CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE:
UNDERSTANDING AND DISTILLING A BIG THING

JUNE 2021
CHILDREN AND YOUTH BH INITIATIVE IN CONTEXT:

- CALAIM
- COMMUNITY SCHOOLS ACT
- MHSA STUDENT SERVICES ACT
- EXPANDED LEARNING OPPORTUNITY GRANTS (ELO)
- EARLY CHILDHOOD MASTER PLAN
- FEDERAL STIMULUS FUNDING (CARES/ARRA)
- LEA STATE PLAN AMENDMENT
- MANAGED CARE REPROCUREMENT
- FFPSA ADOPTION
- SB 803 IMPLEMENTATION

SYSTEMS CHANGE IN ACTION...
FOUR DOCUMENTS DESCRIBE THE CHILDREN AND YOUTH BHI:

Understanding the initial May Revise Proposal, The Youth BHI Timeline, and Emerging Trailer Bill Language (TBL):

HHS MAY REVISE PROPOSAL
1. Behavioral Health Service Virtual Platform
2. Capacity/Infrastructure-Health Plans, County Mental Health Plans, CBOs, and Schools
3. Develop & Scale-up BH Evidence Based Programs
4. Building Continuum of Care Infrastructure
5. Enhance Medi-Cal Benefits
6. School BH Counselor and BH Coach Workforce
7. Broad BH Workforce Capacity
8. Pediatric, Primary Care and Other Healthcare Providers
9. Public Education and Change Campaign
10. Coordination, Subject Matter Expertise and Evaluation

CHILDREN AND BH INITIATIVE TIMELINE
1. Behavioral Health Service Virtual Platform
2. School-Linked Behavioral Health Services: Capacity and Partnership for Health Plans, County Behavioral Health Plans, CBOs, and Schools
3. Develop and Expand Age-Appropriate, Evidence-Based Behavioral Health Programs
4. Building Continuum of Care Infrastructure
5. Plan Offered Behavioral Health Services: Implement Dyadic Services as a Medi-Cal Benefit
6. Workforce, Education and Training
7. Comprehensive and Culturally and Linguistically Proficient Public Education and Change Campaign
8. Oversight, Coordination, Convening, and Evaluation

CHILDREN AND YOUTH BHI TBL
1. Virtual platform In Schools/E Consult for Primary Care
2. Infrastructure grants
3. MCO Incentive program
4. Fee schedule for School Based Services
5. Evidence Based Services Expansion
6. Continuum/infrastructure Grants
7. Public Education Campaign
8. BH Coaches
9. Dyadic Benefit

FY 21-22 FINAL APPROVED BUDGET
1. Behavioral Health Services and Supports Platform
2. School-linked Behavioral Health Partnerships and Capacity
3. Department of Health Care Services (DHSC)
4. Children and Youth-focused Behavioral Health Infrastructure
5. Dyadic Services
7. Office of Statewide Health Planning and Development (OSHPD)
8. Pediatric, Primary Care and Other Healthcare Providers
9. California Department of Public Health
10. DHCS state operations
ESSENTIAL ELEMENTS OF AN UNPRECEDENTED INVESTMENT: $4.4 Billion Over 5 years

1. Technology, Schools, and Continuum
2. Workforce, Education, and Training
3. Public Education and Change Campaign
4. Oversight, Coordination, and Evaluation
CONTENTS AND QUICK LINKS:

ctrl + click number to jump to that page

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
The Legislature’s Response:

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<th>Children and Youth Behavioral Health Investments – Legislative Adjustments</th>
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<th>Legislature</th>
<th>Difference</th>
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* $200 Million Increase (All counties $145 million)
* Shift to OAC
* Reduction
* Reduction
* Reduction
TECHNOLOGY, SCHOOLS, AND CONTINUUM
BEHAVIORAL HEALTH SERVICE VIRTUAL PLATFORM

Year One:

1. Issue request for proposal (RFP) and secure virtual platform vendor, to include eConsult service and direct service provider network.

2. Hire behavioral health Subject Matter Experts (SME) or issue an RFP to hire a contractor to do landscape review of current behavioral health app-based services that appeal to children and youth, selecting the best in the field to link to the platform.

Years Two through Five:


2. Conduct focus groups and testing on iterative drafts of app services.

3. Launch the platform (including eConsult), no sooner than January 1, 2024

4. Conduct continuous quality improvement and build new functionality as additional needs are identified.

TBL LANGUAGE
The bill would require the State DHCS to, among other things, procure and oversee a vendor to establish and maintain a behavioral health services and supports virtual platform to integrate behavioral health screenings, application-based supports, and direct behavioral health services, as specified.
BEHAVIORAL HEALTH SERVICE VIRTUAL PLATFORM

Trailer Bill Language:

Ambitious, cross sector, and integrates MC and commercial payors:

Payor Agnostic

5961.1 (a) State Department of Health Care Services shall procure and oversee a vendor to establish and maintain a behavioral health services and supports virtual platform which integrates behavioral health screenings, application-based supports and direct behavioral health services to children and youth age 25 and younger, regardless of payer.

E Consult for Primary Care

(6) Statewide e-consult service to allow primary care pediatric and family practice providers to receive asynchronous support and consultation to manage behavioral health conditions for their patients

E Consult and Virtual Platform seem like two different thing. Concerns with technology washing and referral landscape.
SCHOOL-LINKED BEHAVIORAL HEALTH SERVICES: CAPACITY AND PARTNERSHIP FOR HEALTH PLANS, COUNTY BEHAVIORAL HEALTH PLANS, CBOS, AND SCHOOLS

Year One:
1. Issue RFP and contract for third party administrator (TPA) to administer the grant program, with close DHCS oversight.
2. Develop the application and funding criteria, with a robust stakeholder process.
3. Develop MCO Incentive Payment Parameters and Expectations

Years Two through Five:
1. Award grants on a phased-in base to school districts, schools, health plans, counties, tribes and community-based organizations, based on criteria developed through the stakeholder process with attention to racial equity and fair geographic distribution.
2. Build statewide school-linked behavioral health counselor network.
3. Establish statewide fee-schedule for school-linked Behavioral Health services.
4. DMHC issues guidance to commercial health plans and promulgates regulations

TBL LANGUAGE
The bill would also require the department, or a contracted vendor, to provide competitive grants to qualified entities to build partnerships, capacity, and infrastructure supporting ongoing school-linked behavioral health services for children and youth 25 years of age and younger, among other purposes.
SCHOOL-LINKED BEHAVIORAL HEALTH SERVICES: CAPACITY AND PARTNERSHIP FOR HEALTH PLANS, COUNTY BEHAVIORAL HEALTH PLANS, CBOS, AND SCHOOLS

Programmatic Detail:

- Competitive Grants (550M)
- MCO Incentive Program (400M)
- CalHOPE Student Services Program (45M)

TBL LANGUAGE:

5961.2 (a) As a component of the initiative pursuant to this chapter, the State Department of Health Care Services, or its contracted vendor, may award competitive grants to entities it deems qualified.

5961.3 (a) As a component of the initiative pursuant to this chapter, the State Department of Health Care Services shall make incentive payments to qualifying Medi-Cal managed care plans that meet predefined goals and metrics...associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in schools.
DEVELOP AND EXPAND AGE-APPROPRIATE, EVIDENCE-BASED BEHAVIORAL HEALTH PROGRAMS

Year One:

1. Agency and DHCS develop the measure and milestone framework for each evidence-based practice model.

2. DHCS secures third-party grant administrator.

Years Two through Five:

1. Issue guidance and requests for proposals.

2. Implement evidence-based practice model projects.

(d) Subject to subdivision (e), entities eligible to receive grants pursuant to this section may include Medi-Cal behavioral health systems, tribal entities, health care service plans, Medi-Cal managed care plans, community-based organizations, and behavioral health providers. Grants for Medi-Cal behavioral health delivery systems for the purpose described in this section shall be administered through the Behavioral Health Quality Improvement Program pursuant to Section 14184.405.
5961.5. (a) As a component of the Initiative pursuant to this chapter, the State Department of Health Care Services shall develop and select evidence-based interventions, to improve outcomes for children and youth with or at high risk for behavioral health conditions.

(d) Subject to subdivision (e), entities eligible to receive grants pursuant to this section may include Medi-Cal behavioral health systems, tribal entities, health care service plans, Medi-Cal managed care plans, community-based organizations, and behavioral health providers. Grants for Medi-Cal behavioral health delivery systems for the purpose described in this section shall be administered through the Behavioral Health Quality Improvement Program pursuant to Section 14184.405.
BUILDING CONTINUUM OF CARE INFRASTRUCTURE

Year One:

1. Complete gap and capacity analysis with robust stakeholder input (estimated completion by end of 2021)
2. Secure third party administrator and technical assistance contractor.
3. Develop criteria and issue applications.

Years Two through Five:

1. Award grants to eligible entities
2. Provide technical assistance

TBL LANGUAGE
This bill would authorize the DHCS to, subject to an appropriation, establish a Behavioral Health Continuum Infrastructure Program to award grants as specified for the construction, acquisition, and rehabilitation of behavioral health treatment resources, as described.
PLAN OFFERED BEHAVIORAL HEALTH SERVICES: IMPLEMENT DYADIC SERVICES AS A MEDI-CAL BENEFIT

**Year One:**

1. Seek stakeholder feedback on the dyadic services benefit.
2. Submit State Plan Amendment to CMS.
3. Implement Dyadic services in Medi-Cal effective July 1, 2022.

**Years Two through Five:**

1. Award grants to eligible entities
2. Provide technical assistance

**TBL LANGUAGE**

The bill would require, no sooner than July 1, 2022, and subject to federal approval, that "dyadic behavioral visits be a covered Medi-Cal benefit. The bill would require the dyadic visits to include screening for, among other things, behavioral health problems, interpersonal safety, and social determinants of health, as specified.

b) **Dyadic behavioral health visits are provided for the child and caregiver or parent at medical visits**, providing screening for behavioral health problems, interpersonal safety, tobacco and substance misuse and social determinants of health such as food insecurity and housing instability, and referrals for appropriate follow-up care.
WORKFORCE, EDUCATION AND TRAINING
1. Establish an advisory committee including K-12, higher education, behavioral health and other subject matter experts to develop a multi-year plan to create behavioral health coaches and counselors within five years. The plan will identify gaps where training needs to be developed.

2. With guidance from the advisory committee, complete an assessment of (1) the range of training, certification and licensure needed to support an effective school behavioral health counselor system and (2) the gaps in current training to determine where training needs to be developed.

3. Working with subject matter experts, identify existing training models that can be immediately expanded for the counselors and coaches.

4. Secure an evaluator for behavioral health counselor and coach workforce project.

5. Issue Requests for Information (RFI)/RFPs that:

6. Fund existing training models to expand skills now.

7. Fund new training models within higher education entities.
1. Based on existing training models identified and assessment results, working with higher education partners and contractor identified through RFI/RFP, develop new training models at each level of higher education that can rapidly supply a diverse and skilled workforce.

2. Recruit soon-to-be graduates and provide training to build skills in age-appropriate and culturally and linguistically-proficient services for children and youth. Students will need different levels of intervention, so behavioral health counselors recruited and trained will have various levels of existing knowledge to build upon.

3. Assess impact of investments to date, adjust plan and contracts as needed to meet demand.

4. Continuous review of data on training needs, retention, and student outcomes.

5. With data from the evaluation, work with the advisory committee to develop sustainability and transition plans for model programs that are effective and need to continue.

TBL LANGUAGE
The bill would require the Office of Statewide Health Planning and Development to award competitive grants to qualified entities and individuals to expand the supply of behavioral health counselors, coaches, peer supports, and other allied health care providers serving children and youth, including those at schoolsites.
BROAD BEHAVIORAL HEALTH WORKFORCE CAPACITY

Year One:

1. OSHPD, with input from subject matter experts, will develop a multi-year plan to build the SUD workforce.

2. OSHPD, in partnership with other agencies, will develop a plan for enhanced training of existing and new staff and behavioral health professionals across a variety of sectors including child welfare, education, and probation on effective behavioral health strategies with justice and system involved youth.

3. OSHPD, in partnership with other agencies, will develop a plan for earn and learn (apprenticeship) models to build a behavioral health workforce. Areas of focus can include community health workers and psychosocial rehabilitation specialists that serve children, youth, and families.
BROAD BEHAVIORAL HEALTH WORKFORCE CAPACITY

Year One (cont):

3. Update existing programs and issue grant opportunities for:
   a. Expansion of the peer personnel training and placement program to support peer providers for children and youth.
   b. Expansion of funding opportunities for behavioral health-related scholarship and loan repayment programs.
   c. Increasing funding to the WET Regional Partnerships to fund recruitment and retention efforts (scholarships, loan repayments, stipends, recruitment incentives, etc.) in their local areas.
   d. Expansion of the Mini-Grants program to build career awareness for youth and students about behavioral health careers, especially careers that serve children and youth.
   e. Expansion of psychiatric education capacity program to provide grants to new and expanding psychiatry programs, especially those that provide child and adolescent fellowships.
   f. Expansion of existing programs to provide loan repayment, scholarships, stipends, etc. for SUD disciplines.
   g. Expansion of educational capacity for programs to train child and adolescent social workers and child welfare workers.

4. Partner with the UC Irvine/UC Davis Train New Trainers Psychiatric Fellowship program to issue scholarships to providers serving children and youth.

5. Develop and issue RFIs/RFPs for new programs, including:
   a. Pipeline programs that provide mentorship, and academic, career, and psycho-social support to prepare students from underrepresented and low-income backgrounds for behavioral health careers.
BROAD BEHAVIORAL HEALTH WORKFORCE CAPACITY

Years Two through Five:

1. Using input from advisory committees established in Year One, develop new funding opportunities for programs that build the SUD workforce, earn and learn programs, and support system and justice-involved youth.

   For example, this can include:
   a. New ‘train new trainer’ model to expand knowledge of existing licensed behavioral health clinicians to provide age-appropriate SUD treatment.
   b. Establishing new earn-and-learn program that provides tuition support and on-the-job training at a behavioral health provider organization while one attends school or completes training.

3. Enhanced training to existing and new staff across a variety of sectors including child welfare, education, and probation on effective behavioral health strategies with justice and system-involved youth.

4. Award grants for new programs and modified existing programs, and begin to implement.

3. With data from the evaluation and contractors, assess impact of investments to date, adjust plan and contracts as need to meet demand.
PEDIATRIC, PRIMARY CARE AND OTHER HEALTHCARE PROVIDERS

Year One:

1. Assess areas of greatest need and gaps in education and training.
2. Determine which existing programs could be immediately augmented and expand access.

Years Two through Five:

1. Implement expanded education and training.
2. For areas identified as gaps, develop, pilot and roll out new education and training.
3. Continue the roll out of implementation, collect data on impact, assess for sustainability and transition or end programs.

Lead: DHCS
Budget: $50M
PUBLIC EDUCATION AND CHANGE CAMPAIGN
COMPREHENSIVE AND CULTURALLY AND LINGUISTICALLY PROFICIENT PUBLIC EDUCATION AND CHANGE CAMPAIGN

Year One:

1. Assess lessons learned from Prevention and Early Intervention statewide projects, using best practices to leverage, scale, or innovate successful projects. Assess how to synergize with other social marketing and public education campaign efforts.

2. Landscape analysis of similar efforts in other states.

3. Collaborate with Agency’s behavioral health SMEs and youth advisory bodies; develop implementation plan with performance metrics.

4. Office of Health Equity (OHE) will establish SME for the Cultural Campaign; develop implementation plan with performance metrics.

5. OHE selects vendors, execute contracts.

6. OSG selects vendor(s), executes contracts, implements OSG ACEs and toxic stress campaign.

7. Establish partnerships, select vendor(s), conduct planning, and develop curriculum for OSG trauma-informed training for educators.

Lead: CDPH AND OSG
Budget: $100M
COMPREHENSIVE AND CULTURALLY AND LINGUISTICALLY PROFICIENT PUBLIC EDUCATION AND CHANGE CAMPAIGN

Years Two through Five:

1. Roll out of statewide behavioral health literacy campaign.
2. Development of culturally specific campaigns by communities.
3. Roll out statewide culturally specific campaigns.
4. Collect data to assess campaign impact, refine campaign efforts, assess for sustainability, and transition or end programs.
3. Assess and refine all efforts.
3. Implement OSG trauma-informed training for educators.
OVERSIGHT, COORDINATION, AND EVALUATION
Oversight, Coordination, Convening, and Evaluation

Year One:
1. Launch a stakeholder workgroup, including a coordinated but distinct Youth Advisory Council. The workgroup will convene regularly to review program progress, grantee reports, evaluation findings, and to provide quality improvement guidance throughout the project.
2. Convene behavioral health subject matter experts.
3. Commission an independent evaluator to conduct a multi-year evaluation to identify best and emerging practices and inform future policy and program work.

Years Two through Five:
1. Evaluator collects data and publishes annual interim reports, with a final report at the end of the five years, which will include recommendations for policy and program improvements and sustainability strategies.
2. On-going coordination with participating CHHS departments, as well as other critical state partners including education and higher education.
3. Regular updates presented to stakeholder workgroup to review progress and provide input.
Oversight, Coordination, Convening, and Evaluation

Section 9: Health Plan Obligations to Pay for Services

Section 9. Section 1374.722 is added to the Health and Safety Code, to read: (a) Effective January 1, 2024, a health care service plan that is required to provide coverage for medically necessary treatment of mental health and substance use disorders pursuant to Sections 1374.72 and 1374.721 shall cover the provision of such services when delivered at school sites pursuant to this section, regardless of the network status of the local educational agency, institution of higher education, or health care provider. Nothing in this section shall be construed to relieve a local educational agency, or institution of higher education from requirements to accommodate or provide services to pupils with disabilities pursuant to any applicable state and federal law including, but not limited to, the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), Part 30 of Division 4 of Title 2 of the Education Code, Chapter 3 of Division 1 of Title 5 of the Code of Regulations, and Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.