Yolo County: Collaboration and Commitment Support Early Progress on CYBHI Implementation

Authors: Dana Petersen, Divya Gupta, Anna Gu, Ruchir Karmali, Gina Sgro, Jessica Laird, Eileen Kazura, Marlena Smith-Millman, Deliya Wesley, and Amanda Lechner

This case study focuses on Yolo County's experience implementing California's Children and Youth Behavioral Health Initiative (CYBHI). 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 transform the behavioral health ecosystem serving children, youth, and families.

In this case study, we describe Yolo County's demographic characteristics, behavioral health needs, and resource availability. We then discuss the behavioral health ecosystem, including connections between children- and youth-serving organizations and themes regarding multisector collaboration. We describe Yolo County's experiences with 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 the CYBHI implementation in nine counties, including Yolo 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 the local implementation of the CYBHI workstreams in the planning or active execution phase as of fall 2024.

The research team conducted analyses of secondary data sources to capture the population and behavioral health system characteristics of Yolo County and California as a whole (see Appendix A for more details on data sources). In addition, between April and July 2024, the research team conducted the Network and Ecosystem Experiences Survey (NEES) and key informant interviews in Yolo County. The NEES explored the connections between organizations in Yolo County to better understand how they 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 connections between organizations in Yolo County's behavioral health ecosystem (see Appendix B for more details on the network analysis methodology and measures).

Between summer and late fall 2024, researchers also conducted 15 interviews with individuals in Yolo County to understand the CYBHI workstream implementation and multisector collaboration. Respondents varied across the survey and interviews 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 the interviews.

I. Summary of Findings

Behavioral health ecosystem multisector collaboration

In Yolo County, agencies and organizations in the behavioral health ecosystem participating in this report described coordinating with each other to support children and youth behavioral health. According to respondents, the small-to-medium size of the county means that a similar set of entities serving children are repeatedly working together in different venues and meetings, which creates a natural synergy and fosters closer relationships among individuals and organizations. These close connections facilitate coordination in pursuit of better outcomes for children and youth and, ultimately, support the CYBHI implementation and other efforts to improve behavioral health. Respondents also said that working together, as of late fall 2024 and prior, on the Assembly Bill 2083 (AB 2083) Interagency Leadership Team and the K–12 Partnership further enabled Yolo County organizations to collaborate, make progress on CYBHI workstreams (especially school-based workstreams), and achieve shared goals.

Yolo County's experience, successes, and areas for opportunity with CYBHI implementation

As of late fall 2024, Yolo County is actively engaged in CYBHI workstreams, and participation in the CYBHI is amplifying existing funding streams to extend behavioral health services and add new services for children and youth. Education sector workstreams, including Student Behavioral Health Incentive Program (SBHIP), School-Linked Partnership and Capacity Grants, CalHOPE Student Support and Schools Initiative (CalHOPE), and Mindfulness, Resilience, and Well-Being Supports for Children, Youth, and Parents, have taken root in the county. Using these workstreams, the county has built school-based mental health services for youth—for example, the Yolo County Office of Education (YCOE), districts, and schools established wellness centers and spaces, hired staff, and purchased materials to support social and emotional learning and resilience of students. In addition, at least two districts invested in curricula specifically designed to support staff and student wellness. The CYBHI also helped build foundational supports for students' behavioral health, including technology for a closed-loop referral process. As participants in the second cohort of the CYBHI Fee Schedule, three YCOE districts will work to prepare themselves, schools and community-based providers to establish needed information capture and billing procedures.

The implementation of the home- and community-based workstreams such as Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs and CDEPs) is just getting started in the county but holds promise to increase child, youth, and family access to diverse therapeutic modalities to better meet their needs. Plans include identifying and hiring clinicians and staff and training staff in new specialized service delivery approaches.

Key progress with CYBHI implementation

- **Student Behavioral Health Incentive Program (SBHIP):** Yolo County is using SBHIP funds for two main interventions: (1) behavioral health wellness programs, also referred to as wellness centers, and (2) information technology enhancements to facilitate a closed-loop referral system. Wellness centers will be established in at least one school in each of the five districts in the county. Four of the five wellness centers are furnished, staffed, and serving students. Although the completion of one physical location is delayed due to school remodeling, students and staff are already engaging in wellness activities. YCOE contracted with an outside agency to develop technology for a closed-loop referral process that will serve students across schools and districts in the county.
- **School-Linked Partnership and Capacity Grants:** All five districts in Yolo County signed a memorandum of understanding (MOU) to outline their participation in YCOE's School-Linked Partnership and Capacity Grant. Four of the five districts agreed to implement a consortium model approach through which they will share a Pupil Personnel Services (PPS)-credentialed staff and other staff to support billing. The fifth school district will work independently.

- **CalHOPE Student Supports and Mindfulness, Resilience, and Well-Being Supports:** YCOE used CalHOPE and Mindfulness, Resilience, and Well-Being Supports funding to help districts and schools meet their unique needs. For example, one district is building wellness spaces in schools; another district is adding new curricula to support relationship skills for students with developmental disabilities or other social learning challenges; yet another district is implementing a multi-tiered social and emotional learning curriculum across all its schools and students. Although CalHOPE funding ended in June 2024, Mindfulness, Resilience, and Well-Being Supports funding is being used to continue CalHOPE activities, particularly staff professional development, across districts and schools.
- **Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs and CDEPs):** The Scaling EBPs and CDEPs funded in Yolo County include many efforts to expand parent and caregiver support programs, enhance trauma-informed programs and practices, and promote early intervention programs and practices, among other topics. Most of these projects are in the planning phase and preparing for service delivery, either by training staff or conducting outreach to expanded service populations. Across the board, EBPs and CDEPs funded in Yolo County will increase the number of clinicians trained in each type of service so that more children, youth, and families can access specific and appropriate care to address their needs.

Exhibit 1. Yolo County's geography

II. County Background

County characteristics

Yolo County is in Northern California, in the Sacramento Valley, and covers approximately 1,000 square miles (Exhibit 1).[1] The county is a mixture of urban, suburban, and rural communities. The three largest cities in Yolo are Davis, Woodland, and West Sacramento.[2] The largest industry is agriculture.[3]

Relative to many other counties in California, Yolo County has a smaller population of 222,000 residents (Exhibit 2). The population of children and youth is proportionally larger: though there are fewer children 0–4 (4.5 percent versus 5.4 percent statewide), there are more youth 5–19 (21.3 percent versus 19.0 percent statewide), and more than twice the number of young adults (15.3 percent versus 6.8 percent statewide). Taken

[1] U.S. Census Bureau. QuickFacts: Yolo County, California. Accessed October 17, 2024, from www.census.gov/quickfacts/fact/table/yolocountycalifornia/PST045223

[2] MapSof.net. Cities & Towns in Yolo County, CA. Accessed on October 17, 2024, from http://www.mapsof.net/yolo-county/cities

[3] Yolo County California Government. Industry Priorities in Yolo County. Accessed on October 17, 2024. https://www.yolocounty.gov/government/general-government-departments/county-administrator/county-administrator-divisions/economic-development/industry-priorities-in-yolo-county

together, the population 0–24 constitutes 41 percent (versus 31 percent statewide), which is, in part, due to the population of young adults residing in the county as students of the University of California, Davis. While the CYBHI aims to address the needs of children and youth through age 25, most respondents who were interviewed for this case study focused on CYBHI efforts serving children and youth up to age 18. As such, our findings primarily focus on that population as opposed to young adults (ages 19 to 25). The Yolo population has grown slightly, by 0.2 percent, over the past five years, substantially more than the 5.4 percent decrease statewide.

Yolo County's residents are racially and ethnically diverse, with large populations of residents who identify as White, non-Hispanic (41.9 percent), Hispanic or Latino (32.3 percent), and Asian, non-Hispanic (15.6 percent). Yolo residents are more likely to be foreign-born (11.2 percent versus 7.2 percent statewide) and more likely to be English-proficient (94.1 percent versus 91.6 percent statewide). The county has a Diversity Index of 7, meaning that it is the county with the seventh-highest probability that two randomly chosen residents have a different race or ethnicity.

Yolo County's residents experience similar economic conditions to residents statewide. Relative to the state as a whole, a slightly larger proportion of the population is below the 200 percent federal poverty line (32.3 percent versus 27.6 percent); however, the county has a similar median income ($53,485 versus $52,520), a similar unemployment rate (5.2 percent versus 5.3 percent), fewer households with a high housing cost burden (36.3 percent versus 40.3 percent), and lower food insecurity overall and for the population 0–18 years old (9.9 percent versus 13.5 percent). In addition, Yolo is ranked 18th (out of 57[4]) in the Healthy Places Index in California, signifying that the county has above-average access to health care, housing, education, and other characteristics that support a healthy population. Fewer Yolo residents ages 0–25 are covered by Medi-Cal than statewide (29.5 percent versus 39.3 percent), with more covered by private insurance (72.1 percent versus 60.2 percent).

Exhibit 2. Yolo County's population characteristics

Metric	Yolo	California	Year(s)
Population			
Total population (N)	222,115	39,029,342	2022
Population, 0–4 years (N; %)	9,949; 4.5%	2,118,386; 5.4%	
Population, 5–19 years (N; %)	47,188; 21.3%	7,404,396; 19.0%	
Population, 20–24 years (N; %)	33,974; 15.3%	2,639,787; 6.8%	
Five-year population change (%)	1.4%	-1.3%	2017–2022
Five-year population change, 0–24 years (%)	0.2%	-5.4%	
Density (population per square mile)	213	254	2020
Race and ethnicity			
White, non-Hispanic (%)	41.9%	33.7%	2022
Black or African American, non-Hispanic (%)	2.9%	5.2%	
American Indian and Alaska Native, non-Hispanic (%)	0.2%	0.3%	
Asian, non-Hispanic (%)	15.6%	15.3%	
Native Hawaiian and other Pacific Island American, non-Hispanic (%)	0.2%	0.4%	
Some other race, non-Hispanic (%)	1.0%	0.6%	
Two or more races, non-Hispanic (%)	5.9%	4.3%	
Hispanic or Latino (%)	32.3%	40.3%	

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

Metric	Yolo	California	Year(s)
Birthplace and language			
Foreign-born, 0–24 years (%)	11.2%	7.2%	2022
English-proficient, 5–17 years (%)	94.1%	91.6%	
Education (18+ years)			
High school or higher (including college) (%)	72.7%	78.8%	2022
College degree or higher (%)	34.7%	34.1%	
Economic indicators, socioeconomic status, and neighborhood characteristics			
Population within urban blocks (%)	92.0%	94.2%	2022
Population within rural blocks (%)	8.1%	5.8%	
Population below 200% of the federal poverty line (%)	32.3%	27.6%	
Median income (USD)	53,485	52,520	
Unemployment (%)	5.2%	5.3%	
Households with high housing cost burden (%)	36.3%	40.3%	2019
Food insecurity, overall (%)	9.6%	10.5%	2021
Food insecurity, 0–18 years (%)	9.9%	13.5%	
Healthy Places Index (rank)	18	N/A	2015–2019
Diversity Index (rank)	7	N/A	
Health status			
Population with a disability (%)	10.9%	11.7%	2022
Population with a disability, 0–17 years (%)	4.0%	4.0%	
Health insurance status (population 0–25 years)			
Medi-Cal or other means-tested public coverage (%)	29.4%	39.3%	2022
Private coverage (%)	72.1%	60.2%	
Uninsured (%)	3.7%	4.9%	
TRICARE/military coverage (%)	0.7%	1.7%	
Medicare coverage (%)	0.8%	1.0%	

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Yolo 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 details).

Behavioral health needs and resource availability

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

Yolo County children and youth experienced overall lower mental well-being than children and youth statewide, with fewer students in grade 9 who felt they were doing things that made a difference (19 percent versus 26 percent), who felt they were doing interesting activities at school (38 percent versus 48 percent), and who felt they were close to people at school (57 percent versus 61 percent). At the regional level, fewer 12- to 17-year-olds in the Sacramento Area region felt that at least two non-parent adults took a genuine interest in them compared with youth across the state (47 percent versus 58 percent), though Sacramento Area youth had similar rates of feeling supported by family and friends as youth statewide. More children and youth insured through Medi-Cal also had a mental health diagnosis or emotional symptoms than children and youth statewide (23 percent versus 18 percent).

However, for clinically severe outcomes, Yolo County children and youth had similar or better outcomes than children and youth statewide. For example, they had similar rates of students seriously considering attempting suicide in the past 12 months in grades 9 and 11 and fewer emergency visits for behavioral health diagnoses per 1,000 children and youth (23 versus 32) than statewide (Exhibit 3).

Exhibit 3. Prevalence of behavioral health outcomes

Metric	Yolo	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 (%)	19%	26%	2019–2021
Students in grade 9 who felt they were doing interesting activities at school (%)	38%	48%	
Students in grade 9 who felt close to people at school (%)	57%	61%	
Regional-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 (%)	76%	73%	2022
Youth ages 12 to 17 years old who felt at least two non-parent adults took a genuine interest (%)	47%	58%	
Youth ages 12 to 17 years old who felt supported by friends (%)	79%	72%	
Behavioral health challenges			
Children and youth insured through Medi-Cal with a mental health diagnosis or emotional symptoms (%)	23%	18%	2022
Children and youth insured through Medi-Cal with a substance use disorder diagnosis (%)	3%	3%	
Rates of suicidal ideation			
Students in grade 9 who reported seriously considering attempting suicide in the past 12 months (%)	16%	15%	2019–2021
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	9	12	2022
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis	23	32	
School engagement, as measured through absenteeism and suspension			
Students in grades K–12 who were chronically absent (%)	24%	25%	2022–2023
Students in grade 9 reporting school absences due to mental health issues (%)	8%	9%	2019–2021
Students in grade 9 reporting school absences due to alcohol or drug use (%)	1%	1%	

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Yolo 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 details).

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

[b] Overall mental well-being metrics for children and youth are measured at the regional level. Yolo is part of the Sacramento Area region, as defined by the California Health Interview Survey. This region also includes El Dorado, Placer, and Sacramento counties.

Resource availability

Yolo County is better resourced than other counties in terms of behavioral health services and workforce capacity; however, gaps still exist. Even though Yolo has more than three times as many child and adolescent psychiatrists per 100,000 children and youth compared with the state as a whole (56 versus 17)[5], unmet needs still exist (Exhibit 4). Most interview respondents across sectors perceived that the county is not able to maintain a sufficient supply of licensed therapists and behavioral health providers, especially non-psychiatrists with a focus on children. A behavioral health sector respondent suggested that many people do their internships or complete their required hours in the county with county-run services or CBOs, but once licensed, they leave the public sector and, sometimes, Yolo County for private practice, remote roles, or other roles with higher pay.

Key providers of behavioral health care services include the county and its clinics, CBOs, and federally qualified health centers (FQHCs). There are 18 FQHCs and FQHC look-alikes per 100,000 children and youth ages 0–25 years, which is similar to the statewide average. An FQHC respondent said that four agencies in the county (including CBOs and FQHCs) are contracted to provide most behavioral health services to children covered by Medi-Cal; as of late fall 2024, all four reportedly faced significant staffing and hiring challenges, which taxed the system's overall ability to serve children and created a time lag in service acquisition for families. In addition, per public records, Yolo County has slightly more outpatient treatment programs for young adults per 100,000 children and youth (6 versus 4) and half as many school-based health programs with mental health services per 100,000 children and youth (2 versus 4) than the state average. Nonetheless, respondents noted that Yolo County has less supply than needed for outpatient services and viewed school-based behavioral health supports as an area of universal access, though the need still outweighed capacity.

Exhibit 4. Availability of behavioral health care resources

Metric	Yolo	California	Year(s)
Primary care health professional shortage area designation	Full shortage	N/A	2019
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	18	20	2024
Number of child and adolescent psychiatrists per 100,000 children <18 years old	56	17	2022, 2024
Number of non-psychiatrist behavioral health providers licensed with county Medi-Cal Specialty Mental Health Services Plans per 100,000 residents	35	37	2021
Number of outpatient treatment programs for young adults per 100,000 children and youth ages 0–24 years[a]	6	4	2021

[5] Based on American Medical Association Masterfile records from 2024, there are 25 child and adolescent psychiatrists in Yolo County. The American Academy of Child and Adolescent Psychiatry used U.S. Census records from 2022 to estimate that these professionals serve a population of 44,537 children and youth younger than 18 years of age.

Metric	Yolo	California	Year(s)
Number of school-based health programs with mental health services per 100,00 children and youth ages <18 years	2	4	2024

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Yolo 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 details).

[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. See: 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).

Youth-focused crisis response and residential and inpatient behavioral health services are significant gaps. Behavioral health, juvenile justice, and child welfare respondents reported that the county did not have a child-focused crisis response team as of late fall 2024; instead, the county relied on its adult crisis response team. One respondent indicated that it can be difficult to find places for youth to get stabilized in crisis situations. Behavioral health, child welfare, and CBO respondents agreed that there are not enough inpatient or residential options for youth up to age 25; this is especially true for residential substance use services for youth. In many cases, youth need to travel outside the county for inpatient and residential care, which is costly and keeps children away from supportive systems such as friends and family.

Additional gaps in services include prevention-, early intervention-, and transitional age-focused behavioral health services. Several respondents across sectors noted that the county could use more preventive behavioral health care and care focused on early intervention when concerns may be remedied or maintained at mild-to-moderate levels in scale. This includes services for prenatal mothers and caregivers because, as one CBO respondent noted, "If a parent is struggling, there is not much they can do to support their child." A few respondents also reported that services may be lacking for youth ages 14 to 21 as they transition between children's and adults' behavioral health services and sometimes fall through the gaps.

Equity concerns: groups facing disproportionate access challenges

Rural areas in Yolo County are the least resourced, which is compounded by a lack of strong or accessible transportation services for families. According to several respondents, services are much less available in locations outside of the three cities in the county, with one respondent characterizing rural communities as "resource deserts." Families who want behavioral health services face transportation challenges because, as interview respondents said, Yolo County's public transportation system is complicated, costly, and inadequate outside of urban areas. Respondents also said that many services in the urban centers are only accessible from rural locations by car, which many families do not have.

> "I do think that we have services available to Medi-Cal beneficiaries, and I think the challenge that we've seen through our school-based programming is that most Medi-Cal kids can get connected to EPSDT [Early, Periodic, Screening, Diagnosis, and Treatment] services or a community-based provider, or they can go through the managed care plan. But a lot of our privately insured kids, basically, they're accessing the publicly funded school-based program because the waiting list with their insurance is nine months long, or they would have to be pulled out of school to go to a therapy appointment, or they can't get the crisis intervention they need. So I think we're really seeing a big gap with our privately insured kids…the kids who have Medi-Cal can get services, and the kids who don't have Medi-Cal can't."
>
> —Behavioral health respondent

Although Medi-Cal-eligible children and youth are a minority of the county's population, respondents across sectors agreed that more services have been available for them than for children who are privately insured. According to respondents, the county has strong coordination with the two Medi-Cal managed care plans serving

Medi-Cal-covered children and youth in Yolo County. Respondents also said that the Mental Health Student Services Act funding increased the availability of behavioral health supports through schools by helping students with preventable mental health illnesses get access to the services they need. However, when schools cannot provide the level of care desired, privately insured children often have more difficulty finding needed services—they either are on months-long wait lists or need to travel (sometimes out of county)—compared with children covered by Medi-Cal. The CYBHI Fee Schedule is designed to help overcome this challenge by creating a reimbursement pathway for LEAs to receive funding for outpatient mental health and substance use disorder services for students provided at a school or a school-linked site, from both Medi-Cal *and* eligible commercial health plans. Under the CYBHI Fee Schedule, students and their families do not pay out-of-pocket expenses. A few respondents perceived the availability of behavioral health services for children and youth as generally sufficient but noted insufficient outreach and advertising related to those services. An education respondent said that it was possible that behavioral health services existed to meet the needs of most publicly insured and uninsured children in the county or those experiencing severe mental health issues as of late fall 2024, but that some families (and school staff) did not know what was available or how to search for help. Juvenile justice and public health respondents agreed and suggested that more could be done to inform families, especially those from immigrant groups, about the availability of services. Given that respondents cited stigma related to behavioral health as a barrier for some family groups, more outreach may help families overcome this barrier and potentially improve service-seeking behavior. CYBHI workstreams, such as the Public Education and Change Campaigns, which launched statewide in late 2024, are designed to promote awareness of resources and services and may help decrease stigma about behavioral health.

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

CalHHS seeks to inspire systems change through the 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 the CYBHI, CalHHS commissioned the Working Paper: California's Children and Youth Behavioral Health Ecosystem (hereafter Ecosystem Working Paper) to gain insights 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 how connected systems are across sectors as context for understanding CYBHI implementation in Yolo County, Mathematica conducted the Network and Ecosystem Experiences Survey (NEES), which asked respondents from child- and youth-serving organizations to rate the strength of their relationships with each other. Using information from the survey, Mathematica created a network map showing the connections between 13 organizations in Yolo County, based on the ratings provided by the 12 organizations that completed the survey in late fall 2024. The map depicts the average strength of the connection between organizations (Exhibit 5).

Understanding connections across the behavioral health ecosystem in Yolo County

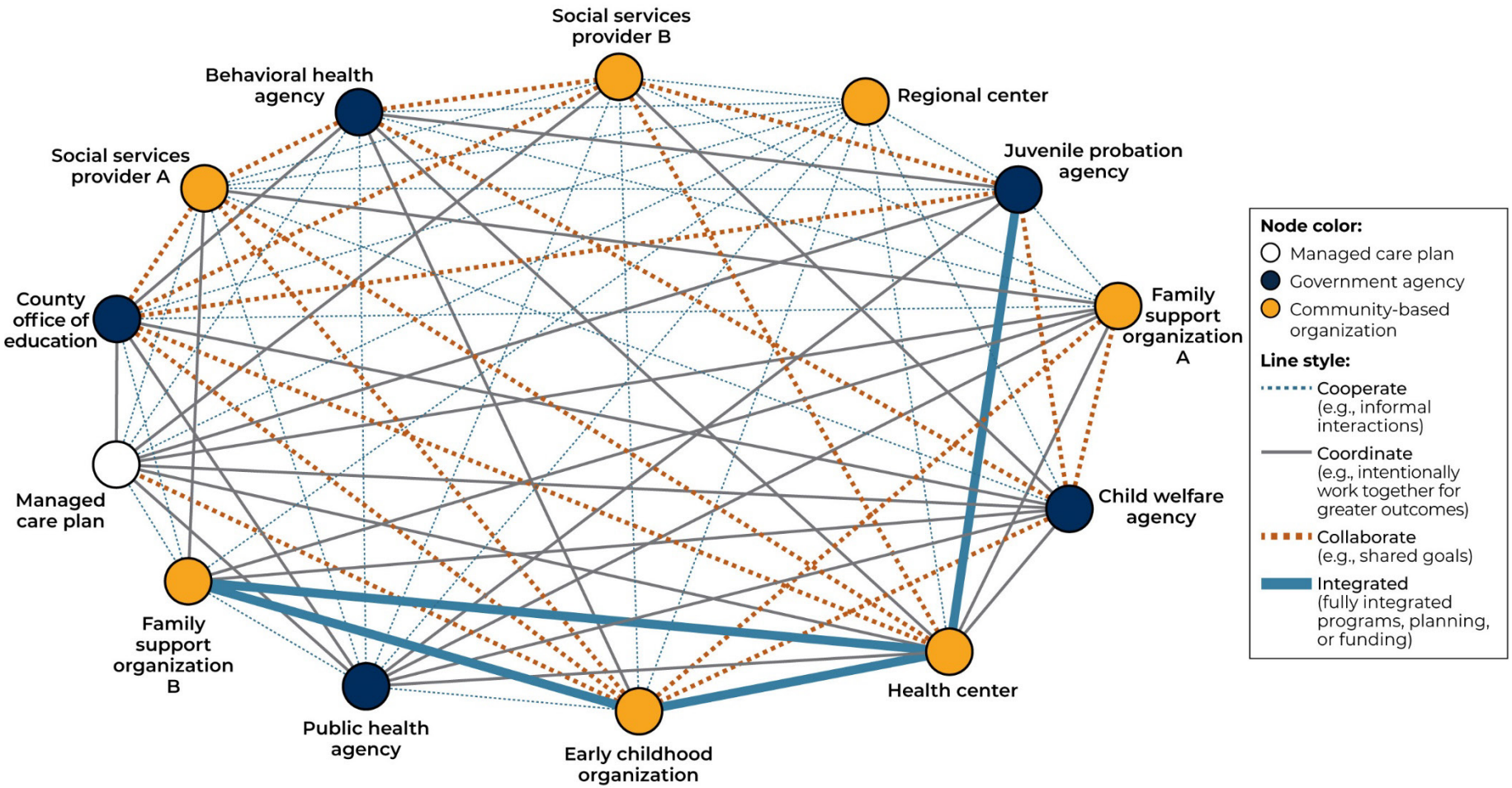
In Yolo County, Mathematica invited 13 child- and youth-serving organizations to complete the NEES via email and received responses from 12. Invited organizations included government agencies and departments, a managed care plan, and CBOs, including organizations that serve youth and diverse communities. Mathematica asked survey respondents, such as directors and executive directors, how their organizations 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.[6] 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 the ratings.[7,8] 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, due to missing data). Thicker, darker lines represent stronger connections in the network. See Appendix B for more information about the network analysis methodology and measures.

[6] Mathematica 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.

[7] In Yolo County, sometimes 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 relationship in similar ways. Based on this analysis, we concluded there was a high rate of agreement in the observed data, and thus, we trusted that a connection rated by a single respondent was a reliable representation of the strength of the connection between organizations.

[8] 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 Yolo County's behavioral health ecosystem



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

Government departments and other organizations reportedly work well together, with interview respondents citing few barriers between sectors. In Yolo County, the average strength of the network is 3.0, indicating that, on average, child- and youth-serving organizations "coordinate" with each other to support children and youth behavioral health (Exhibit 5). As shown in the network map, more than one-third of connections (35.9 percent) have an average strength of "cooperate," indicating informal interactions between organizations, and just under one-third of connections have an average strength of "coordinate" (30.9 percent), suggesting that organizations intentionally work together to achieve greater outcomes. Several connections have an average strength of "collaborate" (21.8 percent), reflecting more formal partnerships between organizations, and four connections in the network (5.1 percent) have an average strength of "integrated," indicating that organizations have fully integrated programs, planning, or funding to support children and youth behavioral health. Three organizations—the health center, the early childhood organization, and family support organization B—are integrated with one another, and the health center is also integrated with the juvenile probation agency. Among government entities, the strongest connections appear between child welfare and behavioral health, child welfare and juvenile probation, and juvenile probation and the county education office. Child welfare, behavioral health, and public health services are housed under the Yolo County Health and Human Services Agency, which may contribute to the strong connection between child welfare and behavioral health organizations. All government agencies coordinate with the managed care plan, and several have collaborative relationships with CBOs. Furthermore, several CBOs collaborate with each other to support children and youth behavioral health.

The network in Yolo County is highly connected. Multiple interview respondents said that the small-to-medium size of the county means that the same set of agencies and organizations serving children are repeatedly working together in different venues and meetings. Survey findings show that nearly half of organizations (46.5 percent) have a connection to every organization in the network, and all organizations have at least nine connections. Although the strength of connections varies across the network, the high level of connectedness indicates that organizations often work together to support children and youth behavioral health. According to interviewees, many connections have been built and maintained through years of working together on the AB 2083 Interagency Leadership Team, which has consistently used practices to promote collaboration and communication among participants. Respondents said that Interagency Leadership Team members "know what each other is doing and are able to build on each other's work without being duplicative." Interviewees also cited their work together on the K–12 Partnership (which predates but now encompasses CYBHI-related grant work) as promoting relationships and working together (especially between behavioral health and education agencies) to achieve shared goals around mental health services for students (see the Spotlight for more details on the K–12 Partnership). Although the Interagency Leadership Team has three seats specifically for community members with lived experiences, interview respondents did not cite other examples of children, youth, and families being integrated into multisector planning and decision making for children and youth behavioral health; an opportunity exists to improve engagement and representation of families.

Factors that influence multisector collaboration

Shared goals promote synergy and support effective relationships and partnerships. Respondents across sectors said that agencies and organizations can work together because they share a collective goal—primarily, supporting the safety and stability of all children and youth. For example, a goal of the K–12 Partnership is to normalize and include behavioral health supports in schools for all children. The K–12 Partnership has helped place school-based mental health clinicians in many schools, whereas, before the partnership, the placement of clinicians was less consistent. In another example, survey respondents said that members of the Transition Age Youth (TAY) Collaborative also strive to meet a shared goal of creating an inclusive and healing-centered behavioral health system (see Spotlight for more details on the TAY Collaborative). Even with shared goals, a few respondents reported that privacy policies and limitations to data sharing sometimes hindered multisector collaboration.

> "I think that every agency that is involved with our collaborative committees and everything are there because they want to be there. They're there because they have a passion for kids.… I think that we all work well together because we all have that same end goal."
>
> —Juvenile justice respondent

Personal relationships, amplified by the small-to-medium size of the county, foster multisector collaboration. According to respondents, the county's modest population results in representatives from child-serving agencies and organizations frequently collaborating across various forums and meetings, fostering a close-knit and trusted professional network. An early childhood respondent said, "we have many opportunities to see, hear, and work together in different ways." Overall, respondents said that close relationships between agencies or organizations facilitate system integration because they know where to turn for specific supports. Several county agencies partner with CBOs to enhance their school-based and community-based services, and several people have been in the child-serving field for years; thus, shared personal and organizational histories help maintain relationships and collaboration.

> "I think it is definitely the individual people and the relationships that we have individually that creates trust."
>
> —Education sector respondent

> "People say Yolo is a goldilocks county. It's not too small that you don't have resources, but not so big that everything is siloed. It's the right size. Where you're able to develop relationships and close connections with different sectors."
>
> —Child welfare sector respondent

Strong meeting infrastructure facilitates multisector collaboration. Several respondents, across the diverse working groups they were a part of, reported that strong leadership supported their efforts through transparent communication, which helped build and maintain trust among different organizations. An early childhood education respondent said that meeting infrastructure such as MOUs she has signed that include lists of partners and their roles improved members' knowledge of and respect for each other's potential contributions, which improved collaboration. She also said that requiring regular participation by the same organizational representatives (as opposed to rotating attendance) improves collaboration, as content does not have to be repeated during subsequent meetings. A public health respondent said that multisector collaboration is the strongest when led by the right leadership, combined with the right backbone staff (who can set agendas and facilitate) and adequate funding. A few respondents noted that—even with strong meeting infrastructure—staffing constraints, limited funding, and competing priorities sometimes restricted the number of meetings they could attend. These respondents noted there could be an opportunity to consolidate some multisector meetings.

Spotlight on multisector collaboratives that support children and youth behavioral health

K–12 School Partnership

The Yolo County K–12 School Partnership is a collaborative effort between Yolo County Health and Human Services and Behavioral Health, Yolo County Office of Education, five school districts, and three community-based organizations. The partnership is focused on expanding mental health services to children throughout the county, improving outcomes for youth, and promoting awareness of mental health issues in schools. The partnership was originally funded in 2020 through the Mental Health Services Act and the Mental Health Student Services Act (MHSSA), and the staff are exploring future sustainable funding alternatives.

> "The K–12 Partnership has brought much-needed resources to our rural community and supported the mental health of our struggling students."
>
> —Survey respondent

According to survey respondents, the K–12 School Partnership is working with the CYBHI's SBHIP grant to develop closed-loop referral systems to improve coordination of behavioral health care across partner organizations and expand upstream solutions (for example, promotion, prevention, and early intervention) to support the well-being and behavioral health of children, youth, and families. Interview respondents agree that another key goal of the K–12 is to place mental health clinicians in all county schools. Most survey and interview respondents said that the K–12 Partnership has made significant progress in reducing barriers for children, youth, and families to access behavioral health supports and services and that it has made moderate-to-significant progress in improving care coordination so that children, youth, and families can access the supports and services they need where they need it. A few K–12 Partnership members reported that while the K–12 Partnership has improved behavioral health supports in schools and participation is mostly high, a few district representatives do not consistently attend due to conflicting priorities.

Transition Age Youth (TAY) Collaborative

Facilitated by the Yolo County Office of Education, the Transition Age Youth (TAY) Collaborative aims to help youth and young adults ages 16 to 24 years thrive in Yolo County by focusing on their well-being, performance, and engagement. The TAY Collaborative seeks to ensure that transition-age youth have their basic needs met, are connected to the community, have access to training and job opportunities, know how to access resources, and feel empowered and hopeful about their lives. Most survey respondents report that the TAY Collaborative has made moderate progress on strengthening trust between partner organizations and community members, reducing barriers for youth to access behavioral health supports and services, and fostering a common desire among partner organizations to create a more inclusive and healing-centered behavioral health system.

Other multisector collaboratives

Survey and interview respondents identified other multisector collaboratives or groups that support children and youth behavioral health in Yolo County. These included the AB 2083 Interagency Leadership Team, Family Strengthening Network, Welcome Baby, Road to Resilience, Interagency Placement Committee, Material Child Adolescent Health Collaborative, Health Council, Child Abuse Prevention Council, and Help Me Grow. One survey respondent described how the AB 2083 Interagency Leadership Team has expanded its initial focus, explaining that they "started meeting because of foster youth, but [they] use the collaborative to also discuss other areas of integration and collaboration."

IV. CYBHI Workstream Implementation Findings

The CYBHI is implementing 20 distinct workstreams, each designed to contribute to transforming the behavioral health ecosystem, with many intended to improve multisector collaboration. As of late fall 2024, the workstreams are at various stages of implementation and are active to varying degrees across California counties.

Overview of workstreams in Yolo County

Overall, Yolo County is locally implementing nine workstreams that involve the distribution of funding to county or community entities, including 45 grants, as of September 2024.[9] This case study discusses the county's implementation experiences with **education sector workstreams**, including the SBHIP, the CYBHI Fee Schedule, School-Linked Partnership and Capacity Grants, CalHOPE Student Support and Schools Initiative, and Mindfulness, Resilience, and Well-Being Supports. The case study also discusses select workstreams occurring in **home and community settings**, including Scaling EBPs and CDEPs grants. Other workstreams active in the county include programs under the Broad Behavioral Health Workforce Capacity workstream, such as the Peer Personnel Training and Placement Program, the Justice System-Involved Youth Pipeline Program, the Health Professional Pathways Program, the Psychiatric Education Capacity Expansion Grants, and the Social Work Education Capacity Expansion Grants.

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

Yolo County is actively engaged in the SBHIP and School-Linked Partnership and Capacity Grants and is looking ahead to the CYBHI Fee Schedule implementation. Supported by SBHIP funding, YCOE is establishing behavioral health wellness programs, referred to locally as wellness centers, in at least one school in each of the county's five districts. YCOE identified locations for all wellness centers, designed, and, in most cases, furnished centers with behavioral health materials and resources to facilitate a range of student engagement preferences, from social to quiet and reflective. Although one school site was delayed in establishing its formal physical location due to school remodeling, staff and students are engaged in wellness activities supported by the SBHIP. Centers are or will be staffed by existing and newly hired school-based behavioral health care staff; these programs are intended for students seeking direct support and, at some sites, for school-wide programming. For example, a social-emotional learning (SEL) paraprofessional at one site engages all students in mindfulness, wellness, and inclusion activities during lunch and recess.

> "We keep track of our numbers to see what is having a benefit. And we compare our year-to-year data on behavioral incidents. The wellness center is helping. [At the school with the wellness center] we had an 11 percent improvement in the reduction of chronic absenteeism, and a 1 percent reduction in suspension."
>
> —Education sector respondent

> "[The wellness centers] have become part of the school and embedded in the culture of the school."
>
> —Education sector respondent

Also supported by SBHIP, YCOE contracted with an outside agency to develop technology for a closed-loop referral process, which it plans to pilot in at least one district during the 2024/25 school year. Respondents credited SBHIP with helping them build capacity for the CYBHI Fee Schedule through meetings convened by one of the county's Medi-Cal managed care plans that brought together education leaders at the county, district, and school levels. Three of the five districts in the county applied and were accepted into the second cohort of the CYBHI Fee Schedule and are beginning

[9] 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.

work to meet requirements for Fee Schedule participation, including submission of a designated provider and practitioner list.

In addition, all five districts have signed MOUs to formalize participation in YCOE's School-Linked Partnership and Capacity Grant with the intent to strengthen capacity for the provision of school-linked behavioral health services and prepare for the implementation of the CYBHI Fee Schedule. As of July 2024, the county-level implementation plan was nearly complete. Four of the five districts are moving forward with a consortium model approach, while the fifth district is working independently. Districts participating in the consortium are planning how they might share a Pupil Personnel Services (PPS)-credentialed professional and staff to support CYBHI Fee Schedule billing.

Respondents in the education sector attributed some of their ability to make progress with education sector workstreams to their history of working together on the K–12 Partnership. The partnership unites education and behavioral health partners in the shared goal of achieving positive mental health and wellness outcomes for all students.

Yolo County is blending the CYBHI school-linked workstream and other funding to amplify the impact for students. Respondents praised that the CYBHI school-linked workstreams can be implemented together to achieve shared goals, in tandem with other funding received by the county. In addition to using SBHIP and School-Linked Partnership and Capacity Grants to prepare for CYBHI Fee Schedule implementation, districts and schools have combined CYBHI and non-CYBHI funding to strengthen the capacity of schools to provide behavioral health supports. For instance, schools across the districts have used SBHIP, Community Schools, and Mental Health Student Services Act (MHSSA) funding to hire new staff for wellness centers, such as behaviorists, social-emotional learning paraprofessionals, and mental health clinicians. In addition, some schools combined SBHIP and Community Schools funding to purchase behavioral health resources. One district, for example, purchased an on-demand, computer-based wellness coaching program that supports students and alerts school staff as needed for follow-up based on the concerns and needs indicated by students.

Technical assistance provided through the CYBHI supported Yolo County's CYBHI workstream implementation efforts. Respondents across sectors indicated that technical assistance provided through the CYBHI was instrumental in helping them make informed decisions across districts and schools. For example, a consultant-facilitated community of practice allowed Yolo to engage with other counties to plan and implement the School-Linked Partnerships and Capacity Grant. In addition, a managed care partner hosted a monthly learning collaborative across counties to share lessons learned for implementing SBHIP and specifically helped YCOE and its districts complete their needs assessment and initial plans and apply for Cohort 2 of the CYBHI Fee Schedule.

Grant requirements for CYBHI school-linked workstreams are substantial and could be streamlined to minimize the burden on staff and organizations. According to staff who were assigned to support the CYBHI implementation, they were required to juggle multiple tasks in their roles, resulting in a heavy burden and sometimes burnout. These staff said that a steep learning curve and multiple reporting requirements impeded their ability to maximize workstream implementation. However, the cross-district SBHIP meetings helped school districts learn from each other and get suggestions from YCOE. Respondents believe that the CYBHI Fee Schedule will help serve the behavioral health needs of students but expressed apprehension related to the participation requirements, many of which will be new to districts and schools and may require additional capacity to implement. Districts and schools expect to need to hire additional staff and develop new processes for collecting student health information and billing under the Fee Schedule. Respondents also expressed concern that the limited capacity of community-based providers, with whom the districts typically contract for student behavioral health services to establish information and billing systems, may delay or interfere with the delivery of services to students. Even though respondents identified potential

implementation challenges, they were optimistic that the CYBHI Fee Schedule would improve schools' abilities to meet the behavioral health needs of students.

Respondents felt pressure to implement SBHIP and the CYBHI Fee Schedule quickly relative to other education initiatives, which respondents said can often take several years to roll out. For example, respondents perceived that the Fee Schedule program needs to occur on a fast timeline relative to the effort involved, particularly given its novel content and multisector involvement, so that districts can begin billing for services. In addition, workstream alignment with the calendar year rather than the school year means that participating districts and schools must complete reporting in December rather than at the end of the school year, which would better align with education sector reporting processes. Nonetheless, respondents expect the CYBHI Fee Schedule to fill gaps in school-based services reimbursement soon. Notably, the CYBHI has undertaken a variety of activities to better understand and address implementation challenges across educational workstreams, including through supports and technical assistance for COEs and LEAs. For example, CalHHS and DHCS hold regular meetings with the California Department of Education and LEAs, contract with education entities to provide grant administration support and inform strategies to improve implementation and engage frequently with a range of education stakeholders at meetings, conferences, and through other venues, including work with COEs on the CalHOPE and Mindfulness, Resilience, and Well-Being workstreams.

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

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 Managed Care Plans (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.

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

CalHOPE and Mindfulness, Resilience, and Well-Being Supports funding facilitated a variety of wellness promotion activities aligned with districts' and schools' capacity and preferences. For example, one district built on the established SBHIP-funded wellness center, already operational at one school site, and used CalHOPE funds to build more wellness spaces across its schools. Two other districts used CalHOPE funds to purchase curricula to support relationship skills and wellness, with one curriculum primarily focused on individuals with developmental disabilities, autism, or other social learning challenges, and the other supporting multi-tiered social-emotional learning, described in further detail below.

> "[The process of selecting the curriculum] was very grassroots, everybody wanted that. So it wasn't one of those things where the district just said, we're going to do this. Everyone bought in. Everybody is excited about it."
>
> —Education sector respondent

Building on prior work to identify a social-emotional curriculum to support students' well-being development, one school district used CalHOPE funding to pilot and scale the use of Character Strong across all its schools. Before the start of the CYBHI, the district provided mindfulness programming for educators and surveyed staff to understand their priorities for social-emotional learning; this work informed the selection of a universal multi-tiered social-emotional curriculum to support students' well-being and skill development. The district then used CalHOPE funding to pilot the Character Strong curriculum. Based on positive feedback from staff about the curriculum during the pilot, the district expanded this purchase and contracted with an outside firm to provide in-person professional development to all staff in preparation for the district-wide launch at the beginning of the 2024/25 school year. With Mindfulness, Resilience, and Well-Being Supports funding, the district will continue to fund professional development activities to implement the curriculum and expand mindfulness and prevention supports for students.

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.

Implementation of home- and community-based sector workstreams

Planning is underway for implementing Scaling EBPs and CDEPs, which will enable staff training and expand service options to new groups of children, youth, and families. Organizations in Yolo County will use Scaling EBPs and CDEPs grants to train existing and newly hired staff in therapeutic modalities they previously could not offer, such as specialized parent–child interaction, attachment, and strength-based approaches to improving social and emotional well-being. YCOE is using a Scaling EBPs and CDEPs Round 5 grant to augment existing adult-focused crisis response services provided by the county to offer youth-focused mobile crisis services during the school day. Other organizations are extending existing services to new populations. For example, a Scaling EBPs and CDEPs Round 2 grantee, experienced in providing Attachment and Biobehavioral Catch-up (ABC) services to court-appointed families, is using CYBHI funds to reach out to and begin serving (in late fall 2024) families who volunteer to participate, including families in the county's rural areas and from Indigenous backgrounds. A Scaling EBPs and CDEPs Round 4 grantee is implementing Q Spaces for the first time in Yolo County, allowing the organization to intentionally engage LGBTQ, BIPOC, and other marginalized youth to ensure the services and spaces they develop meet the needs of the

youth they intend to serve. Collectively, these grants help close specific training gaps that respondents identified, including staff skills in biobehavioral attachment, dyadic caregiver–young child services, trauma-informed support, gender-affirming care, and peer support with lived experience.

Scaling Evidence-Based Practices (EBPs) and Community-Defined Evidence Practices (CDEPs)

The Scaling EBPs and CDEPs workstream provides grants to enhance the accessibility and quality of prevention services and clinical care offered in their communities through evidence-based practices (EBPs) or community-defined evidence practices (CDEPs). Each round of grant funding focuses on a specific area: Round 1: parent and caregiver support; Round 2: trauma-informed programs and practices; Round 3: early childhood wraparound services; Round 4: youth-driven programs; and Round 5: early intervention. To date, the Scaling EBPs and CDEPs workstream has awarded $248 million in CYBHI funding to 424 organizations across all 58 counties in California, with additional awards pending for early childhood wraparound services. The current grant awards support the delivery of more than 30 different evidence-based and community-defined evidence practices across the state. Note that the Scaling EBPs Round 3 grants, which focus on early childhood wraparound services, were announced in September 2024 and are not covered in this report.

Perceptions of workstream effectiveness in addressing behavioral health needs and equity

Respondents across sectors shared examples of how CYBHI workstreams will collectively provide new services and expand the populations served. Education sector respondents, for example, said that SBHIP funds have increased access to a variety of school-based behavioral health supports, including newly staffed and resourced wellness centers in at least one school in each district in the county. Districts are also using CalHOPE and Mindfulness, Resilience, and Well-Being Supports funding to build and expand wellness spaces, including adopting social-emotional learning curricula, which have already increased access to wellness supports for many students. Three districts will begin participating in the second cohort of counties using the CYBHI Fee Schedule, which many respondents perceive as a key to funding and sustaining school-based behavioral health care staff and services.

Many of the Scaling EBPs and CDEPs grants received throughout the county are in the planning phase; respondents expect that implementation of these grants will increase the variety and volume of specialized evidence-based services available in the county and, ultimately, the total number of children, youth, and families who receive needed behavioral health services. Several of these programs have the potential to increase the services and supports available to people from marginalized populations.

See Appendix C for additional details on the implementation of select workstreams in Yolo County.

V. Conclusion

Yolo County children and youth under age 18 face higher rates of mild behavioral health challenges compared with state averages but similar or better outcomes for serious issues. Respondents identified key county-specific challenges to children's, youth's, and families' behavioral health. These included a lack of access to a sufficient supply of licensed therapists and behavioral health providers to meet needs, especially of young children, and gaps in youth-focused services, including inpatient and outpatient options, as well as crisis, prevention, early intervention, and transition-age supports. Respondents also identified county-specific concerns such as resource disparities, especially in rural areas, and limited access to behavioral health services for privately insured children compared with those covered by Medi-Cal.

While initial implementation is still underway, our analysis—drawing from available data, early implementation findings, and interviews with leaders—indicates that CYBHI efforts in Yolo County are improving access to behavioral health services and supports for these underserved populations of children, youth, and families. In particular, education sector workstreams are establishing school wellness centers, adopting social-emotional learning

curricula, and developing a closed-loop referral system and Medi-Cal billing and reimbursement processes. In addition, Scaling EBPs and CDEPs grant-funded projects are enhancing access to specific behavioral health supports, including a parenting program for families with children ages 2 to 7 and an evidence-based home visiting program focusing on previously underserved populations in rural areas. The CYBHI Fee Schedule is anticipated to fill gaps in access to behavioral health services for privately insured children by creating a reimbursement pathway for LEAs to receive funding for outpatient mental health and substance use disorder services for students with multiple insurance types, including commercial health plans.

Yolo County's strong multisector relationships and collaborative infrastructure provide a solid foundation for leveraging CYBHI resources to improve behavioral health access and care. Additional investments to expand inpatient, residential, and crisis service options will help Yolo County build on early successes, as will enhancing service availability in rural areas. More efforts to inform families of the behavioral health services that are currently available and how to access them could further extend CYBHI's reach.

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 (%)		
Economic indicators, socioeconomic, neighborhood characteristics		
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
Food insecurity, overall (%)	Feeding America's Map the Meal Gap data at https://map.feedingamerica.org/	2021
Food insecurity, 0–18 years (%)		

Variable	Source	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 at 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 made 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 (%)		
Students in grade 11 who reported seriously considering attempting suicide in the past 12 months (%)		
Students in grade 9 reporting school absences due to mental health issues (%)		

Variable	Source	Years
Students in grade 9 reporting school absences due to alcohol or drug use (%)	California Healthy Kids Survey County Reports at https://calschls.org/reports-data/search-lea-reports/ and Mathematica's analysis	
Inpatient hospitalizations per 1,000 children and youth for any 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, us, 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]	DHCS needs assessment at https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf	2021
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	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 measures for Yolo County.

Methodology

We invited 13 organizations in Yolo County to complete the NEES via email and received responses from 12 organizations (for a 92.3 percent response rate). Invited organizations included government agencies and departments, a managed care plan, and CBOs, including organizations that serve youth and 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.[10,11] 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 the ratings to calculate the average strength of the entire network.

Exhibit B.1 shows the 5-point scale survey respondents used to rate their organizations' connections to 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 the 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 Yolo County, sometimes only one organization rated the strength of 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 one 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 organization'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 Yolo County, the rate of agreement was 70.0 percent. Due to the high rate of agreement among respondents, we concluded that a connection rated by a single respondent was a reliable representation of the strength of the connection

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

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

between organizations. Therefore, we included connections in the network analysis and map where only a single organization rated the strength of a relationship.

Network measures

Exhibit B.2 shows summary statistics and descriptions from the social network analysis of Yolo County.

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

Network measure	Statistic	Description
Possible network size	13	Number of organizations invited to take the survey.
Number of possible connections	156	The total possible connections between all 13 organizations invited to complete the survey. Because each organization rates its relationship with every other organization, there are two possible connections between any two organizations (each organization's rating of the connection).
Observed network size	13	The number of organizations included in the network map. This count includes organizations that did and did not respond to the survey.
Number of observed connections	142	The total number of connections reported by organizations that completed the survey. This excludes missing data and "not applicable" responses.
Number of unidirectional connections	14	The number of unidirectional connections where only one of the two organizations rated the strength of the connection.
Reciprocated connections	128	The number of bidirectional connections (both organizations rated their connection with each other).
Reciprocity rate	0.90	The number of bidirectional connections out of the total number of observed ties.
Average strength of the network	3.01	The average strength rating for the network, where the denominator is the total number of observed 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	5	6.4%
2.00–2.99	Cooperate	28	35.9%
3.00–3.99	Coordinate	24	30.8%
4.00–4.99	Collaborate	17	21.8%
5.0	Integrated	4	5.1%
Total		**78**	**100.0%**

Appendix C: Details on the implementation of selected workstreams

The following tables summarize key implementation findings related to select workstreams.

Workstream: Student Behavioral Health Incentive Program	
Short overview	• Yolo County is using SBHIP funding for two main interventions: (1) behavioral health wellness programs, also referred to as wellness centers, and (2) IT enhancements to facilitate a closed-loop referral system. • Wellness centers are or will be established in at least one school in each of the five districts in the county. • Locations have been identified and designed, and four of the five are furnished and staffed. Physical upgrades at one site are delayed due to school remodeling; however, students have begun engaging in wellness activities. • YCOE contracted with an outside agency to develop technology for a closed-loop process that will serve all students across schools and districts in the county.
Key implementation findings	**Schools have designed wellness centers, hired staff, and served students.** • Districts and school sites blended funding from multiple sources to equip and staff wellness centers. • Cross-district SBHIP meetings helped attendees learn about progress at other sites and receive input and suggestions from each other and YCOE. **Development of the county's infrastructure to support behavioral health referrals for students is underway.** • The preexisting and strong relationship between YCOE and Yolo Health and Human Services (YHHS) facilitated early conversations and decision making. • YCOE has hired a contractor to develop technology to facilitate a closed-loop referral system and engages with the contractor bimonthly to collaborate on technology development. • YCOE plans to pilot the referral system with one district and one community-based behavioral health care provider in fall 2024, a delay from the original plans to launch the pilot in spring 2024.
Sustainability and what is next	**Early sustainability planning for wellness center spaces, resources, and staff has begun.** • Preliminary sustainability ideas focus on using the CYBHI Fee Schedule. Plans include billing services provided by qualified behavioral health care staff through the CYBHI Fee Schedule and supporting certification of additional staff, such as social-emotional learning paraprofessionals, as wellness coaches to facilitate billing through the CYBHI Fee Schedule. • Some schools plan to use Community Schools funding as short-term bridge funding to sustain efforts after CYBHI funding expires. • Education respondents anticipate applying for non-CYBHI behavioral health-focused grants to fund the ongoing operation of the wellness centers. • Education respondents shared early ideas about incorporating wellness centers into their Local Control Accountability Plan (LCAP). The LCAP is a three-year plan developed by school districts and YCOE and is a component of California's Local Control Funding Formula for K–12 public education. There are early indications of the potential for a wider spread of the wellness center model; one district established wellness centers in two additional schools using non-CYBHI funds. **Yolo County has early ideas for sustaining the closed-loop referral technology.** • Education respondents shared early ideas for sustaining the referral system in the short term, including using non-CYBHI grant funding and MHSSA funding. One respondent indicated that MHSSA funding is available to support this work for a couple more years.

Workstream: School-Linked Partnership and Capacity Grants	
Short overview	• All five school districts in Yolo County signed memorandums of understanding to outline their participation in YCOE's School-Linked Partnership and Capacity Grant. • Four of the five districts plan to form a consortium through which they hope to share a Pupil Personnel Services (PPS)-credentialed professional and staff to support Fee Schedule billing. The fifth district will work independently.
Key implementation findings	• Turnover in key positions at YCOE may slow down progress. • YCOE staff praised that the grant provided funding to prepare districts and schools operationally for the CYBHI Fee Schedule. • The preexisting K–12 School Partnership, funded by the MHSSA, helped the county make informed decisions about how to move forward with CYBHI investments. • CYBHI's community of practice also supported YCOE in interpreting and making informed decisions related to the grant. In addition, respondents from YCOE expressed appreciation for the cross-county participation and learnings shared in the community of practice.
Sustainability and what is next	• Formal sustainability planning has yet to begin, though YCOE staff see the CYBHI Fee Schedule as an amplifier and a complement to their work. • Three of five school districts in Yolo County are in the second cohort of the CYBHI Fee Schedule and are working toward operational readiness to implement the Fee Schedule.

Workstream: CalHOPE and Mindfulness Resilience, and Well-Being Grants	
Short overview	• YCOE used CalHOPE funding to support districts and schools in meeting their unique needs. • One district is building wellness spaces in schools. • One district is adding new curricula to support relationship skills for students with developmental disabilities or other social learning challenges. • One district is implementing a multi-tiered social-emotional learning curriculum across all its schools and students.
Key implementation findings	• County participants generally praised the statewide community of practice meetings because facilitators provided useful information to keep them up to date and help them make informed decisions. • School staff attendance at county-organized cross-district and cross-school community of practice meetings waned over time. This may be due to school staff being occupied with multiple initiatives as the school year ends. It may also be that some school behavioral health care staff are already familiar with the resources being shared during meetings, so they find meetings to be of less value.
Sustainability and what is next	• Although CalHOPE funding ended in June 2024, YCOE is using Mindfulness, Resilience, and Well-Being Supports funding to continue CalHOPE activities, especially professional development, across districts and schools. Plans for future years are uncertain.

Workstream: Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs and CDEPs)	
Short overview	Yolo's Scaling EBPs and CDEPs awards include seven Round 1 grants, eleven Round 2 grants, one Round 3 grant, two Round 4 grants, and one Round 5 grant. • A Round 1 grantee implementing the Parent–Child Interaction Therapy (PCIT) program seeks to serve families with children ages 2 to 7 and reunify child welfare families to support caregiver–child attachment. To provide these services, the grantee is training newly recruited clinicians in PCIT. • A Round 2 grantee implementing Cue-Centered Therapy (CCT) is using CYBHI funding to provide evidence-based services to youth ages 8 to 18 who have experienced chronic trauma, especially foster youth. The program will train clinicians and equip them with tools to provide CCT services. • Another Round 2 grantee is implementing Attachment and Biobehavioral Catch-up (ABC) and aims to serve previously underserved populations in rural areas as well as parents who participate voluntarily (rather than being court-appointed) in the ABC program.
Key implementation findings	Most EBPs and CDEPs grant recipients are in the planning and early implementation phases.* • To bolster the capability of current and new clinicians, grantees have begun identifying and planning clinician training and preparing for recruitment as of late fall 2024. For example, a Round 1 grantee identified a previous trainer to train new clinicians so that they can expand their provision of services. Other grantees have identified staff to train but have not yet begun training.
Sustainability and what is next	Most grantees are in the preliminary stages of their grant projects and have not yet considered sustainability as of late fall 2024. They hope to use the grants to train clinicians to provide specialized care to youth, even after their grant funding ends. For example, one grantee said it will be able to sustain the PCIT program beyond grant funding because it will use the train-the-trainer methods to train newly recruited clinicians over time.

* Note: We interviewed respondents about one Round 1 project, Parent–Child Interaction Therapy (PCIT); two Round 2 grant projects, Cue-Centered Therapy (CCT) and Attachment and Biobehavioral Catch-Up (ABC); two Round 4 grant projects, Transition to Independence Process (TIP) and Q-Spaces; and one Round 5 project, Student Mobile Crisis Response. In this table, we highlight the findings for CCT (Round 2), PCIT (Round 1), and ABC (Round 2).

Let's Progress Together.

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