



breaking barriers

CREATING A COMMUNITY OF CARE

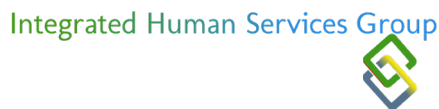
4TH ANNUAL INTERAGENCY SYMPOSIUM

breaking barriers,
building bridges

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BREAKING BARRIERS TOOLKIT 2019



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INTRODUCTION, BACKGROUND AND HISTORICAL CONTEXT

The continuum of services required to effectively serve children, youth and their caregivers is inherently fragmented. Federal and state systems route revenue and policy guidance in silos with varying requirements for eligibility, benefits, purpose and compliance.

Since the mid 1970s, policy makers across the state have consistently invited state and county service systems to explore and develop models for service delivery which effectively bridge or link these historically disparate systems. The Little Hoover, Judicial Council and Child Welfare Council recommendations have universally implored the state to close its funding and service delivery gaps on behalf of California's youth (Annual Report of Child Welfare Council, 2014¹).

Other research validates this need.

“This problem is a direct consequence of fragmentation within and across the schools, agencies, nonprofits, and community organizations that serve young people. Mitigating, and ultimately eliminating, agency fragmentation is crucial for ensuring that vulnerable youth receive comprehensive, streamlined support services to help them grow into successful, fulfilled adults. Doing so will require dramatically rethinking and restructuring the ways in which social service agencies interact with schools, with one another, and with the children in their care.”²

In 2019, the Departments of Health and Human Services and Education are manifesting renewed commitment to realizing a vision of a fully integrated system of community-based, highly coordinated services to increase access, quality and outcomes of care. This invites a whole person, family-centered approach that is equitable, effective and efficient. This will be no easy task.

There is a fundamental, critical difference between systems that act in processes that are coordinated and cooperative, and those systems which are deeply collaborative and structurally integrated. Horwath and Morrison, in “Collaboration, Integration and Change in Children’s Services: Critical Issues and Key Ingredients” (2007),³ articulate a clear imperative that the more integrated the partnership, the more likely it is to identify and address the challenges associated with changing dynamics of policy, finance and social capital.

This toolkit seeks to present promising practices and strategies to facilitate interagency collaboration, address administrative and financing challenges, and implement, replicate, and/or scale successful integrated approaches to addressing the unmet social, emotional and developmental needs of children and their families in California.

1 https://www.chhs.ca.gov/wp-content/uploads/2017/06/Committees/California-Child-Welfare-Council/Council-Information-Reports/CWC_2013-14_Annual_Report_APPROVED.pdf

2 Robson, K; Korman, Haily, (2018). Continuity Counts: Coordinated Education Systems for Students in Transition, Bellwether Education Partners, 2018. <https://files.eric.ed.gov/fulltext/ED585945.pdf>

3 <https://www.ncbi.nlm.nih.gov/pubmed/17210177>

HISTORY OF INTEGRATED CARE IN CALIFORNIA

California has long recognized that integration of care is necessary to realize a comprehensive, accessible and effective system of care for its children and families.

The earliest practices around interagency child and family work across social services and behavioral health systems in California were likely rooted in the mid 1980s, with Ventura County's efforts to construct a formal System of Care. In 1984, State Assembly Bill 3920 granted state funding to Ventura through the State Department of Mental Health to pilot a "new way of doing business" in child and family services. At that time, a State Advisory Board was also created to assess the model and its evaluation efforts for possible statewide replication.

Subsequent legislation, AB 3015 in 1992, "The Children's Mental Health Services Act," federal block grant funding and competitive federal grants from the Substance Abuse Mental Health Services Administration Center for Mental Health Services (SAMHSA) reinforced this early effort in a number of counties.

Evaluation results of the Ventura demonstration documented the California System of Care model's success. As a result, AB 377 was passed in 1988, and Riverside, San Mateo and Santa Cruz were awarded System of Care funding in 1989. AB 377 also required that the model be extensively evaluated, and the California Children's System of Care Evaluation Project found the model to be highly promising. A few other counties were assertive in pursuing integrated System of Care work, but notwithstanding these early outcomes, under economic and policy pressure, over the next 15 years many counties abandoned their full system development efforts, and System

of Care became little more than a mental health funding vehicle in most counties. As of 2015, only a few counties had maintained the original integrity and scope of System of Care. It was largely this inability to build out System of Care in California which led to both the Emily Q. and Katie A. class actions of the last two decades.

More recently, efforts such as the Whole Person Care model and the Substance Use Disorder's Organized Delivery System (ODS) waiver implementation have offered energy toward greater integrative process among departments, although each of these is limited in scope and purpose.

In addition, also realizing the importance of integrating care to maximize accessibility and utilization of California's resources for our children and families, the California Department of Education has been working towards the vision of creating One Coherent System for all California students, an effort memorialized in 2015 by the Statewide Special Education Task Force report.

Numerous efforts to integrate physical and behavioral health care with education have also been launched in California over the past two decades, including most recently the California Mental Health Services Oversight & Accountability Commission (MHSOAC) efforts to incentivize shared behavioral health/ education partnerships.

PROMISING PRACTICES IN INTEGRATED SYSTEMS IN CALIFORNIA

SYSTEM OF CARE

Notwithstanding the state's challenging history in implementation of System of Care, there is a growing body of evidence indicating that the System of Care approach is cost effective and provides an excellent return on investment.

"The emerging data, mostly obtained from analyses conducted by states and counties themselves, along with several multi-site studies, demonstrate a return on investment that can be quantified in terms of cost savings.... In most cases, net cost savings are derived from reduced use of inpatient psychiatric hospitalization, emergency rooms, residential treatment, and other group care, even when expenditures increase for home- and community-based care and care coordination. Cost savings are also derived from decreased involvement in the juvenile justice system, fewer school failures, and improved family stability, among other positive outcomes."⁴

The core System of Care values of community-based, family-driven, youth-guided, and culturally and linguistically competent are now widely embraced. The principles call for a broad array of home- and community-based services and supports, individualized care provided in the least restrictive setting, family and youth involvement, cross-system collaboration, care management and accountability. The system of care concept has resulted in significant changes in service delivery across the country and has been the foundation for national policy as reflected in the recommendations of the Surgeon General's Conference on Children's Mental Health (U.S. Public Health Service, 2000)⁵ and the President's New Freedom Commission on Mental Health (2003).⁶ System of Care principles are also aligned with national health reform efforts to improve the quality and cost of care for populations with significant health challenges (Wotring & Stroul, 2011).⁷

Most recently in California, with the impetus of AB 2083, county partnerships and their state level support departments are now required to construct some form of System of Care, and anchor that partnership within a written formal Memorandum of Understanding, which requires each county to develop and implement shared processes, roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma. The legislation is focused on the child welfare system, but can and must be expanded to look at children and youth served by various other systems. AB 2083 calls for the establishment of a Joint Interagency Resolution Team to provide guidance, support and technical assistance to counties with regard to trauma-informed care to foster children and youth.

For more, see <https://www.chhs.ca.gov/home/system-of-care>

SCHOOL-BASED HEALTH MODELS

The California School-Based Health Alliance defines a School-Based Health Center (SBHC) as a facility that delivers clinical medical, behavioral health, or oral health services on a school campus or in an easily accessible alternate location including a mobile health van. SBHCs are distinct from school nurses in that they employ practitioners licensed to diagnose and treat illness (nurse practitioners, physicians, physician assistants) in addition to registered nurses (the majority of school nurses) who are restricted to implementing practitioners' orders.

The defining characteristic of an SBHC is that the health care providers work in partnership with the school to reach as many students as possible, ensure follow-up, and address health and learning problems comprehensively.

Since they were first established in the 1980s, California's federally qualified School-Based Health

4 Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C. (2014). Return on investment in systems of care for children with behavioral health challenges. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. https://gucchd.georgetown.edu/products/Return_onInvestment_inSOCsReport6-15-14.pdf

5 <https://www.ncbi.nlm.nih.gov/books/NBK44237/>

6 <https://govinfo.library.unt.edu/mentalhealthcommission/reports/reports.htm>

7 https://gucchd.georgetown.edu/products/SOC_Brief_Series1_BL.pdf

Centers (SBHCs) have grown in number. The state currently has more than 226 SBHCs providing health care to more than 250,000 children in grades TK-12. Children served by SBHCs live in many of the state's most distressed neighborhoods where children and families are uninsured, experience barriers to accessing preventive health care, and have high rates of emergency room visits, obesity, asthma, and exposure to violence and trauma.

In the past decade, school-based health efforts have expanded far beyond formal school-based health centers to school-based health services that are not housed in formal federally qualified health care centers, but are a partnership between behavioral and physical health agencies, providers and education to integrate services in school-based settings so children and families can access them. This work is now further incentivized by the California Mental Health Student Services Act which allocates support to the California Department of Education for the release of grants and research regarding county behavioral health and education partnerships.

CALIFORNIA'S INTEGRATED CORE PRACTICE MODEL FOR CHILDREN, YOUTH AND FAMILIES

Tied to System of Care efforts, in May of 2018 the state's Department of Healthcare Services and Department of Social Services released the most recent version of the state's 2011 Integrated Core Practice Model (ICPM).⁸ Unique in the nation, this document provides cross-system guidance to county child welfare, behavioral health and juvenile probation professionals. The guide contains research-based values, principles, and professional and leadership behaviors in support of effective, trauma-informed practice in an integrated, multi-agency system.

The ICPM guidance, implemented in partnership with other system-involved agencies, will do much to support local system integration and long-term success of collaborative efforts. Research on core practice models indicates systems that design and administer with integrity, experience greater permanency, less reentry to care and lower costs.

INTEGRATED CARE FOR KIDS (INCK)

The Centers for Medicare and Medicaid Services (CMS) announced a funding opportunity to test interventions focused on fighting the opioid crisis. InCK is a child-centered model to be delivered through local service systems while using state payment models to fund services. The model will offer states and local providers support to address prevention and intervention supports through a framework of child-centered care integration across behavioral, physical and other child serving providers. Although the deadline has passed for 2019 funding, InCK could be an important model for California's efforts going forward.

HEALTH HOMES FOR CHILDREN

A Children's Health Home is a care management service model where all of a child's caregivers communicate with one another so that a child and family's needs are addressed appropriately. Health homes use a singular care manager to engage and coordinate services to eligible families, children and youth to provide access to all physical, behavioral and social services assuring they have everything necessary to stay healthy, out of the emergency room and out of the hospital. The Care Manager supports services that a family may already be receiving and will help families get new ones as necessary.

The Centers for Medicare & Medicaid Services (CMS) plan to launch Medicaid health homes to provide care coordination for children with medically complex or chronic conditions. The CMS has indicated they will issue guidance on medical health homes in 2020. While MediCal may be a future funding opportunity in California, systems need not wait to practice the principles of effective health home practice.

⁸ https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-022%20Integrated%20Core%20Practice%20Model%20and%20Integrated%20Training%20Guide/Integrated_Core_Practice_Model.pdf

MULTI-TIERED SYSTEM OF SUPPORT

A Multi-Tiered System of Support (MTSS) is a systemic, continuous improvement framework in which data-based problem-solving and decision making are practiced across all levels of the educational system for supporting students. The framework of MTSS is a “way of doing business” which utilizes high quality evidence-based instruction, intervention and assessment practices to ensure that every student receives the appropriate level of support to be successful.

A Multi-Tiered System of Support helps schools and districts organize resources through alignment of academic standards and behavioral expectations, implemented with fidelity and sustained over time, in order to accelerate the performance of every student to achieve and/or exceed proficiency. MTSS in California provides an opportunity to build deep and sustained connections by and between county agencies and school/district partners. Linking a System of Care, for instance to a large SELPA’s MTSS services, can effectively leverage services and reduce costs to schools and partner systems. In that way, counties may begin to identify an integrated framework for the provision of services to children and families, rather than fragmented service delivery systems.

Resources are available on the Mental Health Technology Transfer Center Network website:

<https://mhffcnetwork.org>

FOUR FOUNDATIONS OF INTEGRATED PUBLIC SERVICE FOR YOUTH AND FAMILY SERVICES

In the remaining sections of this toolkit, you'll find four subsections, each outlining one of the anchors which nearly all integrative frameworks hold in common. Each section contains additional information on resources and recommendations to construct a local partner-based care delivery model.

FOUNDATION ELEMENT 1: CROSS-SYSTEM LEADERSHIP AND SHARED GOVERNANCE

The determination and endowment of a locus of control for any integrated care effort is a critical need. It is imperative that the agencies and system partners mutually agree and hold themselves and each other responsible for achieving the collaborative vision, mission and goals.

DEFINITION: Generally, interagency leadership implies the existence of a body that has decision-making authority for a broad set of policy and administrative outcomes. It provides structures and decision-making processes for timely planning and policy issues and resolution of challenges. Most often the interagency team is defined in a written document, along with the collaborative's mission, vision, values and other agreements.

Shared governance refers to the processes and functions of that interagency entity and the systems management structures it authorizes. Those functions generally include decision-making, strategic planning and oversight for the implementation of the shared work.

In high functioning and successful interagency work, alignment and vision across the partnerships are first secured, then nurtured and sustained through leadership, political cycles and fiscal changes. Commitments are authentic and acknowledge the respective partners' different mandates, responsibilities and roles, yet agree on a common purpose. Sharing resources and revenues requires transparency, relationship building and trust for any enduring success. This alignment of vision and values is the anchor for shared governance and interagency work.

Any Interagency Leadership and System effort will seek the following:

1. A single organized and seamless gateway to services and supports. (No Wrong Door.)
2. Service delivery structures, protocols and responsibilities to promote coordinated, collaborative care.
3. Service delivery structures designed to increase access, quality and outcomes of care.

Key Areas of Shared program design and practice include:

- Core practice and teaming approach
- Use of cross-system multidisciplinary teams
- Co-located and integrated unit configuration
- Focus on prevention and early intervention
- Staff development, coaching and cross training
- Focus on connecting youth to natural and community supports

RECOMMENDATIONS FOR SHARED GOVERNANCE AND INTERAGENCY LEADERSHIP:

Key steps in forming an effective interagency leadership and decision-making process include:

1. Form an Interagency Leadership Team/Policy Body

A formal and consistent interagency management or policy team process and meetings are critical to the long-term success of cross-system work. This group meets frequently and consistently to design and approve shared policy, revenue/expenses, training resources, new programs, and to leverage human resources and otherwise chart the mission and vision for the collaborative.

A local Interagency Leadership Team (ILT) serves as the governing board of the collaborative and in California would consist generally of the Chief Probation Officer, the Director of Health and Human Services (HHS) or if no HHS, the Director of Behavioral Health, the Director of Social Services, the County Public Health Director, the Superintendent of the County Office of Education, and member School District Superintendents, depending upon the county. The System partnership's governance generally focuses on Policy Development, Coordination and Monitoring of the system in the following areas:

- Make recommendations regarding submission, preparation and coordination of grant applications and grant deliverables.
- Review and, as necessary, recommend program direction for applicable community partners or providers. Invite providers to present annual reports on program issues, progress and outcomes.
- Participate on related coordinating councils, other advisory committees and multidisciplinary teams which affect the System Partner processes or services.
- Appoint and support staff to serve as liaisons to various shared projects to ensure full continuum of care and linkages back to each department's services.
- Monitor programs for general compliance with statutory and regulatory requirements; provide guidance and technical assistance to ensure program practice is consistent with the values and principles of this interagency partnership.
- Coordinate and develop additional agreements or MOUs, as necessary, to assist in program coordination and problem solving.
- Work with community agencies and consumers to ensure collaborative and integrated strategies are utilized and to promote and utilize strength-based, family-focused practice on a systems-wide basis.

While formal membership of the interagency leadership group is established by the county's AB 2083 MOU, designated other experienced staff members or other senior managers from system partners or other involved agencies, tribal partners and/or identified community stakeholders may also attend leadership meetings and support the collaborative goals.

It is often helpful for the group's system partners to appoint an Action or Executive Advisory group comprised of the Child Welfare Director, the Behavioral Health Children's Director or Deputy, the Deputy Chief Probation Officer, the Associate Superintendent of the County Office of Education, and other agency leadership. This executive advisory team may be charged with completion of assigned tasks as prescribed by the full Interagency Leadership Team.

Effective interagency leadership process uses a shared decision-making framework for all programs and services identified by the system partners. Consensus is the preferable model; however, if consensus cannot be reached, decisions may be made by a simple majority vote of the agency membership.

It is often advisable to appoint an ILT Convener or System Administrator from among the membership. This is usually a supporting or senior member appointed by the full team, who will use their department's or unit's

resources to support agenda and minutes management and meeting facilitation. The ILT Convener would be rotated among agency or department/members every two years to assure consistent interagency leadership practices. The Convener often oversees the activities of the county’s CDSS required “Interagency Placement Committee” (IPC) and all programs and services identified within the collaborative or Children’s System of Care.

While the state provides direction under AB 2083 about which agencies must comprise the local system partnership, optional membership can be key to local success. Counties will want to consider adding the following partners to those required by code:

- Presiding Bench Officer or other judicial authority
- Special Education Local Plan Areas (SELPA)
- Dependency or Family Court Judges or Bench Officer
- County Mental Health Managed Care Plan Representative
- Youth, parents, and family representatives
- County Office of Education administered FYSCP Executive Advisory Council
- Local Education Agencies

Research regarding effective youth service delivery from nearly any discipline indicates that highly integrated and coordinated cross-system service planning and delivery provides a more comprehensive understanding of the child/youth and family’s needs, and therefore can develop, implement and monitor service plan progress and outcomes. Building a highly integrated and collaborative partnership is a challenging endeavor. Interagency practices are often subject to “usual pressures” of operations and changing leadership, budgets and priorities. But when created and supported effectively, well-coordinated care results in improved outcomes and lower rates of re-entry or recidivism. Coordinated, integrated care reduces redundancy of effort, increases access to specialty expertise and resources, and can significantly improve the care experience for the family.

2. Develop and Execute a Formal Memorandum of Understanding

The process of developing interagency agreements is challenging and no one agency can effectively champion cross-agency work.

Effective January 2019, AB 2083 requires counties to design and implement Interagency Memoranda of Understanding, capturing the essential elements of their systems. State Health and Human Services and the Department of Education have, in recent months, made great progress toward development of key ingredients toward single System of Care. Primary to that effort is the now required county-level construction and implementation of a local Memorandum of Understanding between youth-serving agencies.

Interagency agreements or MOUs document the programmatic products of the partnership. They should include a statement of commitment to the collaborative, including an agreement to develop and participate in a structured process for collaborative planning and review of data. Depending upon the level of trust among the partners, initial agreements will have a tendency to be either overly broad or to get bogged down in minute details. Remember that the first attempt at an agreement doesn’t have to be perfect. Start simple and get better! The annual (or more frequently, if needed) review of performance is a good task-focused process to deal with issues and concerns that have arisen within the partnership over the past year.

The MOU should capture the composition of the Integrated Leadership or senior management team, and the frequency and process with which it carries out its shared leadership work. A sample MOU was made available to counties in late 2017. More recently, HHS has published an AB 2083 System of Care Toolkit, which may be found here: <https://www.chhs.ca.gov/home/system-of-care>

While the state-mandated MOU is outlined later in this section, some governance recommendations to consider when crafting documents include:

- Specify Executive Committee members' duties and responsibilities
- Identify how a program level or support team will meet and convene to execute the vision of the ILT
- Specify the frequency of ILT meetings and process for convening meetings
- Define and explain the group decision-making process to be used
- Define a process to obtain new signatures from any new members of the ILT to ensure, on at least an annual basis, that the MOU remains current.

3. Implement the State's Integrated Core Practice Model for Children and Youth

Adoption and implementation of California's Integrated Core Practice Model across the child welfare, education, juvenile probation and behavioral health systems requires the investment of time, resources, patience and system support at all levels, including direct involvement from parents, families and youth with lived experience. Including ICPM implementation content in the MOU is highly recommended.

RESOURCES FOR SHARED GOVERNANCE AND INTERAGENCY LEADERSHIP

- Video: 2-minute primer from SAMHSA on System of Care
https://www.youtube.com/watch?v=_OqSV05jCNY&feature=youtu.be
- A Guide to Implementing Children's System of Care in California, Jordan et al, 1998 <https://www.cibhs.org/sites/main/files/file-attachments/socmanual.pdf>
- How to Collaborate When You Don't Have Consensus, Khane, et al
<https://www.strategy-business.com/article/How-to-Collaborate-When-You-Dont-Have-Consensus?gko=90356>
- California's Integrated Core Practice Model for Children, Youth and Families
<https://www.cdss.ca.gov/inforesources/The-Integrated-Core-Practice-Model>
- Video: Healing Through Equity and Resilience
<https://www.youtube.com/watch?v=PAPB71-mMDo&feature=youtu.be>
- School-Based Health Alliance
<https://www.schoolhealthcenters.org>

FOUNDATION ELEMENT 2: CROSS-SYSTEM SHARED DATA AND OUTCOMES MANAGEMENT

A host of federal and state rules exist in support of the universally accepted desire to protect privacy and confidentiality of program participants' health-related information. These safeguards are the hallmark of a patient- or client-centered health delivery system and society. These data and information prescriptions are, in a multi-agency service environment, made all the more complex by the educationally based limits of student information sharing.

And yet, in the last 30 years, since the passage of the Health Information Portability and Accountability Act, and other protective efforts, service entities have manifested a growing reluctance to engage in the most fundamental of care coordination and service delivery processes. Referral, care management, discharge and transition planning are deeply dependent on the timely and effective sharing of participant information.

This section of the Toolkit will provide users with tools and information in support of information and data sharing, both for client specific and program/outcomes based data.

DEFINITION: In general, an integrated system is one in which partners fluidly share client specific data necessary for care delivery and coordination while the system collects, monitors and analyzes metrics at the child/family, program, system and community levels. Integrated data and outcomes partnerships share the following components: (1) the ability to collect, monitor and analyze clinical and administrative data to generate data-informed decisions and policies; (2) joint governance responsibility for targeted outcomes; (3) shared outcome responsibility for an integrated system, which refers to the expected or desired impacts of strategies, whether these result from changes in system infrastructure, changes in programs, changes in practice or changes in finance; (4) collective responsibility for continuous quality improvement across systems.

Data systems must answer the fundamental question: "How well are we serving youth and how do we know it?" Fully endowed data sharing systems address issues of Efficiency, Effectiveness and Equity in their service community.

RECOMMENDATIONS FOR CROSS-SYSTEM OUTCOMES AND DATA MANAGEMENT

Invest in cross-training of data analysts or other personnel responsible for quality or system improvement. Each of the agency's data professionals only knows what she or he knows, and until each is aware of the potential opportunities to link data, information or process, the value of the partnership will not be evident.

Consider including the following partners when determining the protocols and implementation of data sharing agreements:

- County Health and Human Services and/or Behavioral Health Agency
- County Office of Education
- SELPAs
- LEAs
- Other supporting social emotional and educational service providers that interact directly with foster youth
- Child Welfare or Social Service Department
- Participating legal service providers

Information and Data Sharing Agreements should also contemplate the roles of the following:

- Educational and health rights holder, including any appointed surrogate parents
- School enrollment choice
- Change in residential placement
- Records, lists, notifications and monitoring
- Transportation needs

RESOURCES FOR CROSS-SYSTEM OUTCOMES AND DATA MANAGEMENT AND INFO SHARING

- This Well Being in the Nation website has a deep and comprehensive list of potential measures of wellness, which illustrate the connections in value for providers in shared practice: <https://www.winmeasures.org/statistics/winmeasures>
- This link to the California Alliance of School-Based Health Centers includes guidance for student info sharing: <https://www.schoolhealthcenters.org/start-up-and-operations/student-records-consent-and-confidentiality/>
- This resource outlines steps to help health systems and community-based providers build relationships that draw on each other's strengths, put patients first, and support ecosystem development in local communities: https://www.bettercareplaybook.org/sites/default/files/2019-10/Shared%20Outcomes%20with%20CBOs%20Play_102819_3.pdf

FOUNDATION ELEMENT 3: CROSS-SYSTEM SHARED FISCAL MANAGEMENT AND RESPONSIBILITY

Integrated care models require a significant investment in infrastructure in key areas. Sharing of personnel, training, administrative and other domains is required to effectively institutionalize the cross-department, multi-agency processes required of successful systems. Nowhere is this more necessary than in the management of revenue and expense. Many a system-building effort has been short-circuited due to the inability of the partner's financial systems to adapt or flex to the demands of sharing.

DEFINITION: Shared fiscal management can generally be thought of as the multi-agency responsibility for the development, management and leveraging of disparate funding streams across systems. Shared management of financial resources is necessary to develop and sustain an integrated system, (i.e. financial strategies with potential for addressing multiple determinants of well-being; leveraging, braiding, blending, and pooling of categorical—federal, state, and local government, philanthropic and private funding to improve client and system outcomes).

Public funding in support of services and care delivery is nearly always dis-integrated at the federal and state level. This process dates back many years and likely has its roots in the government's intent to account for services to a specific subset of youth or students with particular needs. While understandable, this segregation of financial resources leads to equally dis-integrated service structures, redundancy and inefficiency, with particular impact on participants and service recipients. It therefore falls to county leaders to effectively re-integrate the discrepant resources in support of efficient, effective and seamless care delivery.

One of the primary barriers to creating and sustaining comprehensive integrated systems, inclusive of school partners, is identifying funding streams that support interventions within and around schools and throughout the state's Multi-Tiered System of Support framework. Students with undiagnosed or untreated mental health issues rank among the most pressing concerns in communities across California, directly impacting student attendance, behavior, readiness to learn and long-term outcomes for youth. The recent research on impacts of untreated mental health for students documents a host of negative outcomes, and invites local policy makers to share fiscal resources by and between schools and other service agencies.

RECOMMENDATIONS FOR SHARED FINANCING AND REVENUE MANAGEMENT

County mental health plans vary significantly in how they deliver specialty mental health and other services. The options available for schools to work with their counties to deliver specialty mental health services depend, in large part, on the county's overall system of care, priorities and how school-based strategies align.

Here are some models of design for shared funding:

- **School district providers:** The school district can contract directly with the county mental health plan to become a contracted provider of specialty mental health services.
- **County providers:** In counties where the majority of specialty mental health services are provided "in house," i.e., by county-employed mental health professionals, schools can develop arrangements with the county to have permanent or visiting county employees provide assessment and treatment services on the school campus.
- **Community providers:** Many counties contract the delivery of specialty mental health services through community providers. These providers can be community mental and behavioral health agencies or individual practitioners and can provide services through agreements with the county agencies how and where need is identified.

Effective interagency revenue sharing invites partners to:

- Keep a child-family centered focus when discussing, planning and determining solutions to local financial

responsibility barriers.

- Work with local partner agencies to cross-train service professionals and conduct joint interagency trainings on financial statutes and regulations to reduce antiquated processes and misinterpreted statutes and regulations.
- Foster relationships with State agencies to support local understanding and interpretation of statutes and regulations.
- Draw upon trainings, State guidance and local partnerships to determine where agencies are financially confined by regulations and statutes and where space is available to be creative and flexible in financially providing efficient and timely supports and services to families and children.
- Through a local partner workgroup, conduct an assessment of current financial barriers and local practices that represent ongoing conflicts and barriers to services and placement.
- Utilize information about local practices to create uniform local practices that can be implemented when financial responsibility is in question.
- Establish a local practice of inquiry by asking clarifying questions of local partner agencies and consumers. Use local partner responses and determinations as an invitation to openly discuss and explore the root of the financial barrier, and to elevate the barriers and inquiries to those in alternative decision-making positions.

Additional partners to consider including when determining the protocols for financial resource management and cost sharing:

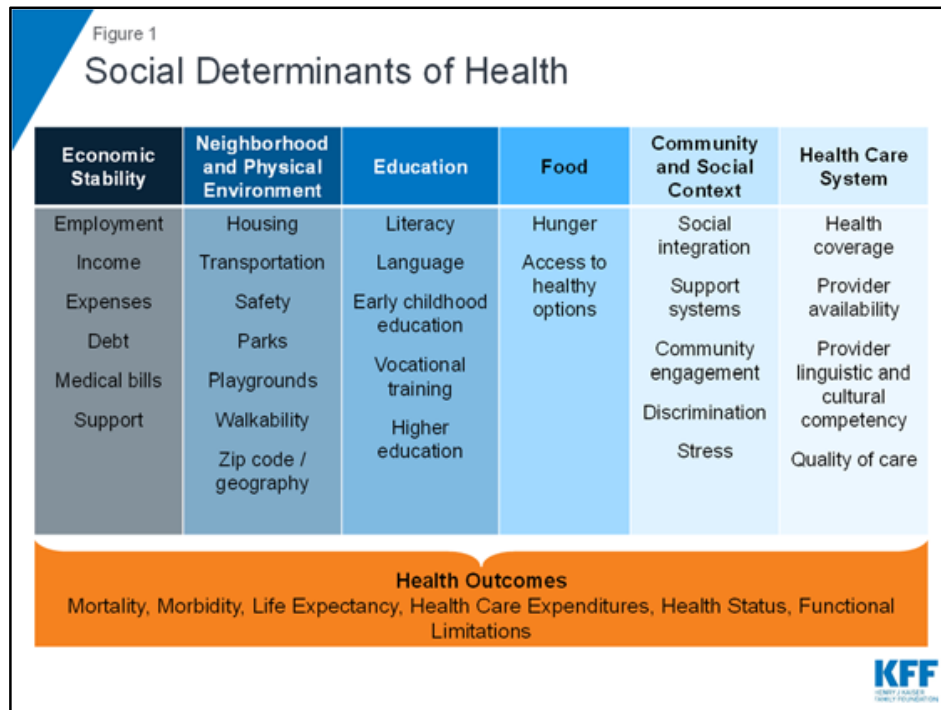
- The Regional Center or centers that serve children and youth with developmental disabilities in the county
- Department of Rehabilitation Regional Office
- County Managed Care Plan
- First Five Commission
- Health care providers
- Youth and families

RESOURCES FOR SHARED FINANCING AND REVENUE MANAGEMENT

- Public Funding for School-Based Mental Health Programs: This resource is intended to identify and explain the public mental health funding streams in California that can support the full continuum of school-based mental health services. It should also help illustrate how schools can best leverage public mental health funding streams and community partnerships to maximize existing resources.
<https://www.schoolhealthcenters.org/start-up-and-operations/funding/mental-health/>
- ESPDT Realignment for Districts: The purpose of this paper is to increase understanding of how counties administer children's mental health services and to explore how the 2011 Realignment of mental health services has created new opportunities for collaboration between schools and counties. The authors hope that school districts and their partners will use this information to initiate and guide collaborative planning efforts at this pivotal juncture. http://www.teachersforhealthykids.org/wp-content/uploads/2017/12/EPsDT-Realignment-for-Districts_Dec2015.pdf
- Return on Investment in System of Care Report: This national compendium of research on program effectiveness comes from SAMHSA, and is the only nationwide study of System of Care to date. It outlines numerous economic benefits associated with effectively designed and delivered Systems of Care. https://gucchd.georgetown.edu/products/Return_onInvestment_inSOCsReport6-15-14.pdf
- This four-page fact sheet from Health Management Associates is a very recent primer in MediCal and Behavioral Health funding in California. <https://www.chcf.org/wp-content/uploads/2019/02/MediCalExplainedBehavioralHealth.pdf>
- This Center for MH in Schools and Student Learning Supports at UCLA has many good resources. <http://smhp.psych.ucla.edu/practitioner.htm>

FOUNDATION ELEMENT 4: CROSS-SYSTEM SHARED COMMUNITY

There is an emerging body of knowledge and consensus across youth and family service sectors, relative to the impact of social determinants of health on individual, family and community health and well-being. According to the World Health Organization, health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” However, there is growing recognition that a person’s zip code is a stronger predictor of their eventual health and well-being than the person’s genetic code for health status. The social determinants of health are the conditions in which people are born, grow, live, work and age. This figure, from the Kaiser Family Foundation, is representative of this recent awareness.⁹



This knowledge consensus, captured most recently by the California Children’s Trust, highlights, among other fundamentals, that:

- Early intervention is critical to healthy development. California faces a crisis regarding the social, emotional and developmental health of children and youth. Investment in early and proactive interventions to protect and promote the well-being of our children is primary.
- Improving children’s and family’s experiences and addressing health inequities, structural racism and multi-generational poverty perpetuated in current systems are central to improving child well-being and long-term outcomes.
- California needs to widen access to behavioral health supports. Children and families need access to a range of behavioral health approaches and strategies that nurture social, emotional and developmental health.
- Collaborative and accountable systems change is the way forward. California’s Health and Human Services Agency’s embracing of System of Care as an integrated and coordinated framework is a significant step forward, but must include key education, advocacy, private sector and community voices.

⁹<https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

Another vision for the desired state is articulated by the California Accountable Communities for Health Initiative (CACHI):

CACHI Vision for a Modernized Health System that Supports Community Health: “Community residents achieve optimal physical, emotional and social health, and well-being by leveraging their own engagement, empowerment, and social assets with care, services, and supports from their local health system. The local health system sets common priorities and invests in prevention and community health. It includes effective multi-sector partnerships that provide integrated and aligned systems of care, services, and supports. Stakeholders and residents share governance and decision-making, as well as a commitment to equity. They all have mutual accountability for, and directly contribute to, improving the community’s health and well-being.”

DEFINITION: A shared community may be broadly defined as a shared understanding that all child and family systems function within the context of local community circumstances and conditions; that no one system has all the resources and mandates to successfully serve every youth’s social, emotional, behavioral and developmental needs; and geographic differences in community history, readiness and resource inequities have profound impact on the quality and longevity of the lives of diverse populations.

As it relates to community, nearly every young person in California is connected to a school system or campus, and increasingly in the last decade, those school systems have been found to be not only a resource for effective services and supports, but an ecology that is often seen as accessible and trusted by youth and their families. Schools, with the support of local and state administrations and advocates, have embraced this movement.

According to the Aspen Institute, “...the basis of this approach is not ideological at all. It is rooted in the experience of teachers, parents, and students supported by the best educational research of the past few decades. More than nine in 10 teachers and parents believe that social and emotional learning is important to education. At least two-thirds of current and recent high school students think similarly. As one student said, “Success in school should not be defined just by our test scores ... but also by the ability to think for ourselves, work with others, and contribute to our communities.”¹⁰

Of course, a comprehensive, community-based strategy, supported by both local and statewide integration efforts, will enhance educational equity and the adult health and well-being outcomes desired. Effective school-community partnership, supported by a linked and integrated System of Care, significantly benefits children from at-risk or impacted communities, many of whom experience trauma and adversity early and often. There are many ways to accomplish this necessary linkage between school delivery systems and the other municipal systems that serve youth and their families.

The Whole School, Whole Community, Whole Child model (WSCC) is CDC’s framework for addressing health in schools. The WSCC model is student-centered and emphasizes the role of the community in supporting the school, the connections between health and academic achievement and the importance of evidence-based school policies and practices. It has 10 components that serve to improve the student’s educational success.¹¹

¹⁰ <http://nationathope.org/report-from-the-nation>

¹¹ <https://www.cdc.gov/healthyschools/wsc/index.htm>

Whole School, Whole Community, Whole Child Model



- The child in the center is at the focal point of the model; the child is encircled by the “whole child” tenets in green: being “healthy, safe, engaged, supported, and challenged.”
- The white band emphasizes the alignment, integration, and collaboration needed among the school, health, and community sectors to improve each child’s learning and health.
- Represented in the blue, the multiple school components surround the child, acting as the hub that provides the full range of learning and health support systems to each child, in each school, in each community.
- The community, represented in yellow, demonstrates that while the school may be a hub, it remains a focal reflection of its community and requires community input, resources, and collaboration in order to support its students.

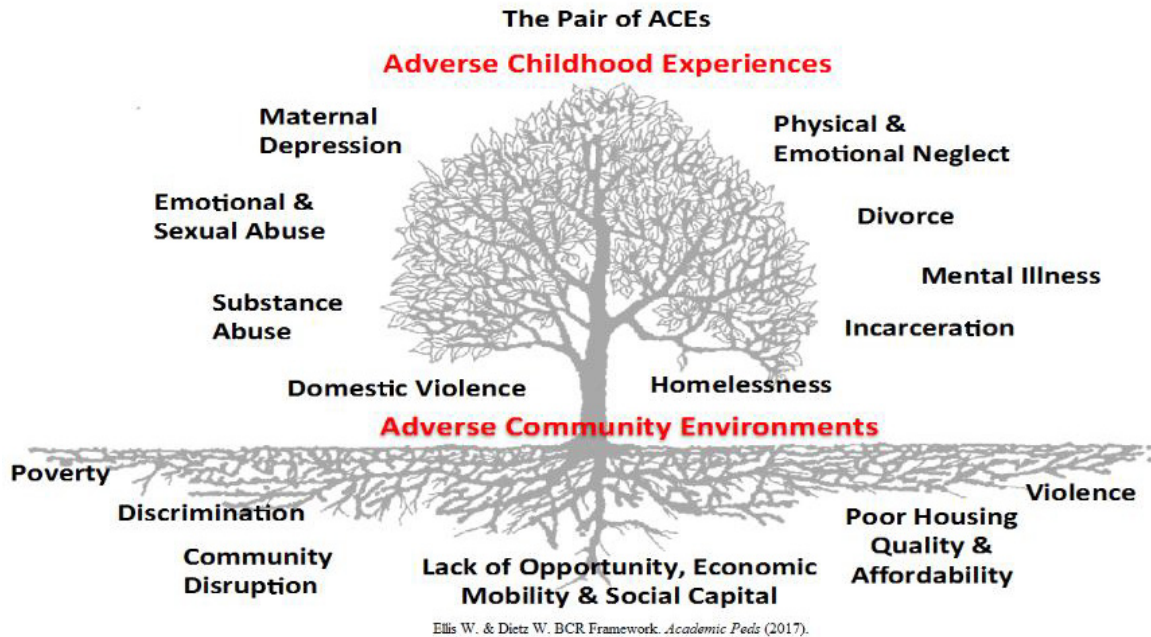
A second opportunity to link systems exists in California. Building on the already existing foundation from Positive Behavioral Interventions and Supports and its related Multi-Tiered System of Support initiative, a focus on engaging or re-engaging the “whole child” in education aligns well with California’s whole person care models in health and behavioral health systems. If connected properly and consistently, schools, county human service systems, health care and local communities can and do have a profound impact on the well-being and future opportunities for the children/youth who are served. School success is becoming much more than academic scores and graduation rates but rather readiness for post-secondary and career options and opportunities to achieve their own aspirations. A recent article, “Four Ways Schools Can Support the Whole Child,”¹² suggests that schools are ready to:

1. Foster a supportive environment that promotes strong relationships among staff, students and families.
2. Implement meaningful, engaging instructional practices that develop students’ ability to manage their own learning.
3. Develop habits, skills and mindsets that build students’ social, emotional and academic competences.
4. Create an integrated system of school supports that includes extended learning opportunities and community partnerships.

¹² https://greatergood.berkeley.edu/article/item/four_ways_schools_can_support_the_whole_child

Recommendations for Shared Community

There are a number of emerging cross-sector partnerships and collaborations that are seeking to promote, design and implement a community health and well-being service delivery approach and framework. The Pair of ACEs is one description of the inter-relationship of child and family issues and their broader community conditions. The child and family Adverse Childhood Experiences are exacerbated by Adverse Community Environments and the lack of local health and human service systems to identify, engage and/or mitigate the child and family adverse childhood experiences.



Another example can be found in “From Siloed Systems to Ecosystem: The evolution of the Camden Coalition’s Complex Care Model”¹³

The graphic below describes the Camden Coalition’s evolution from its original intermittent “hot spotting” efforts to become more comprehensive and effective in its current understanding that systems and models of care must be built around a patient’s complex needs.



Such approaches are encouraging health care systems to “move upstream” in order to prevent or at least delay onset of health-related problems/conditions. It is the basis for any number of collaborations and projects to shift from a sick care system to a health care system that works to prevent a person from getting ill in the first place. This is the essence of what is meant by Shared Community.

In child welfare both the federal Children’s Bureau and California’s DSS are now emphasizing prevention and a public health lens so that service and supports are community-based whenever possible. The Administration for Children and Families’ Information Memorandum ACYF-CB-IM-18-05¹⁴ is a memorandum on primary prevention “to strongly encourage all child welfare agencies and Children’s Bureau (CB) grantees to work together with the courts and other appropriate public and private agencies and partners to plan, implement and maintain integrated primary prevention networks and approaches to strengthen families and prevent maltreatment and the unnecessary removal of children from their families.” This expands the focus of the Child Welfare System to “preventing child abuse and neglect before it happens and before the family is at risk of a foster care placement.”

The recent California Child Welfare Council’s “Promoting Child and Family Well-Being Framework for Child Welfare Prevention Practice”¹⁵ highlighted outcomes of “child wellbeing and achievement, caregiver wellbeing

13 <https://camdenhealth.org/from-siloed-systems-to-ecosystem-the-evolution-of-the-camden-coalitions-complex-care-model/>

14 <https://www.acf.hhs.gov/sites/default/files/cb/im1805.pdf>

15 <https://www.chhs.ca.gov/wp-content/uploads/2019/06/California-State-Child-Welfare-Council-Prevention-Toolkit.pdf>

and achievement, consistent high-quality caregiving and safe and supportive neighborhoods. In addition, CDSS' OCAP funded a statewide Strategies 2.0 “to prevent child abuse and neglect and to promote child, family and community wellbeing.” Combined, these types of efforts in California will do much to enhance the health outcomes of at-risk young people.

RESOURCES FOR SHARED COMMUNITY

There are many sources of expertise and guidance for building a community-based framework for youth. A number of those listed here represent linkages involving schools and communities toward a fully connected Shared Community:

- **Pair of ACEs**
Ellis, W.R. & Dietz, W.H. (2017). A new framework for addressing adverse childhood and community experiences: The building community resilience model. *Academic Pediatrics*, 17(7s), S86-S93.
<https://www.ncbi.nlm.nih.gov/pubmed/28865665>
- **Principles for Building Health and Prosperous Communities**
For work across sectors in low-income communities to improve health and wellbeing.
<https://buildhealthyplaces.org/principles-for-building-healthy-and-prosperous-communities/>
- **Kresge Ecosystem Readiness Assessment Tool**
Local place-based opportunity ecosystems—comprising mutually reinforcing public and nonprofit organizations working across systems such as education, health, workforce development and others – hold enormous promise in advancing social and economic mobility. Kresge seeks to promote collaboration across sectors and the integration of service delivery, community engagement and economic development at local levels.
https://kresge.org/sites/default/files/library/human_services_ecosystem_assessment_tool.pdf
- **The Community Tool Box**
The Community Tool Box is a free online resource for those working to build healthier communities and bring about social change. It offers thousands of pages of tips and tools for taking action in communities.
<https://ctb.ku.edu/en>
- **California Accountable Communities for Health Initiative (CACHI)**
Accountable Communities for Health (ACH) is a groundbreaking vehicle for collaboration across multiple sectors to address critical community health issues. It redefines our local health system to extend beyond traditional institutions like hospitals and health plans. It brings together clinical providers with public health departments, schools, social service agencies, community organizations, and others, in a collective effort to make a community healthier.
<https://cachi.org/resources>
- **National Academy State Health Policy**
The National Academy for State Health Policy is a nonpartisan forum of policymakers throughout state governments, learning, leading and implementing innovative solutions to health policy challenges.
<https://nashp.org/about-nashp/>
- **Partnering to Catalyze Comprehensive Community Wellness**
This report from the Health Care Transformation Task Force provides a framework to facilitate collaborative working relationships between the public health and healthcare sectors, in service of the idea that “none of our distinct systems—not healthcare, public health, nor social services—is fully equipped to accomplish its mission alone.”
<https://www.nationalcomplex.care/research-policy/resources/publications-reports/partnering-to-catalyze-comprehensive-community-wellness-an-actionable-framework-for-health-care-and-public-health-collaboration/>

- **Defining an Accountable Community for Health for Children and Families**
 This discussion paper adapts models of integrated care to seamlessly address the medical, social and developmental needs of children and families, with a focus on shared accountability across sectors as well as financial sustainability.
<https://nam.edu/defining-an-accountable-community-for-health-for-children-and-families/>
- **The Promise of Adolescence: Realizing Opportunity for All Youth**
 Adolescence—beginning with the onset of puberty and ending in the mid-20s—is a critical period of development during which key areas of the brain mature and develop. These changes in brain structure, function and connectivity mark adolescence as a period of opportunity to discover new vistas, to form relationships with peers and adults, and to explore one’s developing identity. It is also a period of resilience that can ameliorate childhood setbacks and set the stage for a thriving trajectory over the life course.
<https://www.nap.edu/catalog/25388/the-promise-of-adolescence-realizing-opportunity-for-all-youth>
- **Fostering Healthy Mental, Emotional and Behavioral Development in Children and Youth: A National Agenda**
 Healthy mental, emotional and behavioral (MEB) development is a critical foundation for a productive adulthood. Much is known about strategies to support families and communities in strengthening the MEB development of children and youth by promoting healthy development and also by preventing and mitigating disorder, so that young people reach adulthood ready to thrive and contribute to society.
<https://www.nap.edu/catalog/25201/fostering-healthy-mental-emotional-and-behavioral-development-in-children-and-youth>
- **Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity**
 All children deserve the opportunity to meet their full health potential and lead fulfilling lives. Yet health inequities in the United States prevent many kids from meeting their full potential. Practice, policy and systems-level changes informed by science can reduce the odds of adverse exposures, narrow health disparities and advance health equity.
<http://nationalacademies.org/hmd/Reports/2019/vibrant-and-healthy-kids>
- **Investing in Children to Promote America’s Prosperity**
 Decades of research have shown that children’s physical health, mental health and well-being are significantly influenced by the states, communities, neighborhoods and families in which they live.
<https://nam.edu/investing-in-children-to-promote-americas-prosperity/>
- **National Interoperability Collaborative: Community of Networks**
 NIC is a new “Community of Networks” designed to increase collaboration among the sectors that impact health and well-being by improving information sharing, interoperability and use of technology. Its goal is to improve outcomes for everyone, particularly vulnerable and under-served members of society. NIC is led by the Stewards of Change Institute and Academy Health. The aim is to identify common themes, needs and areas where collaboration within and among domains could be genuinely valuable.
<https://stewardsofchange.org/wp-content/uploads/sites/2/2018/08/Six-Domains-Full-Documents-Final-03-19-18.pdf>

SUMMARY AND CONCLUSIONS

The continuum of services which are most often required to effectively and efficiently serve children, youth and their caregivers are deeply fragmented and fraught with challenges. Federal and state systems route revenue and policy guidance in silos with varying requirements for eligibility, benefits, purpose and compliance. Local efforts to integrate or even collaborate require consistent and purposeful leadership, and are impeded by regulations and mandates which often prevent the very aligned delivery of care that is invited and needed.

This toolkit has attempted to establish four cornerstones of effective practice, and the strategies within them that foster better care and outcomes. These four practice areas—Shared Leadership, Shared Data and Outcomes Management, Shared Fiscal Management, and Shared Community—if designed and built with focus and intentional leadership, provide the structure to successfully integrate care and services, thereby addressing the unmet social, emotional and developmental needs of children and their families in California. We seek to ensure that every child is safe, healthy, educated and well with a sense of belonging, purpose and opportunity to achieve their aspirations.



breaking barriers
CREATING A COMMUNITY OF CARE