TOOLKIT

Bridging Education and Mental Health:
A Toolkit for Integrating School-Based Mental Health Services in California

REV 5/22

Fresno County Superintendent of Schools

Department of Behavioral Health

“A child’s mental health is just as important as their physical health and deserves the same quality of support..”

- Kate Middleton, Duchess of Cambridge & Youth Mental Health Advocate

Mental health conditions among children, teens, and young adults—specifically depression, anxiety, substance use disorders, and an alarming trend toward suicide—is a growing problem all over America.

The recent global pandemic created further anxiety and stress, exacerbating and deepening equity divides. However, schools can be a crucial player in creating a solution to address our youth’s mental health.

All 4 Youth was an idea born out of the hearts and minds of a few dedicated leaders in Fresno County by bridging the gap between the Fresno County Department of Behavioral Health (FCDBH) and the Office of Fresno County Superintendent of Schools (FCSS). We came together when it was apparent that neither system alone could fully meet the growing needs of youth in the community.

Our team had the experience from many years of working in the fields of education and health care as well as the professional background to understand the upstream predictors of both educational and behavioral challenges. For example, challenges youth may experience can be a direct result of youth enduring poverty, trauma, or food insecurity and ultimately fuel a lack of access to healthcare, healthy food, and mental health services.

All 4 Youth focuses explicitly on addressing mental health as a critical part of learning success and overall wellness, advocating for prevention and early intervention services for every child. Our program also supports early identification of risk and the integrated services, care, and treatment for youth who need help changing the narrative from distress to success. In this service delivery model, mental health clinicians are part of the team within a school-wide, multi-tiered support system.

We understand that no one agency could go at it alone. The journey requires hard work and collaboration with multiple organizations and stakeholders. Nevertheless, this journey is worthwhile and is a priority to support youth in our communities to achieve greater health and education outcomes for generations to come.

Our goal is for the resources in this toolkit to inspire you to take action for all the youth in your communities!

Sincerely,

The Fresno County All 4 Youth Team

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INTRODUCTION

Welcome to Our Toolkit!

When we started our journey to establish All 4 Youth, we didn't have a lot of tools at our disposal or even a framework to build off—we developed this program from the ground up. It turned out to be an extensive process. In fact, looking back at everything our team has learned is humbling. To pay forward our hard work, we are ready to transfer our knowledge to your team.

We know how complex cross-sector work can be, but remember that establishing a similar partnership and program can effectively provide access to a broad continuum of behavioral health services for youth and families in your community.

Outline

The toolkit provides insight into the processes of launching your own unique partnership program. To walk your team through our approach, we've assembled our information into the following sections:

- Our Partnership
- Assessing the Landscape
- Design & Customize a Local Model
- Plan Implementation & Preparing for Launch
- Implementation & Launch
- Evaluation and Quality Management

You'll find that each section has five sub-categories, including Overview, Objectives, How We Did It, Lessons Learned, and Testimonials. We've also sprinkled in some notes from our team to guide you through more specific situations or outcomes we experienced along the way.

Our team intends for this information to be an actionable guide for you to develop a program that meets the needs of your local youth and families, even if your program mission, vision, or goals are vastly different from ours!

Who We Are

Susan L. Holt

Director of Behavioral Health and Public Guardian
Fresno County Department of Behavioral Health

Susan Holt is a Licensed Marriage and Family Therapist and lifelong resident of Fresno County. She currently serves as the Fresno County Director of Behavioral Health and Public Guardian. In this role Susan leverages her diverse professional experiences to lead, strengthen, and advance the public behavioral health system in her community. With over 25 years in the behavioral health field, her clinical experience includes providing treatment in residential programs, schools, outpatient clinics, mobile crisis response, and inpatient psychiatric care settings.

As her career progressed, Susan was inspired by those she served to shift her focus toward system of care development and improvements, particularly for the most vulnerable populations; this ultimately led her to management in behavioral health. Her passion in behavioral health leadership is to cultivate strengths within teams and across sectors to create and enhance environments that promote well-being, resilience, and recovery.

Susan is a graduate of California State University, Fresno, where she received her Bachelor of Science degree in Health Science and her Master of Science degree in Counseling. She returned to the Fresno State campus as an adjunct faculty member teaching nighttime courses in Counseling for the past decade.

Trina Frazier

Assistant Superintendent of Student Services at the office of the Fresno County Superintendent of Schools

Trina Frazier is a native of the Central Valley and has 32 years of experience providing expertise in the areas of program development, pupil personnel services, behavioral health and special education. She is dedicated to maximizing organizational efficiency and empowering others to succeed.

She currently serves as the Assistant Superintendent of Student Services at the office of the Fresno County Superintendent of Schools, where she oversees the Student Services Department, which includes the behavioral health All 4 Youth program, special education and Fresno County's Special Educational Local Plan Area (SELPA).

Trina's passion was sparked when she started her career as a 5th grade classroom teacher where she experienced, firsthand, the intense behavioral health needs of children and youth in Fresno County. Since that time, she has focused her attention on developing programs and services that will integrate behavioral health services in the schools.

The All 4 Youth partnership with the Fresno County Department of Behavioral Health has been the culmination of this vision.

Tammy Frates

Senior Director for Behavioral Health
Programs & Services

Tammy Frates has been employed with Fresno County Superintendent of Schools (FCSS) for 26 years where she oversees the All 4 Youth Behavioral Health program, the Early Intervention Service delivery FRIENDS program and Help Me Grow. Tammy began her career with FCSS as a School Psychologist and later became a Licensed Educational Psychologist. Tammy is now the Senior Director for Behavioral Health Programs & Services.

Tammy's passion began when she first started her career working with children and families who experienced extreme difficulties navigating the behavioral health and early intervention systems. Tammy is committed to creating one seamless system so families can easily access behavioral health and early intervention services and ensure students are connected to appropriate services they so much need. Recently,

Tammy completed the UC Davis Napa Fellowship and is an endorsed Infant Mental Health Specialist where she applies her extensive knowledge and experience with the birth to 5 population.

Trish Small

Fresno County Superintendent of Schools

Trish Small has over 18 years of experience in education serving youth and families of the Central San Joaquin Valley in Fresno County. In her early career, she has served as a school psychologist and special education director in a rural school district and spent the past 12 years at the Fresno County Superintendent of Schools (FCSS) office in various leadership roles, including positive behavior supports and principal for programs for students with emotional disturbance.

For the past 10 years, she has provided leadership in the Pupil Personnel Services Department where she oversees the provision of school psychologist services, All 4 Youth Trauma & Resilience Trainings and other tiered systems of social-emotional support and trainings. Her depth of experience in all of these programs and departments has led her to be a champion for increasing access to mental health supports for underserved populations and integrating systems of support for all youth in Fresno County.

She is one of the founding members of the All 4 Youth behavioral health partnership and her years of cross-sector work with school districts in Fresno County and local community agencies has contributed to the expansion of mental health programs in schools. Trish is an innovative leader who always strives to support her team in making their visions for students and the community become a reality.

Through her work with the Fresno County Suicide Prevention Schools Work Group Trish has been instrumental in developing innovative programs to enhance supports to youth and families contributing to the overall suicide prevention efforts of Fresno County.

all4youth wellness center

Website: https://all4youth.fcoe.org/

Email: All4Youth@fcoe.org

Our Mission

Our mission is to have an integrated system of care that ensures all children have access to behavioral health services to support their social, emotional, and behavioral needs and promote health, well-being, and resiliency.

Our Vision

We envision a community where all children's behavioral health needs are met. Barriers will be removed, and all children and families will have access to a seamless system that promotes a positive, healthy environment to live and learn.

Our Goals for All 4 Youth

- Offer youth and their families easy access to behavioral health services at school, home, and in the community.
- Remove barriers and increase access to a positive, healthy environment where our youth can live and learn.
- Provide help for all youth ages 0-22 years old who are experiencing behavioral difficulties that affect their ability to learn and get along with friends and family at school and home.

The Fundamentals

Throughout this toolkit, you will read about an "integrated system of care," which is the heart of All 4 Youth. Simply put, integrated care connects youth and their families, health care professionals, and others within the school system by focusing on the accessibility of the following services:

- Assessment of youth and family needs
- Individual, group, and family therapy
- Care-coordination with other providers
- Linkage and referrals to needed support services
- Support to primary caregivers
- Case management and psychosocial rehabilitation

PART I: OUR PARTNERSHIP

Overview

Our local Department of Behavioral Health provided mental health services in our schools for many years, and aspired to have a more comprehensive county-wide strategy for serving youth in schools. However, historically, placing clinicians at schools was contingent on numerous variables outside of the control of FCDBH. Penetrating into the schools and navigating the unique school culture across 32 school districts proved challenging.

Further, in 2011 the responsibility for educational-related services for students with an Individualized Education Plan (IEP) due to Severe Emotional Disturbance (SED) shifted from the County Mental Health Plan to the schools. An unintended result was confusion and misaligned expectations between schools and the County Mental Health Plan. Specifically, the responsibilities of who was providing mental health services for students that were Medi-Cal beneficiaries with educationally related mental health services written into their IEP. Therefore, systems-level relationships that had formed during the AB 3632 era—before those changes in 2011—became muddled.

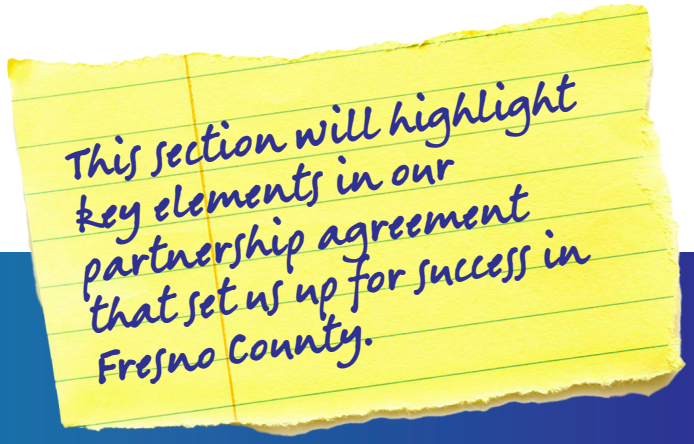
In 2016, stemming from mutual frustration years in the making and heartfelt cross-sector discontent, leaders of FCSS and FCDBH called a meeting. This moment was tense between our two agencies, where literally FCSS and FCDBH leaders sat on opposite sides of the table and outlined numerous challenges, barriers, myths,

and truths. Reflecting back on the tension of this pivotal event in the history of our partnership, we humorously refer to this as "The Meeting." It could have gone badly, each system could have indignantly blamed the other for limitations and barriers, and it could have resulted in nothing changing or, worse yet, further divide and challenges. However, through courageous leadership, we chose to meet again to envision a different future for our community, and we embarked on a committed planning process to carve a new path forward, in partnership, to serve our youth and families.

Understanding that no one agency can achieve our mission and vision alone, we developed a partnership between the FCSS and FCDBH. This partnership allowed us to tap into each other's resources and relationships as distinct systems to bridge gaps and develop shared strategies for addressing youth's mental health needs. We developed a robust contractual partnership whereby FCSS was the organizational provider of the FCDBH Mental Health Plan to provide specialty mental health services to Medi-Cal-eligible youth and their families in their schools, community locations, and homes. In addition to specialty mental health services for Medi-Cal eligible youth and families, all kids benefit from the program through the investment in Prevention and Early Intervention strategies. All kids can receive, at minimum, screening and assessment and be linked to services that are best matched to their needs and resources.

Fresno County is in the San Joaquin Valley and covers a large geographical area of over 6,000 square miles. It has a large urban center with many rural and remote districts across the county. Many of our rural communities are not only far from the urban center where most of the mental health services are located, but also lack other resources such as internet access and other basic services.

We created a hub and spoke model whereby we established ten hubs geographically positioned throughout the county, with the schools within that vicinity serving as the spokes. First, we planned a five-year roll-out process by identifying groups of schools to onboard each year of the roll-out. Then, we developed an onboarding process for orienting each school in preparation for their clinician and required training for all school staff (not just teachers) to recognize and respond to youth who may be experiencing difficulties reflecting a mental health need. We started by prioritizing a part of our county with limited access to mental health services and a high interest in partnership with our program. Our goal by year five was to have a clinician assigned to every school site in Fresno County, totaling over 300 schools and ten hubs strategically throughout the region.



Objectives

- [ ] **Outlining Our Partnership**
- [ ] **Initial Planning**

How We Did It

Outlining Our Partnership

As we worked collaboratively to develop a comprehensive partnership program, each step was a learning curve for our team.

To summarize, our official agreement defines our partnership as the following:

"Fresno County Superintendent of Schools and Department of Behavioral Health are partnering to address social, emotional, and behavioral needs of youth in all schools across Fresno County.

Through this collaboration, we can provide access to all students who need services. Behavioral health services are for all youth ages birth to 22 ranging in frequency and intensity depending upon the individual needs. This collaboration will be expanded to include other community agencies in the future.

In this service delivery model mental health clinicians will serve as team members within a school-wide multi-tiered system of support that address the mental health needs of all youth. Services and supports will be delivered at the school site, in the community, and in the home where appropriate. Training and education for school staff, caregivers and students will be provided. Care coordination, risk assessment and suicide prevention will be embedded throughout this system of care so that all children in rural and urban areas have access to mental health support within their community.

All agency services will be integrated into the schools to create a network of providers and services to reach all students. This collaborative model will provide students and caregivers with one seamless system of care that will remove barriers and increase access to a positive healthy environment in which youth can live and learn. Being prepared to learn is as important as the learning."

Throughout the toolkit, we will reference important aspects of our program. Many, but not all, of these elements are formally reflected in the contract approved by our Board of Supervisors. To view the formal contract, click here:

A Note from Fresno County All 4 Youth

We understood that an extensive partnership, like the one we created, can have a broad impact on the existing network of care. We were cautious about those impacts and deliberately brainstormed ways to keep other organizations involved in meaningful ways. As noted in our outline, we are looking to expand and improve this partnership as we grow. We continuously strive for an inclusive system of care in which many service providers, large and small, can seamlessly coordinate care in our community.

Defining your partnership and developing an outline of your Scope of Work in your contract will help everyone navigate the partnership with a clear and common goal.

Initial Planning

Laying the foundation for our integrated system of care required a lot of time, organization, and communication; especially working with two county agencies. We've outlined areas of responsibility and how we function with respect to a few key tasks in our partnership. We hope this overview assists you to get the ball rolling with envisioning what your partnership might look like.

Defining Leadership Structure

The first step in building mutual consensus as we planned our partnership program was to establish a framework for shared decision-making. Early in the planning we identified a Steering Committee that would serve as the mechanism to keep the program and partnership moving forward with senior executive support. As the planning continued, additional meetings focused on a variety of tasks, functions, and objectives that helped our partnership establish a meeting structure.

We decided that the contracted All 4 Youth program needed two directors, one with educational expertise and the other with behavioral health clinical expertise since our model integrates two very different systems—education and health care. As a result, we needed to have a strong understanding of both worlds to develop our program and support our staff.

Defining Roles and Responsibilities

We strongly recommend that partnership agencies work together to clarify which individuals from each agency's leadership will be represented in each of the various functions of the partnership. This is important so there is a thorough understanding of who will be joining to participate and who has authority for which decisions. For example, we identified our internal leadership as the following:

FCSS Leadership:
Assistant Superintendent of Student Services
Senior Director of Behavioral Health Program Services
Director of Behavioral Health Clinical Services
Director of Pupil Personnel Services
Director of Fiscal Student Services
Accountant
Administrative Support Supervisor
Administrative Assistant

FCDBH Leadership:
Director of Behavioral Health
Deputy Director, Clinical Operations
Division Manager of Children's Mental Health
Principal Staff Analyst
Senior Staff Analyst

Ramp Up Periods

During a program ramp-up period, funding is provided to allow a contracted provider to perform necessary tasks before opening the doors and going live with a new program. In the FCDBH network of care these activities typically include, but are not limited to:

- Recruiting and hiring leadership positions
- Developing policies and procedures
- Preparing for site certification (i.e., meeting specific State requirements to enable Medi-Cal billing capabilities)
- Putting the infrastructure in place
- Recruiting and hiring new staff members
- Training staff (Reference staff training schedule worksheet in the appendix)
- Buying equipment
- Creating a referral process
- Credentialing mental health providers by the Mental Health Plan (MHP)
- Communicating with onboarded schools

When it comes to budgeting, make sure your partnership is familiar with any restrictions during this ramp-up time. For instance, what activities and expenditures can be accounted for in ramp-up funding versus what cannot? Together navigate:

- Organizational and budgetary deadlines for year-end fiscal closure of books
- Timeframes when purchase orders can no longer be processed (Note: We recommend a ramp-up mid-year and start live date at the beginning of August.)
- Periods when items can be received and accounted for to connect with ramp-up funds etc.

All of these areas of focus ensure that on day one, your program is ready to serve youth, your services are ready to be billed, and you can start on the journey of putting your program design into action and becoming self-sustaining.

In order for a provider to receive Medi-Cal beneficiary referrals and begin billing for services, the provider must first be Medi-Cal certified by the Department of Health Care Services through its local Mental Health Plan. The Fresno County Mental Health Plan (FCMHP) is required to conduct a Medi-Cal site certification and a credentialing process to ensure compliance with all federal and state guidelines; however, the exact timing was up to the discretion of FCMHP. Compliance with site certification standards is monitored by FCMHP staff. (Reference “Certification Survey”)

Due to site certification requirements in other settings, we originally planned to certify all service sites. We later learned that school sites are an exception to the certification requirement. However, we still needed to maintain our hubs’ certification process to ensure that our All 4 Youth partnership met County Mental Health Plan requirements.

Additionally, each time a new hub location was established, site certification was required by Managed Care every three years. At the time of site certification, the policies and procedures, credentialing packets, and fire clearances are updated and placed in a large binder with appropriate labels for easy access to ensure all guidelines are up-to-date.

A Note from Fresno County All 4 Youth

It's worth noting that your county may not offer ramp-up periods or may have different ramp-up timelines and procurement processes. If no ramp-up structure to the mental health services program exists, you may want to reach out to procurement and others to establish a timeline.

In Fresno County, a maximum of a three-month ramp-up period is typical for new FCDBH contracts. However, we concluded that we needed a longer ramp-up time to start our All 4 Youth program for the following reasons:

- We realized the learning curve might be steep. Serving as a Mental Health Plan contracted provider was an entirely new business line for FCSS.
- The program is wide-reaching, requiring extensive hiring and training for each year of the partnership agreement, so we would need more time to launch our program.
- For a new program that is anchored in the school system, we learned that ramp-up periods during the summer can be a challenge. We found that aiming to have your contract "Go Live" with actual services and billing Medi-Cal at the beginning of the school year makes the most sense.

In terms of hiring procedures, one critical aspect of our first year was the shared interview process we developed for senior leadership positions. It was essential to FCDBH that someone from the behavioral health service delivery side filled a leadership position since we wanted a candidate who understood service delivery in the public behavioral health and County Mental Health Plan system of care. Therefore, you may want to think about what hiring practices best serve your program's needs. Our partnership conducted joint interviews for this position, which is unique for our Mental Health Plan, as previously, FCDBH had not participated in a contracted provider's hiring process.

Additionally, starting staff training during the ramp-up period is necessary, so they can begin providing services and helping youth as soon as possible!

Funding for Our Model

Funding for our model was through the Mental Health Services Act (MHSA), with most funds allocated for Medi-Cal reimbursable services for youth eligible for specialty mental health services. Additionally, a smaller portion of funds came from Prevention and Early Intervention (PEI) services for youth meeting criteria under a DSM-V diagnosis and eligible for long-term treatment. Youth who did not meet the requirements would receive short-term treatment through PEI funding.

Planning for Funding Requires Transparency From All Parties

Included in your contract should be a funding plan. We knew that to be sustainable for the long-term it would be critical to leverage funding across sectors. We found that transparency by all parties encourages each partner to share how they leverage the funds available and ensure that all children and youth have access to care regardless of their ability to pay.

To overcome the disparity between children who have Medi-Cal and can receive assistance at school and those who don't qualify for Medi-Cal, it's worth exploring all avenues of funding (i.e., AB114, LCAP, Medi-Cal, MHSAP).

For example, by leveraging Prevention and Early Intervention funds (MHSA), we structured our All 4 Youth partnership to ensure that children at any school throughout Fresno County could, at minimum, receive a screening, an assessment, and a brief intervention. Youth covered by Medi-Cal could receive their treatment services through All 4 Youth. However, children without Medi-Cal could only receive care coordination to other available services, connecting to their private insurance for ongoing care. These processes ensure that all children could have assistance when it came to accessing care.

Lessons Learned

1. Have a Plan for All Insurance Referrals

It's important to remember the role of our program is to serve youth who are Medi-Cal beneficiaries. Based on our assessment of the needs in the county we anticipated approximately 90% of our referrals would be for youth who were Medi-Cal eligible. However, what we did not anticipate was the number of referrals for youth with private insurance. We found that many families wanted the convenience of their youth receiving services at their school so that they would be in a place where they were comfortable and did not have to miss out on as much of their education. Other families who are privately insured do not have the ability to cover the cost of high co-pays. It will be important to anticipate this possibility and have a plan for addressing the needs of these youth.

2. Planning Budgets Around the Fiscal Years

Hiring new staff at the end of a school year to start working in July at the start of a new fiscal year presented a few challenges that we were able to learn and grow from moving forward. We found that we needed to plan in preparation for when we were changing budget years because of what's called a "no ordering period," where the ordering of new materials halts temporarily. Making anticipated projections for needs for the items you'll need, such as supplies, computers, printers, etc., will be a key to your success.

This approach to hiring required FCSS to project how many staff would be joining the team and what their equipment or other material needs were before their hire to have these things on hand when the onboarding process began. Meanwhile, our partnership was trying to navigate how to still meet the fiscal requirements of both FCSS and FCDBH that are in place at the new fiscal year rollover.

Testimonials

Through lessons learned, such as the barrier of not being able to bill to private insurance, advocacy through the County Behavioral Health Directors Association of California and supported by leaders in education, have resulted in legislation allowing youth to have access to these services in the future.

All 4 Youth has provided our students with the opportunity to grow and flourish, while focusing on their mental health needs. Having services on our campus, has decreased the stigma of receiving services and has helped all students realize that focusing on mental health is a necessity for good overall health. - Terry Hirschfield, Superintendent of Orange Center School District

PART II: ASSESS THE LANDSCAPE & IDENTIFY MODEL OF CARE

TIMEFRAME: 2016 TO MARCH 2018

Overview

From the moment we committed to envisioning a robust partnership program until we finalized our contract, our team met regularly to plan and strategize. This process of assessing the landscape, designing our model, determining funding, and preparing to operationalize the program initially took about two years, with learning continuing throughout our program development.

Before your team starts to plan what your partnership program will look like, it is essential that you first determine what services and support you will be providing that might fill an existing gap within your county or region. Begin by assessing the landscape and setting up a strategic delivery plan.

Our partnership centered around the coming together of two departments to break down unique barriers and increase access to mental health services for all youth.

To accomplish this, we started by asking two primary questions:

- What services and supports already existed?
- Where did barriers exist?
- Where was there a lack of access to mental health services?

Objectives

- [ ] Establishing a Steering Committee
- [ ] Defining Current Services & Programs
- [ ] Conducting a Gap Analysis to Pinpoint Needs, Access, or Care Delivery Systems
- [ ] Researching Different Models and Systems (healthcare systems, counties, schools)

How We Did It

Establishing a Steering Committee

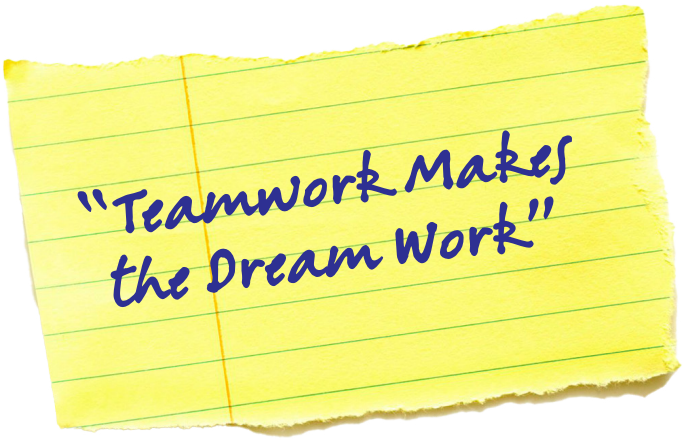
An essential component of assessing the landscape for us was establishing a Steering Committee with leadership from both FCDBH and FCSS. This group would collaborate to learn about each other's systems, talk through all aspects of our model, and provide direction for integrating them into a seamless system of care.

Between the Steering Committee and the FCDBH Onboarding Meetings, our partnership was able to coordinate training needs, fiscal needs, procedural and operational needs, and draft timelines to carry things through before the contract initiation and after contract finalization. Together, our team learned many things that helped prepare us for the launch of our contracted program and the work we would be doing in the future. We learned that it is impossible to entirely understand each other's systems or anticipate every twist and turn, even with the best research, resources, planning, and preparation. Complex situations come up and pull both systems into the mix. There are differing philosophies that can, at times, clash, but the best way to navigate the unknown and unexpected is to be flexible. Be open to listening and learning, practice being adaptable, and have the ability to change when the need arises.

Defining Current Services & Programs

Within the educational system throughout Fresno County, schools and districts had several programs and services to address the mental health needs of students. A continuum of services and supports within each Special Education Local Plan Area (SELPA) was available from trained personnel to provide individual and group support to regionalized programs for students with intense social, emotional, or behavioral needs. These educational programs required an Individual Education Program (IEP), and students who did not have an IEP often needed to rely on specialized support services outside the educational setting to have their mental health needs addressed.

The design of the continuum of mental services within many schools was explicitly for students who had IEPs. In some communities, more mental health resources were accessible than in rural and remote areas, where there was limited availability. Some schools paid for mental health professionals to provide non-IEP services and supports on site, but other schools did not. As mentioned previously, FCDBH, also provided services for Medi-Cal eligible youth on some school campuses. However, the reach was limited and FCDBH was unable to have staff in all schools. FCDBH also operated numerous other programs and had many contracts for services, but schools were largely unaware of these and unsure how to access services.



Our team began assessing the complex landscape of services provided by location, service provider, and eligibility to develop a complete picture of what we had to offer as a new program.

Conducting a Gap Analysis to Pinpoint Needs, Access, or Care Delivery Systems

Our teams spent a considerable amount of time learning about each other's care delivery systems. We built out a map of what services each entity was currently providing and where those services fall on the continuum of care. We then began developing a side-by-side

comparison of the services we each provide. We broke down services into three categories to further analyze what we explicitly offered to youth ages Prenatal-6, 7-11, and 12-22 years old. We utilized this information to identify where there were similarities and differences to identify any gaps in services across our joint continuum.

SEE ATTACHMENT:
FRESNO COUNTY BHP SIDE BY SIDE

Although there were many services available to youth in both sectors and across the continuum, there were limitations. For example, there were restrictions on accessing school sites due to programmatic constraints. There were also obstacles with eligibility requirements for services in many schools, requiring youth to have an IEP or Individualized Family Service Plan (IFSP). However, the gap that stood out the most to our team was mental health services to youth who did not qualify for either of these plans.

Our next step was to take the program and services information in our side-by-side comparison and develop an outline for what we were jointly providing to a continuum. Then, we ranked those services on a scale from Prevention, with the lowest intensity, to Intensive Intervention, with the highest support, frequency, and duration.

We mapped out what services were available at each of the following tiers:

- Prevention
- Early Intervention
- Intervention
- Intensive Intervention

Making a side-by-side comparison clearly illustrated a wide array of services available within the community. The bulk is provided by FCDBH or through one of their contract agencies. Nevertheless, this partnership required us to blend a traditional behavioral health outpatient medical model with an educational model to fill in the gaps and improve access for all youth.

Both the behavioral health medical model and educational model have strengths and vulnerabilities. For example, the behavioral health medical model has the power to provide an array of mental health services to accommodate various needs of a youth and family. Meanwhile, the educational model has easy access to students and solid relationships with their families. Of great significance from a perspective of ease of access to services, a school is where children and youth often find a sense of safety, security, and consistency.

Researching Different Models and Systems

Our team spent extensive time planning and preparing to build our partnership and contract throughout the entire two-year process. It may not take other counties this long, but planning for adequate time to prepare is essential.

During that time, we were researching other behavioral health models that existed in educational systems. As a result, the FCSS team made several trips to the Desert Mountain Special Education Local Plan Areas (SELPA) to learn about their California Association of Health and Education Linked Professions (CAHELP) program. Desert Mountain formed their partnership with San Bernardino Department of Behavioral Health in 2003 and has been operating a successful mental health program since that time.

The Desert Mountain Children's Center staff spent hours describing their program, sharing their job descriptions and forms, and taking us on tours of their facilities. The time they spent with us, and the information and tips were invaluable. Their staff provided us with a framework to build upon and adapt to meet the unique needs of Fresno County.

Our team also spent a lot of time at conferences and workshops focused on mental health integration in schools. There have been numerous conferences addressing this topic, such as Breaking Barriers, Wellness Together, and Advancing Mental Health in the Schools. These conferences provided helpful information from other professionals that gave our team insight into the things we needed to consider as we developed our model.

Our end goal for this process was to absorb as much data, community information, and first-hand experiences from fellow medical behavioral health, and academic sources as possible. This enabled our team to come together to collectively share all of this knowledge. This approach may seem like a daunting process, but it sets the groundwork to help your team customize your program to the exact needs of the youth and families in your community and optimize being prepared from the start.

Tools

County Health Index

The County Health Index is an excellent resource to start expanding your awareness of the unique needs in your county.

Through the Fresno County Health Index, it was clear that our county had many individuals and families living in poverty and lacking access to adequate health care. Since we understood that there is a correlation between the occurrence of trauma and poverty with mental health needs, we prepared our program to address the challenges associated with these areas.

External Quality Review Organization (EQRO)

The FCDBH contract with the California Department of Health Care Services (DHCS) requires an annual external review that the DHCS-contracted External Quality Review Organization performs. We call this the 'EQRO process,' which always results in an associated report.
The EQRO reports dating back several years proved to be a valuable resource when assessing the quality and access to behavioral health care for youth and their families.

One consistent key indicator in Fresno County's EQRO report was low penetration rates. To calculate the penetration rate, the total number of Medi-Cal eligible individuals receiving services from FCDBH is compared to the total number of Medi-Cal eligible individuals in an area or a demographic group. The penetration rate can identify a gap between the percentage of Medi-Cal eligible people expected to need mental health services and the percentage accessing those services. Historically, FCDBH had a lower penetration rate than expected for a county of our size, especially for services in rural areas versus metro areas.

This information demonstrated a need to reduce barriers for rural communities and increase access for youth and their families living there.

Lessons Learned

1. There Will Be Bumps in the Road

One of the obstacles we were able to overcome is related to the vast geographical expanse of our region. Fresno County covers a large area of land sprawling 6,000 square miles within the San Joaquin Valley. Our school districts range from the center of the county to the outer limits. Many remote communities have a 30 to 60-mile drive to the urban center, which takes time away from working and takes money to pay for gas. For many families, time and money are things that are not often at their disposal. As a result, many youth who need services were unable to access them.

The geography of Fresno County is quite large with many of the communities in Fresno County being remote. Many families in these rural communities experience poverty or lack resources. These circumstances make it difficult for parents, caregivers, or other family members to take time off work or childcare obligations to transport their child to an appointment. Similarly, families who have access to mental health care through private insurance are often unable to afford the cost of deductibles and co-pays. As a result, many youths who need mental health support go without it.

Schools are where youth spend the majority of their time. They are often a trusted space where there is an influential support system for children. Our team knew from experience that schools are where many parents prefer their children receive services. This has been particularly true during recent experiences of a political climate in which undocumented families have expressed that they feared seeking support for themselves and their children. Therefore, integrating mental health services into the schools would further reduce the challenge of youth needing to go to an unfamiliar place with an unknown person to share the most vulnerable part of their lives.

Both FCDBH and FCSS had worked with an assortment of rural and urban communities and became familiar with their resources, needs, and challenges. As a result, we were able to lean on their long-standing relationships with members of these communities and understand their needs and accessibility to build a program that matched this challenging landscape.

Testimonials

By assessing the landscape and learning about what existed before starting our work, we were able to enhance the system of care in Fresno County. One thing we're proud to report is the improvement in our penetration rates. Before the onset of our partnership, many rural communities had penetration rates ranging from 3.31% - 3.54%, which indicated that the community was underserved in accessing mental health services. In the third year of our partnership, the penetration rates increased from 3.73% up to 4.72%, indicating that more youth and their families are accessing services.

PART III: DESIGN & CUSTOMIZE LOCAL MODEL

TIMEFRAME: FALL 2017 TO JUNE 2018

Overview

Our next step was to develop a model including all the necessary components based on the information our team learned during the initial landscape assessment. This is the timeframe where our partnership came to an agreement to enter into a contract. We designed our model in order to develop a scope of work, outcomes for FCDBH requirements, and ultimately start planning how to operationalize our program.

It's important to note that different models can be used to overcome specific location or resource obstacles for your area. Our framework might give you an idea of where to start, but it's not a one-size-fits-all solution. With that in mind, we concluded that the best way to maximize youth accessing mental health services was to integrate clinicians into schools.

By offering services in school, parents who have jobs that do not permit them to take substantial time off to take their child to an appointment would feel a weight lifted off their shoulders as they would not have to feel like these services are a burden on their family. The ease of access in the schools also helps reduce the amount of time youth would be required to be out of the classroom, missing instruction.

Objectives

The primary intention for designing and customizing a local model is to produce a system of care that meets the needs of your community. To achieve those goals, focus on the following tasks:

- ☐ **Establishing Your Program's Main Focus**
- ☐ **Determine Your Organizational Framework**
- ☐ **Identify Staff Needs**
- ☐ **Addressing Confidential Information & Privacy Laws**
- ☐ **Forming Policies and Procedures**
- ☐ **Positioning School Districts & Schools**
- ☐ **Establish Insurance Billing Processes**

How We Did It

Establishing Our Program's Main Focus

We started by considering the problems our team hoped to solve by establishing a partnership program. Narrowing our scope of work down took some time, especially because we were starting from the ground up. Here is a look at how our team defined our focus when we developed our program's goals.

Gaps in Services - We engaged in a process of analyzing the array of services provided to youth in our county be each partnership agency.

Access for All — We were intentional about creating a system that provided access to mental health services for all. Our rollout was designed for youth ages 0-22 years old to have access to a clinician or case manager in their schools, homes, or communities within the next five years.

Services in Rural Communities — We specifically prioritized creating access for youth and families in rural and remote communities of our county who we knew were historically underserved and were up against multiple barriers to accessing mental health supports.

Reduce the Stigma — We wanted to create awareness for mental health care by having clinicians and case managers on school campuses just like any other staff. By integrating services in the schools we aimed to normalize mental health as one element of overall health and well being.

These priorities became the center of everything we do in the Fresno County All 4 Youth program. For others embarking on this journey, the focus and priorities will be tailored to the unique landscape and needs of your youth, families, and region.

We found it helpful for our team to develop a mission and vision to anchor our focus and priorities and to serve as a guide in building out our program and keeping us from getting too caught up in the details as we operationalized what this program was going to look like.

Our Mission
Our mission is to have an integrated system of care that ensures all children have access to behavioral health services to support their social, emotional, and behavioral needs and promote health, well-being, and resiliency.

Our Vision
We envision a community where all children's behavioral health needs are met. Barriers will be removed, and all children and families will have access to a seamless system that promotes a positive, healthy environment to live and learn.

Determining Your Organizational Framework

We began our design by choosing to base it on a hub and spoke model as an organizational framework for how we provide services to a geographically diverse region. Although some refer to our program as school-based, in essence we are a community program. We provide services wherever the child or their family are available and prefer to receive assistance—whether at school, at home, a hub or in the community.

The hub and spoke model framework includes a regionalized hub that serves as a home base for behavioral health staff and the schools within the hub's geographic region, extends care after-hours, and provides materials and other needs and resources. Meanwhile, the spokes are the school sites surrounding a regional hub. Each school site connects to a specific regional hub.

The hub is the certified site where care providers and their supervisor make their headquarters, where training and supervision may occur, and serves as a service delivery site.

Identify Staffing Needs

Our partnership planned to hire mental health professionals licensed to provide treatment, therapy, and specialty mental health services as defined by the MHP, and include additional team members who can provide case management and psychosocial rehabilitation. Here's our the complete list of roles we identified throughout this process:

- Licensed Marriage and Family Therapist
- Licensed Clinical Social Worker
- Licensed Professional Clinical Counselor
- Associate Marriage and Family Therapist
- Associate Social Worker
- Associate Professional Clinical Counselor
- Any Unlicensed Staff
- Psychiatry Services
- Interpreter Services

Youth Care Specialist

A Youth Care Specialist provides groups and support to youth who may need assistance managing their behavior and delivers case management support to youth and their families. These specialists can serve as primary providers or secondary service providers who work with a clinician. Youth Care Specialists must have a B.A./B.S. degree or higher and meet eligibility under the medical necessity to access services.

Intervention Specialist

An Intervention Specialist's role is to provide support to students whose behavior is impacting their ability to cope with the school environment, relationships with peers, and who require support as an extension of their therapeutic treatment. These specialists can serve as primary providers or secondary service providers who work with a clinician. Intervention Specialists must have a B.A./B.S. degree or higher and meet eligibility under the medical necessity to access services.

Clinicians

Clinicians are Master's degree-level healthcare professionals trained to evaluate mental health conditions and use therapeutic techniques based on specific training. They work under various job titles based on the treatment setting, including counselor, clinician, or therapist.

Clinicians will conduct an initial assessment for each youth referral. Following the first assessment, the clinician will coordinate which individual, family, group therapy, or rehabilitation services best fit each youth and their family's needs.

All clinicians are registered with the Board of Behavioral Sciences and designated as an associate or licensed: Marriage and Family Therapist, Clinical Social Worker, or Professional Clinical Counselor. Therefore, clinicians can fall into one of two categories:
Clinician I's — Unlicensed or newly licensed clinical staff
Clinician II's — Licensed for two or more years

Telepsychiatry Services

Our partnership offers contracted psychiatric services to youth who request it or show a clinical need. We can complete these services via telehealth in our site-certified hub locations.

When we identify a youth needing psychiatric services, the assigned clinician adds medication services to the youth's treatment plan and gains signatures from the legal guardian.

The clinician then inputs a referral to our Health Information Assistant (HIA) team to begin the processing, which requires their staff to:

1. Call parents or legal guardians to confirm interest in psychiatric services for their youth
2. Schedule the intake appointment
3. Schedules follow-up appointments, keeps track of the doctor's schedule to ensure availability, and handles all requests for rescheduling treatment appointments

Meanwhile, the youth's clinician is to attend every appointment with the psychiatrist to maintain good clinical care and collaboration between the two care providers. The clinician can login via telehealth, as well.

To meet service requirements, youth visiting an office location must have their vitals taken at each appointment and have physical signatures from their legal guardian on all relevant consent forms. Therefore, each site contains the following equipment:

- Scale for weight
- Stadiometer (measure for height)
- Blood pressure cuffs (in various sizes)
- Measuring tape
- Pulse monitor
- Thermometer
- Disposable gloves
- N95 masks
- First aid kit

These items are essential for our team to gather vitals, including heart rate, blood pressure, height, weight, girth, visual cues, like gait/ movement walking from one place to another, and observing the texture of rashes or skin abnormalities or rigidity. The HIA team also handles these tasks.

Additionally, for youth opting for telehealth treatment, our office locations have the necessary equipment to handle those unique technology needs, including:

- **A direct Ethernet connection to the computer for telemedicine**
- **An Internet connection with a minimum of 10 Mbps download speeds and 5 Mbps upload speeds**
- **An adequate speaker, microphone, and video camera for seeing and hearing the youth in real-time**

(Learn more about our technology and equipment later in Part V: Plan Implementation & Preparing to Launch section.)

Interpreter Services

Fresno County's All 4 Youth program has a diverse workforce that speaks nine different languages, exceeding the threshold languages within our community (i.e., Spanish, Hmong, and English). Interpretive services are utilized through a contracted provider when:

1) Bilingual staff are unavailable to translate or provide the service

2) Youth or family speaks another language not spoken by an All 4 Youth staff member.

Similarly, All 4 Youth provides intake documents, resources, and other materials to youth and their families in their preferred language to understand what care they are receiving. To do this, we have a contract with an interpretive service to translate our documents. Anytime we update documents, we make sure to update them in our threshold languages, including English, Spanish, and Hmong.

Addressing Confidential Information & Privacy Laws

Although healthcare and education are very different industries, the All 4 Youth program operates as a healthcare provider working within an education system structure. Therefore, we must adhere to the privacy and confidentiality regulations of the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). Our partnership model is unique in that the clinical staff are hired by FCSS and function as educational employees who provide a medical service and bill into a medical system.

HIPAA and FERPA are two federal privacy laws educators and healthcare providers need to understand reasonably well as violations can come with severe consequences. What may be confusing is that these laws overlap in some areas and differ in other aspects.

HIPAA

Created by the Department of Health and Human Services, HIPAA protects sensitive patient information. This privacy rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronically protected health information, otherwise known as PHI. In addition, they've set forth patient rights and standards for health plans, health care clearinghouses, and health care providers who collect and store identifiable patient information in electronic form. However, HIPAA does not typically apply to primary and secondary schools because in grades K–12, student health records are considered educational records.

FERPA

FERPA is in place to protect student education records' privacy and designates rights for students and their parents. According to the Department of Education, education records include academic report cards, transcripts, class schedules, disciplinary records, contact information, and family information. Additionally, FERPA gives parents certain rights concerning their children's education records. When they reach 18 years old or attend a school beyond the high school level, these rights transfer to the student.

To stay within the boundaries of the law, you need to have the authorization to release and exchange confidential information. You'll need to have a release form signed by the student or the parent or legal guardian of a youth under 12. If someone refuses to sign this authorization, you can still provide services (although you may not be able to transmit any personally identifiable information or PPI). Also, keep in mind that youth or their parents may revoke this authorization by notifying you in writing.

Forming Policies and Procedures

Policies and procedures give direction to our All 4 Youth staff on the care they provide in their everyday work with youth and families. It's like a playbook that everyone can refer to and know how they fit into the more extensive system. This playbook supports new staff as they join our team, helps the existing team stay on track, and keeps the program aligned with county, state and federal standards.

Each program needs to establish policies and procedures to guide the foundational elements of direct service, strategies for delivering those services, and implementation to aid our overall success. Some essential components include:

- Confidentiality
- Record Keeping (i.e., Record Retention, Storage, and Disposal)
- Disaster & Evacuation Plans
- Access to Services
- Service Planning and Monitoring
- Services and Interventions
- After Hours Services
- Health and Safety
- Civil Rights and Complaint Processing Procedures
- Culturally Responsive Service Delivery
- Language and Interpretive Services
- Incident Reporting
- Referrals for Psychiatric or Physical Services
- Coverage and Secured Scripts
- Intake and Admission
- Length of Services
- Referrals and Linkages
- Discharge or Discontinuation of Services
- Consumer Complaints and Grievances
- Interagency Coordination and Collaboration
- Supervision and Case Review
- Requests for Access to Health Records
- Notice of Privacy Practices
- Social Media Policies
- Background Checks for Staff (Verification of Qualifications and Licenses Status for Licensed Clinical Professionals)
- Credentialing of Staff

FCDBH's Managed Care Division oversees the Mental Health Plan in our county. Their team provided our partnership with a standardized outline for site certification that consists of critical elements that are required for all FCDBH program sites to be certified. This outline served as the backdrop to support the development of the policies and procedures needed for All 4 Youth.

We also capitalized on our past clinical mental health experiences of delivering services to youth and families while collaborating with other agencies and organizations—primarily with FCDBH and Desert Mountain SELPA.

It took time to write and edit a set of guidelines that matched our blended model's complex and innovative needs, HIPAA and FERPA regulations, the mental health system of care, and two agencies contracting together to develop All 4 Youth. However, it is important to be precise and reflect on how these processes will unfold in the light of the overall partnership, especially considering the landscape of the delivery of service environment.

For instance, we needed to design our policies and procedures to integrate into the educational setting, which meant a few things:

1. Our two agencies—FCSS and FCDBH—contractually used the same Electronic Health Record. However, FCSS would handle all records requests as the treating provider for All 4 Youth.
2. FCSS needed to establish roles for a Quality Support Supervisor on our team.
    a. FCSS would need to establish a contact phone number, email address, and website for said Compliance Officer and Privacy Officer for potential contacts.
3. FCSS, as a large educational organization, had to adapt existing departments to support the addition of clinical delivery and programming into the structure of its organization. That included:
    a. The Human Resources (HR) department expanded duties to include clinical credentialing and background checks needed for licensed and unlicensed clinical staff while verifying that they are not on the ineligible provider list.
    b. The HR team extended its support with bilingual assessments for our staff to meet the needs of providing care to youth and families in Spanish and Hmong, among other languages.
    c. The Information Technology (IT) department had to expand to meet the growing needs of the clinical program. They worked on problem-solving virtual connections, encryption, secure telehealth technology, technology infrastructure, and bandwidth to support our program needs.

These policies and procedures needed to be vetted by FCSS legal counsel. Then, they were sent off for a final review through the site certification process with FCDBH.

It's important to note that policies and procedures can be updated as needed. For instance, throughout the pandemic, All 4 Youth did a significant pivot to incorporate telehealth services in everyday practice to safely social distance and provide the much-needed care.

Positioning School Districts & Schools

Once you have identified your program model, the scope of services and supports, and have a plan for rolling out your services, it's time to introduce your concept to school districts. Our team devised a positioning process, which started conversations with school superintendents on assigning clinicians to campuses and integrating staff into each district.

First, we identified a regional group of underserved populations in our county as our starting point and expanded across the county from there over the five year roll out. A few of the districts were so large that we needed to onboard them in phases with groups of schools from each district. We then created a regionalized five-year staffing plan to project the number of individuals we anticipated serving and the number of staff members we would need to recruit. Once our school sites were selected for each phase of the five-year rollout, we created an onboarding plan for sharing and integrating All 4 Youth programs and services into those schools.

These early adopters of our program were supportive of our mission, desired our services, and were willing to have honest conversations during our early days when we worked through many unexpected challenges. Our team learned a great deal from them, and we owe much of our future success to the districts that joined us in our initial phases of this All 4 Youth journey.

Lessons Learned

1. Involve Stakeholders Early in Planning

Among your first tasks, and at least annually thereafter, should be to solicit input from stakeholders. While every community has different and unique dynamics, our suggested activities include:

- Hold in-person or online meetings across the county with various stakeholder groups; include the perspective of youth, parents and other caregivers, educators, and other community members
- Create surveys to get input and ideas from your target market (i.e., educators and parents).
- Consider conducting focus groups that run ideas by educators and others in the community, like parents and potentially youth. Note: Marketing agencies often have the resources to facilitate these learning sessions.
- Use the results of all your findings to determine the needs and priorities of your county.

Consistently, our community input called for a few key enhancements:

- Increase services to youth
- Increase services in underserved rural communities
- Reduce barriers to accessing mental health services such as transportation, parents' ability to take time off from work, etc.
- Offer the resources needed for teachers and the campus community to understand better and identify behavioral health issues.

2. No Two Schools Are the Same

Regarding the program performance measurements, we found that each district administered the Healthy Kids Survey at different times and with differing questions. Therefore, it was difficult to use that data and compare it across districts.

Similarly, we found a varying degree of PBIS/MTSS training implementation depending on the school sites. Interestingly, the size of a team didn't matter as much as the presence or absence of a team. Schools that have a team and system in place have more effective integration of mental support within their school climate and culture. The integration of clinicians within this system encouraged collaboration and coordination, increased access to needed services for students, and contributed to the normalization of clinical staff being part of the school team.

Testimonials

> *All4Youth has resolved a longstanding issue of access, or lack thereof, to mental health services for our amazing students and families. The daily presence of our wonderful All 4 Youth partners has worked to erode the stigma associated with mental health which is a great step in embracing the value of self care. - Jeff Percell, Superintendent of Riverdale Joint Unified School District*

PART IV: PLAN IMPLEMENTATION & PREPARING FOR LAUNCH

TIMEFRAME: JUNE 2018 TO DECEMBER 2018

Overview

Now that we understand the landscape of the communities, identified the need our program is designed to address, and prepared a localized model of care, it's time to begin ramping up to launch our program before full implementation.

This section will discuss how we began the implementation process and prepared for launch using our ramp up strategies, which included creating awareness about our programs in and out of the school, hiring staff members, setting expectations for productivity, and investing in technology and office spaces.

Objectives

- Gaining Credibility and Awareness
- Acquiring Appropriate Office Spaces
- Hiring Staff Members
- Setting the Expectations for Productivity
- Investing in Technology and Software
- Drafting Required Forms
- Developing a Referral System
- Evidence-Based Training
- Orienting and Training New Staff
- Establishing a Meeting Structure

How We Did It

Meeting all the needs for youth mental health support is complicated. It would be unrealistic to consider mental health-related issues to fall entirely on mental health professionals alone. Instead, integrated and multidisciplinary services are needed to increase the range of possible interventions, maximize resources, and limit the risk of poor long-term outcomes. That's why you must consider everything, from generating awareness for the program and setting up a space to facilitate your goals to hiring staff that includes a range of versatile talent at various levels of education and training them to all be on the same page.

Gaining Credibility and Awareness

External Communication

First impressions are lasting impressions! Therefore, a marketing strategy is vital to gaining credibility and awareness in your region. Messaging should empower diverse audiences with a strong, unified voice to foster a sense of approachability and understanding of your program's role in the community. Specifically, your messaging should explain the integration of care and the unique partnerships between education and behavioral health services.

Start by creating marketing materials, such as:

- Brochures and flyers for 0-5-year-olds, elementary, and high school youth programs
- Marketing swag, like magnets, pens, highlighters, or bubbles
- Signage for the hub and spoke locations

Additionally, develop a logo to become a visual reference for your program on brochures, fact sheets, business cards, presentations, websites, videos, ads, or other public-facing products. These steps will help foster understanding of your goals and awareness of your program among stakeholder groups.

Acquiring Appropriate Office Spaces

Having appropriate space to support the infrastructure of a program of our scale was a challenge we had to navigate. It will be important to keep this aspect of your program in mind as you plan your budget and logistical needs for where your staff will work on a day to day basis. A few items to consider are:

- **Will the space be adequate to house your staff?**
- **Will you have enough space to meet with staff and treat patients now and in the future?**
- **Is there adequate access and enough parking?**

Space needs and the importance of having confidential space for clinicians and case managers are a must and become part of a lengthy discussion during the onboarding meeting with each school site.

Our definition of confidential space, for the purpose of providing mental health therapy, is a room with four walls, a ceiling, a door, a desk or table, a chair, a phone, and a lockable filing cabinet. It can be used solely by the clinician or case managers or can be shared space used on separate days.

As we explained in "Part I: Our Partnership," hubs are where youth and their families can receive treatment for various reasons, including if they do not want to receive treatment at a school site. In addition, we provide telepsychiatry services at each hub. These hubs also allow clinicians and case managers to utilize office equipment, like fax or copy machines.

Eventually, your team will need to discuss which sites will be certified. For example, our partnership aimed to have ten hub locations certified in five years, six of those certifications would be in the first three years. Your Mental Health Plan's designated team should drive the site certification process.

When you're working on securing space for certified hub locations, use this checklist as a guide:

Hub Location Checklist

Office Space

- ☐ Floor to ceiling walls
- ☐ No pass-through space (no other staff walking through to go to another part of the building)
- ☐ Space allows for the following:
  - ☐ Multiple confidential treatment rooms of varying sizes to accommodate individuals, groups, and families
  - ☐ Office space with an area for psychiatric service delivery
  - ☐ Office with capacity for teletherapy set up (TV screen, etc.)
  - ☐ Conference room for staff meetings and training
  - ☐ Drop-in space for mobile workforce
  - ☐ Unshared space on the same day (alternating days are okay)

Note: *Pass on any office space that accommodates treatment rooms adjacent to the reception or waiting area to limit youth and families from entering confidential areas where staff may be working. For example, ensure that youth and families cannot see others' personal information on computer screens.*

  - ☐ Adjacent restrooms and water fountain for staff and visitors
  - ☐ The building or adjoining buildings with tenants who are seen as allies or additional supports to families

Note: *Avoid locations where another tenant may be seen as a threat or may deter families from wanting to engage in services at the hub location.*

  - ☐ Accessible parking for staff and visitors
  - ☐ Handicap accessible
  - ☐ Fire clearance

Storage

- ☐ Storage for treatment materials and supplies (toys, games, etc.)
- ☐ Storage space for confidential information, such as a file room
  - ☐ Double-locked to meet confidentiality and Site Certification Standards
- ☐ A place for a secure fax machine for confidential after-hours faxes
  - ☐ Double-locked to meet confidentiality and Site Certification Standards

Technology

- [ ] Office space with multiple IT ports, phone lines, and outlets for support staff
- [ ] Keypads or doors with electronic pass cards to ensure security
- [ ] Ability to use sound machines as needed

Hiring Staff Members

Hiring new staff members for our program added a whole new element of coordination and planning to our Human Resources department. In addition to the increased quantity of applicants, our staff also needed to vet specific credentials and licensures. Therefore, when approaching the hiring process, we encourage you to confirm that your HR staff has the resources to take on this expanded workload.

We also wanted to create a culture where staff wanted to work, make a long-term commitment, and would be able to promote within. The goal was to minimize staff turnover rates to create the best environment for the students our team was serving. A large part of that process is hiring the right people for the right jobs!

Credentialing Staff Members

Before any delivery of care or oversight of clinical services begins, each direct care staff member for All 4 Youth requires a credential through FCDBH's Managed Care Division. So, when we hire new direct care staff members, each of their National Provider Identifiers (NPI) needs to be established for the first time or updated so their association of clinical work affiliates with All 4 Youth.

The credentialing packet requires submitting a copy of the employee's current resume, degree, licensure, and current registration with the Board of Behavioral Sciences or other appropriate licensing board. Once the review of the credentialing packet is complete, we fill out an application and submit it to FCDBH Managed Care for approval.

Additionally, note if the direct care staff falls into one of the following categories:

- Licensed Marriage and Family Therapist
- Licensed Clinical Social Worker
- Licensed Professional Clinical Counselor
- Other Unlicensed Staff

If so, then those employees must also register through the Department of Health Care Services (DHCS) Provider Application and Validation for Enrollment (PAVE) system for Medi-Cal providers since All 4 Youth is a Medi-Cal provider. They must also ensure that this information is up-to-date and matches their NPI information as affiliated with All 4 Youth.

A Note from Fresno County All 4 Youth

Building the program from the ground up has allowed us to hire staff that reflects our population. We advise that you collect data on your community demographics first and work to hire a diverse staff that reflects those whom you will serve.

A Note from Fresno County All 4 Youth

We recommend including bilingual pay in your initial contract budget structure. We did not consider these added skillsets in our initial contract. We negotiated with FCDBH on modifying our funding structure and FCSS brainstormed with its HR department on ways to accommodate these adjustments after we had already begun our hiring process.

Likewise, make sure your team comes up with a way to verify staff who self-identify as bilingual. As mentioned above, we set up a contract with a bilingual language testing vendor.

This lesson proves that pivoting and modifying the program can be a challenge but flexibility will prove to be an essential part of developing your program and ensuring it will be a success. However, we warn that frequent changes to protocol and process can impact staff members. So, be mindful of their perspective throughout this process.

Staff members are only authorized to share private information with people or entities that the youth and/or care providers have identified within a signed Release of Information on file within the youth's All 4 Youth medical record. In cases of immediate danger or risk of safety to persons or the public, service providers can share the minimum information necessary to prevent or reduce the potential risk of harm.

Setting the Expectations for Productivity

Our partnership contract states that we meet a productivity expectation of 60%. This productivity rate is a consistent goal that we explain to staff upon hiring. To meet this expectation, we coach our staff to schedule up to 300 minutes of billable service a day. Clinicians should work closely with supervisors on various time management strategies and techniques to improve service delivery.

In the meantime, supervisors monitor each clinician's caseloads to ensure a balance of expectations to set their team up for success. However, when a clinician is working with some youth who have higher needs, their caseload may be lower. Likewise, when a clinician is working with youth who have lower needs, their caseload may be higher. If a staff member has cancellations or no shows, we encourage them to use that time to reach out to care providers to collaborate and coordinate care to use their time wisely. They can also provide supportive interventions to help them meet their 60% productivity rate goal.

Internal Communication

Work as a team to create a system for all internal documents, like:

- Intake Packets
- Assessments
- Documentation in the EHR
- Clinical Preparation and Onboarding Paperwork

Establishing these formats ensures that all youth flow through the same process and are not left out unintentionally.

Investing in Technology and Software

You'll find that a collaborative approach will help everyone understand the scope of technical requirements from the outset and expose new requirements and potential obstacles. We found that to determine the technology and capacity needs for our All 4 Youth program, we needed to consider the following:

- Compatibility of technology with Electronic Health Records (EHR) used by FCDBH
- Technology, like laptops, that best supported this particular EHR
- Technology that supports tracking, storing, and transmitting data safely and securely
- The capacity of the VPN and encrypted servers to comply with Federal mandates, such as HIPAA, safeguard EHRs, and other information
- Level of mobility and accessibility required for particular staff members
- Ease of use for staff members and families

A Note from Fresno County All 4 Youth

Finding reliable and compatible technology can be a challenging obstacle to overcome. We discovered that researching the required specifications for laptops and other equipment was necessary. For example, to support services under the requirements of Medi-Cal and our Managed Care Division, our laptops needed to be a larger size than usual to accommodate the EHR. The EHR has a portion of the record formatted at a very small size, which is not otherwise legible.

Meanwhile, some lessons we learned through first hand experience. One in particular was that 5G hot spots were an essential tool for our staff who were always moving about to different areas of Fresno County. We found that our staff could not depend on schools or site visit locations to have internet connectivity that was secure for access to the Medi-Cal system, especially in rural communities. The inclusion of 5G hot spots worked well for our team in these situations.

To help you kick-start your search, we compiled a list of equipment we're using and some of our best advice on these topics below. Of course, some of these options might work for your team, and some might not. However, we hope this will at least give you a starting point for your program.

Our Technology Selections

Laptops

All 4 Youth staff needed mobility and the technology to support our program's clinical documentation needs. We found a specific brand and style accommodated the formatting of our EHR system the best. Therefore, we recommend consulting with your IT department for recommendations on devices that will work for your program-specific needs.

Internet Access

We chose Verizon-connected laptops to provide confidential stable access to the EHR system (MyAvatar by Netsmart).

The pandemic also required our team to radically and rapidly rethink care delivery. Accelerated by the expansion of telehealth services, we needed an Internet provider that offered reliable, high-speed Internet across our region and became an essential tool for our program.

Bandwidth

To enable doctors to assess patients, we determined we needed an Internet connection providing a minimum of 10 MBPS download speed and 5 MBPS upload speed. This bandwidth allowed us to place our all-in-one systems for telepsychiatry at each of our hub locations that supported real-time audio and visual connections.

Software

Microsoft Teams software provides a virtual telehealth platform that meets confidentiality and compliance with FERPA and HIPAA standards so we can continue to help our youth by providing access to services when stay-at-home orders were in effect.

Phones

Our direct-care staff needed to be reachable by phone, but relying on school campus landlines with confidential voicemail capability was not always possible. Therefore, we decided to provide a stipend for staff to pay for a dedicated cell phone line. This was another unanticipated need that we learned throughout the implementation process, but recommend considering earlier on in planning. We also decided to buy a cell phone for fielding after-hour emergency calls and supporting enrolled families.

Our Technology Licenses

We purchased a range of software and technology access licenses so that staff can meet our program needs.

MyAvatar

This software was the EHR used by the FCDBH. FCDBH staff trained our newly hired team members to use MyAvatar to accelerate our program startup. As a result, our team now feels comfortable accessing MyAvatar to support program needs.

Domo

FCDBH also used Domo to create and maintain performance dashboards and reports. This program helps management access programmatic reports and staff performance dashboards while meeting compliance regulations.

FileMaker Pro

Using this app, our team can track referrals. In fact, we've expanded the number of licenses for FileMaker Pro to meet our growing needs.

SurveyGizmo

This online tool helps facilitate data collection and outcomes through customizable surveys. In fact, our team needed to expand our usage rights for SurveyGizmo to keep up with the growing number of survey recipients.

Drafting Required Forms and Documents

Release of Information (ROI) Document

A Release of Information (ROI) document is essential for care coordination. Staff members are only authorized to share private information with people or entities that the youth and/or care providers have identified within a signed ROI on file within the youth's All 4 Youth medical record. However, to best treat youth, providers often need to be able to talk with other people in their lives regularly or separate entities who can be of assistance and support care coordination.

Consider creating a new ROI or using your partnering organization's version. For example, our team considered using the existing EHR version but created an All 4 Youth version that better met our needs. We included verbal options for releasing information so that we could protect the oversharing of confidential information. Additionally, we specified that care coordination was the purpose and intent of our release.

A Note from Fresno County All 4 Youth

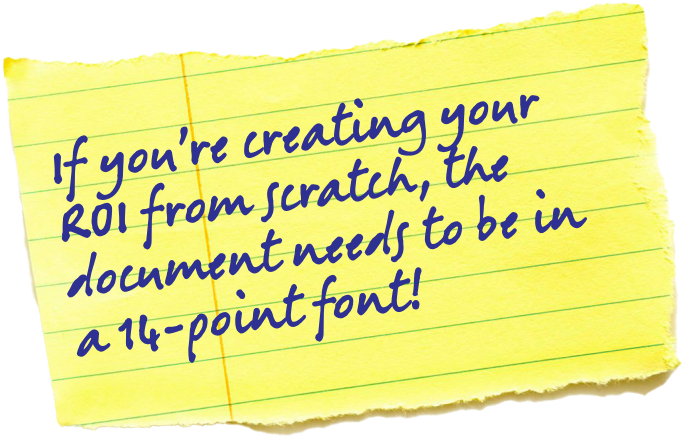
We recommend using an existing ROI if your partnership has access to one. The ideal situation would be if there is an ROI built into the EHR that you're using, and the caregivers can sign for consent electronically. An electronic version will make it easier to use and track the completion and annual updates.

All 4 Youth reviews the ROI with the youth and consenting caregiver during the intake process. This strategy allows our team to collaborate and coordinate care to support the youth as soon as possible.

Notice of Our Privacy Practices

Since FCSS is an educational entity, developing a Notice of Privacy Practices document was not within our usual scope of work. However, to comply with HIPAA regulations, we had to disclose our privacy practices, define how we may use or disclose each patient's health information, and inform those we serve of their rights regarding protected health information.

One revision we had to make during the pandemic was addressing the process of sharing information during telehealth treatments. We needed to disclose the risk of an unintended security breach during telehealth services through the artificial intelligence utilized by school districts.



Request Access to Health Records Form

Adding to the Notice of Our Privacy Practices document, we needed to include a Request Access to Health Records form. Since our partnership shares an EHR system, we needed to specifically state that FCSS is the holder of our All 4 Youth medical records in the Notice of Our Privacy Practices document. Therefore, any requests for records would need to go through FCSS, not FCDBH, even though they are part of our contract.

FOR REFERENCE, A COPY OF THE FRESNO COUNTY AUTHORIZATION TO RELEASE & EXCHANGE CONFIDENTIAL INFORMATION IS AVAILABLE HERE

Developing a Referral System

As we developed our model of care, we kept our vision and mission at the forefront of our minds. Specifically, we have been adamant about removing barriers and increasing access to services. To do so, we created one universal referral pathway that routes all referrals to a centralized intake. So, there is consistency regardless of the community, district, or school.

Our referral pathway is an extensive system that manages up to 4,000 referrals each school year. Therefore, tracking and monitoring data intake was crucial for maintaining equity and uniformity in our process. We receive referrals through our main phone line or via email, and although anyone can make a referral, we have found that the referrals primarily come from school staff.

What about our youth who may not have access to a school or a formal care system yet?

Great question! We identified that children 3 to 5 years old were particularly vulnerable to falling through the cracks when accessing services and support. Therefore, we developed our model intending to connect all youth with our program, from birth to age 22, because we know early prevention is critical. Influencing these younger demographics can also help reduce the stigma around accessing mental health services.

Draft a Referral Form

We reviewed the work that our mentor, Desert Mountain SELPA, had done with their program's referral form. We used their approach as a springboard to design our referral form, which we found helpful.

We went through several modifications throughout the process, taking input from the school district staff. Their assistance helped us realize where we were missing certain information needed to process the referral efficiently and effectively. For example, one element we found was vital to include was the symptoms and behaviors that would potentially qualify youth for our level of services at a Tier III level of intervention. It was also important to have the patient's birth date and social security number or Medi-Cal ID number for verification.

These referral forms are completed by school staff, community partners, or parents of youth. Throughout this process, we created an email pathway to have all referrals flow to one location to process effectively and in a timely manner.

(Learn more about our intake process in Part V: Implementation & Launch)

Minor Consent Eligibility

Some youth express a desire to come into services without parental consent. Therefore, children over 12 years old can be considered for "Minor Consent" enrollment as long as they meet the eligibility criteria set by your county.

If the youth does meet one of these criteria, there is documentation of attempting to reach the parent or reason for not trying to contact the parent regarding services and their response.

In the scenario of Minor Consent, our program will not provide psychiatric evaluations or medications.

Evidence-Based Training

We recommend using evidence-based practice training, which means there is research to demonstrate an effective intervention. Evidence-based training involves steps to include during training or topics that will make the learning process more effective by doing the following:

- Increasing comprehension
- Improving retention
- Discussing potential applications staff may experience down the road

It's important to use evidence-based practices and programs because they are proven to work. Here are just a few examples of evidence-based practice training topics:

- CPP—Child-Parent Psychotherapy
- PCIT—Parent-Child Interaction Therapy
- MI—Motivational Interviewing
- EMDR—Eye Movement Desensitization and Reprocessing
- Triple P—Positive Parenting Program
- TFCBT—Trauma-Focused Cognitive Behavioral Therapy
- AF-CBT—Alternatives for Families Cognitive Behavioral Therapy
- W.R.A.P.—Wellness Recovery Action Plan
- Theraplay
- DBT—Dialectical Behavioral Therapy
- Nurturing Parenting Program

Orienting and Training New Staff

Employees can only achieve a goal that is defined. Since this is a partnership, things can get confusing. It's important to be extremely clear with expectations for each employee, especially when laying out which organization the staff works for and who they report to daily.

Clinical

- Annual County Compliance
- Wellness Recovery
- Reaching Recovery Refresher
- EMDR
- CalAim

Cultural

- Suicide Bereavement Clinician Training
- Cultural Responsiveness Dr. Sahili
- FCSS Racial Trauma Discussion Webinar
- Wellness, Hope & Recovery
- IICR (virtual only 8 hours)
- Suicide Prevention Summit
- Creative Culture
- BHIT - Interpreter Use (8 hours)

Internal

- Trauma Training
- Dynamic Mindfulness
- EFT Tapping & Mindfulness
- Assessment Training
- All Things Trauma Training
- Teaching Positive Discipline
- ASQ
- Motivational Interviewing
- Behavioral Threat Assessment
- Cultural Humility & Responsiveness Professional Development Training w/ Manuel Escandon

When new staff are hired, it's important to have a well-planned onboarding process to effectively orient new staff to your district or county office of education, define what their role is within the organization, and what the expectations are for them as employees. It is necessary for them to understand where they fit in within the bigger picture and in the context of the organization or with other service providers who they will be expected to collaborate with and coordinate services. To do so, reach out to each new employee, coordinate a meeting, and present an agenda that reviews your onboarding plan. This meeting will give you the time to:

- Review the vision and mission of your program
- Explain increasing health care access for all youth 0-22 years of age
- Discuss the tiered system and review the Social Emotional Learning (SEL) document that each school completes
- Talk about specific needs of the program, such as the referral process and space at school sites
- Create protocols for ensuring youth get screened, assessed, and then linked or treated
- Review training modules that all school sites and staff attend
- Look over the crisis plan and follow the lead of the school site protocols
- Provide materials, like referral forms, brochures, and posters for school sites

In addition, we suggest creating a complete training manual for staff members to help them understand their job expectations.

We found it helpful to include details on:

- Overview of intake packets
- Your program vision and mission statements
- Departmental policies and procedures
- Supervisory structure
- FCSS training for the following:
  - **a.** The Multi-Tiered System of Support (MTSS) framework
  - **b.** Trauma modules (Verbal De-escalation, Trauma, and Mindfulness)
  - **c.** Child and Adolescent Needs and Strengths (CANS)
  - **d.** Autism
  - **e.** Assessment and report writing
  - **f.** Incident reporting
  - **g.** Mock assessment activity

FCDBH training for the following:

- Electronic Health Record (EHR) — MyAvatar
- Wellness and recovery
- Compliance and billing practices

Establishing a Meeting Structure

One of the most valuable of these meetings proved to be the Interagency Meeting. The FCSS team proposed convening the two agencies—FCDBH and FCSS—with onboarded school district leadership at routine intervals. This was beneficial on many levels and provided a transparent forum for supplying updates for information, clarifying issues, and sharing learning experiences across all organizations. This has been an excellent process-improvement strategy.

Other meetings also add value in our work. Here's an example of some of the meetings we participate in regularly:

Meeting Title	Purpose	Attendees	Frequency	Duration
Steering Committee	Decision-making body	Leadership from FCDBH & FCSS	1 x per month	1.5 Hours
Leadership Check-In	Group for planning, discussion, raising questions and ideas, following timelines	Leadership from FCSS	2 x per month	1.5 Hours
Management Meeting	Items discussed in Leadership Check-In to be brought forth to Clinicians and other staff	Leadership from FCSS and mid-level management (program and clinical supervisors)	2 x per month	1.5 Hours
Program Meeting	Discuss program needs, rollout Leadership decisions, discuss operational strengths and challenges	Leadership from FCSS and mid-level management (program and clinical supervisors)	4 x per month	2 Hours
Fiscal Meeting	Budgetary items brought forth for discussion	Leadership from FCSS	1 x per month	1 Hour
Care Coordination Meeting	Coordinate Care around referrals and staffing transitions	Leadership and mid-level management from FCDBH and FCSS	1 x per month	1 Hour
FCDBH & FCSS Onboarding Meeting	Discuss challenges and problem solve around programmatic/ operational needs	Leadership from FCSS, mid-level management from FCDBH, and other department leads (IT, Learning and Development, Mental Health Plan, Quality Improvement)	1 x per month	1.5 Hour
District Onboarding	Review of services that will be provided, trainings for staff that are required, confidential space that will be needed	Fresno County Office of Education Assistant Superintendent, Senior Director, Director and Administrative Assistant; A combination of Superintendent, SPED Director, Counselor, and/or School Psychologist	As Needed	1 Hour
Interagency Meeting	Feedback from district representatives; discussion amongst colleagues	Leadership from FCDBH, FCSS, and a representative from each onboarding district (usually a Superintendent or Special Education Director)	Quarterly	1 Hour

You'll notice a variety of different committees on the meeting calendar, each bringing together members of our partnership to discuss essential planning and implementation topics. In addition to those groups, FCSS has joined many existing committees associated with FCDBH County Mental Health Plan. To name a few:

1. The **Children's Mental Health Subcommittee** meets every other month to provide information on the latest numbers of youth served within the county, updates on federal, state, and local policy, presentations on services, and access for referrals and care coordination. All 4 Youth participates as a committee member alongside FCDBH leadership, mental health and educational providers, Short Term Residential Treatment Program (STRTP) providers, foster care organizations, non-profit organizations, and CASA.
2. The **Quality Improvement Committee** meets once per month to oversee policies, practices, and results related to performance outcomes and measurements. This group supports the continuous quality improvement and outcomes-driven strategic plan enforced by FCDBH and the committee. The All 4 Youth program participates as a committee member alongside other organizational providers in Fresno County.
3. The **Behavioral Health Contractors Association** meets once a month to provide a network of peer support amongst organizational providers and a space to share lessons learned, resources, and insight into care coordination. This group includes the All 4 Youth team and each mental health provider contracted with FCDBH, with an elected president, vice president, and secretary who serve as leaders.
4. The **Behavioral Health Providers** meeting is a convening of the Department of Behavioral Health leadership and the network of contracted providers. The group meets bi-monthly to provide updates on regulations, FCDBH processes, new programs/services, and reporting. The meeting also provides space to discuss any concerns or questions from the Mental Health Contractors. The meeting consists of FCDBH and every mental health contractor."
5. The **Cultural Humility Committee** meets monthly to bring forward resources, ideas, quality improvement strategies, and policy innovation that improves cultural responsiveness and inclusiveness within our community and system of care. The All 4 Youth team participates as a committee member with other organizational providers in Fresno County.

A Note from Fresno County All 4 Youth

We found it extremely helpful to provide a structure for feedback. Meet quarterly to review referral data, discuss updates, or simply make a phone call or draft an email. This process builds connections and trust between you and the districts. Fostering a dynamic and fluid line of communication is valuable for quality improvement. They will likely feel more open to providing that honest insight if something isn't working.

This feedback should always be encouraged and never taken personally. We know you invest a lot of time and energy into building this program. It is important to accept constructive criticism to succeed in reaching your goal. Being approachable and open about systems and processes while also being specific and thorough is crucial to finding solutions.

Lessons Learned

1. Be Intentional with Your Relationships

One of the fundamental values of our All 4 Youth program is integration. To integrate into schools means spending time on the campus, learning the culture, and connecting with students and staff. Don't try to take shortcuts in this process!

We want our team to seem like any other staff member at the school sites. Therefore, we instruct them to introduce themselves to the principal, attend staff meetings to introduce themselves to teachers, and share information about their services with faculty. Most importantly, we encourage our team to get to know as many students on campus as possible.

This partnership was never about a separate entity having an office on a school site. Instead, it's about seamless unification and joining together to better our schools and communities.

2. Encourage Your Staff Members

When it comes to staff, be sure to work on integration and collaboration starting on day one. This program is unlike anything we've seen in schools—this is new! Start shifting the mindset about this program by explaining that even individuals with school experience are learning because this isn't a program that brings in outside providers; we're integrating into the school culture.

To do so:

- Encourage staff members to get to know as many people on-site as possible.
- Talk to educators, administrators, and students.
- Build relationships whenever possible.

Our goal is to remove obstacles students may face when accessing mental health services, so make sure your team also works to avoid creating barriers for themselves in this new environment. Be sure to open the door for communication immediately, so they feel like they can ask questions or offer honest feedback. It isn't easy, but it's our job as leaders to encourage them from the start and throughout the steep learning curves with processes, technology, and paperwork. Additionally, by honoring the thoughts and feelings of staff members, we can ultimately bring in more referrals to the program. We're all in this together!

3. Be Clear About Program Needs with Staff

Many potential candidates might assume that because we're working predominantly with students and school districts, they follow the same work schedule as teachers. However, mental health care for students is a year-round responsibility. Our program in Fresno County is open year-round, and our staff expects to work 215 days per year with no more than two weeks off consecutively. Be sure to set these expectations related to schedules and time off for staff members and remind them that continuity of care is vital for overall student success.

4. Site Specific Protocols May Differ

Some sites may have different approaches to integrating clinicians into established schools or teams, decision-making processes, and different definitions of how to handle tiered systems of support.

While each site may have specific protocols for how clinicians will communicate with school staff, the general process of linking children and youth to appropriate care is intentionally flexible. However, considering and adopting protocols tailored to each site is recommended to maximize success of the program.

5. The Value of An Integrated Mobile Workforce

It was essential to have tools for developing a mobile workforce that keeps all staff on the same page no matter where they are in the county. These tools help the team remotely access data, get up-to-date information, report vital information into the EHR, and feel supported with what they need to work from a distance.

Bring IT professionals into your partnership early on to help you set up things like an encrypted server with organized shared files of resources, an EHR, and laptops fully equipped with remote data carrier access and VPN protection.

Additionally, the agencies in our partnership needed to be able to connect to each other's networks in some capacity, from firewall and IT issues to dashboard accessibility. The technology partnership was often evaluated and pushed our leadership to think systemically about our alignment. What started as a technical alignment issue called for improvement in our alignment with other departments.

6. Leave Room for Growth

Our program in Fresno County has grown so quickly that space is already an issue for us. In just over two years, we've added 122 staff members, so we don't have a place where we can all meet as a team. Hindsight is 20/20, but reflecting on our experience, we recommend keeping your potential for growth in mind when considering an investment in technology or office spaces.

Testimonials

For our team, the on-site certification process was a group effort with our County Managed Care Division. There was a formal process that the Managed Care Division supported us through and helped guide us to a successful certification. While each county may have a different approach or framework, we highly recommend working collaboratively across divisions to achieve goals.

PART V: IMPLEMENTATION & LAUNCH

TIMEFRAME: JANUARY 2019 TO PRESENT

Overview

Welcome to a day in the life of All 4 Youth! The implementation stage is when we finally "go live" and put all our planning and preparation into motion.

At this point, we had developed an implementation strategy, and it was time to test it out to see where our successes would be and where we had room to modify and grow. So, in accordance with our implementation plan, we started with a group of rural districts on the west side of our county. We had established trusting relationships with these districts. And through regular conversations with leaders in those schools, we knew that these were underserved communities within Fresno County, so starting the program in these areas first made sense. We found that these rural districts were ready and willing to step into new territory with us for shared learning while also sharing feedback in

the first year of the rollout to ensure success as the program grew.

During the implementation phase, you will work closely with stakeholders to determine how you can move toward the goal of sustaining the program over many years. You may spend hours outside your full-time job coordinating details and building relationships with the school staff. You may work late nights and get up early for morning calls. But most importantly, you'll remember what sparked your passion for this work in the first place: giving space to youth and their families for care and healing.

As exciting as this all was, it was equally as challenging. Our team had invested time, money, and other resources into this project. Our advice would be to keep an open mind to minor adjustments in places and large pivots in others. Remember, those immediate circumstances don't determine the success or failure of your program long term. Realistically, the implementation stage will last a few years before your program fully integrates into the schools.

Objectives

- ☐ **Onboarding School Districts & Schools**
- ☐ **Managing Clinical Staff Roles**
- ☐ **Supervision-Clinical and Administrative**
- ☐ **Setting Patient Intake Processes**
- ☐ **Implementing a Sustainable and Realistic Budget**

How We Did It

Onboarding School Districts & Schools

Components of School/District Onboarding

- Meet with the district staff and administration for an onboarding session
- Schedule a visit at the school site to see confidential space (See Site Visit Form)
- Determine what resources each district already has in place (Link Handout)
- Use the MTSS pyramid to determine existing services (Link Handout)
- Create a Frequently Asked Questions (FAQ) fact sheet (Link Example)
- Onboard all district administration, including the Superintendent, Assistant Superintendent, Principals, Vice Principals, Counselors, etc.
- Train administrators on trauma, verbal de-escalation, and mindfulness
- Create and maintain an events calendar for districts and outside agencies (Ensure staff are present at each event)
- Create and maintain an events calendar for community and stakeholders partners (Ensure staff are present at each event)
- Schedule follow-up meetings to hear how the onboarding process is going at each site

During our positioning and planning, our team had established trusting relationships with leadership and staff in our first onboarded districts. We considered these districts our pioneers and our cheerleaders!

The next step was onboarding—a critical step to the overall program's success. This orientation brought together leadership to expand on our previous conversations during positioning and finally move forward with implementation and launch.
First, we believed it was necessary to start by providing a framework for school staff to acquire the knowledge and skills to support students while still utilizing the integration of mental health clinicians on campus. We wanted to equip school staff with understanding trauma, knowing how to know when a youth was in need of support, and destigmatizing mental health. We felt very strongly that this training was a critical component to the success of our program. We required training for all schools in any onboarded school district, which helped to solidify the foundation of our partnership.

This training helped teachers and staff members recognize and respond to youth with behavioral and mental health needs, destigmatize their experiences, know about available resources, and it opened the door to communication lines about behavioral health in our schools. The training also included a component that addressed integrating mental health service providers on campus within a multi-tiered system of support.

We found that most schools in Fresno County had gone through Positive Behavior Interventions and Supports (PBIS) training and had developed a systems framework to address student behavior at the three tiers of intensity (Tier I, II, and III). However, our added training worked to build on and complement their earlier PBIS work.

Our training modules focused on trauma and resilience. The training describes what trauma is, how it impacts the brain and child development, and how trauma is manifested in student behavior. These training sessions come in the form of three modules:

- Module I: Trauma & the Brain
- Module II: Stress Resilience
- Module III: The Trauma Informed Classroom

In addition, we equipped teachers with strategies to employ within a classroom or campus setting to create a sense of safety, belonging, and acceptance where students can truly thrive.

Generally, there is a tendency in the school system to view student behavior from a disciplinary perspective. For instance, there's typically a stance that students who act in disruptive ways are just 'naughty' and need to be disciplined or corrected. However, for students who have experienced trauma or are experiencing trauma, this is typically a signal that a child needs more support.

Since our youth are constantly developing and changing, mental health issues can also be hard to identify. Some of the most common identifiers that are generally signs of behavioral and mental health issues include:

- Frequent anger/temper tantrums
- Difficulty playing with other children
- Trouble following directions
- Persistent nightmares
- Having a hard time coping with problems and daily activities
- Excessive worry or anxiety (i.e., refusing to go to school)
- Feelings of sadness and hopelessness
- Frequent outbursts of anger
- Difficulty with behavior and frequent suspensions
- Psychosis and other forms of mental health challenges

We hope that educators who understand these key identifiers can help prevent future mental health illnesses from developing with early and appropriate support. In addition, this framework provides teachers with information on what to look for in students and pointers on when to reach out for more assistance when a student shows signs of significant need.

We also talk with each school district about past trauma's impact on the adults on campus, from teachers to administrators. The training goes over how that trauma can impact an adult's capacity to respond to student behavior in a way that helps, not hurts.

A Note from Fresno County All 4 Youth

We asked for anecdotal feedback from school district staff members who participated in the trauma trainings we conducted at this stage. Here are some of their responses on how this training was beneficial to them:

"Understanding the definition of trauma was significant and beneficial to me because I feel that often times as human beings, we forget that everyone has a different experience or feeling of an event compared to others."

"Learning detailed information about what is going on in the brains and bodies of our students will be incredibly helpful as I support students this year."

"I appreciated the immediate real-world applications because they help me integrate the concepts and make our time spent in training feel more valuable."

We provide all this information to K-12 schools as part of the onboarding process. We require schools to participate in the training, although they do not need to complete all three modules before placing a clinician on their campus. Instead, it is highly encouraged to finish all three modules within one year. We noticed there are benefits to spacing out the training. For instance, more time affords staff to reflect on their learning and apply it in the school setting between modules. This delay also allows faculty and staff members to ask questions before moving to the next module.

Our process ensured a unified, organized approach overall. As a result, everyone had the most relevant training and the opportunity to provide feedback and contribute to developing mental health support for schools and students.

A Note from Fresno County All 4 Youth

Before the pandemic, we provided three 2.5-hour training sessions, but we adjusted and shifted our training to a virtual format. We continued to maintain all of the training components we had utilized with our in-person training, including break-out sessions, fillable PDF workbooks, quizzes, and evaluations. Yet, our team found we could move through the material quicker and was able to reduce the length of training to 2 hours.

Managing Clinical Staff Roles

During the implementation phase is the time for your new and existing staff members to start functioning in their assigned positions. Here's our rundown of how clinical staff members operate within our program and schools:

Our clinical staff members provide direct care to youth and families primarily at school sites. As we've mentioned throughout this toolkit, this framework helps remove barriers for youth accessing care and eliminates any disruptions in the classroom.

Clinicians provide mental health assessments, treatment planning, individual therapy, family therapy, and group therapy. They also provide collateral services to support care providers in understanding youth's needs and case management or linkage, and coordination of care with other service providers and support persons in the youth's life.

Meanwhile, youth care specialists and intervention specialists provide psychosocial rehabilitation, coaching and skill development, group services, case management and linkage, and support to youth and families working with an All 4 Youth clinician. These team members also connect with service providers and support personnel to coordinate patient care.

Lastly, family partners provide mentorship to youth and their caregivers and linkage to services and support within the community, using guidance from a youth's clinician.

Supervision: Clinical and Administrative

All clinical services provided in the All 4 Youth program are overseen by licensed clinical staff. Direct services provided to youth and families are delivered by both licensed and unlicensed professional staff. We provide a layered approach to administrative supervision, clinical supervision, and mentorship that offers guidance and support for well-rounded clinicians. Additionally, we

provide support and supervision to non-licensed, unregistered staff in direct care and non-direct care positions.

Administrative supervision includes completing a supervision tool that tracks ongoing tasks, reports data, updates, needs or support, time off, training, and individual caseloads. We track caseloads by the school district and include the date enrolled, assessment date, treatment plan date, outcome tool intervals, and progress reports. These tools do not contain protected health information (PHI), so data exchange between supervisors and direct care staff is acceptable. Each licensed and un-licensed staff receive administrative supervision with their immediate supervisor.

Clinical supervision happens in one of two ways:

- **Through weekly two-hour group sessions provided by the Clinical Supervisor**
- **Through weekly one-hour individual sessions provided by the Behavioral Health Clinician II's (BHC II)**

The BHC II is a clinician licensed for at least two years and can provide clinical supervision while holding their own caseload. These clinicians typically have approximately three Behavioral Health Clinicians I's (BHC I) who meet with them weekly for individual clinical supervision and mentorship. These meetings do not include employment or programmatic expectations, and we expect them to remain clinically focused.

Mentorship opportunities are available to licensed staff in one-hour consultation groups. A program supervisor facilitates these meetings where licensed staff can consult with other licensed staff. These consultations are offered as drop-in spaces two times per month during different time frames to accommodate varying schedules.

Setting Patient Intake Processes

The intake process for youth is a critical step in the implementation phase. This operation brings the youth into our program to get the care and support they need. Here's a rundown of the process we set for our HIA staff:

Accepting Referrals
As we mentioned in "Part IV: Plan Implementation & Preparing for Launch," we receive referrals through our main All 4 Youth phone line or email address. These referrals come primarily from school staff, parents, and community partners.

Once a referral is received, our office staff calls the family to confirm interest and collects relevant insurance information.

Insurance Status
Next, our HIA team processes the referral based on insurance status and enrolls the youth into the EHR.

The primary coverage type served by All 4 Youth is Medi-Cal. Our team runs Medi-Cal eligibility benefits and confirms an active status at the

start of services and every month following. Our FCDBH billing department completes all billing for Medi-Cal and pulls the billing report from the EHR, which lists the services provided based on progress notes written by the clinical team.

All 4 Youth also accepts private insurance, which we also process through the county billing department. However, we are considered an out-of-network provider for all private insurance types. Therefore, if a family's insurance doesn't cover services or the out-of-pocket cost is too high, we will connect the family with an in-network provider so that they can access services elsewhere. Although, we can enroll them in treatment if the out-of-pocket cost is low enough for the family to agree to pay their portion of the services.

When youth and their family have both private and Medi-Cal insurance, we will process their referral the same way. Our HIA team will explain any costs not covered by their private insurance and what Medi-Cal will cover as usual. In this dual coverage scenario, the family has no co-pay. If the family agrees for us to bill both insurances, we will bill the private insurance, receive a denial, and then bill Medi-Cal. After that, we will enroll them in treatment.

Screening

Youth can have a triage visit, depending on the situation. Program supervisors will triage youth for the level of risk and assign them appropriately.

Consent

Once our staff receives the case assignment email, they schedule a meeting with the family for formal consent and assessment within ten business days.

Assessment

The assessment will occur with a clinician on staff who may request follow-up meetings to interview youth, their family, and/or school staff to complete their evaluation.

Treatment

After completing the assessment, our clinician creates goals with the youth and obtains signatures from the family agreeing to their plans for treatment. These plans also include information on the frequency of services needed.

Community Linkages

Throughout treatment and during the discharge and graduation process, the clinician will utilize case management services to provide linkages to community resources that the youth and family may need.

Planning for Various Student Statuses

The heart of our program is to provide services to all youth, no matter their background. Therefore, it's essential to create a process for the various situations a youth could have when they seek your assistance.

For instance, there is a possibility that a family comes to seek services as undocumented immigrants. Therefore, we train our staff to be sensitive to this particular situation.
First, we ask our team to provide as much information about our services to the family. Then, if the youth does not have Medi-Cal, our staff can help the family apply for Medi-Cal if desired and walk them through the process. We also have family partners that can provide families with resources on citizenship, if requested.

Another situation could be that a family comes to seek services but is uninsured. Like the above case, we offer families who do not have insurance a support staff member to walk them through their options. Our team can also direct families to Covered California to find out more information and apply for Medi-Cal. When a youth comes in that is high risk, our clinical team can provide short term intervention and support while the family is linking to an insurance carrier.

Implementing a Sustainable and Realistic Budget

Our implementation phase is when we realized some major lessons on funding. To summarize, budgeting is complex. Below is a recap of all the challenges we faced and our recommendations for your team as you develop a similar program.

Budgeting Fluctuations

Our budget has required modification often.

First, we overestimated our operations budget. We have been fortunate thus far not to need as much funding in the operations area due to leveraging relationships to co-locate hubs on a school campus and within existing buildings. Thankfully for us, these arrangements helped reduce our overhead costs.

Meanwhile, we underestimated our salary and benefits budget for staffing. According to our contract, we had to keep any budget modifications under 10 percent, so the overestimation of our operations budget restricted the number of direct care staff we could hire even though we needed them.

A Note from Fresno County All 4 Youth

From our experience with these budget fluctuations, we recommend future partnership contracts have flexible language that extends to the budget and the ability to modify as you build out your program. This will help provide the space for your team to learn and adapt, as necessary, without some of the obstacles or limitations our team encountered.

Moving more than 10 percent in a modification would have been helpful to match our needs as they arose, but, since the contracts structure didn't permit that large of a shift, we have not been able to reallocate what we budgeted to operations for personnel.

Funding Staff Positions

We realized our original staffing plan didn't anticipate the number clinicians we would need and along the way we made modifications to adjust for the needs once they became apparent.

Our HR team also conducted a classification study to ensure their funded positions are within the labor market rates. This led to a salary increase for the intervention specialist positions. In response, we created a new youth care specialist position with a lower pay rate to better match the budgeted salary.

Insurance Expectations vs. Reality

Mental health does not discriminate, but billing and insurance systems are not all created equal.

From the beginning, our team anticipated that some of the non-clinical staff would be able to bill for medical services. But unfortunately, we later discovered that wasn't the case.

Furthermore, we underestimated the rates of private insurance and Medi-Cal in our county. For instance, we miscalculated the number of kids who would get a referral for our program with private insurance. As a result, a much higher percentage of youth had private insurance than anticipated. This issue impacted the structure and flow of services and created a steep learning curve for our team in processing private insurance.

When creating a new service program, have meetings about these situations beforehand. Work with your County Mental Health Plan to learn what may be possible as you design a contract.

A Note from Fresno County All 4 Youth

Having a diverse group of staff members will help you see many perspectives. These individuals will also help you bridge the gap in cultures, processes, procedures, and expectations of medical versus educational models.

We recommend expanding your planning team to include people who can articulate different services and systems. This team will help you have the best possible level of understanding of it all—from levels of supervision and auditing to processes and procedures needed between your agencies, like FCDBH and FCSS.

Some examples of people to bring to the table for discussion are:

- County Managed Care Division (or Mental Health Plan oversight team)
- County Fiscal Department
- Educational Leadership
- Clinical Leadership

In our case, FCDBH provided training opportunities on different processes, like invoicing, budget modifications, setting up an organizational NPI, etc. We encourage you to take advantage of that training if it's available to your team!

Other Miscellaneous Expenses

- Food and water purchases could only be in the budget if tied to a specific service or student.
- Parking was only reimbursable for families receiving services, which was a challenge with staff assigned to buildings in parts of the community that required them to pay for parking. As a result, we recommend hub locations have free parking that is easily accessible.

Lessons Learned

1. Integrating Staff on School Sites

Discuss ways you can enhance the integration of clinicians on school sites with your staff. One thing that came up in our partnership was that on a school campus, adults are referred to by their last name (i.e. Mrs. Smith) instead of first name. This was a big shift for our clinicians who were accustomed to being called by their first name in other clinical settings. We found using the formal classroom titles helped blend the staff into the campus culture.

We also encouraged clinicians to build relationships with school employees and students, attend collaborative meetings, and try not to say 'no' to opportunities to learn and grow as part of the school.

2. Staffing Patterns Will Change

Anticipate needing to hire positions you don't already have planned as part of your program or organization. Our original staffing patterns had to change for a variety of reasons. Based on those experiences, we recommend hiring upstream before you even post job openings. This planning and provisional hiring will afford you options if the need for those employees arises.

Another lesson we learned was setting competitive wages to help prevent turnover rates. This practice, paired with setting clear expectations during the interview and onboarding process on time off, work schedules, and the overall fast-paced work environment, will set your program up for success. However, one caution for the general impacts in the County Mental Health Plan network of care is that competitive wages in the partnership program may destabilize other providers if their contracts are not set up to adjust wages to compete with the new program.

Remember that your staff members are the face of the All 4 Youth program. They're boots on the ground, doing the work, and making those connections to bridge the gap in access to mental health services and support. Be clear about this with your team, as well. Many clinicians will come from a traditional setting where they conceal themselves with persons they serve in their office all day. That's not the All 4 Youth experience or expectation so it could be a steep learning curve for staff unfamiliar with that mindset.

3. Human Resources Challenges

This program will challenge everyone, even the Human Resources department. For instance, we experienced multiple rounds of revisions with job descriptions, ramp-up period deadlines, mass amounts of hiring and onboarding of employees, and many, many, many meetings.

Don't forget that the HR department is helping to coordinate the heart of your program: staff. Therefore, they will need administrative support and infrastructure to sustain their newly increased workload. Keep them updated with as much information as possible and give them time to sort through everything they need to make this implementation process a success.

Testimonials

When we initiated the development of our contract, we were starting from scratch to determine our staffing needs, budget needs, and all the details of what we needed to run a program for all 32 districts in our county. We attended conferences non-stop, traveling all over California and even out of state to research everything we could to design the best program for our county.

We worked everywhere: in cars, airplanes, and hotel rooms. We scribbled our ideas in notebooks, on the back of documents, and carted giant 2x3' Post-its with us wherever we went. We did whatever it took to get our momentary idea bursts and brainstorms down on paper.

We worked around the clock for several months. (Even when the water in our hotel shut off and we had to wash our hair in the swimming pool!) But, in the end, getting these valuable resources and services to our students was worth it.

PART VI: EVALUATION & QUALITY MANAGEMENT

Overview

If we deliver quality service to students, they can heal. We can help change the trajectory of their lives and leave a lasting impact on the community at large. Evaluation of our program and quality management can help us measure if we are accomplishing the goals we set out to achieve. For example, are we delivering meaningful services to youth and their families?

The innovation of this program requires you to accept defeats and tolerate failures. You'll fall down, get back up to try again, succeed, learn from the process, and repeat. Continually refining, adjusting, and reviewing your processes allows you to get better. This strategy is vital for improving your services and building lasting relationships with the community.

Reflecting on outcomes also ensures compliance with standards and offers an avenue for transparency, accountability, and appropriate multidirectional visibility with your schools, students, staff, and stakeholders. This approach also helps build trust and credibility for your program in an effort to prove your worth!

Objectives

- Launching a System to Measure Program Performance
- Utilizing Data Collection Procedures
- Staffing for Quality Control and Improvement
- Developing Grievance and Complaint Procedures

How We Did It

Launching a System to Measure Program Performance

An essential part of program design is tracking key indicators, measuring program performance, and collecting outcome data. This outcome data can then inform quality improvement efforts and provide the necessary feedback to make pivotal decisions as the program progresses.

First, our team had to consider the following questions:

- What outcome tools are accessible to us, or we could gain access to or create ourselves?
- Who were the administrators of these tools?
- How do we interpret and report on the data to stakeholders?

To do so, we evaluated what was clinically appropriate. What would fulfill the statewide assessment strategy required by our partnership contract for tracking youth progress?

Our team checked to see what data we had access to from partnering with districts and leveraged resources already within our EHR. Then, we explored methods for measuring outcomes created by other organizations that we could purchase and implement. However, we eventually found that these did not quite meet our needs and ultimately decided to use multiple other sources to provide data for our outcomes report.

To accomplish this task, we used a blended approach of existing tools that FCDBH already had in place, making implementation simpler. For example, the Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptom Checklist (PSC) measure a youth's performance based on caregiver view of progress throughout treatment.

Meanwhile, we requested aggregate absentee, expulsion, suspension and Healthy Kids Survey data for our districts to determine treatment effectiveness based on the youth receiving services. Therefore, reducing those key factors.

We learned it could sometimes be challenging to obtain absentee, expulsion, and suspension data from schools, especially within the timeframes that outcome reporting may be due based on contract deadlines. Developing outcome tools takes time, consideration, and feedback from both the recipients and administrators, but it's essential for creating a quality tool. Therefore, we developed our own tools, like the All 4 Youth Service Delivery Survey, Treatment Outcome Survey (6-22 y/o), and Treatment Outcome Survey (0-5 y/o).

Surveys are given to our youth, families, and the schools we serve, either bi-annually or annually, and are administered using the Alchemer survey software. This platform allowed us to use a web link so that subjects could submit answers electronically, and we could compile data into presentation formats with various pie charts and graphs.

THE ALL 4 YOUTH SERVICE DELIVERY SURVEY
Click here

TREATMENT OUTCOME SURVEY 6-22 Y/O
Click here

TREATMENT OUTCOME SURVEY 0-5 Y/O
Click here

Tips:

Use Translation As A Tool: All tools designed for families also needed to be translated into household languages, like Spanish and Hmong.

The Shorter, the Better: We learned from our administrators that our Treatment Outcome Surveys were too long and needed to be simplified. Not only did this result in copy revisions, but we needed to re-translating the entire tool.

Welcome All Help: Being able to leverage existing resources from your behavioral health department is also advised, if possible. Utilizing outcome measures within an EHR, like CANS or PSC, can help track clinical outcomes and align with statewide implementation.

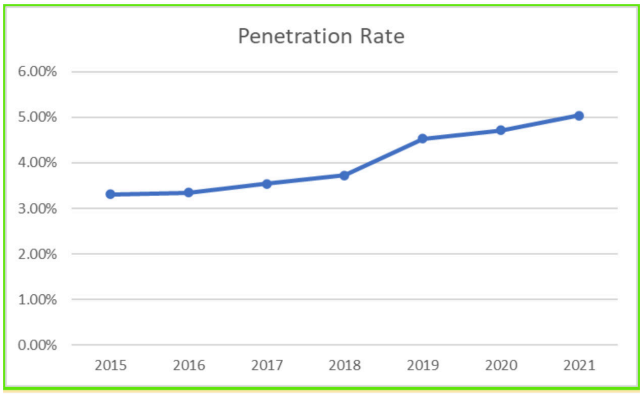
Utilizing Data Collection Procedures

The key to evaluating the impact of your program is analyzing data, from penetration rates to student surveys. There is so much information out there for your team to use in this stage of development. Below are a few data points we relied on for our analysis.

Impact on PEI and Penetration Rates

For our team, the first step in collecting relevant data was requesting information from districts to see the overall impact we were having on PEI using trauma training and other early intervention strategies. Data included school indicators, like suspension, expulsion, attendance, and truancy numbers. We tracked this information through our Treatment Outcome Surveys for youth enrolled in our program.

Next, our team jointly evaluated our program's impact on local penetration rates. As we mentioned earlier in this toolkit, we calculate the penetration rate data by dividing the percentage of Medi-Cal eligible youth versus the eligible youth receiving services. We identified this information through the Medi-Cal Eligibility Data System (MEDS) Monthly Extract File (MMEF) data uploaded directly into our EHR. We have a list with zip codes for all schools served in Fresno County and extract data from the MEDS report for those districts precisely. Zip codes help us reflect correlations of our impact on youth and their families in those designated areas. What we've seen is that penetration rates have steadily been increasing.



Prior to the All 4 Youth program, the penetration rate was 3.54% and increased to 5.04% as of the fourth operational year. The implementation of All 4 Youth was designed to be rolled out in a five-year, phased approach by first providing access to the regions of Fresno County that historically lacked mental health resources and then into the metropolitan school districts which historically had more readily available resources. Each year, All 4 Youth developed two treatment hubs to serve the respective region of schools to be onboarded to create the hub and spoke model.

The hubs were Medi-Cal certified by the MHP and treatment space is available for families that prefer more traditional treatment facilities. The hubs have other advantages outside of the additional treatment space. They are leveraged to maneuver around the traditional cost of treating individuals in areas spanning great distances. By designating hubs as home sites for clinical professionals to begin their work for the day, it alleviates and reduces the usually high travel time associated with serving large areas.

Although the target population identified are Medi-Cal beneficiaries, All 4 Youth's priority is to increase access to mental health services regardless of payor source or lack of coverage. Each child or youth identified and referred to All 4 Youth will receive at least a screening and/or assessment to determine service needs and appropriately provide referral and linkage to community resources.

Through the hubs and school sites, the All 4 Youth program was able to increase services for the community as evidenced by the increase in penetration rate. The All 4 Youth program has leveraged resources from both FCSS and DBH to create a system of care within the school system and continues to work to increase accessibility to services and reduce stigma.

Access to Timely Services

In compliance with state standards, All 4 Youth must ensure youth referred for services have access to services in a timely manner. Therefore, we expect clinicians to contact families within one business day of receiving the enrollment to offer an assessment appointment within ten business days from enrollment. If the family cannot meet within ten business days, our program policy is to continue to offer appointments for at least 30 days from enrollment before closing the referral. If a clinician cannot provide an appointment within ten business days, a supervisor will assess if another clinician is available to meet the timeliness expectation.

To report on this data, we use an Access Form that provides an overview of the clinician's initial contact attempts to engage with youth and their family, offered dates for the assessment, and the dates provided for treatment.

A Note from Fresno County All 4 Youth

Based on a fiscal year cycle, July 1 to June 30, the annual reports are due in September, which is often challenging because teams are getting ready for the new school year. With so many things happening during this timeframe, like training and school site introductions, getting data from school districts during the summer when trying to put the outcome reports together is complex. It reflects one of the challenges of an integrated system because healthcare services do not operate on a school calendar, but the staff in the partnership program are impacted by the demands of certain periods in the school calendar.

Data Written Into Our Partnership Contract

As part of our partnership, FCSS must provide FCDBH with an annual outcome report both quarterly and annually. The information included in the outcome reports are:

- Fiscal Information
- Program Goals
- Target Population
- Demographics
- Penetration Rates
- Attendance Rates
- Direct Services Claimed
- Timely Access to Services
- Training Provided to Schools and Staff
- Outcome Survey Items Provided by Youth and Families
- Scores from Outcome Tools, like Reaching Recovery, CANS, and PSC-35

Any data reported to the county includes an interpretation of the data and an explanation of efficiency. Our team compiles the information into outcomes reports with data organized into easily viewed charts broken down by data points, such as the percentage of change from initial to re-assessment, satisfaction rates, referrals, discharges, etc. Also, in the report, we have information on our hub location statuses and an overview of the diversity of youth we serve.

Maintaining Referral Data

Referral data is reported monthly to the county and the school districts. We break down our referral data by the status of each youth, which explains whether a child is receiving services, if their referral is in-process, or if they have declined or discharge from services. We pull this information often to keep current on the number of youth enrolled in the program at any given time. It's also easy to see which schools need support based on these referral numbers. These schools typically have more youth disengaged from wanting therapy services and a higher number of youth receiving short-term PEI services.

Staffing for Quality Control and Improvement

Quality Support Supervisor

Going into this planning phase, we realized we would need a Quality Support Supervisor to oversee the HIA staff. So we designed this position to continually look at the quality of our program and services by handling things like audits, data collection and analysis, and overall productivity. Here's a sample of the tasks we listed for this role in our job description:

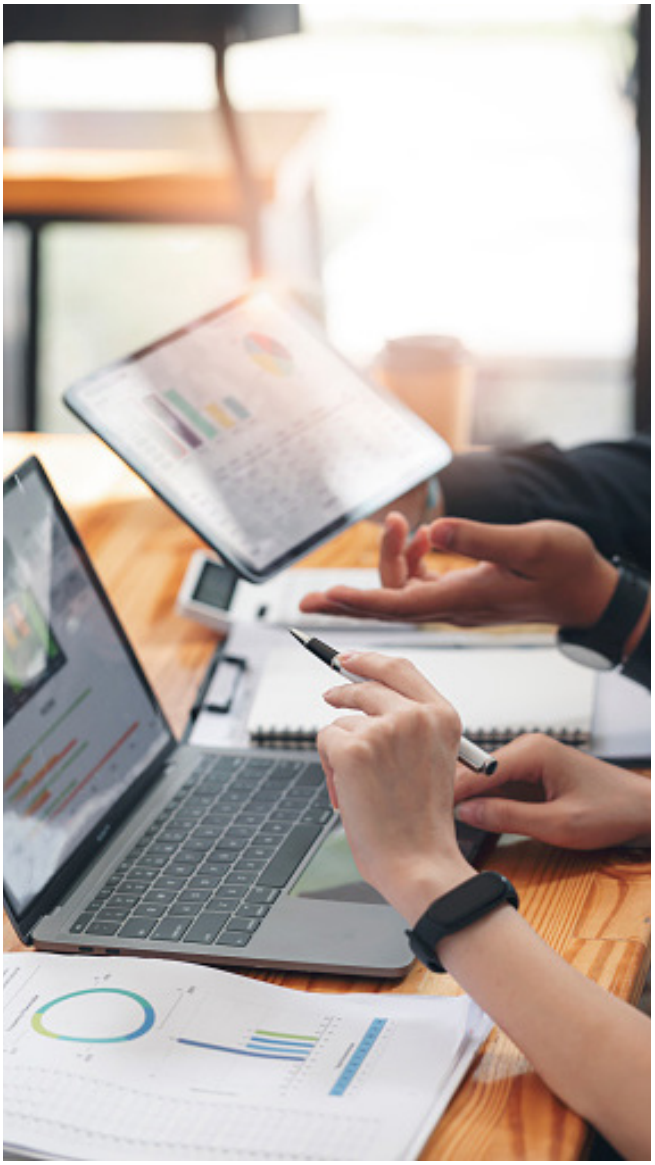
- Prepare for monthly county and state audits, update audit tools, review staff and supervisor audits, and give feedback.
- Prepare outcome data (annual outcomes, NACT, surveys, etc.)
- Run reports on various items from MyAvatar, Domo, and FileMaker Pro to present data.
- Direct the onboarding of new staff training on MyAvatar, incident reporting, documentation, etc.
- Provide oversight and support for MyAvatar and FileMaker Pro
- Act as a liaison with FCDBH on MyAvatar, billing, compliance, documentation, etc.
- Collaborate with other supervisors and directors
- Communicate information from program and management meetings to staff members
- Collaborate on new strategies for quality improvement
- Serve as an FCDBH committee member and liaison for EQRO, Access, and CQI

Other Staff Roles

All staff members require training on documentation standards and the auditing processes at the time of hire and begin putting these skills into practice right away.

The Quality Support Supervisor was in charge of working with the Clinical Director and supervisory team to develop documentation training that taught staff what and where to document information appropriately. Our team divided training into sections: intake training, assessment and treatment plan training, progress note training, and discharge planning. Then, we would use mock assessments, mock progress notes, and other tools to help staff members practice these skills before moving into real-life work.

As mentioned above, the Quality Support Supervisor oversees audit processes and procedures. Audits are done every month and cover the services for the previous month.



A Note from Fresno County All 4 Youth

At the start of our program, we would audit every youth chart each month. As the program grew, the percentage of charts changed to half, leaving each staff member with approximately seven to ten charts to audit per month. The 50% of audits alternate alphabetically so that each youth gets audited at least once every other month. Staff members also have two weeks from the date audits are assigned to complete them, with time set aside in regional staff meetings to help do so.

Audit tools help clinical staff ensure that each item that they need to audit is covered and recorded promptly. For example, one audit tool captures the progress notes for that audit period, and another tool captures the youth's assessment and intake documents. Staff members are trained on these tools towards the end of their new hire training.

Lastly, our team reviews staff performance monthly using reports from the EHR to show productivity, timeliness, documentation due dates, etc. Our monthly peer audits allow staff to reflect on how others on their team maintain and organize their documentation, get ideas for interventions, and ensure charts are always audit-ready. These peer audits help provide staff with the time they need to review the information included in an audit, as well as an internal reflection of how that process looks for other people and where there may be room for progress.

A Note from Fresno County All 4 Youth

The FCDBH Managed Care Division also audits each site-certified hub location once per year. There are currently six hub locations, so this process is equivalent to six audits per year. Additionally, the state conducts Triennial Reviews, and All 4 Youth has participated in this audit previously.

Overall, the key is to train staff members based on your expectations when evaluating them moving forward. This training is a continual process revisited through supervision, refresher training, and peer audits where staff assess each other's documentation processes. Eventually, your staff members will learn from what they see others doing well in their work and what is not up to standard.

During these procedures, the supervisory team should remain on the same page with everything from instructions for these training sessions to clearing modifications to training sessions. While the Clinical Director and Quality Support Supervisor guide the decision-making process, it's important to stay a team, get feedback for revisions from every supervisor, and keep the lines of communication open to changes.

Training Curriculums

In our partnership, it was the responsibility of FCSS to develop training curriculums for the onboarding process. These pieces of training would prepare staff for service delivery within the integrated model of care that All 4 Youth offers. For example, our intake training curriculum involves a thorough review of the documents and role-play of the intake procedures to mimic how our staff would communicate information to youth and their families. This practice allows our clinical team to feel comfortable discussing the forms and answering questions from the beginning.

Intake training also dives into the legal requirements for what must be discussed during consent for treatment, including mandating reporting and limits of confidentiality while discussing, collaborating, and integrating into the school system and establishing referral teams on campus. Other training curriculum covers documentation, trauma-informed care, EHR, incident reporting, etc. In addition, we leverage staff development and learning opportunities through our partnership with FCDBH, other organizations, other departments within FCSS, and separate contracted providers.

Training Checklists

Each training provided to staff has an accompanying checklist that acts as a "how-to" guide for their expectations. These checklists cover various topics, including what forms to fill out during intake, assessment, discharge, transfer from one clinician to another within our agency, what to check during audits, what to complete before going on vacation, etc.

In addition to checklists, each task our clinical staff is in charge of comes with step-by-step directions on the processes. These documents include things like screenshots of navigating our electronic systems, where to save documents, and how to complete forms. Supervisors can use these guides to direct staff when they have questions.

Developing Grievance and Complaint Procedures

We established grievance and complaint procedures based on standards of care and sound clinical practices and in accordance with the policy set forth by the FCDBH Mental Health Plan. We ensure youth and families receive a full explanation of the grievance and complaint process and change of provider process as soon as their services begin. For accessibility, these youth/patient rights are displayed prominently in all hub waiting room areas in Spanish, Hmong, and English, the threshold languages for Fresno County. Additionally, we place a change of provider and grievance and complaint forms in the waiting rooms of each hub location with self-addressed envelopes.

If youth or their families have any grievances or complaints. In that case, we encourage them to speak with their clinician about concerns, needs, or desires, except if those concerns are about the clinician. In that case, we encourage youth and their families to speak with another team member or supervisor to maintain continuity of care before any disruptions and while we find a resolution that supports the youth.

Lessons Learned

1) Early Bird Gets the Worm

Don't underestimate the value of quality control. And certainly don't divert your resources away from this process! We learned that early adaption could help move you on a steady path forward rather than backtracking in certain areas. Here's a rundown of some places we felt like we could have adapted to earlier on in the planning process:

2) Leadership & Staff Development

As we mentioned in this section, we did not originally anticipate the need to hire a Quality Support Supervisor at the start of our program planning. This position brings everything together, from audits and data reviews to productivity and staff development. Having leadership in this sector ensures your program will deliver its promises and enhance the mental health services for youth and their families.

3) Development of a Data System is Essential

A comprehensive data system is needed to support quality improvement data. A system that communicates with our EHR allows us to see data organized by individual staff members and supervisors. This portal enables us to view employee metrics, including:

- Documentation timeliness
- Items by caseload (youth who received a service within the last 30 days)
- Assessments and treatment plans that are out of compliance
- Documents that are in draft
- Types of services provided by percentage, count, and no show rate
- Total hours billed monthly.

Our partnership reflected on quality management data, including aggregate data and overall trends in youth progress, at a programmatic and individual level. Additionally, the youth and staff data on performance indicators were reviewed internally with FCSS to find areas of improvement and build upon strengths. Our supervisors use these systems to provide feedback to staff and coach them on strategies to use to improve service delivery.

Our advice is to establish this data system early on in your planning. These tools are essential to evaluating your progress and controlling the quality of your services.

Tools

- [ ] Supervision and Case Review Policy
- [ ] Grievance and Complaint Form
- [ ] Change of Provider Form
- [ ] Incident Report Form
- [ ] Audit Tools
- [ ] Outcome Report - Template
- [ ] Referral Report - Template

Closing Statement

By now, you've learned about Fresno County All 4 Youth and our many adventures getting this mental health program off the ground. It has been a journey, for certain, with many successes and a few bumps along the way. We've learned from the challenges and used these experiences to improve continuously. The future of mental health services in schools is brighter than ever, with abundant opportunities to increase access to support and care for our students. We wish you luck in your journey to customizing your model for supporting youth in your community.

Sincerely,
Fresno County All 4 Youth

ACKNOWLEDGMENTS

Throughout the process of developing All 4 Youth in Fresno County, we listened, learned, and leaned on the support of so many fantastic individuals. Without these relationships, we wouldn't have been able to help build the foundation for real prevention and healing to happen here in our county.

Former Fresno County Superintendent of Schools, Jim Yovino
Fresno County Board of Supervisors
Fresno County Superintendent of Schools, Dr. Michele Cantwell-Copher
Desert Mountain SELPA/CalHELP team
Former County Administrative Officer, Jean Rousseau
Fresno County Administrative Officer, Paul Nerland
Former Director of Behavioral Health, Dawan Utecht
Fresno County managers, supervisors, and team members who have worked on All 4 Youth
FCSS departments: HR, Finance, Facilities, Finance, Legal Services, Information Systems & Technology
The Caregivers and Children of Fresno County
The All 4 Youth Staff
Alvina Elementary
Big Creek Elementary
Burrel Union Elementary
Caruthers Unified
Central Unified
Clay Joint Elementary
Clovis Unified
Coalinga-Huron Unified
Firebaugh-Las Deltas Unified
Fowler Unified
Fresno Unified
Golden Plains Unified
Kerman Unified
Kings Canyon Unified
Kingsburg Elementary
Kingsburg Joint Union High
Laton High
Mendota Unified
Monroe Elementary
Orange Center Elementary
Parlier Unified
Pine Ridge Elementary
Raisin City Elementary
Riverdale Unified
Sanger Unified
Selma Unified
Sierra Unified
Washington Colony Elementary
Washington Unified
West Park Elementary
Westside Elementary