Alameda County Case Study: Early CYBHI Implementation Progress Paves the Way for Sustainable Improvement of the County's Systems of Supports

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This case study focuses on Alameda County's experience implementing California's Children and Youth Behavioral Health Initiative (CYBHI). The CYBHI is an ambitious multi-year, $4+ billion systems change initiative focused on improving the behavioral health and well-being of children, youth, and families. To realize the initiative's values and goals, the CYBHI is implementing 20 distinct workstreams, each designed to contribute to transforming the behavioral health ecosystem serving children, youth, and families.

The case study starts with a description of Alameda County's demographic characteristics, behavioral health needs, and resource availability. We then discuss the behavioral health ecosystem in the county, including connections between child- and youth-serving organizations, and describe Alameda County's experience implementing select CYBHI workstreams as of late fall 2024.

Background and methods for the CYBHI evaluation and case study

Mathematica is evaluating the CYBHI on behalf of the California Health and Human Services Agency, in partnership with Health Management Associates, James Bell Associates, and the Prevention Center of Excellence at the University of California, Los Angeles. The evaluation began in November 2022 and will continue through June 2026. As part of the evaluation, the research team completed county-level case studies of CYBHI implementation in nine counties, including Alameda County. The purpose of these case studies is to provide information about the relationships between entities in the children and youth behavioral health ecosystem at the county level, and to gain insights into local implementation of the CYBHI workstreams in the planning or active execution phase as of late fall 2024.

Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Alameda County and California as a whole (see Appendix A for data sources for each metric). In addition, between April and July 2024, the research team conducted the Network and Ecosystem Experiences Survey (NEES) and key informant interviews with local leaders in Alameda County. The NEES explored the connections between organizations in Alameda County to better understand how organizations work together to support children and youth behavioral health. Using results from the NEES, we conducted a social network analysis and developed a network map showing the average strength of the connections across organizations within the ecosystem (see Appendix B for more details on the network analysis methodology and measures).

Between summer and late fall 2024, researchers also conducted 19 interviews with individuals in Alameda County to understand CYBHI workstream implementation and multisector collaboration. Respondents across the survey and interviews varied and included purposively selected leaders from county behavioral health departments; county offices of education; school districts; Medi-Cal managed care plans; community-based organizations; public health departments; and other behavioral health, early childhood, juvenile probation, and child welfare leaders. Five individuals participated in both the survey and an interview.

I. Summary of Findings

Behavioral health ecosystem multisector collaboration

Alameda County benefits from strong connections across many of the agencies and organizations in the children and youth behavioral health ecosystem. These relationships, both formal and informal, facilitate collaboration across several of the CYBHI workstreams as well as other initiatives. The CYBHI is improving multisector collaboration by encouraging memoranda of understanding (MOUs) between county agencies through cross-sector workstreams, such as the CYBHI Statewide Multi-Payer School-Linked Fee Schedule and Student Behavioral Health Incentive Program (SBHIP). However, some organizations in Alameda County—particularly community-based organizations (CBOs)—perceived that opportunities exist for more collaboration across sectors.

County's experiences, successes, and challenges with CYBHI implementation

CYBHI implementation in Alameda County is progressing on many fronts. Several CYBHI workstreams are expected to increase multisector collaboration, improve the sustainability and ease of providing reimbursement for school-based and school-linked behavioral health services, and increase the capacity of county CBOs' and local education agencies' (LEAs') behavioral health workforces. Several workstreams included in this case study are still in the early stages of implementation.

Work to expand access to **behavioral health services in the education sector** is advancing in Alameda County.

- Workstreams facilitating the *delivery of behavioral health services in and near schools*, including SBHIP, the CYBHI Fee Schedule, and School-Linked Partnership and Capacity Grants, have laid the groundwork to enable schools to provide and receive reimbursement for services. The Alameda County Office of Education (ACOE) has developed and will soon launch technical assistance (TA) infrastructure for LEAs. This infrastructure will streamline the flow of information and data to suppor claims submission across the county, easing the administrative burden on individual LEAs. This includes a county health record-keeping system, a data warehouse that contains school and community-based data, as well as a centralized claims submission process for LEAs that have opted in. Respondents were optimistic about the potential for Certified Wellness Coaches to further augment behavioral health staffing.
- Alameda County partners and LEAs are actively *promoting prevention and wellness services* through the CalHOPE Student Support and Schools Initiative and the Mindfulness, Resilience, and Well-Being Supports for Children, Youth, and Parents grants.

Alameda County is in the early design phase of the Transforming Together (T2) Demonstration Project, which supports integration of the CYBHI workstreams with the California Community Schools Partnership Program. Implementation of many relevant **home- and community-based workstreams** are demonstrating early signs of progress. Interviews with four organizations implementing the CBO Behavioral Health Workforce Grant Program reported that they are strengthening CBOs' ability to recruit and retain behavioral health care providers. According to one grantee, the Never a Bother Youth Suicide Prevention Media and Outreach Campaign has successfully engaged youth. Respondents saw the Youth Suicide Reporting and Crisis Response Pilot Program grants as helping the county take steps to strengthen community-level capacity, although it could use more dedicated resources to support syndromic surveillance in Alameda County. Other home- and community-based workstreams, such as Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs/CDEPs) grants, were just beginning implementation at the time of our interviews, and thus their successes are still unknown.

Key progress with CYBHI implementation

- **Student Behavioral Health Incentive Program:** SBHIP is supporting important projects across several LEAs in Alameda County, including constructing new wellness centers, helping schools build out different tiers of intervention services, and holding learning exchanges to share specific, timely information about topics such as reimbursement for services. Respondents praised the workstream's flexible funding, focus on building cross-sector relationships, and minimal reporting requirements. ACOE has played a strong leadership role in SBHIP implementation, offering LEAs meaningful organizational support.
- **The CYBHI Fee Schedule:** ACOE has built strong awareness of the CYBHI Fee Schedule and is actively supporting implementation. Respondents indicated that the CYBHI Fee Schedule will (1) fill behavioral health service gaps for students with mild to moderate behavioral health needs in the county and (2) improve access to behavioral services at or near schools. Early successes include ACOE's acquisition and development of technical infrastructure to support LEAs' claims submission, including using School-Linked Partnership and Capacity Grant funding to acquire and customize an electronic health record (EHR) system that integrates with other state and county data systems. Alameda County LEAs are starting CYBHI Fee Schedule implementation from different baselines, and some LEAs could benefit from more technical assistance (TA) from the state on operational readiness to implement the CYBHI Fee Schedule, including specific steps, best practices, and sample communication language. CalHHS and DHCS efforts to support implementation of the Fee Schedule are expected to help address some of these challenges both for LEAs in Alameda County and those in other counties. For example, these efforts include the use of a cohort system to enable later cohorts to benefit from the lessons learned and promising practices established by earlier cohorts, offering TA under the School-Linked Partnership and Capacity Grants, and updating guidance outlining policies and operational requirements for the Fee Schedule and resources to support claims processing, in partnership with the third party administrator.
- **Scaling EBPs/CDEPs:** Two CBOs and a federally qualified health center (FQHC) noted their excitement about launching their programmatic services under their Round 1 and 2 Scaling EBPs/CDEPs grants. These grants provided funding to implement or expand several EBPs/CDEPs or related practices or programs, including dialectical behavior therapy and culturally responsive family resource center services, such as Effective Black Parenting programming. As of summer 2024, all three grantees were in the process of training staff and recruiting potential participants.
- **CBO Behavioral Health Workforce Grant Program:** We spoke to three CBOs and one FQHC that were drawing on this workstream to support workforce recruitment and retention. Through grants made under this workstream, these organizations participated in various efforts, including offering behavioral health workers hiring and retention bonuses and student loan forgiveness, and creating and running a formal internship training to prepare people for careers at the post-bachelor's and post-master's level. Respondents said these activities helped their organizations recruit and retain behavioral health employees in a competitive job market. In particular, they said the internship program is growing and drawing applicants from communities they serve, which is positively affecting equity.
- **Youth Suicide Reporting and Crisis Response Pilot Program:** The grant is housed in the county public health agency's new Office of Violence Prevention and has successfully brought new resources to Alameda County, extending existing initiatives and starting new ones. For example, the Crisis Support Services' Organizing and Responding to Crisis for Alameda Youth (ORCA) provides more direct counseling services as a result of this grant. One respondent shared that the suicide prevention work in Alameda could be further strengthened through investments in a system to collect real-time data and effectively track, document, and respond to children and youth in crisis in real time.

II. County Background

County characteristics

Alameda County is a large, populous county located in the San Francisco Bay Area, covering 821 square miles and occupying much of the East Bay, including several large cities (Oakland, Fremont, and Hayward) (Exhibit 1).[1] Alameda County is much denser than the rest of California, with an average of 2,281 residents per square mile, compared with 254 statewide, and nearly all of the population (99.5 percent) lives within urban blocks (Exhibit 2). Relative to other counties in California, Alameda County is larger, with more than1.6 million residents. The population of children and youth is proportionally smaller than across California as a whole, with slightly fewer children ages 0–4 (5.2 percent versus 5.4 percent statewide), fewer youth 5–19 (16.7 percent versus 19.0 percent statewide), and fewer young adults (5.7 percent versus 6.8 percent statewide). Alameda County's population under age 24 has declined by 7.4 percent over the past five years, somewhat more than the 5.4 percent decrease statewide.

Exhibit 1. Alameda County's geography

Alameda County is characterized by rich diversity and culture; it is one of the most ethnically diverse counties in the Bay Area and the nation. Compared with statewide statistics, Alameda County has fewer White, non-Hispanic residents (27.9 percent versus 33.7 percent) and Hispanic or Latino residents (22.2 percent versus 40.3 percent). Instead, the county has larger populations of Black or African American, non-Hispanic residents (9.6 percent versus 5.2 percent) and more than twice as many Asian, non-Hispanic residents (33.2 percent versus 15.3 percent). It has the third highest diversity index in the state, meaning it has the third highest probability that two randomly chosen residents have a different race or ethnicity. A larger share of the county's population ages 0–24 is foreign born compared with statewide (11.3 percent versus 7.2), though there are similar rates of English proficiency among the school-age population.

In general, Alameda County residents have better economic conditions than residents statewide, although this trend masks economic and racial/ethnic disparities that exist throughout the county. Relative to the state as a whole, a smaller proportion of the Alameda County population is below the 200 percent federal poverty line (20.5 percent versus 27.6 percent). The county also has a higher median income than the state ($73,240 versus $52,520), a lower unemployment rate (4.1 percent versus 5.3 percent), and lower food

[1] Alameda County. "Your Government." 2024. https://www.acgov.org/government/. Accessed December 10, 2024.

insecurity overall (8.1 percent versus 10.5 percent) and for the population 0–18 years (8.7 percent versus 13.5 percent). In addition, Alameda is ranked fifth (of 57[2]) on the Healthy Places Index in California, signifying that the county has some of the highest levels of access to health care, housing, education, and other resources that support a healthy population in California. Consistent with Alameda County residents being more economically advantaged than California residents as a whole, substantially fewer residents ages 0–25 are covered by Medicaid (24.9 percent versus 39.3 percent statewide), and more are covered through private coverage (74.9 percent versus 60.2 percent).

Exhibit 2. Alameda County's population characteristics

Metric	Alameda	California	Year(s)
Population			
Total population (N)	1,628,997	39,029,342	2022
Population, 0–4 years (N; %)	83,828; 5.2%	2,118,386; 5.4%	
Population, 5–19 years (N; %)	272,592; 16.7%	7,404,396; 19.0%	
Population, 20–24 years (N; %)	92,852; 5.7%	2,639,787; 6.8%	
Five-year population change (%)	-2.1%	-1.3%	2017–2022
Five-year population change, 0–24 years (%)	-7.4%	-5.4%	
Density (population per square mile)	2281	254	2020
Race and ethnicity			
White, non-Hispanic (%)	27.9%	33.7%	2022
Black or African American, non-Hispanic (%)	9.6%	5.2%	
American Indian and Alaska Native, non-Hispanic (%)	0.2%	0.3%	
Asian, non-Hispanic (%)	33.2%	15.3%	
Native Hawaiian and other Pacific Island American, non-Hispanic (%)	0.6%	0.4%	
Some other race, non-Hispanic (%)	0.7%	0.6%	
Two or more races, non-Hispanic (%)	5.7%	4.3%	
Hispanic or Latino (%)	22.2%	40.3%	
Birthplace and language			
Foreign-born, 0–24 years (%)	11.3%	7.2%	2022
English-proficient, 5–17 years (%)	92.0%	91.6%	
Education (18+ years)			
High school or higher (including college) (%)	83.3%	78.8%	2022
College degree or higher (%)	49.9%	34.1%	
Economic indicators, socioeconomic status, neighborhood characteristics			
Population within urban blocks (%)	99.5%	94.2%	2022
Population within rural blocks (%)	0.5%	5.8%	
Population below 200% of the percent federal poverty line (%)	20.5%	27.6%	
Median income (USD)	73,240	52,520	
Unemployment (%)	4.1%	5.3%	
Households with high housing cost burden (%)	37.1%	40.3%	2019
Food insecurity, overall (%)	8.1%	10.5%	
Food insecurity, 0–18 years (%)	8.7%	13.5%	2015 - 2019

[2] The Healthy Places Index does not include Alpine County and therefore ranks 57 of California's 58 counties.

Metric	Alameda	California	Year(s)
Healthy Places Index (rank)	5	NA	2015–2019
Diversity Index (rank)	3	NA	
Health status			
Population with a disability (%)	10.7%	11.7%	2022
Population with a disability, 0–17 years (%)	3.3%	4.0%	
Health insurance status (population 0–25 years)			
Medi-Cal or other means-tested public coverage (%)	24.9%	39.3%	2022
Private coverage (%)	74.9%	60.2%	
Uninsured (%)	3.6%	4.9%	
TRICARE/military coverage (%)	0.7%	1.7%	
Medicare coverage (%)	0.9%	1.0%	

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Alameda County and California as a whole (see Appendix A for more detail).

Behavioral health needs and resource availability

Prevalence of behavioral health needs in county versus California as a whole

Across almost all behavioral health outcomes, Alameda County children and youth are comparable to the statewide population (Exhibit 3). Alameda County's statistics on overall mental well-being for children and youth are similar to statewide statistics, with similar rates of students in grade 9 who felt they were doing things that made a difference, were doing interesting activities at school, and felt close to people at school. The county's children and youth also have roughly similar rates of behavioral health challenges as children and youth statewide, including similar rates of children and youth who are insured through Medi-Cal with a mental health diagnosis or emotional symptoms, who seriously considered attempting suicide, and who exhibit chronic absenteeism. One area where there are slight differences is that, compared with the entire state, the county has slightly fewer inpatient hospitalizations (10 in the county versus 12 statewide) and emergency department visits (29 versus 32) for behavioral health diagnoses per 1,000 children and youth.

Exhibit 3. Prevalence of behavioral health outcomes

Metric	Alameda	California	Year(s)
County-level overall mental well-being for children and youth[a]			
Students in grade 9 who felt they were doing things that made a difference (%)	27%	26%	2019–21
Students in grade 9 who felt they were doing interesting activities at school (%)	48%	48%	
Students in grade 9 who felt close to people at school (%)	63%	61%	
Region-level overall mental well-being for children and youth[b]			
Youth ages 12 to 17 years old who felt their family stood by them during difficult times (%)	77%	73%	2022
Youth ages 12 to 17 years old who felt at least two non-parent adults took genuine interest (%)	60%	58%	
Youth ages 12 to 17 years old who felt supported by friends (%)	72%	72%	
Behavioral health challenges			
Children and youth insured through Medi-Cal with a mental health diagnosis or emotional symptoms (%)	19%	18%	2022
Children and youth insured through Medi-Cal with a substance use disorder diagnosis (%)	1%	3%	

Metric	Alameda	California	Year(s)
Rates of suicidal ideation			
Students in grade 9 who reported seriously considering attempting suicide in the past 12 months (%)	13%	15%	2019–21
Students in grade 11 who reported seriously considering attempting suicide in the past 12 months (%)	16%	16%	
Emergency department visits and hospitalizations for children and youth with behavioral health-related conditions			
Inpatient hospitalization stays per 1,000 children and youth for any behavioral health diagnosis	10	12	2022
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis	29	32	
School engagement, as measured through absenteeism and suspension			
Students in grades K–12 who were chronically absent (%)	27%	25%	2022–23
Students in grade 9 reporting school absences due to mental health issues (%)	7%	9%	2019–21
Students in grade 9 reporting school absences due to alcohol or drug use (%)	0%	1%	

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Alameda County and California as a whole, providing the most recent year available for each data source as of September 2024 (see Appendix A for more detail).

[a] County-level metrics of mental well-being are only available for some counties and are included in a subset of these case studies where possible.

[b] These well-being metrics are only measured at the regional level. Alameda is part of the Greater Bay Area region as defined by the California Health Interview Survey.

Resource availability and infrastructure

Alameda County's behavioral health ecosystem consists of an expansive, decentralized network of private and public partners, providers, and supports. The Alameda County Health's Behavioral Health Department runs the Child and Young Adult System of Care (CYASOC) programs serving individuals from birth up to 24 years old, which include Child and Young Adult Mental Health Services (a network of county-run outpatient clinics and contracted CBOs); School-Based Behavioral Health (SBBH) Services, which offers school-based services for eligible students; and Crisis Services. The county contracts out most of its behavioral health services and programs to CBOs. School-employed providers, including school counselors, social workers, psychologists, nurses, paraprofessionals, and restorative justice practitioners, are also a vitally important part of the behavioral health infrastructure in Alameda County.

ACOE is also a key provider of behavioral health services for students. The agency has a long history of serving children in schools and, in 2023, it restructured and created an overarching Student Services Division, which covers all school health services, including physical and behavioral health services. The Student Services Division aims to support systems alignment and coordination to ensure all students in Alameda County's 18 LEAs, County Court Schools, and county-run schools for students expelled from their home districts and for parenting teens have access to whole-child supports and services through Community Schools and integrated school-based and -linked services. Through this restructuring, the Student Services Division hired and trained new staff and began to shift its focus toward aligning strategic priorities across its various grants and throughout the larger behavioral health system. The Student Services Division provides capacity-building supports to LEAs and seeks to remove the administrative burdens they might face related to reimbursements for health services.

Child and Young Adult System of Care programs in Alameda County

- **Child and Young Adult Mental Health Services:** Alameda County Behavioral Health Department offers outpatient services through its seven clinics across the county, all of which have psychiatry services and one of which is dedicated specifically to early childhood. Alameda County contracts out 85 percent of its behavioral health services and programs to CBOs, according to two interview respondents. For instance, CBOs provide all services related to substance use disorder in the county.
- **School-Based Behavioral Health (SBBH) Services:** Alameda County Behavioral Health Department runs SBBH, where students can receive behavioral health services in schools if they are enrolled in Full Scope Medi-Cal and meet the medical necessity standards for Medi-Cal Specialty Mental Health Services. A primary strategy used to get students at school sites referred for SBBH is through Coordination of Services Teams (COST). COST is a multidisciplinary team of school staff and providers who integrate learning supports and resources for students and look at the overall landscape of school climate, trends, and needs. Families in need of services work directly with the school to obtain information on initiating a COST referral or they may contact the Alameda County ACCESS line. Beyond SBBH, schools in Alameda County provide behavioral health services to all students, regardless of insurance status, through social workers, counselors, and liaisons employed directly by schools.
- **Child and Youth Crisis Services:** Children and youth in need of acute or crisis mental health services can receive treatment at the Willow Rock Psychiatric Health Facility or at contracted public hospitals. The Behavioral Emergency Response Team (BERT), a program of the University of California San Francisco's Benioff Children's Hospital, provides crisis assessments at emergency departments (EDs) for children and adolescents having a psychiatric emergency. BERT can provide stabilization and determine whether more intensive psychiatric services are needed by transferring patients to a different facility.

Based on available metrics, Alameda County generally has similar rates of behavioral health resource availability as California as a whole (Exhibit 4). The county and state have the same number of child- and adolescent-specializing psychiatrists per 100,000 children and youth (17), but psychiatrists who treat Medi-Cal and other safety net patients remain scarce.[3] Alameda also has a slightly smaller number of non-psychiatrist behavioral health care providers licensed with county Specialty Mental Health Services (SMHS) plans per 100,000 children and youth, compared with the state (32 versus 37 statewide). Interview respondents said the county has limited availability and accessibility of intensive outpatient program, partial hospitalization, inpatient, and residential services. The number of outpatient treatment programs for young adults per 100,000 children and youth are similar in Alameda County versus the state, but the county has more school-based health programs with mental health services per 100,000 children and youth (10 versus four statewide).

Exhibit 4. Availability of behavioral health care resources

Metric	Alameda	California
Primary care health professional shortage area designation	Full shortage	N/A
Mental health professional shortage area designation	Full shortage	N/A
Number of FQHCs or FQHC look-alike sites per 100,000 children and youth ages 0–25 years	31	20
Number of child and adolescent psychiatrists per 100,000 children <18 years	17	17
Number of non-psychiatrist behavioral health care providers licensed with county Specialty Mental Health Services plan per 100,000 residents	32	37
Number of outpatient treatment programs for young adults per 100,000 children and youth 0–24 years[a]	4	4

[3] California Health Care Foundation. "San Francisco Bay Area: Regional Health Systems Vie for Market Share." 2021. https://www.chcf.org/wp-content/uploads/2021/04/RegionalMarketAlmanac2020BayArea.pdf. Accessed October 16, 2024.

Metric	Alameda	California
School-based health programs with mental health services per 100,000 children and youth <18 years	10	4

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Alameda County and California as a whole (see Appendix A for more detail).

[a] The numerator for this measure is based on the number of outpatient treatment programs for *young adults*, while the denominator is inclusive of all children and youth 0–24 years because documentation suggests that many of these programs may pertain to children as well as young adults. (Manatt Health and Anton Nigusse Bland. *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications.* Report prepared for California Department of Health Care Services. January 2022. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf).

Perceptions of the degree to which resources in the county can meet demand

According to interview respondents, Alameda County could use many more behavioral health care workers within the county-run system, including psychiatrists, psychologists, licensed marriage and family therapists, and licensed clinical social workers. Although Alameda County is not an outlier in the state regarding behavioral health care workers, much need remains in terms of licensed behavioral health care workers within the county's managed care network. Respondents from the Alameda County Behavioral Health Department and CBOs alike reported significant challenges hiring behavioral health care workers overall. They found it especially difficult to hire licensed clinicians with master's-level credentials, such as licensed marriage and family therapists and licensed clinical social workers, who can oversee other providers in the process of getting licensed.

Given the shortage of providers, the CYASOC's county-run clinics and contracted CBOs face stiff competition when hiring. Some respondents noted challenges maintaining adequate staff within the county system because providers outside of the network offer more generous salaries and benefits packages. Some clinicians begin their careers in community-based settings and then move on once they gain experience. Furthermore, some respondents said clinicians can earn higher salaries working in San Francisco and will leave Alameda County to work there.

Alameda County interview respondents highlighted a need for more diversity among behavioral health care providers, including nontraditional providers with relevant lived experiences and those willing to work with special populations. First, interview respondents identified a need for more bilingual and bicultural professionals who understand the culture of the communities they serve. The limited number of bilingual and bicultural providers impairs the county's ability to serve its substantial population of immigrants and refugees, many of whom do not speak English as their first language. Respondents also reported a shortage of nontraditional providers with lived experience who know how to navigate the behavioral health system. This might be caused by limited knowledge of these career paths and the challenges of providing appropriate compensation that reflects the high cost of living in the Bay Area.

A few respondents identified a shortage of therapists able to provide services to children 8 years and older and those 0–5 years old, which are critical ages when children with behavioral health and developmental needs should be identified. A CBO respondent emphasized the lack of provider capacity and ability to effectively address the needs of children with disabilities; this person cited the stigma associated with intellectual and emotional disabilities (which they said is worse than the stigma linked to physical disabilities) and the lack of provider training and understanding of people with disabilities as those with diverse needs (for example, mental health needs), not just disability needs. Moreover, a juvenile justice respondent noted the lack of providers in the county willing to work with in-custody youth, leaving juvenile justice systems unable to offer 24-hour on-site mental health staff, resulting in delayed care for patients in crisis.

> "If you [a child or youth] have a disability, [behavioral health care providers] tend to just put you in the place of, this is really about the disability itself. And so people have not been trained to think about the fact that a person with a disability is more than just that label."
>
> —CBO respondent

Alameda County's behavioral health system benefits from a strong, flexible network of nonprofit partners; however, there is an opportunity to enhance resource coordination and capacity tracking to better meet community needs. The Alameda County Behavioral Health Department manages several concurrent initiatives, including some aspects of California Advancing and Innovating Medi-Cal (CalAIM) implementation, all within limited resources. According to respondents, an extensive network of nonprofit partners plays a crucial role in providing behavioral health services, but this broad network of varied partners can sometimes lead to coordination gaps. Respondents emphasized that strengthening the county's ability to systematically track service gaps and provider capacity presents a key opportunity.

III. Systems Change, Relationships, and Multisector Collaboration Across the Behavioral Health Ecosystem

CalHHS aims to inspire systems change through CYBHI by strengthening opportunities for partnership across sectors and building foundational elements for more coordinated efforts across the children and youth behavioral health ecosystem. When planning CYBHI, CalHHS commissioned the Working Paper: California's Children and Youth Behavioral Health Ecosystem to gain insight into critical issues within the behavioral health ecosystem and identify ways to strengthen collective capacity and capability to transform the ecosystem, with a goal of improving the behavioral health and well-being of all California's children and youth.

To better understand the behavioral health ecosystem and the extent to which systems are connected across sectors as context for understanding CYBHI implementation in Alameda County, Mathematica conducted the Network and Ecosystem Experiences Survey (NEES), which asked respondents from child- and youth-serving organizations about their relationships with each other. Using information from the survey, a network map was created showing the connections between nine organizations in Alameda County. The map depicts the average strength of the connection between organizations (Exhibit 5).

Understanding connections across the behavioral health ecosystem in Alameda County

In Alameda County, we invited 14 child- and youth-serving organizations to complete the NEES via email and received responses from nine. Invited organizations included government agencies and departments; the managed care plan; and CBOs, including health centers and organizations that serve Native populations and other diverse communities. We asked survey respondents, such as directors and executive directors, how their organizations currently work with other organizations in the county to support children and youth behavioral health. Respondents rated their organizations' working relationships with the other organizations invited to complete the survey on a 5-point scale: (1) coexist, (2) cooperate, (3) coordinate, (4) collaborate, and (5) integrated.[4]

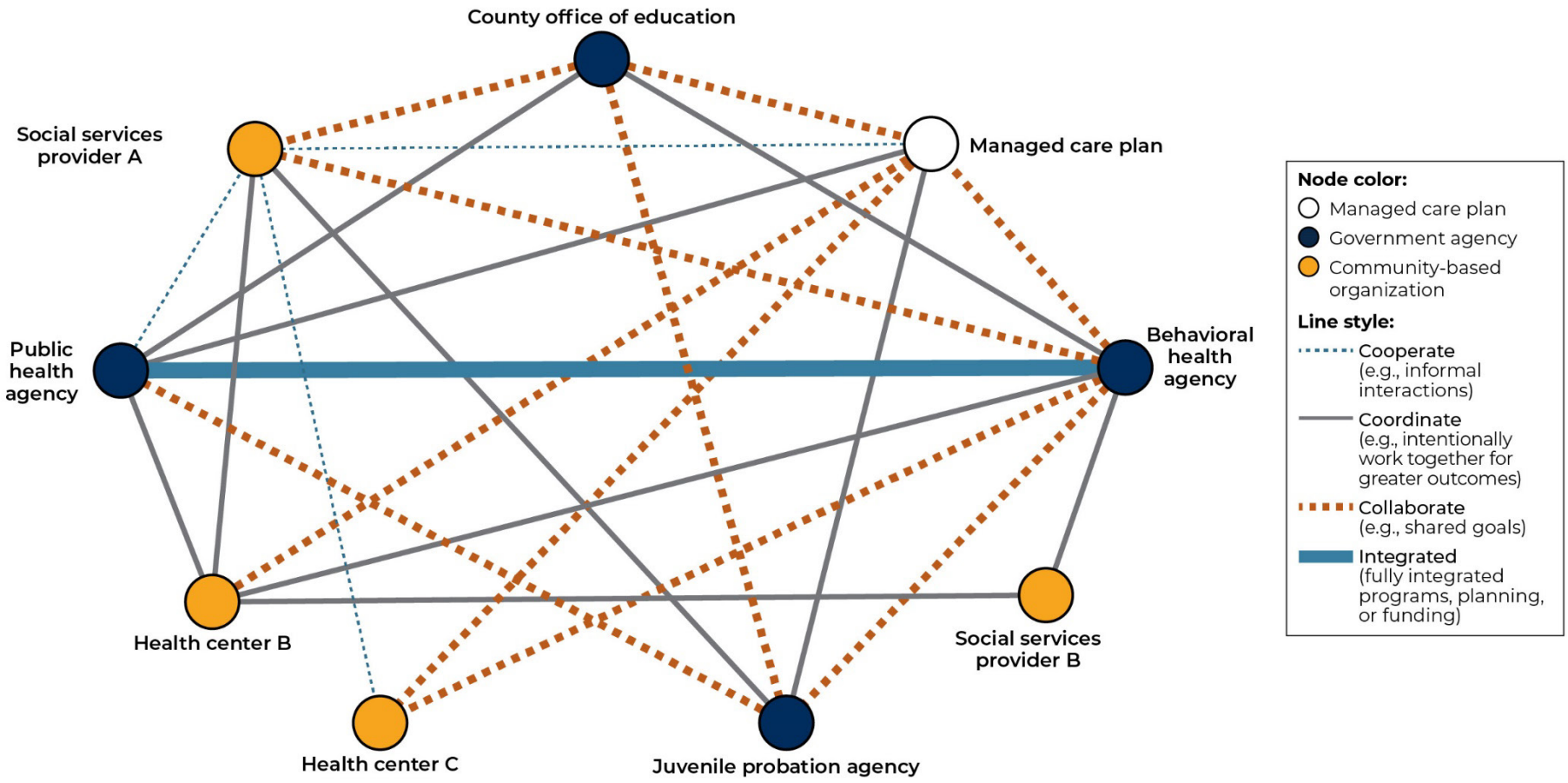
These ratings were used to conduct a network analysis and develop a network map showing the average strength of the connections between organizations based on each organization's rating of the other.[5,6] A line between two organizations shows that a connection exists. No line indicates that the organizations either coexist or no connection was reported (for example, missing data). Thicker, darker lines represent stronger connections in the network. See Appendix B for more information about the network analysis methodology and measures.

[4] We did not ask interview respondents to define terms such as "collaboration" and "integration," so their use might vary from the definitions provided to survey respondents.

[5] In Alameda County, there were instances where only one organization rated a connection between two organizations. Using data where we had responses from both sides of a connection, we conducted an agreement analysis to understand whether survey respondents tended to rate the strength of their relationships in similar ways. Based on this analysis, we concluded that the level of agreement did not meet our threshold to include ratings from one side of a connection in the network map. Therefore, the network map does not include connections rated by a single organization or connections with organizations that were invited to participate but did not complete the survey.

[6] The ratings of connections between organizations are subjective and reflect the perspectives of the individuals who completed the survey on behalf of their organizations at a single point in time.

Exhibit 5. Connections across Alameda County's behavioral health ecosystem[a]



[a] The network map does not show organizations that did not complete the survey, including Health center A.

Note: Coexist = limited or no relationship between organizations (no connection); Cooperate = informal interactions on specific activities or projects; Coordinate = intentionally plan/work together for greater outcomes; Collaborate = shared mission, goals, decision makers, and/or resources; Integrated = fully integrated programs, planning, or funding.

Perceptions of multisector collaboration to support children and youth behavioral health

Multisector relationships and collaboration

Many government agencies and organizations partner to support child and youth behavioral health in Alameda County. These findings align with the network map, in which the average strength of all connections reported across the network in Alameda County is 3.35, indicating that child- and youth-serving organizations often coordinate and collaborate to support children's and youth's behavioral health. Across the network, most organizations surveyed (n = 7) have connections to at least five other organizations, though the strength of those connections varies, and the network map does not represent the entirety of Alameda County's broad network of providers (Exhibit 5). Among organizations surveyed, more than one-third of connections in the map have an average strength rating of "collaborate," representing formal partnerships designed to support children's and youth's behavioral health. An equal number of connections have an average strength of "coordinate," suggesting that the organizations intentionally work together to achieve shared outcomes.

Several interview respondents reported especially strong relationships between the "big five" county government agencies that work with children (education, behavioral health, child welfare, public health, and probation) and between these agencies and managed care. In the network map, the four government agencies that responded to the survey are connected to one another through coordinated, collaborative, or integrated relationships. An interview respondent from the behavioral health department corroborated the presence of these partnerships, noting that the CYASOC collaborates and coordinates care for children, youth, and young adults in Behavioral Health, Social Services, Probation, Office of Education, Regional Center of the East Bay, and Bay Area Collaborative of American Indian Resources systems. The respondent also cited monthly meetings with various agencies and other partners, and the work done through the No Wrong Door initiative. The relationship between the county's behavioral health and public health is integrated, likely because both departments operate under the same agency, Alameda County Health. In addition, the managed care plan (MCP) surveyed reported collaborative relationships with the behavioral health department and ACOE, possibly reflecting the substantial work these partners have done on CYBHI workstreams, such as School-Linked Partnerships, SBHIP, and the CYBHI Fee Schedule.

In such a large and diverse county with significant behavioral health needs, opportunities to improve partnerships with CBOs and LEAs remain. Some interview respondents, particularly from those outside of government and managed care, reported somewhat limited connections with other child- and youth-serving agencies and organizations.

Barriers to multisector collaboration

Respondents reported some systems, funding, and communications barriers to cross-sector partnership in Alameda County. Several respondents cited opportunities for more collaboration in Alameda County. Public health and behavioral health departments independently manage their own systems, and there may be opportunities to develop synergies across systems. Large public agencies are needed to support Alameda County's large population. The size of those agencies may make cross-sector partnership challenging, as it may be difficult to identify the right people to work with when organizations are large. Respondents also cited staff turnover as an impediment to cross-sector partnership. Several respondents also noted that with the numerous CBOs in the county, some might be competing for the same grant funds (from the CYBHI or other sources). Lastly, one CBO respondent noted the challenge of limited time when participating in multisector collaboratives, citing the need to balance activities directly related to services provision, such as implementing evidence-based behavioral health care, with participation in committees.

Facilitators of multisector collaboration

Alongside other initiatives, the CYBHI is improving multisector collaboration by encouraging MOUs and funding specific workstreams that require work across sectors. For example, to improve collaboration and the ability to coordinate services for children across settings, the behavioral health department now has MOUs with the probation department, the regional center, Bay Area Collaborative of American Indian Resources, and ACOE. Their ability to share data across these agencies has helped agencies ensure that children and youth in various systems receive appropriate and coordinated behavioral health services. Preparation for the CYBHI Fee Schedule has prompted the creation of a partnership between the behavioral health department, MCPs, and ACOE to assess children's and youth's needs and how they can best use their respective expertise and collaborate to ensure timely access to behavioral health care. As another example, several schools in Alameda County built Wellness Centers through SBHIP, which one CBO respondent described as hubs for increasing partnerships between behavioral health and education. Another respondent shared an example of a school district that now has regular meetings with the child welfare and behavioral health departments as a result of the CYBHI. Finally, several respondents noted the importance of the county's new superintendent in bringing together county agency leaders to form connections across agencies, draw on CYBHI funding, and hire new service coordinators.

CBOs reported several meaningful connections with one another that facilitate their work and expressed interest in deeper involvement in formal multisector collaboration. As examples of their connections with other CBOs, respondents cited their reliance on First 5's shared list of providers with openings for patients; specific schools with excellent coordinators who enable collaboration with behavioral health care providers; and relationships with families and the community.

Spotlight on multisector collaboratives that support children and youth behavioral health

School Health Steering Committee

Facilitated by the Alameda County Office of Education and the Center for Healthy Schools and Communities, the School Health Steering Committee (SHSC) brings together leaders from behavioral health, managed care, public health, education, and more. Several interview respondents reported participating in SHSC. Survey respondents indicated that SHSC was recently formed and is now recruiting youth, families, and diverse underserved and unserved communities to take part. The committee is also conducting a needs assessment of Alameda's school-linked behavioral health system and its effectiveness. An ACOE interview respondent said this assessment would help establish "coherence and alignment" for multisector collaborative work.

According to survey respondents, SHSC has a governing body or leadership team and includes diverse voices and perspectives from multiple relevant sectors. The committee is implementing or plans to implement several activities, such as establishing relationships across sectors to ensure delivery of a comprehensive array of supports and services (from preventive to intensive) and pursuing financing structures and funding streams that can be blended or braided across partner organizations. To date, SHSC has helped strengthen the capacity of organizations in the county to work together toward shared goals for children's and youth's behavioral health and has fostered a common desire to create a more inclusive, healing-centered behavioral health system.

Pre to 5 Collaborative

The Alameda County Public Health Department leads the Pre to 5 Collaborative, an advisory body and think tank that guides and influences efforts to enhance the health and well-being of pregnant women, young children, and their families. The collaborative seeks to improve alignment and coordination across agencies and early childhood programs, increase connection and access to services for families, and collaborate with agencies to address health inequities.[7] No interview respondents reported participating in the Pre to 5 Collaborative.

According to survey respondents, the Pre to 5 Collaborative includes diverse voices and perspectives from multiple relevant sectors and is expanding upstream solutions (such as promotion, prevention, and early intervention) to support the well-being and behavioral health of children, youth, and families. The collaborative consults or involves historically marginalized communities. Most organizations reported that key areas of progress include strengthening the capacity of organizations in the county to work together toward shared goals for children's and youth's behavioral health and fostering a common desire among partners to create a more inclusive and healing-centered behavioral health system.

Other multisector collaboratives

Other multisector collaboratives that support behavioral health for children and youth in Alameda County include the Interagency Leadership Team (ILT), School Coordination of Services Team (COST), and the Alameda County Board of Supervisors' Public Protection Committee.

- **The Interagency Leadership Team.** According to survey respondents, the ILT, funded through AB2038, is a collaboration between behavioral health, juvenile probation, child welfare, the county education office, and the Department of Developmental Services Regional Center. The ILT meets monthly to review mandates and address care coordination for foster youth. An interview respondent involved in Alameda County's ILT said one of the benefits of the collaborative is that it separately convenes three distinct levels of staff (department heads, high-level managers, and front-line workers) from several agencies to talk about systems issues and how to rectify them. One example of the ILT's work is a juvenile landscape mapping project, an initiative of the juvenile justice department. The ILT is developing a website to share the products and work emerging from its meetings, which should boost visibility and improve dissemination of information about resources for youth in foster care.
- **The School Coordination of Services Team.** COST is a collaborative care coordination structure that coordinates mental health services for students and identifies strategies to address mental health barriers for underserved communities. The county has invested significant resources to build capacity, and COST now exists in a significant number of LEAs as a best practice. COST in Alameda County is partially funded through the Mental Health Services Act in partnership with Alameda County Behavioral Health, the Center for Healthy Schools and Communities, and local LEAs.
- **The Public Protection Committee.** Several interview respondents cited this committee, facilitated by the Alameda County Board of Supervisors, as a forum to talk about how to connect people to resources and social supports. The collaborative has reportedly bridged connections and helped improve cross-sector collaboration across the public health, social services, probation, and CBO sectors, among others.

IV. CYBHI Workstream Implementation Findings

The CYBHI is implementing 20 distinct CYBHI workstreams, each designed to contribute to transforming the behavioral health ecosystem, with many intended to improve multisector collaboration. To date, the workstreams are at various stages of implementation and are active to varying degrees across California counties.

[7] ALL IN. "ALL IN Alameda County Strategic Plan 2019–2020." 2019. https://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_1_16_19/GENERAL%20ADMINISTRATION/Regular%20Calendar/ALL_IN_strategic_plan_draft_1_16_19.pdf. Accessed October 24, 2024.

Overview of workstreams in Alameda County

Overall, Alameda County is locally implementing 12 workstreams that involve the distribution of funding to county or community entities, including 127 grants, as of September 2024.[8] This case study discusses the county's implementation experiences with **education sector workstreams**, including SBHIP; the CYBHI Fee Schedule; the School-Linked Partnership and Capacity Grants; CalHOPE Student Support and Schools Initiative; Mindfulness, Resilience, and Well-Being Supports; and Certified Wellness Coaches. The case study also discusses the county's experiences with the Transforming Together demonstration and select **workstreams occurring in home and community settings**, including the Community-Based Organization Behavioral Health Workforce Grant Program, Youth Suicide Reporting and Crisis Response Pilots, Scaling EBPs and CDEP grants, and Never a Bother (Youth Suicide Prevention and Media Outreach Campaign). Other workstreams active in the county include programs under the Broad Behavioral Health Workforce Capacity workstream and Behavioral Health Continuum Infrastructure Program (BHCIP) grants. For example, Alameda County has one BHCIP Round 4 grant intended to fill in gaps in infrastructure by adding a community wellness/prevention center for youth. Broad Behavioral Health Workforce Capacity programs active in the county include the Health Careers Exploration Program, Health Professional Pathways Program, Justice System-Involved Youth Pipeline Program, Peer Personnel Training and Placement Program, Psychiatric Education Capacity Expansion Grants, and Social Work Education Capacity Expansion Grants.

Implementation of workstreams designed to facilitate the provision of clinical care in and near schools

In Alameda County, implementation of the CYBHI Fee Schedule, SBHIP, and School-Linked Capacity Grants is progressing, and reimbursement for school-based and school-linked behavioral health services (across most payers) will be available to the first cohort of LEAs participating in the CYBHI Fee Schedule. These workstreams, according to a few respondents, have the potential to increase provision of school-linked services by making them more sustainable, more predictable, and less administratively burdensome for LEAs. Respondents attribute successful early implementation largely to ACOE's significant leadership role. ACOE has worked to build awareness of all three workstreams and sought to secure meaningful connections surrounding the workstreams across county partners. For instance, respondents noted that ACOE invested in significant communication efforts for the CYBHI Fee Schedule, describing it not only as a reimbursement program but also as an important benefit for students' health and well-being. These communication efforts have included educational and coaching sessions with districts, office hours, and work with a communications team to craft messages that support specific communities' understanding of the Fee Schedule. In addition, an education respondent said the county has used SBHIP funding to host learning exchanges to facilitate information sharing between Alameda County LEAs preparing for Fee Schedule implementation.

[8] The sum of CYBHI workstreams and grants operating in this county encompasses all awards to entities operating CYBHI workstreams in the county as of September 2024, including awards that seek to reach multiple counties. For the purposes of calculating the number of awards at the county level, we relied on publicly available award announcements or direct departmental confirmation of counties in which awardees operate or intend to use funding; as a result, these estimates do not reflect select Broad Behavioral Health Workforce programs for which this information is currently unavailable.

Respondents credit these workstreams with helping to forge multisector partnerships and develop the technical infrastructure to make providing school-linked services easier for LEAs. For instance, ACOE played a key role in building relationships across diverse county actors to tackle issues with workstream implementation, such as claims submission. Catalyzed by the CYBHI Fee Schedule, ACOE, the behavioral health department, and MCPs worked together to assess community needs and develop a plan for using their respective expertise to ensure timely access to behavioral health services. ACOE is working to bring smaller districts interested in the Fee Schedule together into a well-coordinated consortium to support their participation. SBHIP funding supported cross-sector efforts, such as one LEA's partnership with a local CBO to physically remodel and staff a wellness center that provides necessities to families, including clothing, food, college counseling, and a space for youth and families to decompress. During implementation of School-Linked Capacity Grants, the county worked with a vendor that uses the Salesforce platform to acquire and customize a new EHR system that will integrate with other student information and county data systems, addressing a strong need in the county for better data sharing across child- and youth-serving organizations. CYBHI Fee Schedule implementation also involved preparation to house and analyze data. This included acquiring and setting up data warehouse hardware to support one consolidated data warehouse for all LEAs to streamline the flow of information, developing data-sharing agreements, collecting National Provider Identifiers, and hiring a consultant to analyze security measures needed to comply with HIPAA.

> "Alameda County has done a really great job of building a comprehensive team that understands both education and the health care system, and really thinking through how to not just design a claim submission process but really design one that works for schools.... Having worked in the health care space and worked in the school space, you can't just take the health care structures and then apply them to schools and think that it works. It doesn't."
>
> —ACOE respondent

The implementation of Certified Wellness Coaches, a new type of behavioral health care professional positioned to operate within a care team in a wide variety of settings, is in its early stages in Alameda County. ACOE received a Certified Wellness Coaches Employer Support grant to fund the hiring of Certified Wellness Coaches across the majority of LEAs in the county. ACOE respondents reported actively providing office hours for districts and others interested in learning more. ACOE planned to pilot Certified Wellness Coaches in 2024 to support the provision of school-linked and school-based services, such as individual and group support, wellness promotion and education, care coordination, screening, and referral. When identifying candidates for certification, some education sector respondents said they will lean on community partners for help, and others noted that they will seek people already involved in this type of work in LEAs. Respondents agreed this workstream has the potential to promote the use of school-based wellness centers as a new service delivery model and expressed excitement about the sustainability of their work through Fee Schedule reimbursement. Respondents anticipated that Certified Wellness Coaches will be well poised to provide key mild to moderate mental health supports for students, which in turn could free up more credentialed and licensed workers to support more complex student cases.

The CYBHI Fee Schedule, SBHIP, the School-Linked Partnership and Capacity Grants, and Certified Wellness Coaches

The **CYBHI Fee Schedule** provides a consistent and predictable funding mechanism for school-linked services by establishing a specific set of behavioral health services and rates at which Medi-Cal and commercial plans must reimburse school-linked providers. The Fee Schedule provides guidance for LEAs to receive reimbursement for school-linked behavioral health services using a fee-for-service model. Specifically, it (1) defines the scope of services for outpatient mental health and substance use disorder treatment, (2) identifies applicable billing codes and rates for behavioral health services, and (3) specifies which providers may bill for behavioral health services. The Fee Schedule requires commercial and public payers to pay school-linked providers. In addition, behavioral health services provided under the Fee Schedule may not require co-payments, co-insurance, deductibles, or any other form of cost sharing. Unlike the certified public expenditure approach of the LEA Medi-Cal Billing Option Program (LEA BOP), LEAs receive reimbursement for the entire service rate, which frees up local funds for further investment in schools and prevents the administrative burden of cost settlement reconciliation.

SBHIP focuses on developing a behavioral health infrastructure by helping MCPs and LEAs partner to address identified gaps in school-based behavioral health infrastructure through a set of targeted interventions. Counties and LEAs can select one to four targeted interventions from a list of 14 outlined by DHCS; depending on the interventions selected, SBHIP activities may support increasing capacity for promotion and prevention or decreasing administrative barriers to clinical care in or near schools, and are intended to enhance partnerships between LEAs and MCPs.

School-Linked Partnership and Capacity Grants are one-time investments intended to enhance school-linked behavioral health services and support operational readiness for the Fee Schedule. The Santa Clara County Office of Education, in partnership with the Sacramento County Office of Education, oversees fund distribution to all 58 COEs and provides training and TA to help COEs successfully implement the Fee Schedule; counties and LEAs are responsible for drafting implementation plans that reflect and address locally defined infrastructure development needs.[1] Seventy percent of the funds allocated should be used to achieve LEA operational readiness to implement the Fee Schedule. This can include work in the following four areas: Medi-Cal enrollment, service delivery infrastructure and capacity building, data collection and documentation, and billing infrastructure.

Certified Wellness Coaches (CWCs) are a new behavioral health professional role established under the CYBHI for people holding associate's and bachelor's degrees. This workstream is linked to other investments in the CYBHI to support overall scaling and innovation of the behavioral health workforce. CWCs will primarily serve children and youth and operate as part of a care team in a wide variety of settings, including school-linked settings. The creation and integration of this role into school-linked behavioral health provider teams is intended to help address workforce shortages and support the sustainability of the Fee Schedule by adding another reimbursable provider type.

Implementation of workstreams designed to facilitate classroom and campus supports for behavioral health

Respondents reported that Alameda County partners and districts are in various phases of preparedness to deploy classroom and campus behavioral health supports to increase schools' capacity to promote wellness, provide prevention services, and identify behavioral health needs. Partners are implementing CalHOPE; Mindfulness, Resilience, and Well-Being Grants; and BHCIP and the creation of implementation plans for the Wellness Coaches Workforce Program. According to respondents, the county has already seen early success implementing CalHOPE social-emotional learning (SEL) programs to provide training and support to educators. For example, ACOE has worked with the Emery Unified LEA to incorporate SEL processes, leadership, and practices into its school sites; partnered with Oakland Unified School District to support field trips and Soccer Without Borders, an after-school SEL and sports-focused program; provided stipends for participating in UC Berkeley's SEL Fundamentals course, created using CalHOPE dollars; developed an SEL community of practice for educators; and supported the Reach Ashland Center, which trains young leaders on incorporating SEL practices into their after-school programs. Oakland Unified is using Mindfulness, Resilience, and Well-Being Grants to launch Peace Oasis, a train-the-trainer program on creating calm spaces in classrooms. Emery Unified is using an online tool from Kelvin Education to collect information on the school climate and check in on the social-emotional well-being of students and staff through

surveys of students, staff, and possible parents. ACOE is also working to identify six recipients for smaller equity-based Mindfulness Grants, one of which will be an ACOE school (court and community schools, juvenile detention, or pregnant/parenting teen programs). Lastly, a CBO in Alameda County is using BHCIP funding to acquire and renovate a building in downtown Oakland to serve as a new wellness and prevention center.

Workstreams facilitating classroom and campus supports for behavioral health

The **CalHOPE Student Support and Schools Initiative** workstream focuses on providing training and support to educators to help them develop SEL environments, which build students' skills and destigmatize behavioral health concerns. By equipping educators with additional skills to bolster students' resilience, these programs increase mental health competency among some adults whom children and youth interact with most.

The **Mindfulness, Resilience, and Well-Being Supports workstream** builds on this foundation by funding student-facing programs that promote SEL, mindfulness, and well-being in schools, and data collection tools for schools to obtain real-time information about students' well-being.

The CYBHI's infrastructure strategy includes investing in physical infrastructure through **BHCIP,** with projects intended to expand physical infrastructure for behavioral health treatment in communities that lack inpatient or outpatient facilities.

Implementation of the Transforming Together (T2) demonstration to integrate CYBHI workstreams and the California Community Schools Partnership Program

ACOE respondents expressed enthusiasm about their participation in the T2 demonstration and believed they could be sparking meaningful systems change. One respondent described their overarching objective for participating in T2: to ensure youth can access a continuum of needed services wherever they are—at school, at home, or in the community. ACOE respondents described themselves as being in the early design phase of T2. They are currently analyzing the system of partnerships, teams, and meetings to support the identification of common goals and outcomes related to their T2 demonstration school site. One respondent said they viewed T2 less as a program to be implemented and more as a space to learn, grow, and develop systems and resources to support the needs of the whole student. One of Alameda County's biggest strengths in launching T2 is the slow, meticulous, and intentional use of this one-time funding to develop sustainable infrastructure. As one ACOE respondent noted, this includes building out relationships and connections across agencies and working to adopt appropriate infrastructure.

> "I'm really excited to see [T2] evolve…. The concept of bringing together folks with such [a] high level of experiences, and coupling that with boots-on-the-ground connection of sites and county offices across very diverse regions, is a great model."
>
> —ACOE respondent

> "For me, I believe, 'Let's go slow to go fast,' so that we're really thinking about the systems aspects of this…. Once all the CYBHI one-time dollars are gone and all the community schools' one-time dollars are gone, we have an infrastructure that can be sustained and maintained. For me, that's probably the biggest strength that we've seen so far."
>
> —ACOE respondent

Leveraging the intersection of schools and behavioral health: Transforming Together

The CYBHI is one piece of California's comprehensive statewide approach to address the negative effects of the COVID-19 pandemic on student learning and social and emotional well-being. With the passage of the California Community Schools Partnership Program (CCSPP) in 2021, the state allocated $4.1 billion to establish and expand community schools. Community schools are designed to connect students to local services and resources that address the needs of the whole child. The California Community Schools Framework, in alignment with most traditional community school models, incorporates four evidence-informed pillars: (1) integrated support services, (2) family and community engagement, (3) collaborative leadership and practices for educators and administrators, and (4) extended learning time and opportunities. Guided by this framework, the CCSPP awards grants to support schools' efforts to partner with community agencies and local government to address students' academic, cognitive, physical, mental, and social-emotional needs.

To integrate efforts to improve students' behavioral health and well-being across the education and behavioral health sectors and maximize their impact, CalHHS and the California Department of Education have partnered on a demonstration project called Transforming Together (T2). The project, administered by the San Bernardino County Superintendent of Schools, draws upon the principles of the Ecosystem Working Paper and seeks to break down silos and build coordinated systems that center children, youth, and families. T2 is intended to identify effective, scalable tools and approaches for enabling integration across systems.

An ACOE respondent said they are looking to make the T2 pilot useful in Alameda County by improving communication and better integrating behavioral health for youth served through Court Schools. Currently, youth in Court Schools may interact with social agencies or case managers from up to four agencies. Making communication easier between these sectors and actors could make a meaningful difference to students.

Implementation of home- and community-based sector workstreams

Alameda County's home- and community-based sector workstreams have already helped strengthen CBOs' and an FQHC's ability to recruit and retain behavioral health care providers, according to respondents. For example, CBO Behavioral Health Workforce Grant Program funding has helped CBOs and an FQHC recruit and retain staff members and the FQHC to run a formal internship training program with local universities. One CBO hired four new staff who will benefit from the loan forgiveness grant, enabling the organization to expand its scope of services to additional schools with which it partners to provide on-site services. The FQHC said the internship program has successfully recruited bilingual providers from the communities it serves in a competitive job market. CBO respondents also see these grants as helping their organizations retain clinicians because the improved benefits (such as student loan forgiveness) makes working for a CBO more desirable. Although it is too soon to tell, these respondents hope that these gains will contribute to clinicians seeing employment at a CBO as a meaningful, long-term career path, rather than as something providers only do early in their career to gain training.

> "We've had interns say to us, 'I have never had a supervisor that looks like me, and that's very powerful and impactful.' We are really trying to move into that space to increase identification, representation, and shared experience."
>
> —FQHC respondent

Through the Never a Bother Campaign (Youth Suicide Prevention Media and Outreach Campaign), a recipient of several grants is providing communities with the knowledge to support young people, with a focus on providing communication and public education, workshops, and support for youth participating in local efforts (such as youth advisory boards). A CBO respondent said their organization received funding from the California Department of Public Health for efforts to help youth communicate about their behavioral health needs, to reduce stigma associated with behavioral health services, and to deploy culturally appropriate outreach strategies to conduct this public education. To promote this work, the CBO has developed various campaign materials, such as coping mechanism cards and social media content. One respondent said their CBO has a school-based

department and established relationships with schools, which has eased their implementation of Never a Bother Campaign workshops on site. These grant funds have also supported the convening of a youth council in San Francisco and Alameda, which discusses the change youth want to see in their communities; a youth advisory board from Alameda County; youth attendance at a Native youth conference to learn about career and leadership development; and youth participation in volunteer events. Driven by the youth council, the focus of these local efforts is on unhoused and LGBTQ youth.

The Youth Suicide Reporting workstream is taking steps to strengthen community-level capacity to develop and improve local-level planning for rapid suicide reporting and response. To better understand gaps in county services, the county is using Youth Suicide Reporting funding to map the current system of care through surveillance and rapid reporting of youth suicide-related data. According to a public health respondent, this mapping work involves successful engagement and collaboration with county staff from the behavioral health department, school-based initiatives, service providers, the 988 collaborative, crisis teams, and other partners. Respondents anticipate that mapping the system of county behavioral health services supporting children and youth will help identify service gaps in suicide prevention. While the grant supports the mapping effort, a public health respondent expressed a desire to invest in a system to collect real-time data, such as BioSense, a program that other counties use for syndromic surveillance. If acquired, the respondent believes this system would allow them to better track, document, and respond to youth in crisis.

Other home- and community-based sector workstreams, according to respondents, have the potential to increase parent and caregiver capacity and patient engagement, but these initiatives had not yet begun at the time of our interviews in summer 2024. For example, local CBOs are using Round 1 Scaling EBPs/CDEPs funding to offer a new parent and caregiver curriculum called Effective Black Parenting and to provide culturally responsive family resource center services, including parenting programs. Likewise, an FQHC system is using Round 2 Scaling EBPs/CDEPs funding to begin offering dialectical behavior therapy to youth patients at risk of suicidality. Respondents were excited to begin providing these services and were on the cusp of program launch at the time of our interviews.

Home- and community-based sector workstreams

The **Community-Based Organization (CBO) Behavioral Health Workforce Program** provides four-year grant funding to eligible CBOs to support the recruitment and retention of behavioral health personnel. The funding can be used to provide loan repayments, scholarships, and stipends for both paid and volunteer CBO behavioral health staff, in exchange for a 12-month service commitment. In March 2023, approximately $116 million was awarded to 134 CBOs across the state.

The **Scaling EBPs/CDEPs grant program**, administered by DHCS, distributes grants to organizations seeking to scale EBPs or CDEPs. EBPs are defined as having rigorous empirical evidence of effectiveness in improving children's and youth's behavioral health, whereas CDEPs are community-based behavioral health practices that have reached a strong level of support within specific communities. The program is distributing five rounds of grants to organizations seeking to scale EBPs or CDEPs to enhance the accessibility and quality of prevention services and clinical care offered in their communities. Many of these grant awards focus on training additional behavioral health care providers in EBPs. The five grant rounds cover (1) parent and caregiver support programs and practices, (2) trauma-informed programs and practices, (3) early childhood wraparound services, (4) youth-driven programs, and (5) early intervention programs and practices.

Never a Bother (Youth Suicide Prevention Media and Outreach Campaign) is a multilingual marketing, education, and outreach suicide prevention campaign that includes a website, social media, content and resource creation opportunities, advertising, and partnership marketing. To complement the campaign, 34 CBOs and tribal partners received grants to help promote and implement the campaign's community-level suicide prevention strategies. CDPH's Office of Suicide Prevention launched Never a Bother in March 2024, following an eight-month planning phase that incorporated input from more than 400 youth. Throughout the year-long campaign, various activation points are being planned, such as Mental Health Awareness Month. The campaign focuses on youth populations disproportionately affected by suicide: American Indian/Alaska Native youth, Hispanic and Latino youth, and African American or Black youth, as well as intersectional groups, such as youth with mental health conditions, substance use issues, or both; youth in the foster care system; and two-spirit/LGBTQ+ youth.

The **Youth Suicide Reporting and Crisis Response** workstream was established to develop and improve local-level planning for rapid suicide reporting. The California Department of Public Health allocated approximately $50 million to the 10 pilot counties, seven of which have youth suicide rates exceeding the state average. The pilot counties are developing and testing models that quickly report and respond to youth suicide and suicide attempts. The pilots are intended to develop or enhance equitable, timely, and culturally responsive suicide prevention and postvention strategies at the local level. By enhancing reporting and youth-focused crisis response systems after a suicide attempt or death, the program aspires to prevent further suicides and attempts.

Perceptions of workstream effectiveness in addressing behavioral health needs and equity

Alameda County respondents perceived that CYBHI workstreams in the education, home, and community-based sectors are beginning to address the behavioral health needs of children, youth, and families. The county has used SBHIP funding to support the remodel of a wellness center, offering students at that school a safe, supportive, and staffed space on campus that provides holistic wellness supports that students can access throughout the day. Through CalHOPE, respondents noted that the county has already seen tremendous progress implementing SEL programming directly with students, such as an after-school SEL and soccer program. In addition, the county has used Never a Bother Campaign funds to help youth communicate about their behavioral health needs, discuss the changes they want to see in their communities, attend a leadership development conference, and take part in volunteer events.

See Appendix C for more details on the implementation of select workstreams in Alameda County.

V. Conclusion

Alameda County is a large, populous, and diverse county with a great need for accessible behavioral health services. Children and youth in Alameda County experience similar rates of behavioral health challenges compared with those statewide, though the county's population size and large network can make connecting them with services more complex. Respondents cited major behavioral health workforce issues in Alameda County, with a particular need for more licensed providers; providers who are willing to work in county-run, CBO, and FQHC settings; linguistically and culturally diverse professionals; nontraditional, front-line behavioral health care providers with lived experience; and providers who are willing to work with in-custody youth.

In the context of these challenges, efforts to develop a more comprehensive and accessible behavioral health ecosystem in Alameda County through CYBHI are progressing. Many respondents expressed confidence that some CYBHI programs and initiatives were improving the county's school-based and school-linked behavioral health programs, bolstering the behavioral health workforce, and strengthening cross-sector collaboration. ACOE has led the county in efforts to leverage CYBHI funding to invest in technical infrastructure and human resources, as well as to streamline billing for school-based behavioral health services in the county. Several CBOs and an FQHC were able to strengthen their provider workforce, with an important focus on recruiting and retaining bilingual providers.

Alameda County benefits from many strong connections across its large network, with respondents from government agencies and the managed care sector reporting strong partnerships among themselves, though some CBO interview respondents perceived opportunities for greater connection with county agencies and other organizations. To maximize the impact of early CYBHI success to improve the behavioral health needs of children, youth, and families, respondents indicated an ongoing need to increase and diversify the behavioral health workforce, particularly in supporting recruitment and retention of licensed and bicultural/bilingual providers; enhanced collaboration with and among CBO partners and other sectors; and support for ongoing implementation of school-based and school-linked behavioral health programs.

Appendix A. Data Sources for County Population Characteristics, Prevalence of Behavioral Health Symptoms and Diagnoses, and Behavioral Health Resources

Variable	Source	Years
Population		
Total population (N)	American Community Survey at https://data.census.gov/table	2022
Population, 0–4 years (N; %)		
Population, 5–19 years (N; %)		
Population, 20–24 years (N; %)		
Five-year population growth (%)	American Community Survey at https://data.census.gov/table	2017–2022
Five-year population growth, 0-24 years (%)		
Density (population per square mile)	U.S. Census at https://maps.geo.census.gov/ddmv/map.html	2020
Race and ethnicity		
White, non-Hispanic (%)	American Community Survey at https://data.census.gov/table	2022
Black or African American, non-Hispanic (%)		
American Indian and Alaska Native, non-Hispanic (%)		
Asian, non-Hispanic (%)		
Native Hawaiian and other Pacific Island American, non-Hispanic (%)		
Some other race, non-Hispanic (%)		
Two or more races, non-Hispanic (%)		
Hispanic or Latino (%)		
Birthplace and language		
Foreign-born, 0–24 years (%)	American Community Survey at https://data.census.gov/table	2022
English-proficient, 5–17 years (%)		
Education (18+ years)		
High school or higher (including college) (%)	American Community Survey at https://data.census.gov/table	2022
College degree or higher (%)		
Population within urban blocks (%)	U.S. Census at https://www2.census.gov/geo/docs/reference/ua/2020_UA_COUNTY.xlsx	2020
Population within rural blocks (%)		
Population below 200% of the federal poverty line (%)	American Community Survey at https://data.census.gov/table	2022
Median income (USD)		
Unemployment (%)		
Households with high housing cost burden (%)	KidsData.org analysis of the American Community Survey	2019

Variable	Source	Years
Food insecurity, overall (%)	Feeding America's Map the Meal Gap data at https://map.feedingamerica.org/	2021
Food insecurity, 0–18 years (%)		
Healthy Places Index (rank)	Healthy Places Index at https://map.healthyplacesindex.org/	2015–2019
Diversity Index (rank)		
Health status		
Population with a disability (%)	American Community Survey at https://data.census.gov/table	2022
Population with a disability, 0–17 years (%)		
Health insurance status (population 0–25 years)		
Medi-Cal or other means-tested public coverage (%)	American Community Survey at https://data.census.gov/table	2022
Private coverage (%)		
Uninsured (%)		
TRICARE/military coverage (%)		
Medicare coverage (%)		
Prevalence of behavioral health outcomes		
Children and youth insured through Medi-Cal with a mental health diagnosis or emotional symptoms (%)	Transformed Medicaid Statistical Information System Analytic Files at https://resdac.org/cms-virtual-research-data-center-vrdc and Mathematica's analysis	2022
Children and youth insured through Medi-Cal with a substance use disorder diagnosis (%)		
Youth ages 12 to 17 years old who felt their family stood by them during difficult times (%)	California Health Interview Survey (Center for Health Policy Research at the University of California, Los Angeles) and Mathematica's analyses; applied for data https://healthpolicy.ucla.edu/our-work/california-health-interview-survey-chis/access-chis-data	2022
Youth ages 12 to 17 years old who felt at least two non-parent adults took genuine interest (%)		
Youth ages 12 to 17 years old who felt supported by friends (%)		
Students in grade 9 who felt they were doing things that make a difference (%)	California Healthy Kids Survey County Reports at https://calschls.org/reports-data/search-lea-reports/ and Mathematica's analysis	2019–2021
Students in grade 9 who felt they were doing interesting activities at school (%)		
Students in grade 9 who felt close to people at school (%)		
Students in grade 9 who reported seriously considering attempting suicide in the past 12 months (%)		

Variable	Source	Years
Students in grade 11 who reported seriously considering attempting suicide in the past 12 months (%)	California Healthy Kids Survey County Reports at https://calschls.org/reports-data/search-lea-reports/ and Mathematica's analysis; Year 2019 - 2021	2019–2021
Students in grade 9 reporting school absences due to mental health issues (%)		
Students in grade 9 reporting school absences due to alcohol or drug use (%)		
Inpatient hospitalizations per 1,000 children and youth for behavioral health diagnosis	California Department of Health Care Access and Information; applied for data at https://datarequest.hcai.ca.gov/csm	2022
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis		
Students in grades K–12 who were chronically absent (%)	California Department of Education data at https://www.cde.ca.gov/ds/ad/filesabd.asp	2022–2023
Behavioral health care resources		
Primary care health professional shortage area designation	Agency for Healthcare Research and Quality's Social Determinants of Health Database at https://www.ahrq.gov/sdoh/data-analytics/sdoh-data.html	2019
Mental health professional shortage area designation		
Number of child and adolescent psychiatrists per 100,000 children <18 years	American Academy of Child and Adolescent Psychiatry, U.S. Census, at https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx	American Medical Association Masterfile 2024, U.S. Census 2022
Number of non-psychiatrist behavioral health providers licensed with county Medi-Cal Specialty Mental Health Services Plans per 100,000 residents	DHCS needs assessment at https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf	2021
Number of outpatient treatment programs for young adults per 100,000 children and youth 0–24[a]		
School-based health programs with mental health services per 100,000 children and youth <18	School-Based Health Alliance information at https://www.schoolhealthcenters.org/school-based-health/sbhcs-by-county/	2024
Number of FQHCs or FQHC look-alike sites per 100,000 children and youth ages 0–25 years	Health Resources and Services Administration FQHC and look-alike locator at https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs	2024

[a] While the numerator for this measure is based on the number of outpatient treatment programs for *young adults*, we use a more inclusive denominator of all children and youth 0–24 years because the original data (https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf, Table E-4) suggest that many of these programs may pertain to children as well.

Appendix B. Network Analysis Methodology and Measures

This appendix describes our network analysis methodology and the measures for Alameda County.

Methodology

We invited 14 organizations in Alameda County to complete the NEES via email and received responses from nine organizations (for a 69.2 percent response rate). Invited organizations included government agencies and departments; the managed care plan; and CBOs, including health centers and organizations that serve Native populations and other diverse communities. Administrators of child- and youth-serving organizations, such as directors and executive directors, rated the strength of their organizations' connections with the other organizations invited to complete the survey on a 5-point scale, ranging from (1) coexist to (5) integrated.[9,10] After using R software to conduct a network analysis based on these ratings, we then produced and developed the network map using Kumu software. We also used ratings across all organizations to represent the average strength of the whole network.

Exhibit B.1 shows the 5-point scale that survey respondents used to rate their organizations' connections with other organizations.

Exhibit B.1. Connection ratings and descriptions

Score	Rating strength	Rating description
1	Coexist	No or limited relationship between organizations
2	Cooperate	Informal interactions on specific activities or projects
3	Coordinate	Intentionally plan or work together for greater outcomes
4	Collaborate	Shared mission, goals, decision makers, or resources
5	Integrated	Fully integrated programs, planning, or funding

When two organizations rated their connection with each other, we calculated the average strength of their connection for inclusion in the network map. For example, if Organization A and Organization B rated their connection with each other as "cooperate" (2) and "coordinate" (3), respectively, the average strength of the connection between the two organizations would be 2.5, or "cooperate."

In Alameda County, sometimes only one organization rated a connection between two organizations. To determine whether to include these ratings in our analysis and network map, we conducted an agreement analysis using cases for which we had ratings from both sides of a connection (that is, both organizations rated the connection). This analysis showed us whether two organizations that reported a connection with each other tended to rate the strength of their relationship in a similar way. Because the 5-point rating scale is subjective, we defined agreement as two organizations providing the same rating or being only 1 point apart. For example, if one organization rated the connection "cooperate" (2) and the other organization rated it "coordinate" (3), we considered them to be in agreement. Using this standard, we then calculated how often organizations agreed with each other about the strength of their relationships.

Across all nine counties included in the case studies, a high rate of agreement (70.0 percent or greater) suggests that respondents typically agree with each other about their connection ratings, and thus a single respondent's rating of the strength of a relationship can be used to represent the actual strength as reported by both ends of the connection. In Alameda County, the rate of agreement was 63.0 percent. Because this did not meet the threshold for a high rate of

[9] We adapted this scale from the Tamarack Institute's Collaboration Spectrum Tool: https://www.tamarackcommunity.ca/hubfs/Resources/Tools/Collaboration%20Spectrum%20Tool%20July%202017.pdf?hsLang=en-us.

[10] The connections in the network map may not represent the perspectives or experiences of all organization staff.

agreement, we did not include ratings of a connection in the network analysis or map when only one organization rated the relationship.[11]

Network measures

Exhibit B.2 shows summary statistics and descriptions from the social network analysis for Alameda County.

Exhibit B.2. Alameda County's network analysis summary statistics

Network measure	Statistic	Description
Observed network size	9	The number of organizations included in the network map. This count includes organizations that responded to the survey.
Number of observed connections	54	The total number of connections reported by organizations that completed the survey. This reflects the number of connections that were bidirectional (that is, both organizations rated their connection with each other).
Average strength of the network	3.35	The average strength rating for the network, where the denominator is the number of observed bidirectional connections.

Exhibit B.3 shows the average connection strength range, rating, and the number and percentage of connections in the network map that fell into each rating category.

Exhibit B.3. Number and percentage of connections in the network map by average strength rating

Average strength range	Rating strength	Number of connections	Percentage of connections
1.00–1.99	Coexist	3	11.1
2.00–2.99	Cooperate	3	11.1
3.00–3.99	Coordinate	10	37.0
4.00–4.99	Collaborate	10	37.0
5.0	Integrated	1	3.7
	Total		**100.0%**

[11] As a result, the network map does not include connections with organizations that were invited to participate but did not complete the survey.

Appendix C. Details on Implementation of Selected Workstreams

The following tables summarize key implementation findings about select workstreams, drawn from interviews conducted with a subset of grantees between summer 2024 and late fall 2024.

Workstream: Student Behavioral Health Incentive Program	
Short overview	• To support behavioral health infrastructure, SBHIP helps LEAs address identified gaps in school-based behavioral health infrastructure through a selection of targeted interventions. • In Alameda County, Alameda Alliance, a local MCP, worked with ACOE and LEAs to conduct a needs assessment to determine top implementation priorities and funding allocations across sites. Some sites conducted focus groups with students and families to help shape project priorities.
Key implementation findings	**SBHIP supported important projects across numerous LEAs in Alameda County.** • Respondents used SBHIP funding in a variety of ways, including (1) constructing new wellness center spaces for behavioral health services to be provided in a school, (2) helping schools create different tiers of intervention services, and (3) holding learning exchanges for LEAs in the county to prepare for the CYBHI Fee Schedule. • For example, Quest Academy, a Community School serving expelled youth in the county, used SBHIP funding to build and staff a wellness center with team members from a local CBO. Behavioral health staff are on site throughout the day and provide necessities to families, such as gift cards, food, and laundry detergent. **Respondents saw SBHIP as successful because of its flexible funding, inherent focus on relationship building, and minimal reporting requirements.** • The flexibility of the funding mechanism allowed LEAs to develop projects tailored to their unique needs. Respondents reported building strong relationships across Alameda Alliance, ACOE, and the LEAs through the initial needs assessment and project implementation. • One respondent said SBHIP's simple reporting structure enabled project staff to focus on implementation instead of meeting cumbersome reporting requirements. **ACOE played a strong leadership role during SBHIP implementation, offering LEAs meaningful organizational support.** • This included connecting Alameda Alliance with the right LEA staff members and resources to support impactful projects and providing TA to LEAs to help them with implementation and reporting. • Without this level of support, some respondents indicated the projects would not have been deployed so smoothly.
Sustainability and what is next	Alameda Alliance considered sustainability when selecting fundable projects and provided LEAs with capacity-building support, although sustainability concerns remain. • As DHCS included in its state-issued SBHIP project plan template, each potential project created a sustainability plan from the outset, and Alameda Alliance used sustainability as an important criterion when selecting projects. • Alameda Alliance also developed learning collaboratives to train LEAs' social workers, behavioral health care providers, and community health workers on billing for services through the CYBHI Fee Schedule, which should help sustainability.

Note: The grant implementation experiences described in the table are based on the subset of grantees participating in interviews.

Workstream: CYBHI Fee Schedule

Short overview

- Alameda County is participating in Cohort 1 of the CYBHI Fee Schedule. The CYBHI Fee Schedule provides a consistent and predictable funding mechanism for school-linked services by establishing specific behavioral health services and rates at which Medi-Cal and commercial plans must reimburse school-linked providers.
- Respondents believe the CYBHI Fee Schedule will fill service gaps in Alameda County, especially for those with mild to moderate behavioral health needs, and increase access to services regardless of insurance type.

> "[I] was very excited about…the attempt to create a structure that allows for services according to need, as opposed to type of insurance. I do think that's a very positive step, to recognize that issue and start to try and create structures to solve it."
>
> —CBO respondent

Key implementation findings

ACOE built strong awareness of the CYBHI Fee Schedule and is actively supporting implementation.

- ACOE successfully built awareness of the CYBHI Fee Schedule among LEA staff and behavioral health care providers through carefully crafted messaging.
- ACOE has further supported implementation by offering TA to LEAs through monthly learning exchanges, targeted educational and coaching sessions, and regular office hours; collaborating across sectors and developing new partnerships with LEAs, the behavioral health department, and MCPs; and building infrastructure for the claims submission process. ACOE respondents also hired several new personnel to support CYBHI Fee Schedule implementation.

Early successes of the CYBHI Fee Schedule include ACOE's acquisition and development of technical infrastructure for claims submission.

- ACOE has acquired data warehouse hardware and engaged consultants to consolidate data from across county LEAs into the warehouse, ultimately to streamline the flow of information from districts to the third-party administrator.
- ACOE drew on School-Linked Partnership and Capacity Grant funding to acquire and customize an EHR system that integrates with other state and county data systems to support CYBHI Fee Schedule implementation.
- One respondent said ACOE has done a good job of framing the CYBHI Fee Schedule as not just a reimbursement program but as an opportunity to integrate technology and better serve student needs.
- Other technical successes include ACOE's work to develop data-sharing agreements, collect National Provider Identifier numbers, and analyze security and compliance practices.

LEAs are starting CYBHI Fee Schedule implementation from different baselines and could benefit from more state TA.

- Some LEAs in the county are reportedly well equipped to implement the CYBHI Fee Schedule, given their existing billing systems and work with insurance providers.

Other LEAs are beginning this work from a different baseline. As a result, an ACOE respondent recommended that the state provide more training, capacity building, and TA on operational readiness to implement the CYBHI Fee Schedule, including specific steps, best practices, and sample communication language. For instance, school sites must develop front-end processes, such as a process for capturing student insurance information. *Note: CalHHS and DHCS efforts to support implementation of the Fee Schedule, including through TA, are expected to help address some of these challenges.*

> "There's a lot of capacity building that needs to be done to help people think through the revenue cycle management process for this work, [which] is more front-end facing. And what does it mean for the providers themselves, and particularly providers that work on school sites, so that they are better able to think through the actual practice implications, not just the technical pieces of 'I documented it, and now the claims can be done.'"
>
> —ACOE respondent

At least one district reported planning to pilot the CYBHI Fee Schedule on a small scale to demonstrate proof of concept and build trust that claims will be reimbursed.

- Respondents hope that piloting the CYBHI Fee Schedule on a small scale will demonstrate that it can be fiscally neutral and provide evidence that reimbursement money will flow, giving LEAs and CBOs the confidence to hire additional providers.

Workstream: CYBHI Fee Schedule	
Sustainability and what is next	**The CYBHI Fee Schedule provides billing infrastructure and a sustainable revenue source by facilitating reimbursement for various school-based and school-linked services.** • Some respondents in Alameda County expressed a desire to increase the CYBHI Fee Schedule rates for certain services in order to ensure sufficient reimbursement to support both behavioral health and administrative staff needed to provide these services. *Note: The CYBHI Fee Schedule rates and codes are finalized, but remain pending CMS approval of SPA 23-0027.*

Note: The grant implementation experiences described in the table are based on the subset of grantees participating in interviews.

Workstream: Scaling EBPs/CDEPs	
Short overview	In Alameda County, we spoke to three CBOs about their Round 1 and 2 Scaling EBPs/CDEPs grants. All three CBOs are recruiting potential participants from existing patient populations for their grant-funded services, which include the following: • **Effective Black Parenting:** This EBP is a group-based parent skills training program designed to serve Black and African American families at risk for child maltreatment. The CBO implementing this program selected this curriculum as a complement to its existing portfolio, which includes an evidence-based curriculum for Latino parents, and because it wanted to offer support specific to the Black community. • **Dialectical behavior therapy:** Implementation of this EBP is intended to serve youth in danger of suicidality. The FQHC implementing this program intends to train and supervise its network of 80 clinicians across three counties to offer dialectical behavior therapy. • **Culturally responsive family resource center services, including parenting programs:** These programs are intended to improve student outcomes, increase parent attendance at school functions, aid families with individual obstacles to student success, and help school communities thrive. The CBO implementing this program applied for and received this grant to support low-income families' ability to meet basic needs and achieve socioeconomic mobility.
Key implementation findings	**CBOs are relying on existing staff and other CYBHI workstream funding to support implementation of their Scaling EBPs/CDEPs grants.** • The CBO implementing Effective Black Parenting expanded the role of an existing on-call parent educator who could work behind the scenes to prepare the curriculum during a seven-month delay in receiving state funding. *Note: DHCS subsequently provided grantees with an option for a no-cost extension to extend the period of service provision.* • Family resource center services will soon be available in another CBO's new Wellness and Prevention Center in Oakland, funded through the CYBHI's BHCIP (previously, all services were provided directly through schools or in the communities). **All grantees noted their frequent engagement with families and youth to inform their programming and expressed appreciation to CYBHI for funding these often-overlooked programs.** • Grantees reported actively engaging families and youth to inform their programming through face-to-face conversations, surveys, and questions. Although these programs were in the early stages, all grantees expected to take families' voices into account during implementation. • Grantees felt it was challenging to obtain funds for parenting programs, and they appreciated CYBHI taking on this role. One CBO respondent said the state has led much of the innovation in the area of CDEPs, and the respondent appreciated these efforts to fund more culturally affirming and responsive practices.
Sustainability and what is next	**Grantees identified funding instability as a perennial problem for parent education programs and CDEPs.** • One grantee said they are investing substantial time and effort in dialectical behavior therapy, with the goal of truly incorporating it into their ongoing work.

Note: The grant implementation experiences described in the table are based on the subset of grantees participating in interviews.

Workstream: Broad Behavioral Health Workforce Capacity: CBO Behavioral Health Workforce Grant Program	
Short overview	• Several organizations in Alameda County received grants through the CBO Behavioral Health Workforce Grant Program (which county respondents also referred to as Department of Health Care Access and Information (HCAI) grants). • The program offered four-year funding for (1) undergraduate educational scholarships, (2) clinical master's and doctoral graduate education stipends, (3) loan repayment programs, and (4) recruitment and retention. • CBO respondents and an FQHC reported conducting the following activities through this workstream: (1) offering behavioral health workers hiring and retention bonuses and loan forgiveness; (2) creating and running a formal internship training to prepare people for careers at the post-bachelor's and post-master's level; and (3) identifying and encouraging students interested in behavioral health careers. • Grantee organizations in Alameda County expressed appreciation for the opportunity to build their behavioral health workforce.
Key implementation findings	**Offering hiring and retention bonuses and loan forgiveness helped organizations recruit and retain behavioral health employees in a competitive job market.** • One respondent specifically cited the support as being helpful in hiring linguistically diverse providers. • Another said some clinicians historically treat CBOs as a "training hub" and move on to larger hospital systems, where pay is more competitive, after several years. They saw the grants as helping their organizations retain good clinicians because they make working in community-based settings more desirable and could help change clinicians' perceptions of working in a community-based setting as a long-term career path. • One CBO respondent said their organization expected to expand the scope of its work in part because of these programs. The CBO hired four new staff who will benefit from the loan forgiveness option; these hires will enable the organization to expand its services to additional schools. **The formal internship program achieved its goals to hire from the communities served and to provide mentors, role models, and supervisors of new hires who have a shared life experience.** • An FQHC respondent said one of the major benefits of the CBO Behavioral Health Workforce Grant Program was that it enabled them to increase the pipeline of students interested in behavioral health careers and to further support their education and career advancement. • This respondent noted a five-fold year-over-year increase in applicants to their internship programs, with almost exclusively bilingual/bicultural applicants in the most recent cohort. • They attributed the increase to the HCAI grants' support for compensating a single administrative point of contact for internship programs—someone who can work directly with schools and oversee outreach, recruitment, screening, onboarding, and acknowledgment cycles. This person coordinates the internship experience and coordinates the FQHC's internal staff so clinical supervisors can focus on clinical work.

> "We now have built a pipeline and an advancement hierarchy that creates a good experience for undergraduates to get exposure to behavioral health careers. Then, when they're ready when they graduate, we have jobs that they can come into. We support them in those jobs. We've got internships at that level, and then we've tried to build on internships all the way up to the master's level."
>
> —FQHC respondent

Workstream: Broad Behavioral Health Workforce Capacity: CBO Behavioral Health Workforce Grant Program	
Key implementation findings (continued)	**The grants' administrative processes were straightforward, and the grants' flexibility enabled organizations to set their own tailored policies.** • Respondents said the process for applying for the HCAI grants was simple and the parameters set forth were straightforward. • Some respondents appreciated the grants' flexibility: within certain parameters, organizations were able to set their own policies about who qualified for and would receive the hiring bonuses, loan forgiveness, and retention bonuses. This required them to think carefully about how to develop an equitable and transparent process.
Sustainability and what is next	**CBO respondents expressed optimism around the near-term impacts of this funding on workforce recruitment and retention, and highlighted both opportunities and challenges for sustainability.** • Participants in the formal internship program were optimistic about the sustainability of the investments. • The FQHC respondent said their organization is excelling at hiring and building up the workforce from the communities they serve and noted they could continue to scale through continued statewide partnership.

> "Why did that [five-fold increase in applicants] happen? That happened because we had a coordinator who could run all of the cycles of outreach, recruitment, screening, onboarding, evaluation, celebration, acknowledgment, etc., and you just can't do that on the back of somebody else. That's what HCAI did for us. It was a complete game changer."
>
> —FQHC respondent

Note: The grant implementation experiences described in the table are based on the subset of grantees participating in interviews.

Workstream: Youth Suicide Reporting and Crisis Response Pilot Program	
Short overview	• The Youth Suicide Reporting and Crisis Response Pilot Program seeks to develop and test models that quickly report and comprehensively respond to youth suicides and suicide attempts in these counties. • In Alameda County, the grant is housed in the public health agency's new Office of Violence Prevention and is intended to help identify gaps in reporting and crisis response for children 5–24 years old.[12]
Key implementation findings	**The grant program has enhanced existing efforts and created new partnerships.** • The Youth Suicide Prevention and Response Network has provided helpful TA as part of grant implementation, supporting meetings and providing trainings about the grant and about syndromic surveillance, among other topics. • In Alameda County, the Crisis Support Services' Organizing and Responding to Crisis for Alameda Youth (ORCA) program supports the county's 988 number and provides other tailored resources; because of this grant, ORCA can provide more direct counseling services. • To better understand gaps in county services, the public health agency is working with partner agencies to map the system of care, from surveillance through rapid reporting and crisis response. • This mapping is leading to positive engagement across behavioral health department staff, school-based initiatives, service providers, the 988 and crisis teams, and other entities. **A major, ongoing need in Alameda County is to improve syndromic surveillance or to develop a system to detect and monitor suicide attempts.** "We can bring people together [to do mapping work]. They can talk to each other and see and understand how they fit in or don't fit in or what's needed. They begin to have their own conversations that have nothing to do with the grant. The grant gives us [the] opportunity to bring people together to establish a rudimentary map … The more people we have adding to the map, it's like, oh, this is what we need." —Public health agency respondent
Sustainability and what is next	**The goal is for the success of this grant to lead to the search for further funding to fill gaps identified through the mapping effort.** • A public health respondent said they expected aspects of this grant to be sustained past the CYBHI, such as some of the enhancements to Crisis Support Services' work that have been funded through the grant. • Once the mapping is complete, they will seek ways to fill gaps identified.

Note: The grant implementation experiences described in the table are based on the subset of grantees participating in interviews.

Let's Progress Together.

For any questions regarding this evaluation, please email CYBHIEvaluation@mathematica-mpr.com.

mathematica.org

[12] The grant is technically applicable to those ages 0–17, but suicidality is low in the 0–5 range and higher in the 18–24 range, hence the focus on older age groups.