Recommendations on Behavioral Health System Accountability and Performance Improvement

Presented by the Behavioral Health Committee of the Child Welfare Council

November 10, 2024

On March 2, 2022, the Child Welfare Council (CWC) adopted the Behavioral Health Committee's recommendations for a Universal Array of Behavioral Health Services for youth in or at risk of being involved in California's Child Welfare System.

Since then, the state has developed multiple initiatives aligned with the expansion of some of the services outlined in the Universal Array. Among these efforts are:

1) The Children and Youth Behavioral Health Initiative, a part of the Governor's Master Plan for Kids, is a 5-year initiative whose goal is to ensure that all children and youth ages 0-25 with access to behavioral health services. This initiative was launched in 2021.

2) The Behavioral Health Continuum Infrastructure Program (BHCIP) provides $2.2 billion in grants to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure. DHCS has been releasing these funds through multiple grant rounds targeting various gaps in the state's behavioral health facility infrastructure. DHCS was authorized to establish this program in 2021.

3) The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration, a new Medicaid Section 1115 Demonstration waiver. DHCS' central goal of the BH-CONNECT Demonstration is to leverage this opportunity to expand a robust continuum of community-based behavioral health care services for Medi-Cal members living with significant behavioral health needs. DHCS' proposal aims to amplify California's ongoing behavioral health initiatives and is informed by findings from DHCS' 2022 report

Assessing the Continuum of Care for Behavioral Health Services in California. BH-CONNECT becomes effective January 1, 2025.

4) Family First Prevention Services, the state's initiative to implement the federal Family First Prevention Services Act, includes the development of community pathways to better support families through services and supports prior to having to enter the child welfare system. California's approved Prevention Plan outlines the ten evidence-based practices (EBPs) that have been adopted for California. These include services such as Nurse-Family Partnership, Healthy Families America, Multisystemic Therapy, and Parent-Child Interactive Therapy. Each county must select from those EBPs in the state prevention plan but is not required to use all EBPs.

In addition to the Universal Array of Behavioral Health Services, the Behavioral Health Committee's Policy Recommendations includes a recommendation for the development and implementation of **System Performance Data and Strengthened Accountability.** California has embraced the direction of the federal government and built upon it to add further flexibility and ensure that a broader continuum of care can be in place for families.

As the state departments have worked to roll out these new initiatives, the CWC's Behavioral Health Committee has worked to further define what is needed to meet these goals. Outlined below are the four recommendations that will drive us towards building a system that captures the necessary data on access and impact of behavioral health services for children and youth.

- Recommendation 1: Integrate data systems and provide timely access to data
- Recommendation 2: Mandate only one CANS for each youth
- Recommendation 3: Utilize CANS to track needs and strengths over time at the individual, program, and systems level
- Recommendation 4: Provide training and ongoing technical assistance to ensure fidelity to CANS

Recommendation 1: Integrate Data Systems

There currently exists a great deal of data available to help us evaluate system performance and strengthen accountability. Harnessing, integrating, and analyzing this data will create a more equitable and transparent reporting approach to ensure that children and youth in or

at risk of foster care are effectively served. Integrated data systems at both the state and local levels are vital to achieving these goals and reducing duplication of work with youth and families. Ensuring that we have a timely, consistent, and robust system of reporting and monitoring the outcomes of behavioral health services for children and youth supports the state's Master Plan for Kids.

The Behavioral Health Committee reviewed data sets currently being submitted to the State and would recommend building on data reported through the Performance Outcome System (WIC Section 14707.5), including data required by the Katie A settlement, by using available data across systems to measure access to care as well as life outcomes. Timely access to services is critical for all youth in need, but especially for youth involved in the Child Welfare system. As such, we would recommend more timely reporting by DHCS on access to care, penetration rates, and engagement for child welfare youth to ensure that statewide investments/initiatives are improving access for our most vulnerable youth.

Another tool that is utilized statewide for this population is the Child and Adolescent Needs and Strengths survey (CANS). Currently, at the county level, Child Welfare Services (CWS) enters CANS into CMS-CARES which is submitted to CDSS. In specialty behavioral health (EPSDT), the County Behavioral Health departments (including contracted providers) submit CANS data to DHCS. The departments' joint ACL 18-85/BHIN 18-029 clarifies expectations for counties to share this information. To ensure that this information is integrated and analyzed, there will need to be a state level integration mechanism that ensures that this data is accessible across systems, including service providers completing the CANS and those providing direct services to the youth.

More specifically, the committee recommends that the state establish mechanisms to integrate 1) the Patient Access Application Programming Interface (API) record systems, which Mental Health Plans (MHPs) are required to establish to grant beneficiaries access via an app to their health care data and 2) the CWS-CARES system. In 2018, CDSS stated that the CWS-CARES system would allow CDSS and DHCS to merge client data, allow CANS-certified providers to transfer and integrate completed CANS data and enable multiple users to access multi-rater reports via an online dashboard (see APL 18-09, p.5). However more recent announcements indicate that the first version of CWS-CARES, which is not due to be implemented until October 2026, will not grant access to Specialty Mental Health Service (SMHS) providers (CWDS Frequently Asked Questions | Child Welfare Digital Services (ca.gov). We recommend that the state ensure that this integration be a high priority in its implementation of the CWS-CARES updates.

Provide Timely Access to Data

To effectively assess both the access to and availability of appropriate services to children, youth and families in the child welfare system, it is essential that data is available to counties and providers in a more timely manner than it is currently available. Despite child welfare youth receiving presumptive eligibility for SMHS when CalAIM was established starting in January of 2022, stakeholders are still unable to tell whether they are accessing services at a higher rate. This is because currently, information on SMHS lags by at least 2 years. An assessment of current data systems and identification of the infrastructure needed to get current data on penetration rates, access to various types of services and effectiveness of services will significantly improve county and providers' ability to increase or adjust services based on data.

The first step in this effort is to clearly identify where data is currently captured and whether this data matches agreed upon shared statewide goals. This is an opportunity to reduce data that may have been captured previously that may no longer be necessary.

The State's CalAIM goals include ensuring that behavioral health services for children and youth are provided through managed care plans, including new services and supports such as Enhanced Care Management and Community Supports. As this integration continues, it is essential to ensure that data from managed care plans (MCPs) is being captured. Timely access to data will likely require more investment by the state, with a focus on identifying the most critical data elements across child-serving systems.

Recommendation 2: Mandate Only One CANS for Each Youth

Building off our first recommendation for integrated data systems at the state level, we are also recommending similar integration at the local level. Currently, youth who enter our child welfare system are often asked to complete CANS with Child Welfare, County Behavioral Health and community based behavioral health providers. In some instances, one service provider is not even aware that another service provider has completed a CANS for a youth. As we focus on preventing placement of youth outside of their homes, the importance of having public child and family-serving systems aligned and integrated becomes critical. Ensuring that youth and their caregivers are not asked to go through repeated assessments reduces the systemic trauma that many families associate with our public systems. This goal of "one youth, one CANS", refers to developing communication strategies and information sharing that guarantees the use of one CANS for purposes of both child welfare and behavioral health services. Defining how, at the state and local

levels, public and private service organizations will work together on this is vital to meeting this goal.

This committee recommends that county systems adopt explicit guidelines for the completion of the CANS through the Child and Family Team Process and in compliance with the Interagency Core Practice Model. Specifically, it is this committee's recommendation that the CANS is either completed in full at the Child and Family Team (CFT) meeting, or is at the very least, reviewed and adjusted during a CFT meeting, ensuring the scoring is inclusive of all team members.

While it is not the intention of this committee to define the requirements for completing the CANS, it is the intention to affirm the necessity to adequately include all team members, as is best practice and necessary to maintain fidelity to the tool. The CFT meeting presents an important opportunity to gain consensus on presenting needs and strengths, to address disagreement where that might exist, and to leverage the family and team-based approach in defining priorities, action steps and goals.

Additionally, where a youth is involved in multiple public, child-serving systems, every effort should be made across county departments to adopt 1 CANS per reporting period, per child. Indeed, no other entity (county department or service provider) would be required to complete a separate CANS, if the youth has a current and active CANS in place with another entity. For example, if a child enters the child welfare system and receives an initial CANS assessment and is then referred to the behavioral health department for EPSDT Medi-Cal services, it is this committee's recommendation that the initial CANS that was completed by the Child Welfare department, become the CANS of record for the BH department, unless and until additional information presents that warrants a new/updated CANS. When the CANS is updated, that should then be shared across all entities (other county departments, service providers, etc.) and act as *the* CANS of record with both departments, regardless of which department conducted the CANS. Where there might be a necessity for modification and additional insights to fully represent the needs and strengths of a youth and family, it is the responsibility of the department conducting the CANS to gather all relevant parties to represent all perspective. Noted above, the recommendation of this committee is to use the CFT meeting for this purpose.

Recommendation 3: Utilize CANS to Track Changes in Needs and Strengths Over Time at the Individual, Program, and System level

CANS is a meaningful tool to assess the needs and strengths of a youth and their family. This assessment can and should be used to measure the presenting needs for a youth and

family when they first come to the attention of our public systems (Child Welfare, Behavioral Health, Juvenile Justice, etc.) and throughout their journey in our public systems. It is the committee's recommendation to use the CANS to also track needs and strengths at a program and system level and for systems to use this information to improve care and support for youth involved in child welfare.

This committee recommends that the State works with Praed Foundation to determine the recommended approach to using CANS scores for outcomes reporting. Also, this committee recommends that any outcomes measurement, reporting, and accountability be tied to the ultimate outcomes intended for the youth receiving services in a particular setting, not simply changes in CANS scores. For example: for a youth population receiving behavioral health, child welfare, education and/or juvenile justice services, outcomes might include changes in: days of hospitalization; percent of youth in school/working; percent of youth living at home; school performance at grade level (or per educational plan), law enforcement contact/no new arrests, placement disruptions, youth missing from placement, substance use, self-harming behaviors.

Recommendation 4: Provide Training and Ongoing Technical Assistance to Ensure Fidelity to CANS

With any statewide initiative such as the current one that aims to implement a tool across systems, it is imperative that there is both initial training, and a clear ongoing continuous quality improvement (CQI) process that addresses issues of implementation of the tool. This is certainly true of California's efforts to use the CANS as a tool for determining the level of care for foster youth.

California will not be the first state to implement CANS across systems, and this committee recommends that the State learn from other states' efforts as they consider implementation approaches to garner lessons learned. The state of Washington has used CANS statewide for years and has implemented approaches to "remediating" situations in which a child's CANS score may not match the level of care that their care team believes is appropriate. More research and work with states like Washington will allow the State to be proactive in its approach to implementation.

We understand, for example, that CDSS plans to establish a process through which Administrative Law Judges will assess whether a CANS has been completed to fidelity, if a youth or family raises questions about the tier to which a youth has been assigned. We are concerned that this process may not be easily accessible to youth and families -- especially when resource parents are supporting a youth with intensive needs. We urge CDSS to

ensure that providers as well as youth and families are offered a logistically simple procedure for raising concerns if they believe the youth has been assigned to a tier that will not adequately address their needs.

Robust Training

A robust and consistent initial training, ongoing coaching, and certification process for all service providers across systems is a critical step. This should be designed to be implemented statewide, so that individuals receive the same information and training, regardless of what system they work in. This will require resources and support that must be considered in the state budget process and must be funded by our State on an ongoing basis if we are to be successful.

Ongoing training and coaching must similarly be provided and resourced to ensure that everyone involved in the use of the tool is utilizing it effectively. Outlining the specifics of this ongoing support state-wide will be critical to the success of implementing the CANS across systems.

Ongoing Data Collection and Continuous Quality Improvement (CQI) Processes

The committee recommends that the State collect data on CANS scoring that provides information regarding fidelity to all aspects of the CANS, or concerns regarding this, to determine where improvements need to be made. As the State moves to use the CANS to determine both level of care for foster youth and the rate for services, it is imperative that ongoing CQI efforts consider how the CANS may or may not fully reflect the level of service that a youth requires to be safe, stable and with family.

In addition to state level data collection, it is essential for counties to identify discrepancies across CANS users to ensure that foster children and youth are effectively assessed and receiving services and supports they need to thrive.

Discrepancies in CANS Across Service Providers

Of particular concern in implementing the use of CANS across systems, is the assurance that there is some consistency across those individuals who are completing the CANS for a foster child. Particularly now that Child Welfare and Probation will be required to use the CANS to determine placement levels of care, mechanisms must be put in place that will allow for review of the CANS when any member of the CFT identifies a concern about the level of care being received based on a CANS score. The State and system partners must design methods for ensuring that discrepancies are addressed early on, and do not result in children and youth's needs not being met in a timely manner.

Conclusion

As CalHHS, DHCS and CDSS work together to implement the various initiatives that envision all youth having timely access to necessary behavioral health services, the Behavioral Health Committee presents these recommendations to the Council for approval. These recommendations support and align with efforts of other committees on the Council, including the Prevention and Early Intervention Committee's Financing Recommendations to Build and Sustain Community Pathways, and the Data Committee's ongoing efforts to support data collection and integration.

Without robust and integrated data systems, a concerted effort to limit the number of CANS that a young person and their family must have completed, and ongoing training and continuous quality improvement processes, it will be difficult if not impossible to assess the State's progress in meeting the needs of children and youth involved in, or at risk of involvement in the child welfare system. We offer these recommendations to guide the work of the CWC and support our shared goal of timely access to the right care that meets children, youth and families' needs and supports them remaining together.