November 18, 2022

Autumn Boylan, Deputy Director
Office of Strategic Partnerships, Department of Health Care Services
1501 Capitol Ave
Sacramento, CA 95814

Dear Ms. Boylan,

Thank you again for meeting with The L.A. Trust School Health Policy Roundtable (Roundtable) to inform members on the school-based workstreams of the Children and Youth Behavioral Health Initiative. The Roundtable is comprised of thirty-three cross-sector organizations committed to advancing schools as centers of wellness in Los Angeles County. We see the CYBHI as a transformative opportunity to help schools establish integrated, youth centered systems of care that support student success in school and life. We have prioritized two workstreams for comment: the School-Linked Partnership and Capacity Grants and Statewide All-Payer Fee Schedule for School-Linked Behavioral Health Services.

General Comments

Embed youth leadership throughout the behavioral health ecosystem.
Several studies confirm what we know from experience: young people need to be engaged as partners—not consultants—in the behavioral health system of care.[1] Young people are the experts of their experience, and it is critical that our behavioral health system recognize and honor the agency of youth over their health and healing. We applaud DHCS for its commitment to youth engagement in the development of CYBHI workstreams and urge you to build infrastructure for continued youth involvement through implementation and beyond. Programs established by the CYBHI should include evaluation indicators that measure youth involvement and youth ownership of new programs.

Consider opportunities for holistic health service integration.
Mental, behavioral, and physical health are interdependent. School-based mental health programs have the potential to increase students' access to primary care and vice-versa. Physical health providers are often the first to identify early behavioral health needs and other health care needs often co-occur with behavioral health conditions. While CYBHI funding should primarily expand behavioral health services, we strongly urge that grants advance a whole person care model and do not exclude integration of other health services. For example, building school-based health centers (SBHCs), where behavioral health and primary care can be delivered in tandem, should be allowed.

Ensure minor consent access to services.
In California, minors over 12 years of age can consent to some behavioral health services in certain circumstances, without parent/guardian consent. While including adults in a young person's health care is a best practice, in some cases, requiring parental consent can serve as a barrier to a young person's

[1] Youth-Centered Strategies for Hope, Healing, and Health; Helping Center Youth Voices in Mental Health; and 2022 State of Student Wellness

access to needed care. DHCS should ensure that minors can consent to appropriate confidential behavioral and mental health services, consistent with state law.

Use caution when leveraging the potential of telehealth.
Any tele-behavioral health services expanded through CYBHI should be age-appropriate, affordable, culturally relevant, cost-effective, and follow sound clinical guidelines. This is especially true for children with special health care needs whose families report that telehealth did not adequately address all their child's needs. Providing families with choice is key, which may include offering private space and equipment for students to take telehealth appointments at school and in other community spaces, given the persistent digital divide for low-income households. Telehealth services should be provided by clinicians that are knowledgeable about community resources and local health needs/assets, with the ability to facilitate ongoing care and referrals. Telehealth providers should connect students to health homes if they have them, strive for integration with a child's source of regular care by sharing health information with primary care providers, or screen and refer students to local providers. And DHCS should ensure that telehealth providers have a process for making ongoing improvements based on direct feedback from students and families.[2]

School-linked Partnership & Capacity Grants

ROUND 2 GRANT CYCLE RECOMMENDATIONS

Facilitate communication between health care and education systems.
We strongly encourage allowing the use of funds help schools create the care coordination and billing platforms needed to ensure effective implementation of the 2024 school-linked fee schedule. This could include use of funds to modify existing data and billing platforms, creating new platforms or collaboration across LEAs to develop more universal solutions Students with health care needs may have various health care providers and may change school districts in the middle of the academic year. Likewise, students who are unhoused/housing insecure and involved in the foster and/or justice system, among others, often go in and out of various health and educational systems. An investment in data and technology would allow cross-system communication that improves continuity and coordination of care.

Allow facility costs for school-based sites.
On-campus facilities are not eligible projects for Round 4 of the Behavioral Health Continuum Infrastructure grants. As the CYBHI invests in school-based staffing and programming, it should also fund facility projects, like school-based health clinics (SBHCs). Schools will need youth-oriented spaces in which to provide services. SBHCs are a proven model, but the upfront costs of planning, staff, and building are a huge barrier to the expansion.

[2] See the California School-based Health Alliance resource, Telehealth in Schools and SBHCs, and The Children's Partnership report, Telehealth and Children of Color with Special Health Care Needs: Lessons from the Pandemic for more information.

Assist smaller educational systems with billing infrastructure.
Technical assistance is needed to support small to medium sized school districts that may not have experience with providing and billing for integrated mental health services. Districts will need TA and on-going coaching in the initial years to set up systems and build understanding of common language and processes. Likewise, small, and large school districts alike, need TA to access and braid various funding streams provided by state and federal initiatives. This includes California's recent one-time investments in whole child success: the California Community Schools Partnership Program, Learning Recovery Emergency Fund, and the ACEs Aware Initiative, in addition to the CYBHI.

ROUND 3 GRANT CYCLE RECOMMENDATIONS

Build and strengthen data tracking systems to target and improve services.
Robust data systems enable schools and providers to identify community health needs and evaluate the effectiveness of interventions. For example, The L.A. Trust Data xChange is a robust, HIPPA/FERPA compliant, secure database that integrates academic data from LA Unified School District and wellness data from its network of Student and Family Wellness Centers. When paired with collaborative leadership structures, data exchanges like this enable responsive health care systems that provide targeted interventions. Navigating complex data sharing and privacy laws is a barrier for schools who are rightfully cautious about sharing student data. In addition to funding new systems, DHCS should provide TA to help schools and providers understand when and how it is safe to share data.

Build infrastructure for meaningful student and family engagement.
Student and family engagement should be continuous through planning, implementation, and ongoing evaluation. DHCS can help schools get it right from the start by funding community engagement infrastructure to establish equitable feedback loops between schools, students, educators, and providers. Grants should fund permanent structures and personnel that engage students and families in sharing their experiences seeking/receiving culturally responsive and gender-affirming care and evaluating whether the CYBHI, and other transformative investments, are having the intended impact.

Require applicants to demonstrate how programs will address disparities.
A critical component to addressing disparities in student health and educational outcomes, based on race, class, gender, ability, sex, and the intersection of those identities, is to hold service providers accountable to providing targeted supports that produce measurable impact on outcomes for BIPOC and other marginalized students. DHCS should require that grant applicants incorporate culturally responsive and anti-racist practices/language into their grant logic model, identify key policies within their agency aimed at addressing disparities in BIPOC communities, demonstrate having a diverse and culturally competent workforce or strategies aimed at diversifying, and confirm past or planned participation in implicit bias/culturally responsive trainings.[3]

[3] For more information, see Practice 4 of the Anne E. Casey Foundation's resource, 10 practices: A Child Welfare Leader's Desk Guide to Building a high-performing agency.

Statewide All-Payer Fee Schedule

Ensure community-based organizations are valued part of the provider network.
CBOs play a key role in supporting community health and health behaviors, especially for youth identifying as Black, Indigenous, and people of color (BIPOC). When appropriately leveraged and engaged, CBOs can be an essential asset to school-based behavioral health systems. CBOs and LEA's share similar challenges (i.e., sustainable funding, partnerships with MCOs, workfroce shortages), which can lead to unproductive competition for resources. School-based services meet student needs where they may not have access to community resources but where possible—LEAs and CBOs are better together. CBOs can leverage additional funding sources and provide key linkages to social capital and other community assets. CBOs fill coverage gaps by providing students access to care during out-of-school time and during crisis situations that can extend beyond traditional school hours. And importantly, CBO staff often share culture and lived experience with the children and youth these programs intend to reach, increasing the accessibility and appropriateness of care. It is important to delineate the various services provided by both the CBO and LEA to ensure there is no overlap. The CYBHI can facilitate deeper collaboration and resource sharing between government and community-based organizations by including a diverse group of CBO providers in the fee schedule and addressing barriers to CBOs receiving adequate reimbursement for services rendered. The provider network should have proportionate representation of BIPOC and youth-led organizations in every county.

Include care coordination services in the fee schedule.
Much of the critical services provided by SBHCs and school-based/linked providers are not eligible for reimbursement, regardless of the student's insurance status. These services include school staff and teacher consultation and participation in service coordination teams. Sustainable funding for care coordination services through Medi-Cal is historically limited to students with a diagnosis or acute needs. However, a critical practice in any school-based health intervention is to serve students beyond clinical services. This includes engaging with guardians, teachers, and other service providers; referring and following up on referrals to other educational, health, and social services; and participation in service coordination meetings. The fee schedule should allow reimbursement for this critical time spent coordinating services.

Include Tier 1 prevention services.
The fee schedule can strengthen Tier 1 interventions by allowing schools to enhance billing for health education and other preventative services in addition to SMAA and LEA BOP options. This may include psychoeducation and capacity building of teachers and school administrators, parents and caregivers, and the broader school community. One example that could be replicated is a contract between Alameda Alliance and SBHCs to reimburse for classroom health education.[4] Where expanding reimbursement options for tier 1 prevention services, it is critical that DHCS establish clear definitions and guidance to ensure there is no overlapping of reimbursement and schools can continue to offer specific services and do not experience a negative impact to their current reimbursement programs.

[4] The Alameda Alliance for Health MCP approved a health education curriculum and reimburses the SBHC per education session per Alliance member.

Include non-traditional services in the fee schedule.

The over-reliance on clinical mental health modalities and lack of acknowledgement and respect of cultural and indigenous healing practices are consistently identified by youth as barriers to receiving appropriate mental health care.[5] Young people want expanded access to non-traditional and non-clinical services, including art, animal and music therapies, recreational activities, peer support, mindfulness programs, and indigenous and cultural healing practices.[6] We need to build the capacity of youth-serving systems to provide effective and culturally responsive care by making a diverse set of healing modalities reimbursable under the all-payer fee schedule.

Youth Peer Support

Youth peer support can include peer-to-peer (P2P) interventions such as healing circles, 1-on-1 and group support, and advocacy. Leveraging the power of young people to support their own mental health and the health of their peers is an effective healing practice and vehicle for improving school climate. Given the existing clinical workforce's majority composition of white middle-income professionals, for many students of color, peer-led programming could be a rare opportunity to engage in healing with others who look like them, come from their communities, share their histories of marginalization, and can more readily connect through shared lived experiences. Because young people, particularly BIPOC youth, are deeply impacted by the social conditions, community trauma, and racial injustice around them, P2P programs that incorporate civic engagement offer additional healing opportunities.[7]

P2P programs can be facilitated by credentialed teaching staff, like Pomona Unified's Peer Resources, or by a CBO like Sacramento City Unified and Pro Youth & Families' MindOneSix program. Likewise, Community Health Workers (CHWs), Peer Support Specialists, and the new Behavioral Health Coach are well-suited to facilitate P2P programs.

Cultural and indigenous healing practices

Positive ethnic-racial identity is a strong protective factor for BIPOC youth.[8] For native youth, strengthening connections to their communities, elders, and cultural practices is a necessary part of healing.[9] The fee schedule and provider network should include indigenous and cultural healing practices/practitioners that honor the cultural wealth our communities possess. While CalAIM enabled reimbursement for traditional healers and natural helpers providing specific services to a specific population, we hope the fee schedule will reimburse for a range of cultural healing services provided to children and youth from multiple ethnic and cultural communities, in addition to American Indians and Alaska Natives. These are critical advancements towards building health equity and trust in healthcare.[10]

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[5] A Right to Heal: Mental Health in Diverse Communities.

[6] The L.A. Trust School Health Policy Roundtable BH Coach Youth Survey; Youth-Centered Strategies for Hope; Healing, and Health; Helping Center Youth Voices in Mental Health; and 2022 State of Student Wellness.

[7] Adverse Childhood Experiences and Adolescent Mental Disorders: Protective Mechanisms of Family Functioning, Social Capital, and Civic Engagement; Exploring the Role of Engagement on Well-Being and Personal Development: A Review of Adolescent…; and An Innovative Community Organizing Campaign to Improve Mental Health and Wellbeing among Pacific Island…

[8] Pathways to Ethnic-Racial Identity Development and Psychological Adjustment: The Differential Associations of Cultural Socialization by Parents and Peers.

[9] Youth-Centered Strategies for Hope, Healing, and Health

[10] Promoting healing and restoring trust: policy recommendations for improving behavioral health care for American Indian/Alaska Native adolescents.

Include an ability to reimburse for activities provided by broad provider types.
Given the importance of peer support and non-traditional behavioral health interventions, we strongly encourage the inclusion of broad provider types in the fee schedule, including CHWs, Peer Support Specialists, and unlicensed providers and paraprofessionals. It is noted that LEAs would ultimately decide on their billing infrastructure to reduce the duplication of billing and potential audits.

Address social drivers of health.
Services may include ACES (Adverse Childhood Experiences) screenings for children and youth (including expanded screenings that include experiences of discrimination or community/racialized trauma), early childhood mental health consultations for young children in early learning and care settings, as well as transportation for foster and homeless youth to their school of origin to maintain their social connections and relationships to schools and providers. DHCS can strengthen the behavioral health delivery system by including services designed to address social drivers of health in the statewide fee schedule. Such investments would pay dividends over a child's lifetime, as they are less likely to develop serious mental health conditions resulting from preventable trauma.

Ensure community-based behavioral health providers are eligible for reimbursement.
We would like to emphasize how important it is that behavioral health providers *not employed by LEAs* are eligible for reimbursement through the fee schedule. One of the strengths of and main challenges to sustaining school-based behavioral health services is that services are available to all students, regardless of insurance status or ability to reimburse for care. Many SBHC providers tell us that they struggle to sustain behavioral health services to privately insured students.[11]

Thank you again for the opportunity to provide feedback on the exciting CYBHI workstreams led by DHCS. We look forward to supporting the implementation of these efforts. Please contact Gabby Tilley at g.tilley@thelatrust.org if you would like to discuss any of these comments further.

In partnership,

Alliance for a Better Community
Azuza Pacific Department of Psychology
California School-Based Health Alliance
Centinela Youth Services
Children's Institute
Children Now
City of Los Angeles Mayor Eric Garcetti
Community Clinic Association of L.A. County
Community Coalition
Communities in Schools Los Angeles
Dr. Lena Al Sarraf, Community Health Care Clinician
Helpline Youth Counseling
L.A. Care
Los Angeles County Office of Education
Los Angeles Unified School District
Planned Parenthood Los Angeles
Sycamores
The Children's Partnership
The Los Angeles Trust for Children's Health
UNITE-LA
United Way of Greater Los Angeles
Youth Leaders: Taaliyah Tucker, Victoria Virgen, and Chris Anthony

CC: Melissa Stafford Jones

[11] According to the California School-Based Health Alliance, one SBHC run by a CBO estimated that the cost of providing care to privately insured students (primarily Kaiser) in 2015 was $20,000 over three months.

November 18, 2022

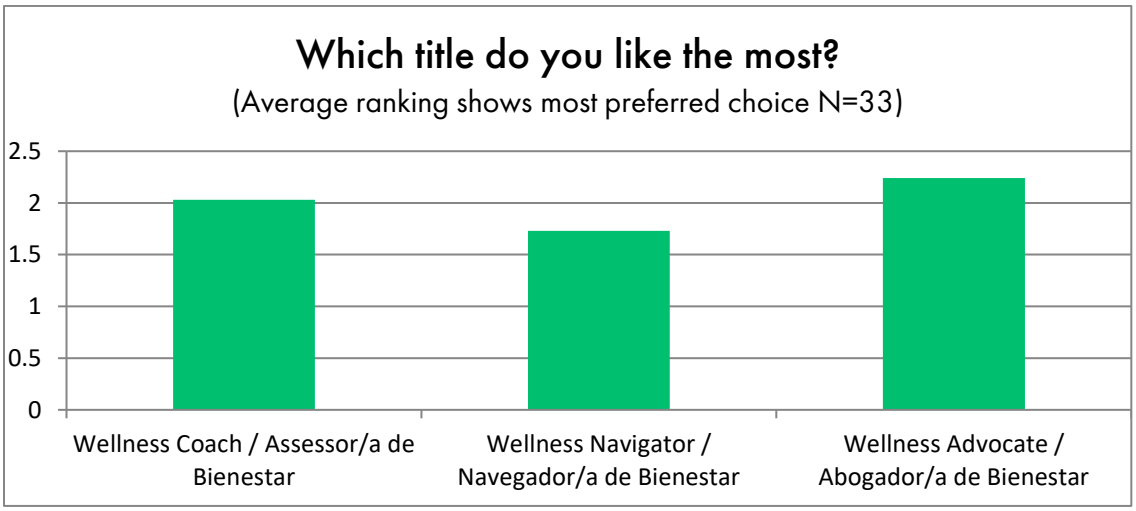
California Department of Health Care Access and Information
2020 W El Camino Ave #800
Sacramento, CA 95833

Dear Elizabeth Landsberg,

The L.A. Trust School Health Policy Roundtable (Roundtable) is comprised of thirty-three cross-sector organizations committed to advancing schools as centers of wellness in Los Angeles County. We see the CYBHI as a transformative opportunity to help schools establish integrated, youth centered systems of care that support student success in school and life. Our members who serve children and youth in K-12 school settings widely experience workforce challenges that affect the quality and quantity of services provided. Often, it means students miss out on critical prevention, early intervention, and care coordination services that comprise the foundation of a healthy behavioral health ecosystem. We are hopeful that Behavioral Health Coaches will strengthen this system and encourage you to consider the following feedback as you continue developing the role.

BH COACH TITLE

We agree with the decision to select a new title for the role, as 'Behavioral Health Coach' carries a stigmatized association with mental health diagnosis and clinical treatment. We surveyed young people across our network to gather their input on (1) the alternate title and (2) the kinds of services that young people want and need help accessing.[1] Wellness Advocate was the most preferred title with 45% of respondents selecting it as their first choice. Wellness Navigator was the least preferred with only 6 respondents selecting it as their first choice.



[1] We collected 33 responses: 28 from youth aged 13-17 and 5 from youth 18-25 years old. See results: The L.A. Trust School Health Policy Roundtable BH Coach Youth Survey.

SCOPE OF SERVICES

Reduce Non-Youth facing Activities by 10 percent.

We need more individuals to provide direct care not just duplicating current roles and efforts in screening and referrals. We urge caution when assigning screening and coordination of services duties because they might be duplicative of other people's roles on a campus. This could create a "choke" point then of students needing services but there not being enough direct service providers to serve them. Along with administrative activity, site support, and professional development—non-youth facing activities should be reduced by 10% so that youth-facing activities comprise 80 and 90 percent of the BH Coach I and II respectively.

Underscore importance of Tier I Interventions.

When asked to pick the top five services that students want but need help accessing, youth survey respondents identified eating disorder treatment (82%), substance abuse treatment (61%), life skills coaching (58%), arts/music therapy (52%), and cultural/Indigenous healing practices (52%). All these needs can be addresses to some extent at the tier 1 level and provision does not necessarily require advanced degree or licensure. BH Coaches should be equipped to address behavioral health disorders and explore alternative healing modalities when a coach's skillset and cultural background align.

Add peer support facilitation as suggested youth-facing activity.

When asked, "If you needed mental health support, who at your school would you ask for help?"—68% of the youth respondents to our survey selected: another student, friend, or peer (see chart below). This and several other studies confirm that young people need to be engaged as partners in the behavioral health system of care.[2] The BH Coach is perfectly positioned to facilitate peer support programs in middle and high schools. This can include restorative justice programming to promote school safety and positive school culture.[3] The BH Coach should also co-develop and present wellness promotion and education modules, so they are responsive to young people's priorities.

Clearly delineate substance use prevention and treatment services.

The current scope of services described under BH Coach I and II in HCAI's model does not mention prevention and early intervention for substance use disorder (SUD). In the past 12 months, Los Angeles County experienced at least twelve reported overdoses of youth who had taken illicit substances that contained fentanyl.[4] This includes the tragic death of Melanie Ramos, a 15-year-old student at Helen Bernstein High School in Hollywood. BH Coaches should be one of several on-campus staff trained to administer naloxone, which can reverse overdoses, and be able to provide fentanyl test trips and Naloxone to students. SUD prevention and treatment should be clearly delineated under the BH Coaches' scope of services and provided in collaboration with trained peers, SUD counselors, and other members of a student's care team.

[2] Youth-Centered Strategies for Hope, Healing, and Health; Helping Center Youth Voices in Mental Health; and 2022 State of Student Wellness.

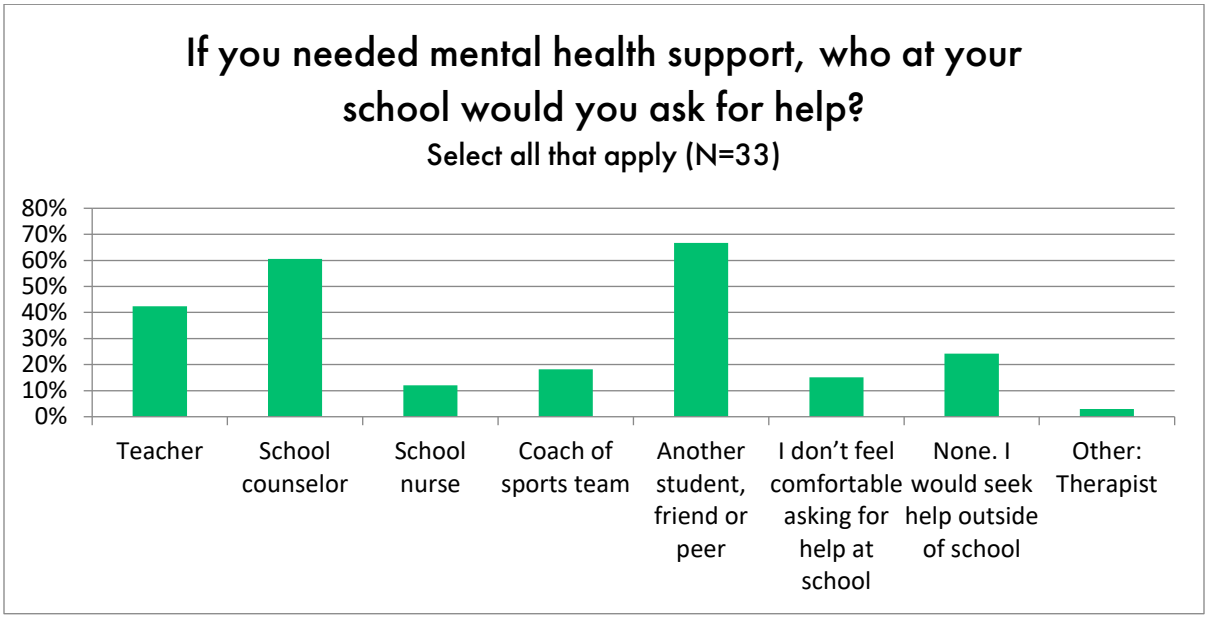
[3] See Restorative Justice Program at Fremont High School – OUSD.

[4] Empowering Schools and Youth to Respond to the Drug Overdose Epidemic.

OPERATING MODEL

Emphasis integration with school programs and operations.

As other stakeholders have mentioned, we are concerned that BH Coach activities may be duplicative of those assigned to current school staff and school-based behavioral health providers. To ensure BH Coach services are additive and targeted according to each school's needs—there must be an emphasis on integration. That might include participation in school site coordination teams, partnership with SBHCs and CBOs, and allowing access to data tracking systems. After peers, the chart below indicates that students feel most comfortable asking teachers and school counselors for mental health support. As noted in HCAI's BH Coach model, BH Coaches shoud collaborate with teachers and counselors, among other school site staff, to coordinate and deliver services.



RECRUITMENT AND TRAINING

Facilitate recruitment of culturally and ethnically diverse Coaches.

We applaud HCAI's effort to make the position accessible to people from a wide range of backgrounds and want to underscore the importance of recruiting culturally and ethnically diverse Coaches. Young people, especially BIPOC youth, will more readily engage in healing with Coaches who look like them, come from their communities, and can connect through shared lived experiences. We recommend HCAI fund CBOs to offer and promote BH Coach training and field work opportunities.[5] Likewise, we recommend HCAI provide ample grants and accommodations, like remote learning opportunities, to ensure the pre-requisite and training requirements are financially attainable and widely accessible to all demographics and regions.[6]

[5] CBOs, like TransCanWork and the LA Opportunity Youth Collaborative, can be effective at pipelining diverse candidates into the role.

[6] Consider funding CBOs to offer compensation and mentoring/job placement services for program participants, like The Us Program, a Peer Specialist training and employment program based in Sacramento.

Recognize youth leadership experience in health education.
We agree with the recognition of hours from related experience. One example of related experience is participation in peer-to-peer health education and leadership programs. The L.A. Trust for Children's Health runs Student Advisory Boards (SABs) in partnership with LA Unified Wellness Centers that prepare students to educate and help navigate peers to mental health and other wellness services. Planned Parenthood Los Angeles has a Peer Advocate program that prepares students to educate their peers on sexual and reproductive health and its intersections with all other facets of health. Both programs should qualify as related experience hours toward the 400 hours of required field work.

Promote a holistic approach to behavioral health.
Training should prepare coaches to implement positive youth development strategies that are strengths-based and connect students to their cultural and racial identity, like the Madison Park Academy Mentoring curriculum. Further, given the demand among youth for alternative healing modalities, BH Coaches should receive introductory training in using art, music, and movement in a tier 1 therapeutic practice, as well as exploring cultural/spiritual healing practices, when appropriate.[7] These kinds of supports can be provided alone or in conjunction with tier 2 and 3 interventions. A holistic approach can provide significant relief to young people experiencing anxiety, depression, and other behavioral health challenges.[8]

Thank you again for the opportunity to provide feedback on this exciting work. We are grateful for your team's leadership and partnership with us and the stakeholder community to ensure the initiative is successful. We look forward to supporting implementation of these efforts. Please contact Gabby Tilley at g.tilley@thelatrust.org if you would like to discuss any of these comments further.

In partnership,

Alliance for a Better Community
Azuza Pacific Department of Psychology
California School-Based Health Alliance
Centinela Youth Services
Children's Institute
Children Now
City of Los Angeles Mayor Eric Garcetti
Community Clinic Association of L.A. County
Community Coalition
Communities in Schools Los Angeles
Dr. Lena Al Sarraf, Community Healthcare Clinician
Helpline Youth Counseling
L.A. Care
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Sycamores
The Children's Partnership
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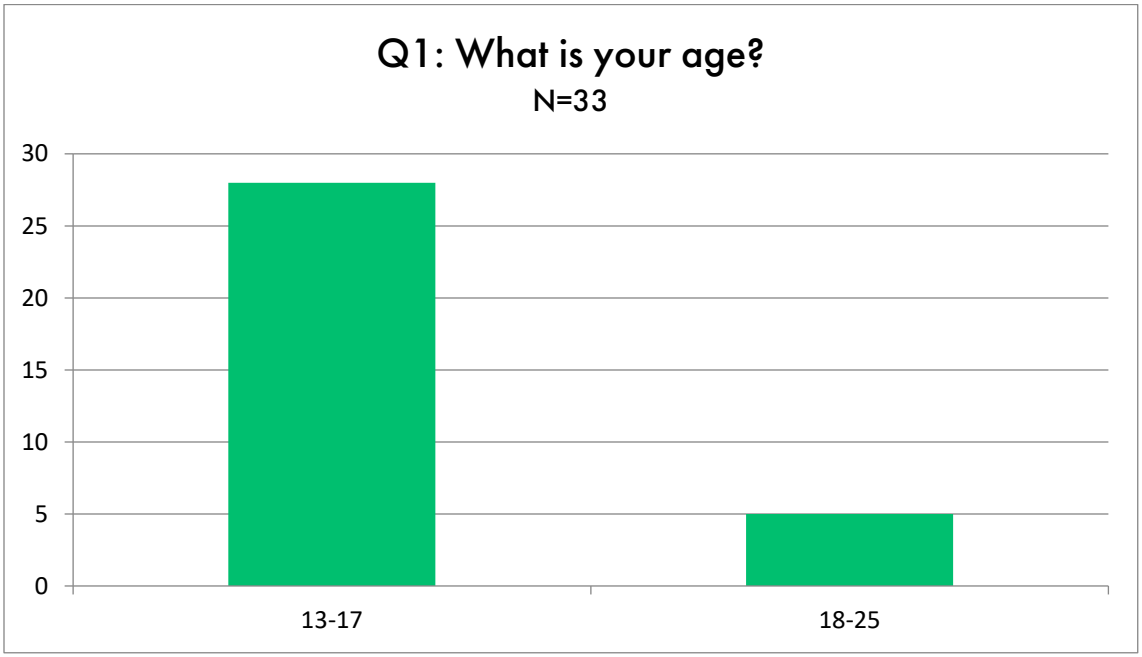
United Way of Greater Los Angeles
Youth Leaders: Taaliyah Tucker, Victoria Virgen, and Chris Anthony

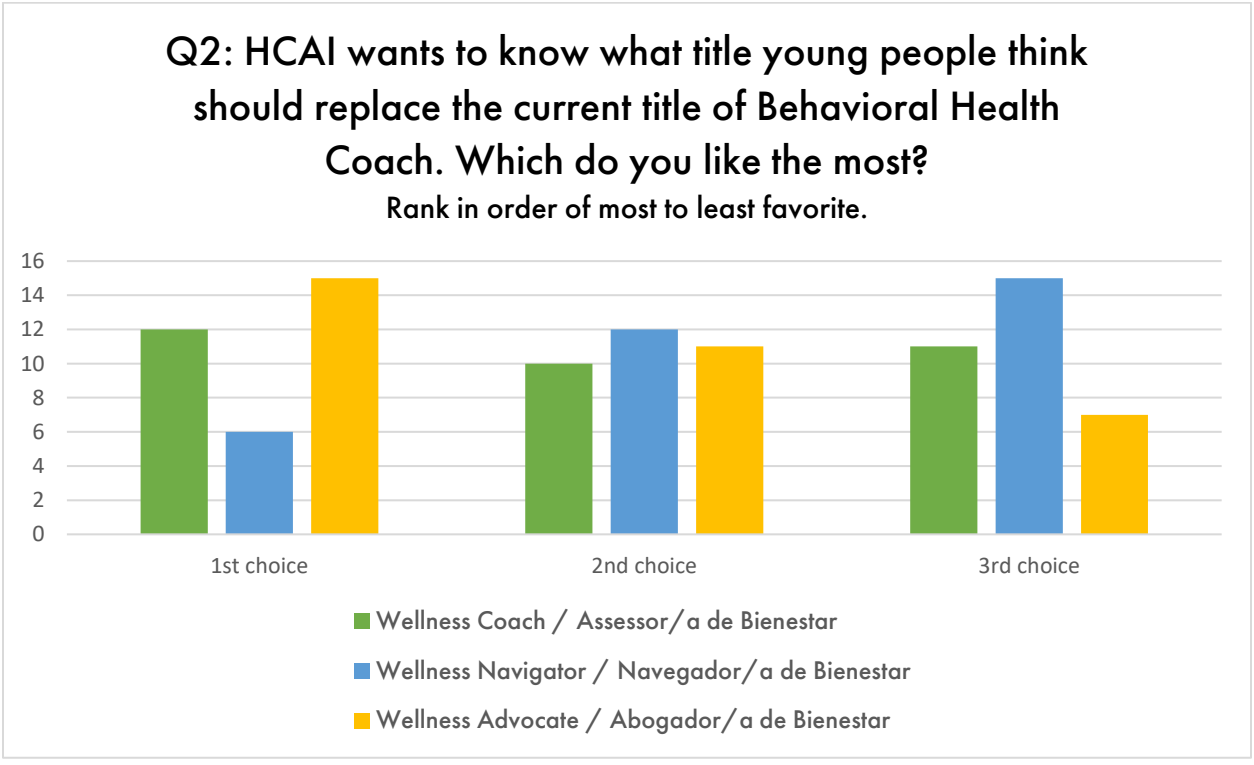
CC: Caryn Rizell, HCAI
James Regan, HCAI
Lindsay Bradshaw, HCAI

[7] The L.A. Trust School Health Policy Roundtable BH Coach Youth Survey; Youth-Centered Strategies for Hope, Healing, and Health; and Helping Center Youth Voices in Mental Health.
[8] A Holistic Self-Learning Approach for Young Adult Depression and Anxiety Compared to Medication-Based…

The Los Angeles Trust for Children's Health

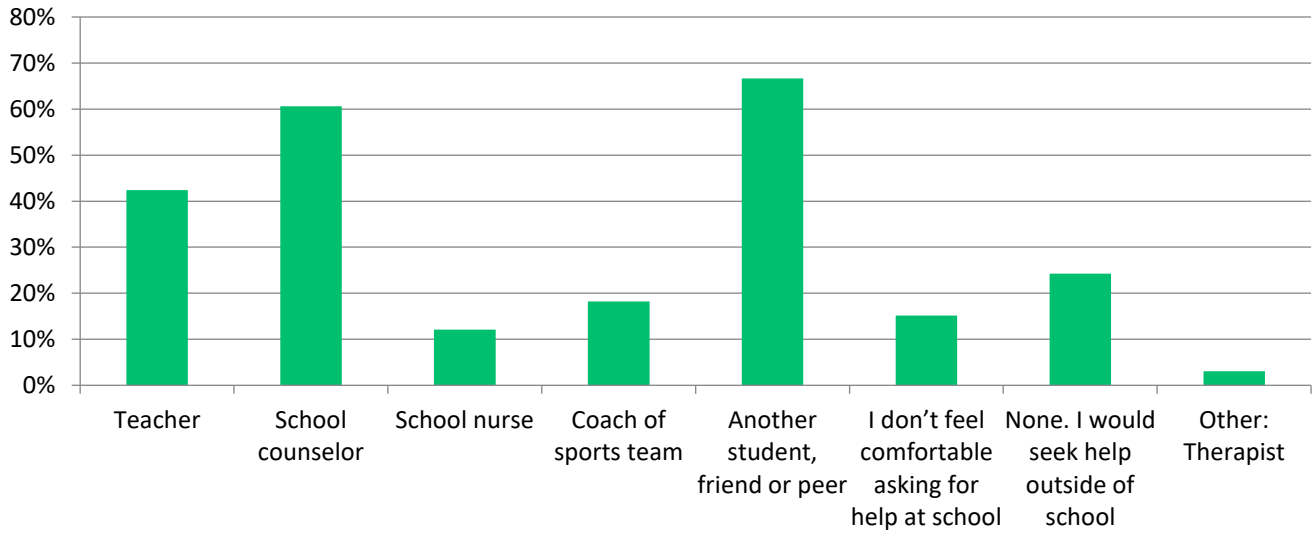
The L.A. Trust School Health Policy Roundtable surveyed young people across our network to gather input on the role of the Behavioral Health Coach in K-12 school settings. Specifically, the survey sought youth input on (1) an alternate title for Behavioral Health Coaches and (2) the kinds of services that young people want and need help accessing. We collected 33 responses between October 4-28, 2022. The order of choices on questions 3-5 were randomized for each respondent to help reduce order bias.





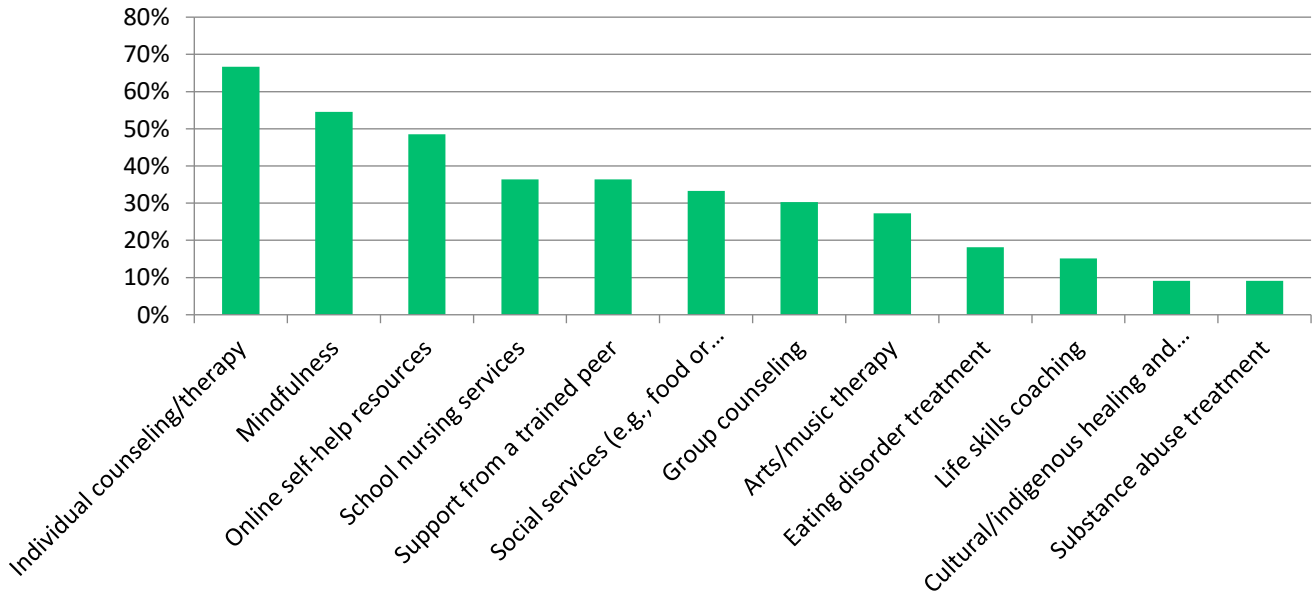
Q3: If you needed mental health support, who at your school would you ask for help?

Select all that apply (N=33)



Q4: If a student at your school needed mental health support, which services could they access easily (without much help)?

Select all that apply (N=33)



The Los Angeles Trust for Children's Health