University of California San Francisco

School of Medicine | Department of Pediatrics | Center for Child and Community Health

Health Equity Action Time

Session 2: An Unprecedented Mental Health Reform Landscape in California and What It Means for Bay Area Children and Families

5/31/2022

Land Acknowledgement

Ramaytush Ohlone

"We would like to acknowledge the Ramaytush Ohlone people, who are the traditional custodians of this land. We pay our respects to the Ramaytush Ohlone elders, past, present, and future who call this place, the land that UCSF sits upon, their home. We are proud to continue their tradition of coming together and growing as a community. We thank the Ramaytush Ohlone community for their stewardship and support, and we look forward to strengthening our ties as we continue our relationship of mutual respect and understanding."

Health Equity

Community Guidelines

- Honor Multiple Perspectives
- Create Brave Spaces
- Hold Patience & Urgency
- Take the Lessons Forward, Leave the Stories Behind
- Commit to Collaboration and Learning

Today's Agenda:

- **1:00-1:30 PM**

  Session Opening

- **1:30-2:15 PM**

  Alex Briscoe & Mark Ghaly

- **2:15-3:00 PM**

  Discussion panel with Bryan King, Melanie Moore, Lisa Fortuna, Tom Insel, Alex Briscoe, Mark Ghaly

- **3:00-3:10 PM**

  Break

- **3:10-3:55 PM**

  Breakout rooms and large group discussion with local healthcare leaders

- **3:55-4:00 PM**

  Session Close

Photo by Daiwei Lu on Unsplash

Health Equity Action Time (HEAT) Series

Focus on Child and Adolescent Mental Health

Session 1: Critical Reflection and a Shared Path Forward

- **April 26, 2022; 1:00-4:00 PM**
- Creating space for critical dialogue and provide a landscape analysis to better understand the current state of what happens to children and adolescents with mental health needs across UCSF sites and services

Session 2: An Unprecedented Reform Landscape in California and What It Means for Bay Area Children and Families

- **May 24, 2022; 1:00-4:00 PM**
- Meeting with leaders who are re-envisioning California's systems of care and take a deep dive into unprecedented State reform around behavioral and mental health.

Session 3: Moving from Promise to Practice: Roadmap for the Future

- **June 28, 2022; 1-4 PM**
- Identifying concrete steps we must take as providers, policy and system leaders, and advocates to create a shared roadmap to improve the mental and behavioral health and well-being of children and families

Please visit the event page for more information and registration:
https://pediatrics.ucsf.edu/events/heat-health-equity-action-time

HEAT Planning Committee Members



- **Amy Beck**, MD, MPH
- **Cherrie Boyer**, PhD
- **Baylee DeCastro**, MPP
- **Archna Eniasivam**, MD
- **Anne Glowinski**, MD
- **Lauren Haack**, PhD
- **Joan Jeung**, MD, MPH, MS
- **Anda Kuo**, MD
- **Dayna Long**, MD
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- **Zarin Noor**, MD, MPH
- **Francine Ostrem**, PhD, MFT, MA
- **Noemi Spinazzi**, MD
- **Saun-Toy Trotter**, MFT
- **Cassandra Vega,** MPH

Recap of Session 1 on 4/26

Session 1 Goal: To create space for critical dialogue and provide a landscape analysis to better understand the current state of what happens to children and adolescents with mental health needs across UCSF sites and services.

What is 1 goal you hope UCSF/ZSFG will accomplish in the next 1-3 years to better support the mental health and wellbeing of children, adolescents and/or families?				
Integrated Care Coordination System	Diversity, Equity and Inclusion	Partnerships	Advocacy Initiatives	Capacity Building

Recording and slides available online! Scan QR Code:

Alex Briscoe, MA

Principal, California Children's Trust

California Children's Trust

REIMAGINING CALIFONIA'S MENTAL HEALTH SYSTEM TO ACHIEVE EQUITY AND HEALING FOR CHILDREN AND YOUTH

- Context
- The MediCaid Map in California
- Understanding the Landscape
- What You Can Do Now

UCSF Health Equity Action

THERE IS A CRISIS IN YOUNG PEOPLE'S MENTAL HEALTH

Consider the facts before COVID-19:

Increase in inpatient visits for suicide, suicidal ideation, and self injury
for children ages 1-17 years old, and 151% increase for children ages 10-14

Increase in mental health hospital days
for children between 2006 and 2014

Increase in the rate of self-reported mental health needs
since 2005

11

California ranks low in the country for providing behavioral, social, and development screenings that are key to identifying early signs of challenges

IMPACT OF COVID: What we feared is coming to pass…

ED VISITS

Beginning in April 2020, the proportion of children's mental health-related ED visits among all pediatric ED visits increased and remained elevated through October

24/31%

Compared with 2019, the proportion of mental health related visits for children aged 5 to 11 and 12 to 17 years increased approximately 24% and 31% respectively

25%

One in for young adults between the ages of 18 and 24 say they've considered suicide because of the pandemic, according to new CDC data that paints a big picture of the nations mental health during the crisis

RADY CHILDREN'S HOSPITAL IN SAN DIEGO:

Between FY2011 and FY2019, annual behavioral health volume has increased

1746%

From 163 visits to 3,009 visits in 8 years

Comparatively, total Emergency Department visits has grown 23% during this same time period

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THE “PRICE” IS HIGHER FOR BLACK AND BROWN CHILDREN

Many receive the wrong services at the wrong time…in restrictive or punitive settings.

75% of children on Medicaid in CA are **children of color.**

2X The **suicide rate for black children**, ages 5-12, is 2x that of their white peers.

70% 70% **of youth in California's juvenile justice system have unmet behavioral health needs**, and youth of color are dramatically over-represented.

Making Healing Centered Systems a reality isn’t simply a matter of tweaking access or programs…

It requires acknowledgment of how racism and poverty impact the social and emotional health of children

- Approximately 75% of mental illness manifests between the ages of 10 and 24. Since adolescents have the lowest rate of primary care utilization of any demographic group, it makes early warning signs difficult to detect.
- Provider shortages at the PCP and mental health practitioner level compound the challenge—even if you wanted to you couldn't.
- Diagnosis-driven models are only appropriate for some children. Mental health must be reimagined and infused with contextual understanding of the SDOH and ACES.

How did we get here?

We have no common framework for defining and understanding behavioral health among and between public systems and clinical care providers.

Our public systems are deeply fragmented and under-resourced. Commercial payers have not effectively partnered with child-serving systems.

A lack of clarity over whether youth mental health care is an essential benefit, or a public utility prevents commercial payers from fully engaging.

Our definition of medical necessity is outdated and inconsistent with emerging trends and evidence regarding the impact of trauma and adversity on social and emotional health.

The field is young. Many clinical modalities with widespread application are less than 20 years old.

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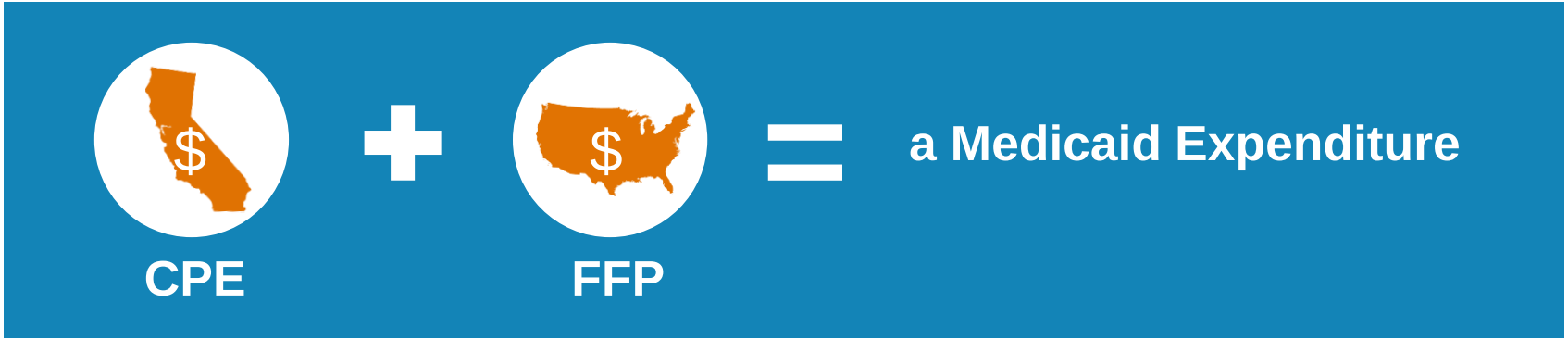
ELIGIBILITY FOR MENTAL HEALTH SERVICES HAS INCREASED, BUT ACCESS REMAINS LIMITED

60% of California's 10 million children are covered by Medi-Cal and EPSDT entitlement

A **33% increase over the last five years**, and **growing rapidly** with the economic crisis due to COVID-19

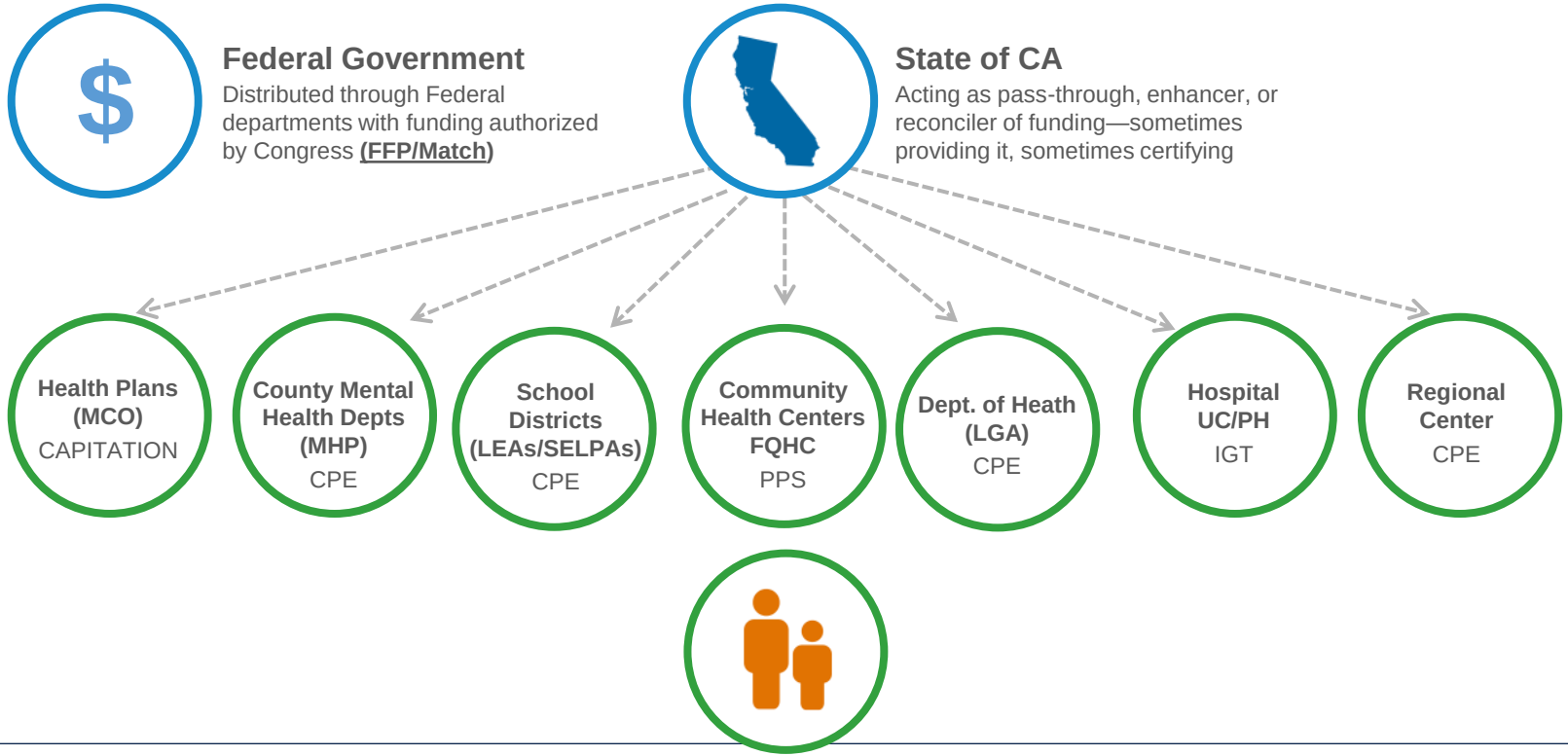
Less than 5% get access to any care, and only 3% are in ongoing care.

THE FEDERAL MATCH IS GUARANTEED:



- **Certified Public Expenditure (CPE) =** A state's use of public funds spent by other government entities (state or county) to claim federal reimbursement for Medicaid services.
- **Federal Financial Participation (FFP) =** The Federal share of Medicaid dollars – GUARANTEED match without limit or cap.

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



DRAMATIC UNDER-INVESTMENT IN CHILDREN

California is in the bottom 1/3 nationally for health spending at $2,500 per child enrollee.

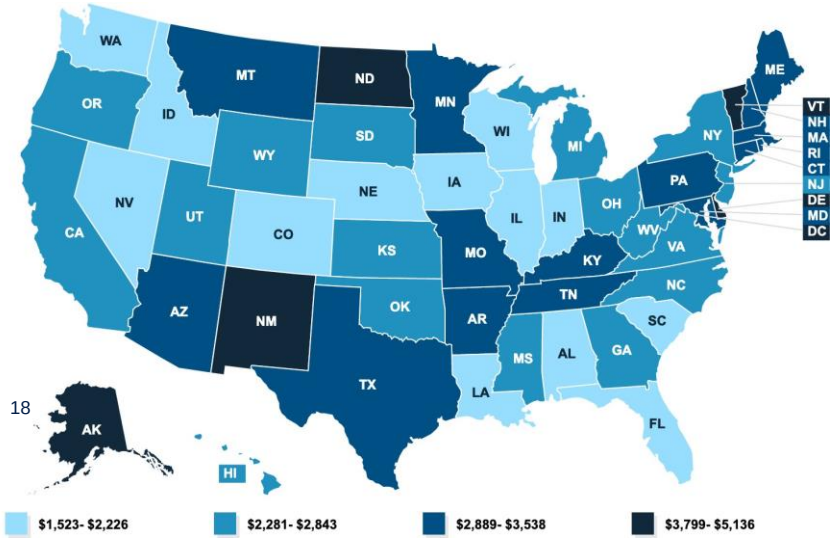
Children represent **42% of enrollees** but only **14% of all expenditures**.

California ranks **44th in the nation of** in access to care for children.

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

Medicaid Spending per Child

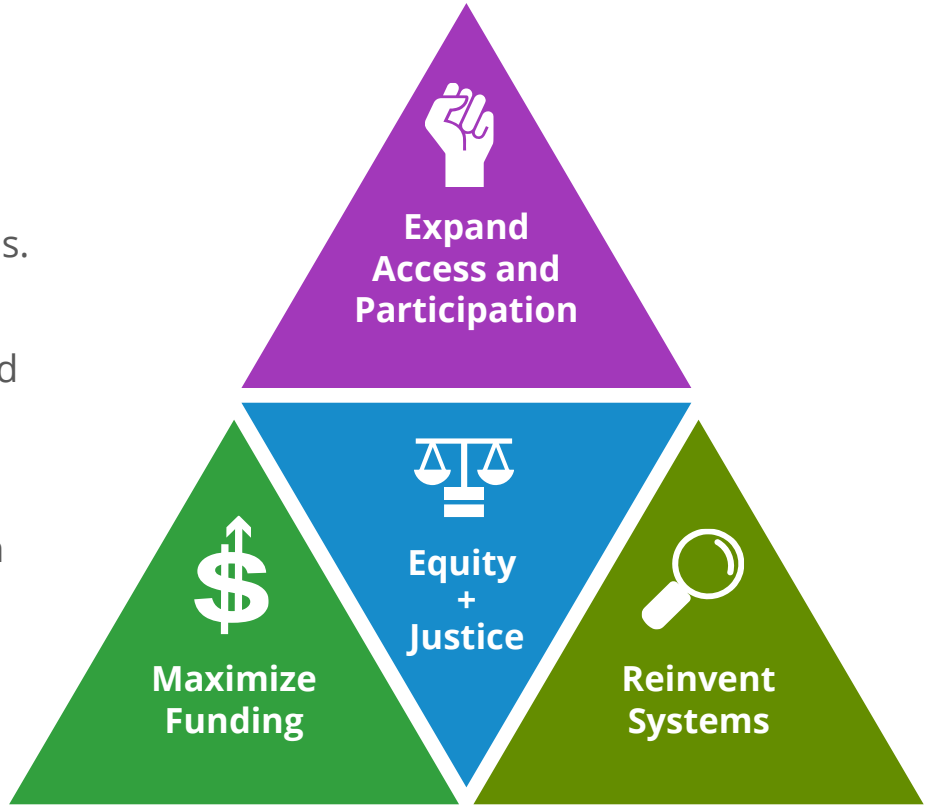
FY 2014



CALIFORNIA CHILDREN'S TRUST (and many others):

- **Transforming the mental health system:** We are a coalition-supported initiative to reimagine how California defines, finances, administers and delivers children's mental health supports and services.

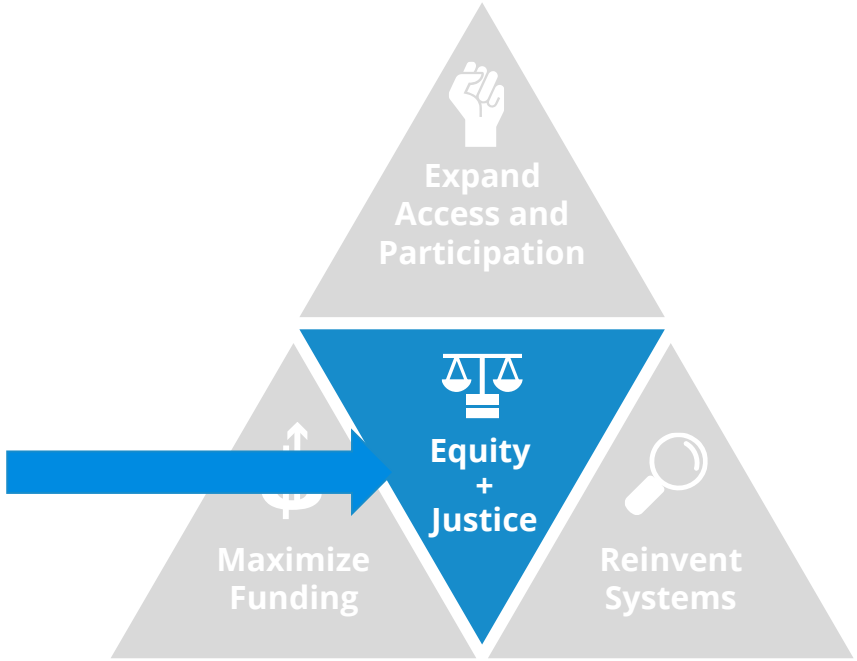
- **With a focus on equity + justice:** We frame our approach to state and county finance reform with a clear and open acknowledgement of the ways existing child-serving systems have underserved, excluded, and in some cases harmed populations of children and families.



THE STRATEGIES ARE CENTERED ON EQUITY + JUSTICE

- **Transformed behavioral health systems are not simply financed or administered differently, they are:**

  - Anchored in new principles that acknowledge structural racism and poverty,
  - Informed by relationships to and with beneficiaries and
  - Designed as methods for accountability.



- **Equity and Justice must include Shifting Agency (who does the work) Power (who gets paid to do it).**

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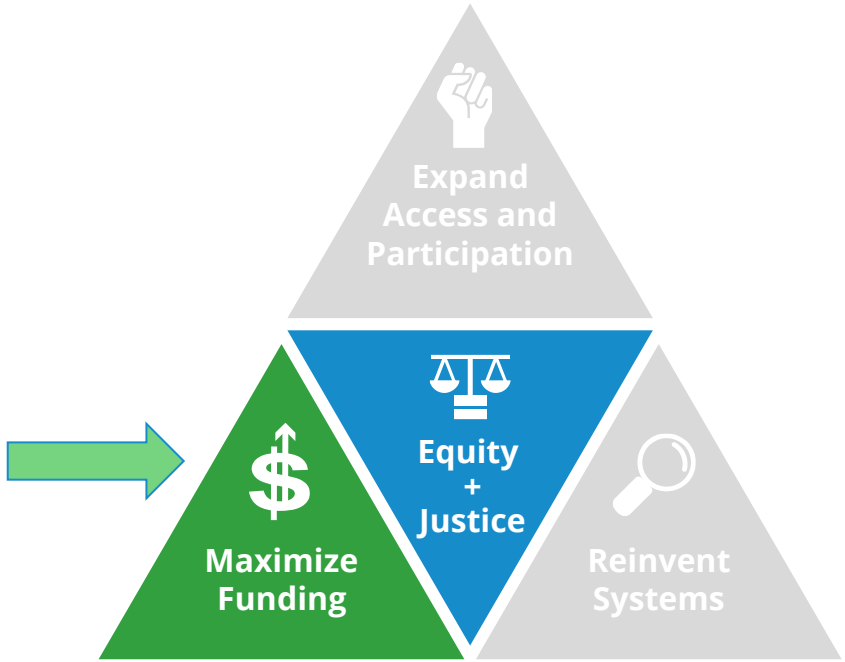
MAXIMIZE FEDERAL INVESTMENT IN MEDI-CAL

- Cross sector state and federal commitments are being made, but the vast majority are one time.

- The payment reform components of CalAIM would create unparalleled opportunity to maximize federal revenue and increase access to services for Medi-Cal beneficiaries.

- **Shifting Carved Out MH services to IGT from CPE** will increase FFP and reduce admin burden:. Will allow access to un-leveraged sources of eligible Certified Public Expenditures (CPEs) across the child-serving systems, and

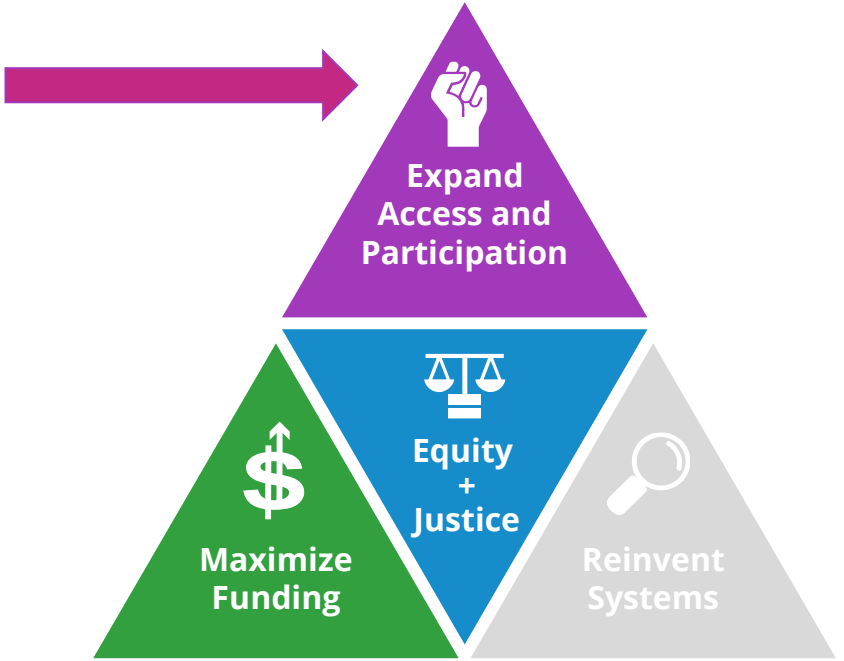


BROADEN THE DEFINITION OF MEDICAL NECESSITY FOR CHILDREN AND YOUTH

- **We must shift from a diagnosis-driven system to an approach that reflects an understanding of the impact of trauma and the social determinants of health on long-term health and mental health outcomes.**

- **Center the impact of racism, poverty, and adversity** in new eligibility criteria.

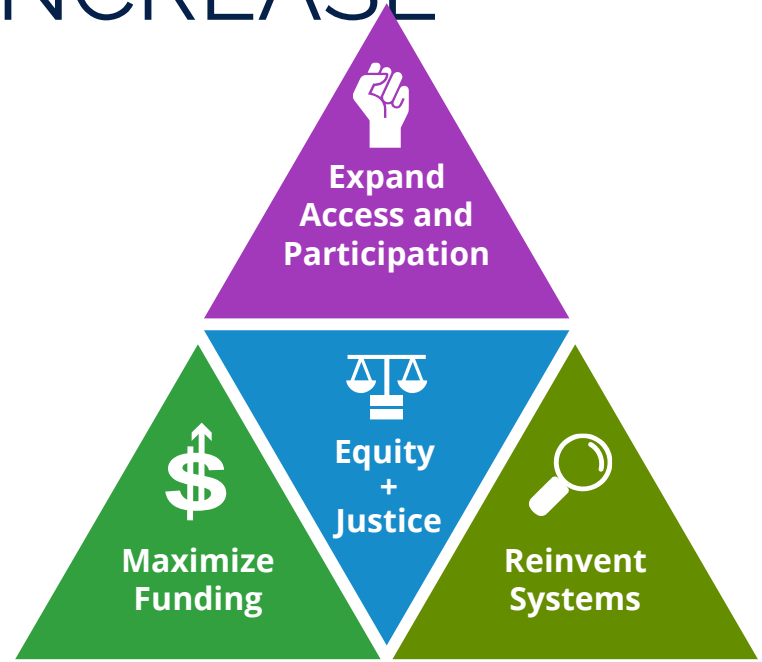
- **Expand eligible providers** (peers, CHW's, Doulas, BH Coaches) to center culturally concordant providers with relevant lived experience.



ELIMINATE MEDI-CAL ADMINISTRATIVE INEFFICIENCIES TO SAVE MONEY AND INCREASE ACCESS

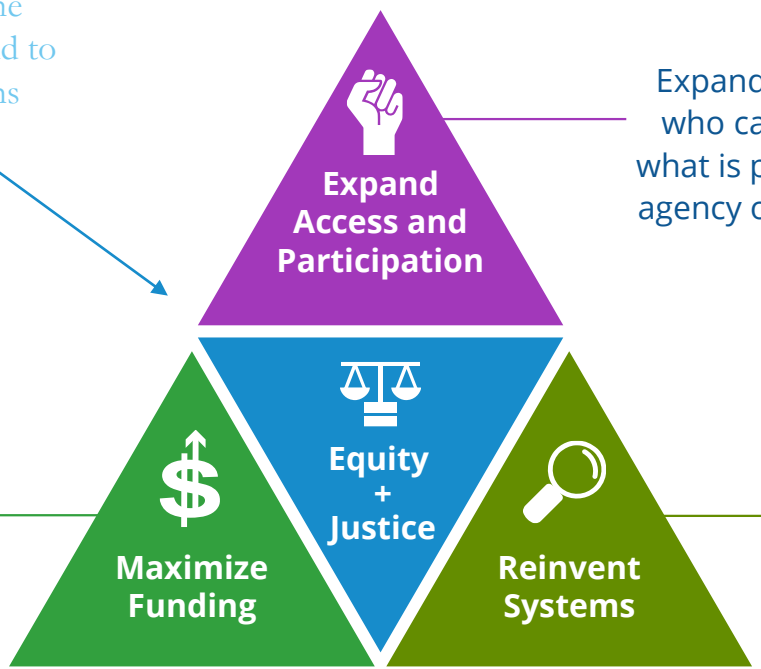
The fragmented system creates myriad barriers to care, and many of the opportunities to simplify and streamline administrative inefficiencies are well within the purview of the state to implement without federal approval or authorization.

- Statewide documentation forms and requirements that are standardized across all counties.
- A centralized credentialing process at the State (instead of at the MHP/MCO level) for providers.
- Consistent guidance across MCOs and MHPs
- Consistent healtng focused models across child serving systems.



THIS IS THE TRUST'S FRAMEWORK FOR SOLUTIONS

Shifting agency (who does the work) and power (who gets paid to do it) in child serving systems



Expand who is eligible, who can provide care, what is provided, and the agency of the beneficiary

Increase state and county spending, and fully claim the federal match

Increase transparency and accountability

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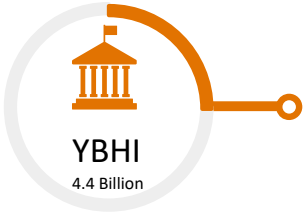
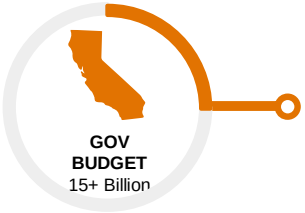
UNPRECDENTED INVESTMENT IS COMING TO SCHOOLS AND SYSTEMS:

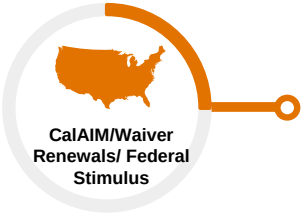
FUNDING OPPORTUNITIES FOR SOCIAL, EMOTIONAL AND MENTAL HEALTH IN SCHOOLS AND SYSTEMS:



- **SBHIP ($389 million)**
- School Competitive Grants Program ($550 Million)
- MHSA SSA funding ($250 million)
- Workforce including BH Coaches ($800 Million)
- BH Virtual Platform: ($750 Million)
- Expanding Evidence Based Programs (429 Million)
- DYADIC Benefit



- Expanded Learning Opportunity Grant Program (4.6 Billion)
- ELOP ongoing 1.75 (proposed at 4.4)
- Learning Loss Mitigation (5.3 Billion)
- Community School Partnership Grant Program ($3B)
- Educator Effectiveness Grant (1.5B)
- HCSB/Special Ed/Other....(1.5 Billion))



- ESSER III (ARP Act) - $15.1 billion

CalAIM:
- Enhanced Case Management
- Community Supports
- Population Health Management
- Universal Eligibility for System Involved Children

OUR CALL TO ACTION

1. **Remove diagnosis** as a requirement for treatment (expand Medical Necessity Criteria in context of EPSDT and ACES). Name and center the experiecn of racism and poverty on the social and emotional health of children.
2. **Capture Medicaid dollars** by claiming against exisitng expenditures in child serving systems.
3. **Center schools** as healing and anti-racist centers of support
4. **Expand Eligible Provider Classes** to address workforce shortages, build culutrally concordant workforce, and honor the widsom and intelligence of lived experience,
5. **Focus on Benefit Design in Managed Care Organizations to develop scaleable reimbursement for Dyadic Models** in Pediatric Primary Care.
6. **Focus on Care Coordination models** to bring culturally concordant non clinicla CBO's into health system networks.
7. **Develop social model, cascading mentorship, and mutual aid** strategies as essential social capital building strategies in Medicaid.
8. **Embrace technology** enabled tools and strategies.

Read and share our policy briefs

cachildrenstrust.org

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@CAChildrenTrust

Sign up for the CCT Newsletter

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WHAT UCSF HEALTH SYSTEM CAN DO:

1. **Understand the changing landscape of Medical Necessity**
2. **Understand the growing role of MCO's and how to leverage FQHC status**
3. **Learn about both the SMHS and NSMHS system and develop specific requests to leadership at both the county and the plans.**
4. **BILL Z65.9!!!! (UNDERSTAND NEW BENEFIT LANDSCAPE) and Prepare for Dyadic Benefit.**
5. **Center schools** as healing and anti-racist centers of support and **formalize your connectivity** to school-based programs and supports.
6. **Hire from and Expanded Provider Classes** to address workforce shortages, build culutrally concordant workforce, and honor the widsom and intelligence of lived experience,.
7. **Focus on Care Coordination models** to bring culturally concordant non clinicla CBO's into health system networks (and increase MCO investment).
8. **Track and Apply for Systems Transformation Grants** (Evidence Based Practice and Practice Transformation Grants in next 6 months.)
9. **Scale System Level Supports and Interventions** CAPP and the Dyadic TA Center.

Read and share our policy briefs

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References

Slide 2: 104% increase inpatient, 50% increase in MH hospitalizations, 61% increase in self reported MH needs (CA Healthy Kids Survey)

Slide 3: $11.6 billion hospital visits, 37% students with mental illness age 14 and older dropout of school

Slide 4: 81% of children on medicaid are black or brown, 2x suicide rate for black children, aged 5-12 than that of their white peers, 70% of youth in California's juvenile justice system have unmet behavioral health needs

Slide 6: 66% of the state's 9 million children are in public schools, 57% of all adolescents nationally access mental health services via their school

Slide 7: Nearly a quarter of people in the United States are experiencing symptoms of depression, 1 in 4 youth ages 18 to 24 said they had "seriously considered" suicide in the past 30 days

Slide 15: 75% of mental illness manifests between the ages of 10 and 24

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Mark Ghaly, MD, MPH

Secretary, California Health & Human Services

Today's discussion

Objectives

- Share how California plans to reimagine behavioral health for all children, youth, and families
- Introduce the focus areas and key components of the Children and Youth Behavioral Health Initiative
- Share new investments proposed in recent May budget.

Source: California Health and Human Services Agency

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Why it is important to address behavioral health needs and challenges

Many mental health challenges begin in childhood and early adulthood

of all lifetime cases of diagnosable mental illnesses **begin by age 14**[1]

of all lifetime cases of diagnosable mental illnesses **begin by age 24**[1]

The COVID-19 pandemic compounded the behavioral health challenges faced by children and youth

of 11th graders and about one-third of 7th and 9th graders in California experience chronic sadness[2]

suicide deaths among Black youth (ages 10-24) has doubled since 2014[3]

Behavioral health challenges disproportionately impact some populations (e.g., racial and ethnic minority youth, LQBTQ+ youth, youth with disabilities, youth facing socioeconomic challenges etc.)

of **youth in the juvenile justice system have mental health needs**[4]

of **LGBT youth reported feeling** so **sad or hopeless** they stopped doing some of their usual activities[5]

1. Kessler R, Berglund P, Demler O, Jin R. "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication." Walters E. Arch Gen Psychiatry. 2005, 62:593-602.
2. Youth Youth Mental Health and Supports: 2020-2021 California Snapshot, Project Cal-Well, UCSF
3. Suicide in California – Data Trends in 2020, COVID Impact, and Prevention Strategies, CDPH, 2021
4. Underwood LA, Washington A. Mental Illness and Juvenile Offenders. *Int J Environ Res Public Health*. 2016;13(2):228. Published 2016 Feb 18. doi:10.3390/ijerph13020228
5. CDC. 2019 Youth Risk Behavior Survey

What will addressing the behavioral health needs of children and youth mean for Californians?

Better Health Outcomes

Children who receive **behavioral health care** integrated with pediatric primary care experience a **significant reduction in behavioral problems and anxiety**[1]

Increased Resilience

Additional support and resources for children and youth with **23% of youth** in California ages 12-17 **needing help for emotional or mental health** conditions (such as feeling sad, anxious, or nervous)[2]

Increased Economic Opportunities

Lifetime earnings quintupled for people with serious mental illnesses when they received more than a high school education, compared to those who did not[3]

1. Kolko DJ, Campo J, Kilbourne AM, Hart J, Sakolsky D, Wisniewski S. Collaborative care outcomes for pediatric behavioral health problems: a cluster randomized trial. *Pediatrics*. 2014;133(4):e981-e992. doi:10.1542/peds.2013-2516
2. UCLA Center for Health Policy Research, California Health Interview Survey (Aug. 2020).
3. Seabury, SA., Axeen S, Pauley G, Tysinger B, Schlosser D, Hernandez J, Heun-Johnson H, Zhao H. "Measuring The Lifetime Costs of Serious Mental Illness and the Mitigating Effects of Educational Attainment." Goldman D. Health Affairs, April 2019

Overview of the Children and Youth Behavioral Health Initiative

The goal of the **Children and Youth Behavioral Health Initiative** is to **reimagine** the way behavioral health support is provided to **all children and youth in California,** by **aligning the systems that support behavioral health** for children and youth to create **an ecosystem that fosters social and emotional well-being and addresses the behavioral health challenges** facing children and youth

The initiative takes a **whole system approach** by creating **cross-system partnerships** to ensure that **the reimagined ecosystem is child and youth-centered and equity-focused**

Source: California Health and Human Services Agency

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Reimagine behavioral health and emotional well-being for ALL children, youth, and families in California by delivering equitable, appropriate, timely, and accessible mental health and substance use services and supports from prevention to treatment to recovery an integrated ecosystem focused on emerging behavioral health needs

Advance Equity

Designed for Youth by Youth

Start Early, Start Smart

Center around Children and Youth

Empower Families and Communities

Right Time, Right Place

Free of Stigma

Source: California Health and Human Services Agency

How California plans to redesign and reimagine the system

- Focus on the entire continuum of care
- Increase system capacity
- Center on the experiences and needs of children and youth
- Address stigma
- Catalyst for system redesign within and across sectors

Source: California Health and Human Services Agency

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Building a Coordinated Ecosystem: Workstreams for the Children and Youth Behavioral Health Initiative

As of March 29, 2022

Workforce training and capacity		BH ecosystem infrastructure		Coverage architecture	Public awareness
School BH Counselor and BH Coach Workforce	Pediatric, Primary Care and Other Healthcare Providers	School-Linked Partnership and Capacity Grants	BH Continuum Infrastructure Program	Enhanced Medi-Cal Benefits – Dyadic Services	Public Education and Change Campaign
Broad BH Workforce Capacity	CalHOPE Student Services	Student Behavioral Health Incentive Program (SBHIP)	Mental Health Student Services Act Program	Statewide All-Payer Fee Schedule for School-Linked Behavioral Health Services	ACEs Awareness Campaign
Trauma-informed training for educators	Behavioral Health Virtual Services Platform				
	Evidence-Based and Community Defined Practices				

Source: California Health and Human Services Agency

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Overview of the CYBHI Workstreams

CYBHI focus areas	CYBHI Workstreams	Description of workstreams
Workforce capacity and capability	School BH Counselor and BH Coach Workforce	Develop a multi-year plan to launch and implement a BH coach or counselor system by which students can receive in-person and/or virtual one-on-one and group supports
	Pediatric, Primary Care, and Other Healthcare Providers	Provide opportunities for primary care and other health care providers to access culturally proficient education and training on BH and suicide prevention
	Broad BH Workforce Capacity	Build and expand the workforce, education, and training programs to support a workforce that is culturally and linguistically proficient and capable of providing age-appropriate services
	CalHOPE Student Services	Support communities of practice in all 58 County Offices of Education to enhance Social Emotional Learning Environments; engage youth as partners in contributing to a positive, supportive learning environment
	Trauma-Informed Training for Educators	Provide ongoing training to educators on trauma-informed care
BH ecosystem capacity and infrastructure	Evidence-Based and Community-Defined Practices	Support statewide scale and spread of evidence-based interventions proven to improve outcomes for children and youth with or at high risk for mental health conditions
	Behavioral Health Virtual Services Platform	Implement BH service virtual platform to be integrated with screening, clinic-based care and app-based support services
	Mental Health Student Services Act Program	Provide competitive grants to counties for partnerships between county BH departments and local education entities for the purpose of increasing access to mental health services
	BH Care Continuum Infrastructure	Ensure youth living in every part of California can access the care they need without delay and, wherever possible, without having to leave their home county
	Student Behavioral Health Incentive Program (SBHIP)	Incentive payments for Medi-Cal Managed Care Plans (MCPs) to build infrastructure, partnerships, and capacity, statewide for school behavioral health services
	School-Linked Partnership and Capacity Grants	Build infrastructure, partnerships, and capacity to increase the number of students receiving preventive and early intervention BH services
Coverage and benefits architecture	Enhanced Medi-Cal Benefits – Dyadic Services	Implement dyadic services in Medi-Cal, based on the HealthySteps model of care
	Statewide All-Payer Fee Schedule for School-Linked BH Services	Implement fee schedule for health plan reimbursement
Public awareness and education	Public Education and Change Campaign	Raise the BH literacy of all Californians to normalize and support the prevention and early intervention of mental health and substance use challenges
	ACEs Awareness Campaign	Raise awareness of Adverse Childhood Experiences (ACEs) and toxic stress

Source: California Health and Human Services Agency

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Other Key Initiatives – Workforce

Care Economy Workforce Development - $1.7B investment for the Labor and Workforce Development Agency and CalHHS to create innovative and accessible opportunities to recruit, train, hire, and advance an ethnically and culturally inclusive health and human services workforce, with improved diversity, compensation, and health-equity outcomes.

- **California 10x25 Initiative—$350M** to recruit, train, and certify 10,000 new community health workers
- **California Social Work 2030 Initiative—$200M** to support social work training programs and to create a new pipeline for diverse social workers
- **Psychiatric Resident Program—$100M** to create training positions for psychiatric residents, psychiatric mental health nurse practitioners, psychology interns/fellows, and psychiatric nurses.
- **Multilingual Health Initiatives—$60M** to expand scholarships and loan repayment programs in healthcare and social work for multilingual applicants, with the goal of increasing language and cultural competencies throughout the care workforce.

Governor's May Revise Budget Proposals

Youth Mental Health Additional Investments

- Youth Suicide Prevention and Crisis Response
- Wellness and Building Resilience of Children, Youth, and Parents
- Emergent Technologies

Source: California Health and Human Services Agency

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May Revision - Behavioral Health Priorities

$290M GF - Address the Immediate Mental Health Crisis Among Children and Youth

Prevent Youth Suicide

- **Youth Suicide Prevention Program**—$40M to develop and implement a data-driven targeted community-based youth suicide prevention program for youth at increased risk of suicide such as Black, Native American, Hispanic, LGBTQ+, and foster youth.
- **Crisis Response—$**50M to provide grants to pilot school and community-based crisis response and supports following a youth suicide or youth suicide attempt and pilot a new approach of designating youth suicide and youth suicide attempts as a reportable public health event, which would trigger screening and resource connections at the local level for the impacted community.

May Revision - Behavioral Health Priorities

Support Wellness and Build Resilience of Children, Youth, and Parents

- Wellness and Mindfulness Programs—$85M over two years for grants for wellness and mindfulness programs in schools and communities and expansion of parent support and training programs
- Video Series—$15M to develop and distribute a video series for parents to build their knowledge, tools and capacity to support the behavioral health of their children.

Career Development

- $25M to identify and support the early career development of 2,500 highly talented and culturally diverse high school students interested in mental health careers.

Assessment and Intervention

- $75M for next generation digital supports for remote and metaverse based mental health assessment and intervention.

Medi-Cal Transformation Program

- $700M to support practice transformation with a specific $100m for children's health focused transformation and additional funding for behavioral health transformation.

UCSF

CalHOPE Layers of Intervention and Support

CalHOPE addresses the stress and anxiety that people may feel due to isolation, health challenges, economic uncertainty, food insecurity and other negative consequences of the COVID-19 pandemic.

What does this all mean for UCSF?

- 1. Build teams within primary care that integrate BH services – similar to Kempe and Asthma Clinic at SFGH
- 2. Support training programs for expanded BH professionals – new funding for NP and SW positions
- 3. Partner with PK-12 and Higher Education schools in new ways
- 4. When available integrate the statewide eConsult for pediatric practices
- 5. *CalHOPE is available now for any Californian.*
- 6. Consider how to build in behavioral health coaches into your clinical model
- 7. Work to hire individuals from the communities you most serve – the community "professionals" and those with lived experience.
- 8. Add to resource list: Children's Mental Health Resource Hub - California Health and Human Services
- 9. Work with your local health plan – Yolanda Richardson is the new CEO at SF Health Plan – to determine how UCSF supports this work broadly.

Questions and Comments

Please reach out to **CYBHI@chhs.ca.gov** with questions and inquiries or to sign up for our stakeholder mailing list

For additional information please visit the Children and Youth Behavioral Health Initiative webpage

Discussion Panel

What are specific and concrete ways health care team members can optimize their role within the mental health ecosystem given the new and unprecedented state reform?

Bryan King, MD, MBA, Vice Chair, UCSF Child & Adolescent Psychiatry

Lisa Fortuna, MD, MPH, Chief of Psychiatry & Vice Chair at ZSFG/UCSF

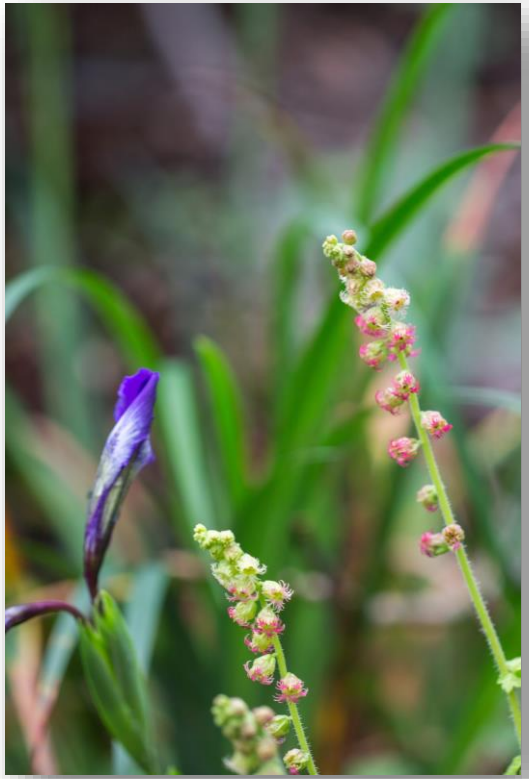
Melanie Moore, PhD, Chief Executive Officer, Oakland Thrives

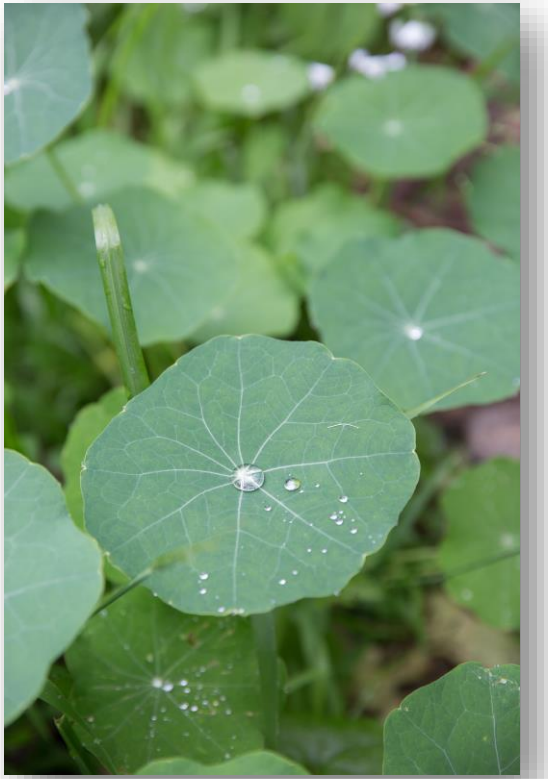
Thomas Insel, MD, Former Director of National Institute of Mental Health

Mark Ghaly, MD, MPH, Secretary of California Health & Human Services

Alex Briscoe, MA, Principal of California Children's Trust

10 Minute Break





Breakout Rooms

How can we work together in the Bay Area to approach these opportunities to maximize funding for programs and care of mental health needs in our region?

San Francisco County

- **Hali Hammer,** MD, Director of Ambulatory Care, SFHN
- **Hanan Obeidi,** MPH, CHES, Vice President, Health Services Programs, SFHP
- **Vanessa Aranda,** LMSW, Children and Families Program Manager, SFHP
- **Carissa Avalos,** Regional Program Manager, Anthem

Facilitators: **Anda Kuo, Amy Whittle**

Alameda County

- **Dennis McIntyre**, MD, FAAP, Medical Director, Anthem
- **Khamisi Jackson**, LVN, MPH, Practice Transformation Specialist, Anthem
- **Melanie Moore**, PhD, Chief Executive Officer, Oakland Thrives
- **Palak Shah**, BA, Consultant, Oakland Thrives
- **Diane Dooley**, MD FAAP, Chair, AAP Chapter 1 Mental Health Committee

Facilitators: **Dayna Long, Saun-Toy**

UCSF Benioff Children's Hospitals

- **Bryan King**, MD, MBA, Vice Chair, UCSF Child & Adolescent Psychiatry
- **Jennifer Miller,** Behavioral Health Service Line Director, UCSF BCH
- **Petra Steinbuchel**, MD, Medical Director, Mental Health and Child Development, BCH Oakland
- **Lee Atkinson-McEvoy**, MD, Chief Division of General Pediatrics, UCSF

Facilitators: **Joan Jeung, Francine Ostrem**

Looking ahead to Session 3...

"Moving from Promise to Practice: Roadmap for the Future"

Given your conversation in the breakout groups, what is 1 important thing to consider or that you would like to happen as we structure the 3rd session scheduled for June 28th?

Please share in the chat or unmute yourself

Evaluation Survey Scan QR Code:

UCSF

Session 3: Moving from Promise to Practice

Roadmap for the Future

Tuesday, June 28, 2022; 1:00-4:00 PM

In the third session, we will consolidate what we have learned and identify the concrete steps we must take as providers, policy and system leaders, and advocates to create a shared roadmap to improve the mental and behavioral health and well-being of children and families.

Speakers: Leaders from across our systems including school and health system leaders including: Matt Cook, MBA, George Weiss, MHA, Raphael Hirsch, MD, Bryan King, MD, MBA

Scan QR Code to Register:

Photo by Brandon Nelson on Unsplash


THANK YOU

University of California
San Francisco