within 2 days.

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**Hi, We're CalTrin!**

*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 CSBC/CalTrin and do not necessarily reflect the views of the California Department of Social Services.

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






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

**TODAY'S TOPIC:**  
**FUNDING PRIMARY AND  
SECONDARY PREVENTION  
STRATEGIES: PART 1**



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**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



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### 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.




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

### OUR PRESENTERS

Moderated By:



KHUSHI COOPER, MSW, PhD  
President & CEO, Implematis  
Adjunct Professor, UCLA



ALEX BRISCOE  
Principal, California Children's Trust



RICHARD KNECHT, MS  
Integrated Services Advisor, CDSS




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### SUSTAINING PREVENTION & COMMUNITY SUPPORTS




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### 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.



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### 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.



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### 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



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**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




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**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.




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**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!




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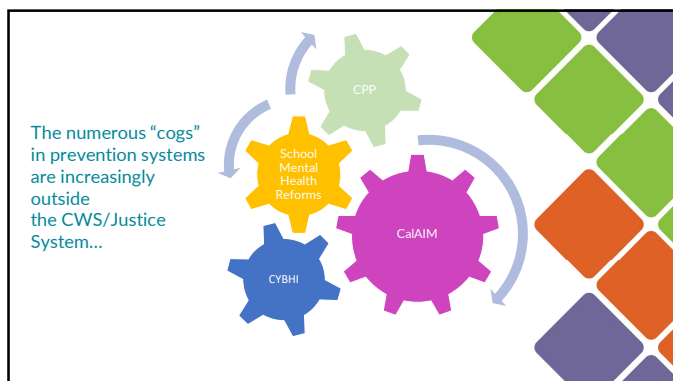
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- MANY FISCAL/PROGRAM "COGS" NOW FOUND IN SCHOOL SYSTEMS**
- Multi Tiered Systems of Support
    - Tiered Framework (P, S, T) providing potentially broad spectrum of early social/emotional supports and services
  - Wellness Centers
    - On-campus 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

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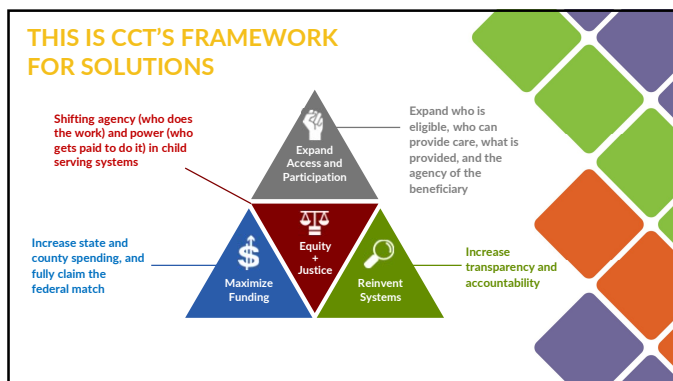
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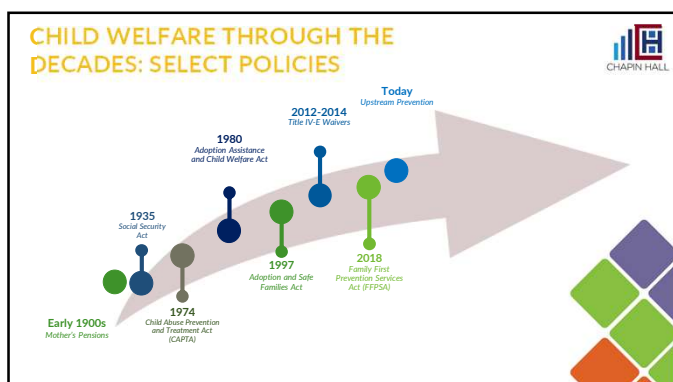
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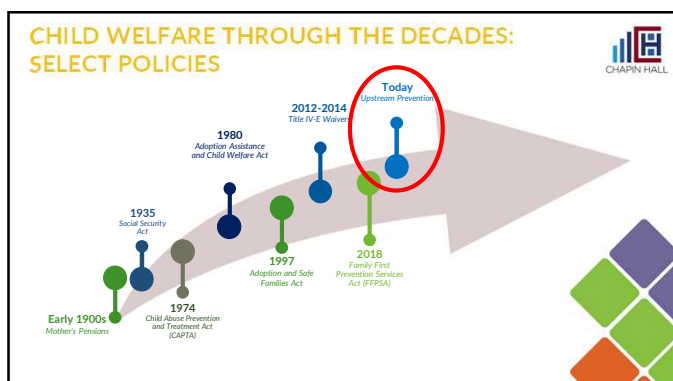
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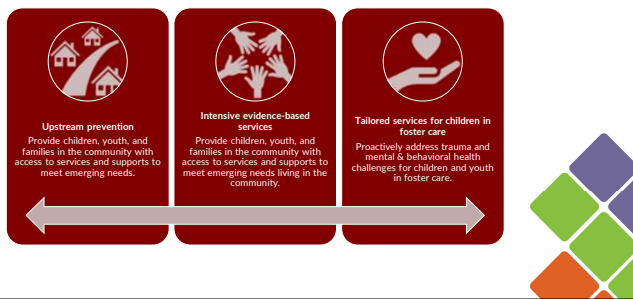
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### MEDICAID & CHILD WELFARE IMPACT AREAS



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### SDOH: A MEDICAID & CHILD WELFARE INTERSECTION



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### 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/bhcci-b08182022.pdf>

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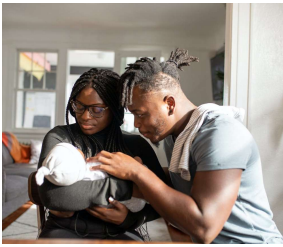
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**AS WE DESIGN UPSTREAM PREVENTION STRATEGIES , HOW CAN WE REACH FAMILIES NOT INVOLVED WITH CHILD WELFARE?**



*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

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**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 existing 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 wisdom and intelligence of lived experience
5. **Focus on Benefit Design in Managed Care Organizations** to develop scalable 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  
[cachildrentrust.org](http://cachildrentrust.org)

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**TAKE AWAYS:**

- BIG CHANGES ARE HERE... AND MORE ARE COMING SOON.**
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- MEDI-CAL WILL PAY FOR THINGS IT DIDN'T PAY FOR BEFORE
- MEDI-CAL WILL PAY FOR NEW TYPES OF PROVIDERS

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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
- 44<sup>th</sup>** California ranks low in the country for providing access to behavioral, social, and development services and screenings

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### 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 four 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

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### 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 payer-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.

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**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.




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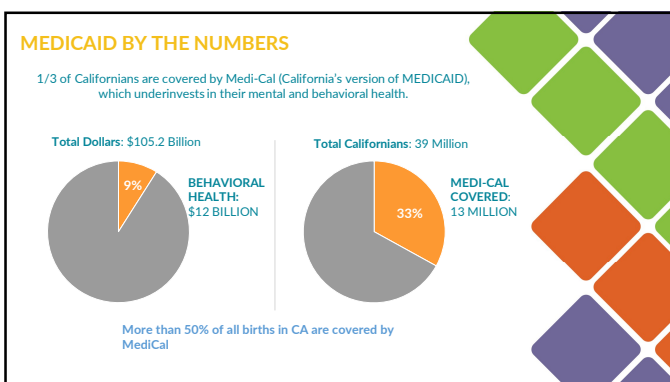
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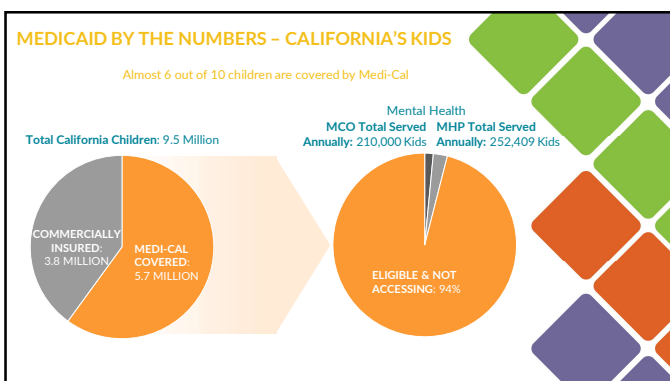
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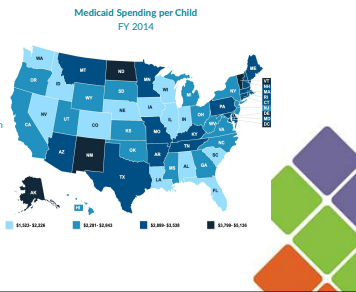
### DRAMATIC UNDER-INVESTMENT IN CHILDREN

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 44<sup>th</sup> in the nation in access to needed mental health care for children (38<sup>th</sup> overall).

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



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### 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 regardless 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.

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### 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

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# THE ARCHITECTURE OF MEDI-CAL

How it works and who pays for what

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## THE FEDERAL MATCH IS GUARANTEED:

**CPE** + **FFP** = a Medicaid Expenditure

**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.

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

**Federal Government**  
Distributed through Federal departments with funding authorized by Congress (FFP/Match)

**State of CA**  
Acting as pass-through, enhancer, or reconciler of funding—sometimes providing it, sometimes certifying (CPE)

Health Plans (MCO) CAPITATION

County Mental Health Depts (MHP) CPE

School Districts (LEAs/SELPA) CPE

Community Health Centers (FQHC) PPS

Dept. of Health (LGA) CPE

Hospital UC/PH IGT

Regional Center CPE

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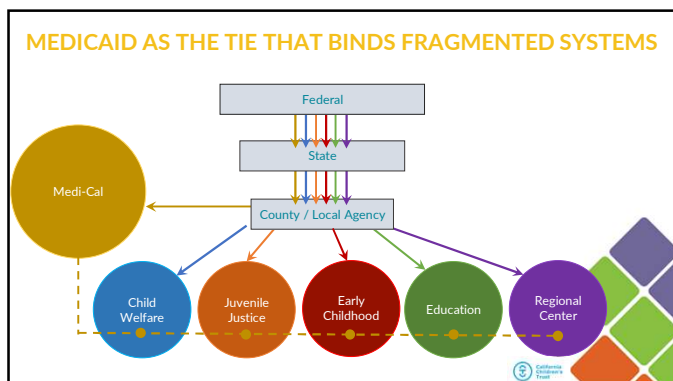
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### DO WE?

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

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### MEDI-CAL AND CALIFORNIA'S UNPRECEDENTED REFORM LANDSCAPE

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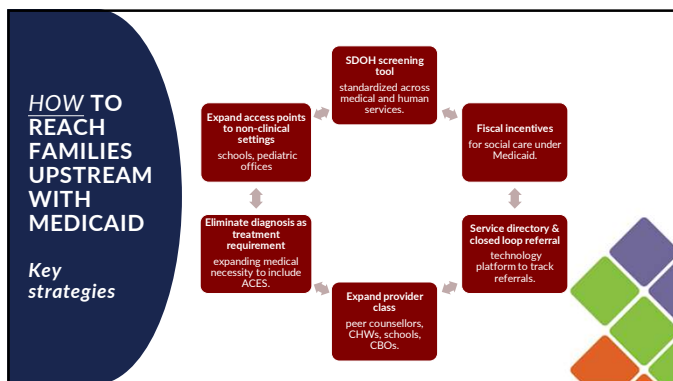
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**PARTNERSHIP IS CRITICAL TO LEVERAGE THESE FUNDING OPPORTUNITIES**

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### 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.



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### 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".



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### 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.



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### 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).



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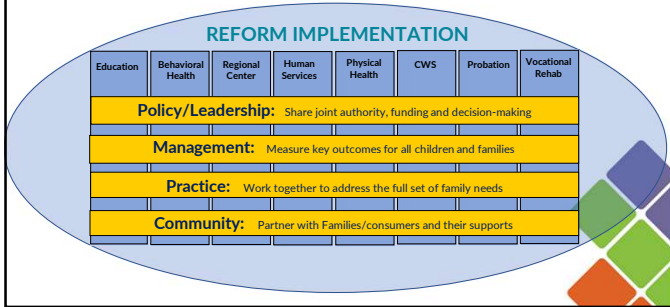
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### IMPLEMENTATION OF PROGRAMS AND SERVICES REQUIRES CONNECTING ON MULTIPLE LEVELS



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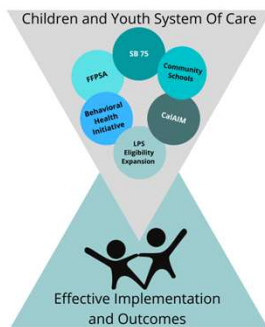
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### SYSTEM OF CARE EFFECTIVE IMPLEMENTATION AND OUTCOMES



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**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).



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

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

Univ. Of South Florida, 2005



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**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\\_inSOCsReport6-15-14.pdf](https://gucchd.georgetown.edu/products/Return_inSOCsReport6-15-14.pdf)

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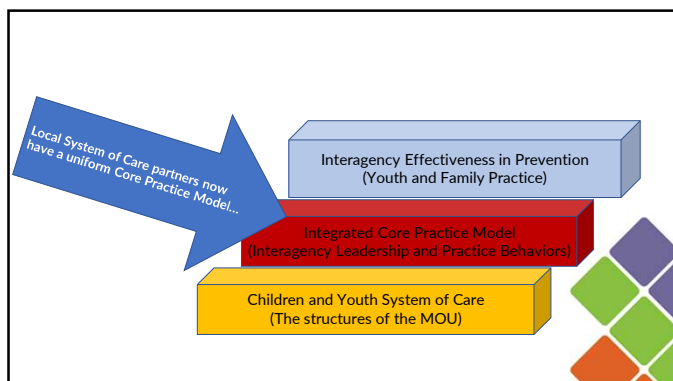
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**WHEN VISION IS ABSENT & BLENDING AND SHARING IS SKIPPED**

- 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

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**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.

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### 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!



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### QUESTIONS & DISCUSSION



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### 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



STAY CONNECTED FOR MORE FREE TRAINING & RESOURCES!



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