CHCF Issue Brief

FEBRUARY 2023

by Manatt Health

Behavioral Health Care for Youth: Opportunities for Technology-Based Solutions in Schools

The past decade saw a worsening mental health crisis among youth nationally and in California. Marked by an increase in the number of mental health hospitalizations, deaths by suicide, and increases in depression and anxiety, the situation has been compounded by COVID-19 and measures taken to prevent its spread. This crisis is heightened for youth of color, who experience historic systemic racism and discrimination, impacting their behavioral health[1] and access to care and preventive services. One in 13 youth in California has a serious emotional disturbance,[2] with Black and Latino/x youth having higher rates compared with other racial and ethnic groups statewide. California's youth mental health crisis is underscored by recent statistics:

- More than 15% of youth report suicidal ideation,[3] and since 2007, there has been a 30% increase in youth age 15 to 24 dying by suicide.[4] Over 40% of LGBTQ youth have seriously considered attempting suicide in 2020.[5]
- Emergency department utilization nearly doubled for eating disorders among teenagers and young women since 2019.[6]
- Since 2016, there has been a 70% increase among California's children age 3 to 17 who are diagnosed with depression or anxiety,[7] with 66% of children with depression not receiving treatment.[8]

In addition to these troubling behavioral health trends, youth are also experiencing an increase in traumatic events as COVID-19 roils everyday patterns. Since the start of the pandemic through December 2021, more than 16,000 California youth have lost at least one parent/caregiver due to the pandemic and two out of three of the parents/caregivers who died were Latino/x.[9] Given these stresses and the historic racism and discrimination that youth and families in communities of color are experiencing, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a national state of emergency in child and adolescent mental health in October 2021.[10]

California's Student Behavioral Health Incentive Program

Recognizing the imperative to reach youth at scale with prevention and treatment services, in 2021 the California Health and Human Services Agency (CalHHS) announced a historic, five-year, $4.4 billion initiative to reimagine and transform the way California supports children, youth, and families, called the Children and Youth Behavioral Health Initiative (CYBHI).

Focus Areas of the Children and Youth Behavioral Health Initiative

The Student Behavioral Health Incentive Program (SBHIP) is one program of several in the California Health and Human Services Agency (CalHHS)'s $4.4 billion Children and Youth Behavioral Health Initiative (CYBHI). CYBHI investments cover programs focused on California's behavioral health workforce, ecosystem infrastructure, health coverage, and public awareness, including the following:

- **Behavioral Health Virtual Services Platform.** A virtual platform for youth to access educational content, screening tools, clinic-based care, and app-based support services.
- **Health care provider training and e-Consult.** An e-consult system allowing pediatricians, primary care physicians, and other providers to access consultation support from behavioral health professionals.
- **Scaling evidence-based and community-defined practices.** Support for the adoption and scale of evidence-based practices that improve outcomes for youth with mental health conditions.
- **Broad behavioral health workforce.** Support to build and expand culturally and linguistically competent workforces, education, and training.
- **Behavioral health counselor and coach workforce.** A multiyear plan to develop a coach and counselor system that makes in-person and virtual support available for students.
- **CalHOPE.** Crisis counseling assistance and training program that includes a toll-free phone line for students to connect with peer counselors; access to telehealth visits and group support sessions led by peers, community health workers, and other non-licensed personnel; and training for teachers and school staff to identify at-risk students, provide emotional support and crisis counseling, and connect students to appropriate resources.
- **Trauma-informed training for educators.** Ongoing training for child care providers, educators, and school personnel on trauma-informed care.
- **School-linked partnership and capacity grants.** Infrastructure and capacity to increase the number of students receiving preventive and early intervention behavioral health services.
- **Behavioral Health Continuum Infrastructure Program.** Ongoing development of sites across California where youth can receive the mental health and substance use disorder services they need without delay and, wherever possible, without having to leave their home county.

As part of that initiative, the California Department of Health Care Services (DHCS; California's Medicaid agency) launched the Student Behavioral Health Incentive Program (SBHIP).[11] SBHIP provides financial incentives to increase coordination among Medi-Cal (California's term for Medicaid) managed care plans (MCPs) and local education agencies (LEAs) to improve access to and delivery of mental health services.

Student Behavioral Health Incentive Program Objectives

- Break down silos and improve coordination of student behavioral health services through increased communication with schools, school-affiliated programs, managed care providers, counties, and mental health providers.
- Increase the number of students enrolled in Medi-Cal receiving behavioral health services through schools, school-affiliated providers, county behavioral health departments, and county offices of education.
- Increase non-specialty services on or near school campuses.
- Address the health equity gap, inequalities, and disparities in access to behavioral health services.

This comes at a critical time for a vulnerable population, given that nearly 4 in 10 California students are enrolled in Medi-Cal.[12] The DHCS's SBHIP overview and requirements publication details the milestones and outcomes required of participating MCPs and LEAs to unlock the incentive payments.[13] For a summary, see Figure 1.

Figure 1. Student Behavioral Health Incentive Program (SBHIP) Milestones and Payment Incentive Timeline

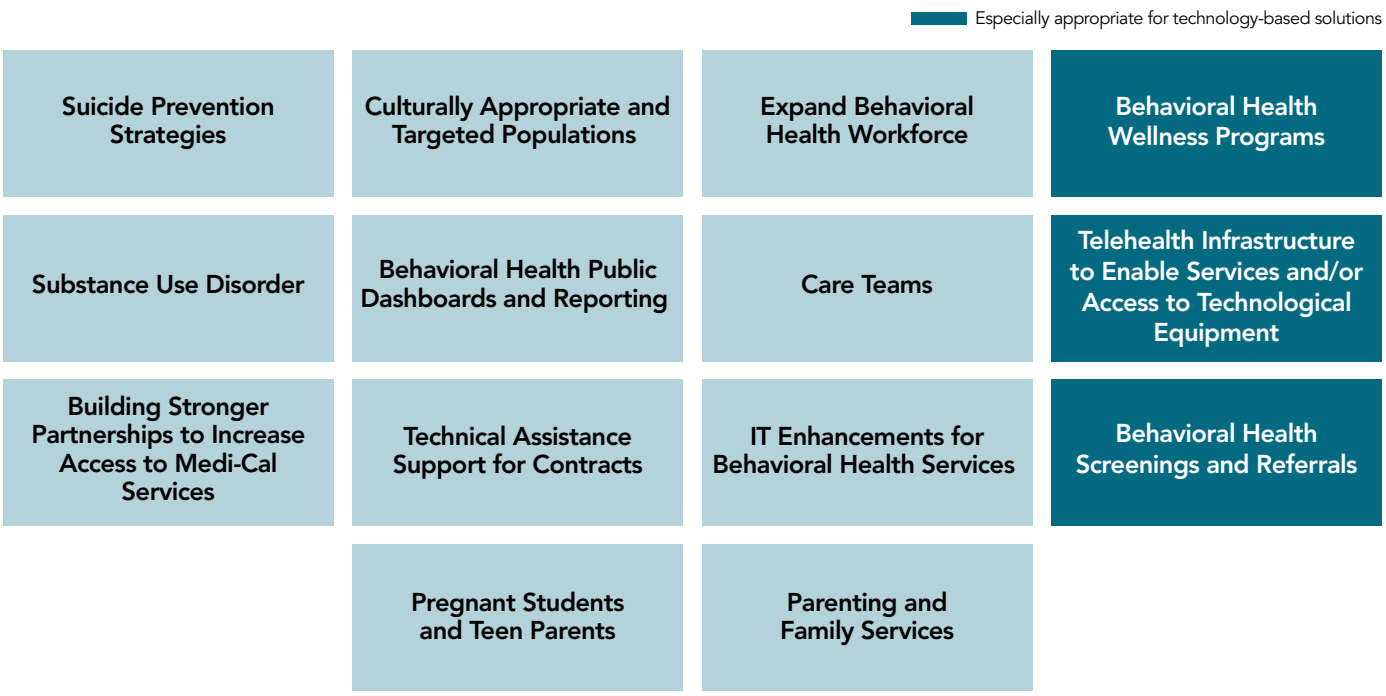
2022	2023	2024
Year-round: MCPs and LEAs collaborate, select partners, conduct needs assessment. **March:** MCPs submit Partners Form to DHCS to signal interest in SBHIP; MCPs receive interim payment to support needs assessment. **December:** • MCPs and LEAs identify targeted intervention(s) and student populations for 2023/2024 launch. • MCPs receive assessment funds upon submission of needs assessment and DHCS approval of the interventions. • MCPs submit Project Plan (Milestone One) to DHCS; funds are provided to support report completion.	**Year-round:** • MCPs and LEAs implement SBHIP-targeted intervention(s) and submit biquarterly and annual project outcome reports. • MCPs receive incentive payments based on achieving outlined milestones and performance metrics.	**Year-round:** • MCPs and LEAs implement SBHIP-targeted intervention(s) and submit biquarterly and annual project outcome reports. • MCPs receive incentive payments based on achieving outlined milestones and performance metrics. **December:** • MCPs submit project outcome report for each intervention to DHCS. • SBHIP concludes (creating concerns about a funding cliff).

Source: *Student Behavioral Health Incentive Program (SBHIP) Application, Assessment, Milestones, Metrics: January 1, 2022–December 31, 2024* (PDF), California Department of Health Care Services, accessed December 7, 2022.

Opportunities for Technology-Based Solutions

Technology-based solutions are a key resource for reaching and supporting youth at scale, especially given ongoing pandemic limitations, workforce shortages, and increased demand for behavioral health care services. These solutions may play an important role in supporting youth to manage day-to-day stressors and preventing escalation to more serious mental health challenges. MCPs and LEAs participating in SBHIP are partnering to select from a menu of 14 targeted intervention categories that address a range of student behavioral health needs and improve coordination of student behavioral health services. Several have a direct or potential technology focus. Figure 2 outlines the range of interventions MCPs and LEAs may choose for implementation in the three-year SBHIP funding period. Three of the categories are especially opportune for technology-based solutions. These are highlighted in blue in the figure, and the full DHCS descriptions follow below.

Figure 2. Student Behavioral Health Incentive Program (SBHIP) Intervention Categories



Source: *Student Behavioral Health Incentive Program (SBHIP) Application, Assessment, Milestones, Metrics: January 1, 2022–December 31, 2024* (PDF), California Department of Health Care Services, accessed December 7, 2022.

DHCS's SBHIP overview and requirements publication provides the following summary of these interventions:[14]

- **Behavioral Health Wellness Programs.** Develop the infrastructure for, or pilot behavioral health wellness programs, to expand greater prevention and early intervention practices in school settings (examples include building a school site dedicated and appropriate for behavioral health wellness activity, planning, partnership development, and capacity building for programs such as Mental Health First Aid and Social and Emotional Learning) by Medi-Cal MCPs. The project may build or expand a dedicated school behavioral health team to engage schools and address issues for students with behavioral health needs. Projects include, but are not limited to, infrastructure, capacity building, partnership development, materials, training programs, and staff time.

- **Telehealth Infrastructure to Enable Services and/or Access to Technological Equipment.** Increase behavioral health telehealth services in schools, including app-based solutions, virtual care solutions, and by investing in telehealth infrastructure within the community health worker or peer model. Ensure all schools and students have access to equipment to provide telehealth services, like a room, portal, or access to tablets or phones, within their school with appropriate technology. The project may build the capacity of behavioral health professionals through trainings to utilize this mode of service delivery.
- **Behavioral Health Screenings and Referrals.** Enhance adverse childhood experiences (ACEs) and other age and developmentally appropriate behavioral health screenings to be performed on or near school campuses, and build out referral processes in schools (completed by behavioral health providers), including when positive screenings occur, with providers taking immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) on or near school campuses and ensuring access or referral to further evaluation and evidence-based treatment, when necessary.

Early Insights on Partnerships and Technology

In response to SBHIP, the California Health Care Foundation (CHCF) asked Manatt, Phelps & Phillips to interview and survey MCPs and LEAs about their early efforts to partner with and design SBHIP programs, and the role they believe technology could play in increasing access to behavioral health care for students. Zeroing in on the three technology options available through SBHIP — behavioral health wellness programs, telehealth-enabled services, and behavioral health screenings and referrals — Manatt engaged MCPs and education entities between March and July 2022 for their insights.

Interview and Survey Methodology

Interviews. Manatt interviewed four MCPs and five LEAs/associations between March and May 2022. Interview questions were shared in advance. Over video calls, interviewees shared their insights on SBHIP and their teams' experiences selecting SBHIP interventions to pursue.

Surveys. Between June and July 2022, Manatt designed and distributed two surveys, one for MCPs and one for LEAs and California-based educational associations, with questions focused on the organizations' approach to SBHIP, experience forming cross-sector partnerships, and thoughts on the role of technology in their initiatives. Manatt received completed surveys from 11 MCPs and six LEAs and/or educational associations.

Interviewees shared their thoughts on SBHIP and the opportunity to partner to address the growing need and demand for youth behavioral health interventions. For a list of survey and interview participants, see Appendix A.

Both MCPs and LEAs are generally excited, eager, and interested in SBHIP. Molina Healthcare of California said they can "already feel the silos crumbling" as they design SBHIP with LEAs. MCPs and LEAs are organizing and working together in new ways to address the youth mental health crisis.

Blue Shield of California Promise Health Plan noted that it is collaborating in a monthly meeting with Los Angeles County's other MCPs and subcontracted MCPs to share lessons learned from SBHIP. L.A. Care Health Plan said that it "could not have opened the door to schools without the County's partnership" and has leveraged SBHIP to build on existing programs and relationships with local schools and county mental health departments.

CASE STUDIES

San Diego Managed Care Plans and Countywide Workgroup

There are more than 481,000 children in San Diego County's schools, with nearly one in two youth identifying as Latino/x.[15] San Diego County's Medi-Cal managed care model is Geographic Managed Care (GMC), meaning there are multiple Medi-Cal managed care commercial health plans serving the county, including more than 372,000 children.[16] As of August 2022, there are seven plans in San Diego: Aetna Better Health of California, Blue Shield of California Promise Health Plan, Community Health Group Partnership Plan, Health Net Community Solutions, Kaiser Permanente, Molina Healthcare of California Partner Plan, and UnitedHealthcare Community Plan.

The seven MCPs have collaborated through Healthy San Diego, an organizing workgroup for the county's MCPs. Through this workgroup, they developed an SBHIP Committee to share learnings across the MCPs. The SBHIP Committee is working with the National Alliance on Mental Illness (NAMI) and the San Diego County Mental Health Plan (which has an active presence in San Diego school systems) to conduct the needs/gap assessment in 2022 and to coordinate the implementation of SBHIP interventions in 2023 and 2024. Healthy San Diego and the San Diego County Office of Education (SDCOE) jointly presented the SBHIP opportunity to San Diego's 42 school districts to solicit participation in SBHIP, and five expressed interest.

Note: In August 2022, the state announced results of a procurement process to identify the MCPs with which the state would contract to deliver Medi-Cal managed care services between January 2024 and December 2028.[17] The intended MCP awardees in San Diego County are Molina Healthcare and Health Net; an appeal process is ongoing.

Partnership Health Plan and County Offices of Education

Partnership Health Plan (PHP) is active in 14 County Organized Health Systems (COHSs), where each county has elected to have a single MCP serve the Medi-Cal population. PHP is that single MCP in Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo Counties. Covering more than 38,000 square miles, PHP is engaged with 14 county offices of education (COEs) to select LEAs within their counties to participate in SBHIP. PHP relied on the COEs to solicit and select interested LEAs to support the more than 288,000 students across these counties,[18] ensuring that SBHIP participants were selected at a local community level and not by the MCP.

Though COEs in PHP counties reported that the PHP-COE relationship was nascent, Mendocino County expressed hope that the SBHIP partnership would result in more seamless Medi-Cal interactions and billing processes in the future.

Note: The state's procurement process of new MCPs does not impact COHS counties.[19]

In Sacramento and Imperial Counties, Molina Healthcare of California is working with LEAs to identify SBHIP interventions, and in Sacramento, the MCP has accelerated its SBHIP project with LEAs to "leverage already established" programs and "inspire programs needing embellishment." Central California Alliance for Health aims to leverage recent work and relationships with LEAs when responding to COVID-19 to build upon the student behavioral health infrastructure to implement SBHIP.

Some MCPs, including Blue Shield of California Promise Health Plan, said that LEAs were hesitant to partner with MCPs prior to SBHIP and that SBHIP has created positive momentum for future partnerships. Mendocino COE (an LEA) expressed a similar sentiment, noting that SBHIP is the first school-MCP partnership in Mendocino County; the county hopes that "these initiatives will align service delivery and reimbursement models seamlessly with current Medi-Cal billable school-based assessments and services." Other California counties, including Lassen and Shasta Counties, plan to continue working with MCPs on other related initiatives, including the recently extended Mental Health Student Services Act grant program, which aims to foster partnerships with county behavioral health departments and LEAs.[20]

Guidance for School Systems and Managed Care Plans

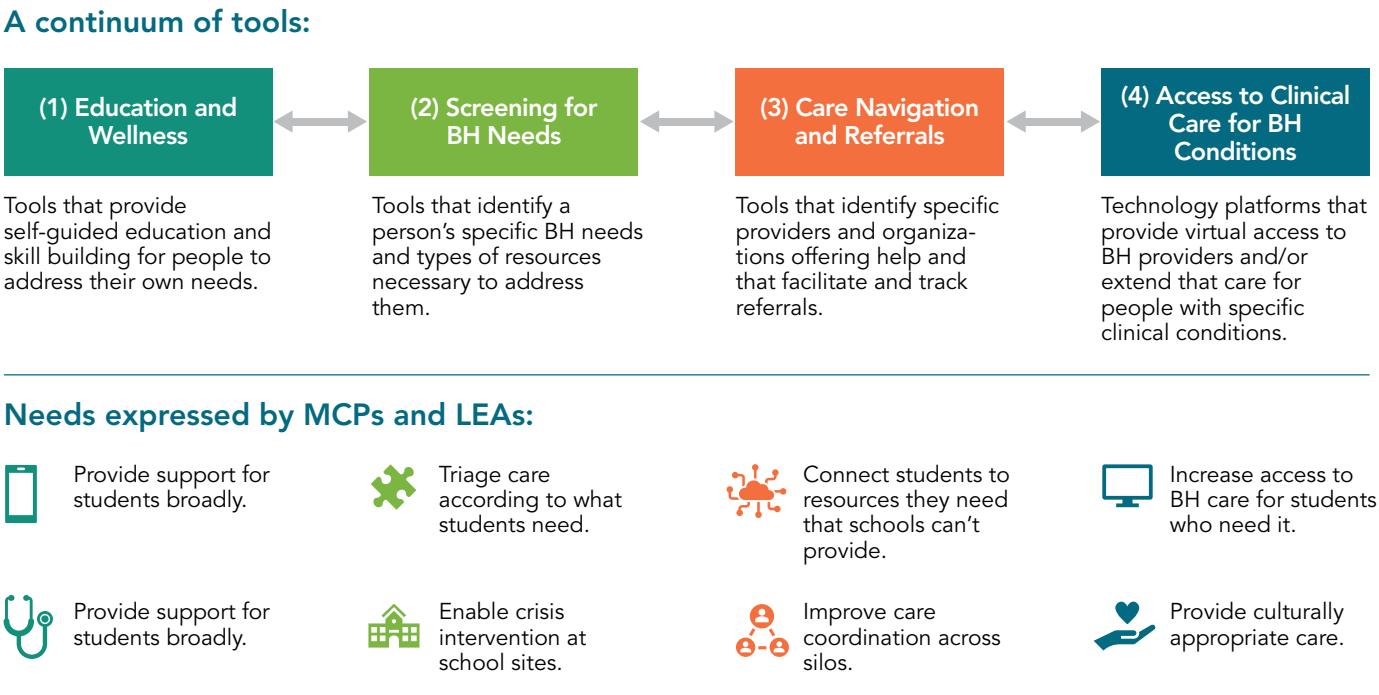
Schools and MCPs agreed that technology can be helpful in supporting youth with behavioral health challenges, as well as in helping schools address students' individual concerns. Survey respondents and interviewees noted that technology-based solutions have potential for reasons that include alleviating behavioral health workforce shortages, improving care coordination across siloed service providers, ensuring school-based access to crisis intervention, and increasing access to behavioral health care that is culturally appropriate via telehealth. Some schools and MCPs reported they already use one or more technology solutions to meet students' needs. Others reported feeling overwhelmed and confused by the wide array of solutions available to them for the purposes of SBHIP and other initiatives.

Framing the Technology-Based Solution Space

To help MCPs and LEAs understand the types of technology-based solutions available to address youth behavioral health needs, CHCF asked AVIA Health, a market intelligence firm focused on health care technology solutions, to provide a framework describing those solutions and aligning them with the needs expressed in interviews and survey responses.

AVIA's framework arranges solutions along a continuum of tools that provide (1) education and wellness, (2) screening for behavioral health needs, (3) care navigation and referrals, and (4) access to clinical care for behavioral health conditions (see Figure 3). Ideally, these services are integrated such that young people can move through them bidirectionally over time, according to their needs. Appendix B provides a non-comprehensive list of technology-based solutions that follow these categories.

Figure 3. Youth Behavioral Health Solutions Framework



Notes: *BH* is behavioral health. *LEA* is local education agency. *MCP* is managed care plan.
Source: © 2022. AVIA. All rights reserved.

Defining the Solution Categories

1. Education and Wellness

Many digital solutions provide self-guided and on-demand access to information about mental health and wellness, and help users develop skills to address their symptoms independently. Some of these solutions enable users to move from educational content to live coaching and teletherapy, and track users' emotional health over time. These tools have the potential to relieve pressure on the behavioral health workforce — a concern flagged by MCPs and LEAs — by increasing access to preventive care. Most vendors in this category charge consumers directly for access to their services, requiring users to enroll in their programs and pay a monthly subscription fee. Some contract with employers, health plans, and/or school districts to pay to make services freely available for employees, members, students, and/or families.

2. Screening for Behavioral Health Needs

Many behavioral health technology platforms offer screening, typically as one component of a broader offering. Early identification of youth with behavioral health adjustment difficulties or symptoms of a specific psychiatric condition (e.g., depression, anxiety) enables students, families, and/or school staff to seek targeted interventions or referrals to community-based providers. These technologies can be used to identify at-risk youth before they reach a crisis point, and/or to track changes in health status over time at the individual or population level and assess the efficacy of interventions being used to improve health.

3. Care Navigation and Referrals

Referral solutions help people identify and connect with providers of behavioral health, medical, and other social services in their communities. Some offer consumers direct access to comprehensive resource directories, and others are used by care managers and service providers to search and make referrals on their clients' behalf. Some have developed robust electronic networks that support information exchange and bidirectional communication between care managers and service providers, and others can track and report on the number and type of services requested in a specific community and/or the history of services requested and received by a specific individual. In general, the value of these solutions depends on the quality of the information in the resource directory, the quality and number of organizations participating in the network, the information on utilization the platform collects and makes available over time, and the platform's ease of use.

4. Access to Clinical Care for Behavioral Health Conditions

Basic telehealth services connect youth with remote therapists and/or psychiatrists for synchronous conversations. More comprehensive clinical programs and/or ancillary services offer youth and families virtual group therapy, peer support, coaching, and self-guided educational resources. Provider-facing tools include e-consult platforms that offer primary care providers and school nurses with direct access to the clinical information they need to treat patients, and remote monitoring tools enabling them to monitor biometric, PHQ-9 (Patient Health Questionnaire-9), and other measures at a distance. While most behavioral health companies support adult populations, some specialize in caring for youth and/or focus on the specific conditions prevalent among them (e.g., eating disorders, autism).

Characterizing Robust Solutions

Overall, technology-based behavioral health solutions for youth are relatively new to the market. The majority are designed to be used directly by consumers and paid for out of pocket. When MCPs and LEAs step in to contract for services on behalf of members and students, they should expect solutions to have well-established processes for important clinical and administrative processes, including those listed in Table 1. Appendix C provides some additional questions for MCPs and LEAs to assess the services and potential of technology-based youth behavioral health solutions.

Table 1. Capabilities and Features of Robust Solutions

Capability	Feature
Support for Administrative Processes	
Automated data sharing	Ability for users (e.g., care managers, school staff, providers, plans, end users) to exchange administrative and/or clinical information electronically, aligned with consent, privacy, and regulatory guidelines.
Interoperable IT systems	Integration between the technology-based solution, the provider-based EHR, and/or the school-based IT system to allow a seamless experience for customers and users.
Established billing and reimbursement processes	If services are covered by insurance, efficient processes to collect administrative information, generate medical claims, bill insurance plans, and secure reimbursement.
Attention to Enablers of Clinical Functionality	
Consent management	Attention to Enablers of Clinical Functionality Efficient processes to secure, store, and update youth and family consent to services.
Escalation of at-risk students	Data analytics and other processes to identify at-risk patients/students and quickly and reliably notify appropriate family members, educators, and/or care teams.
Equitable reach	The ability to reach and engage all youth, including students with different language preferences, technical skills, and cultural and socioeconomic backgrounds.
Business Traction and Sustainability	
Implementation and training experience	Support team for implementing a new solution (e.g., workflow redesign, staff training, patient/student/family onboarding) and ongoing help desk for technical questions from end users.
Commercial traction	Established relationships with paying customers and end users, especially in California and reimbursed by Medicaid, and a track record of successful implementations.
Evidence of clinical and operational value	Evidence of outcomes on key organizational targets, both operational and clinical (e.g., effective processes, positive user experiences, clinical results, cost savings).

Notes: *EHR* is electronic health record. *IT* is information technology.

Source: Interviews and surveys of MCPs and LEAs conducted by Manatt, Phelps & Phillips between March and July 2022.

Guidance for Innovators of Technology-Based Youth Behavioral Health Solutions

Be Aware of Significant Challenges and Barriers Related to SBHIP Implementation

Given the magnitude of the youth behavioral health crisis and the sizable amounts of public funding available to address it, a great number of innovative young companies are working to build new solutions that increase access to care. Entrepreneurs should remember that the majority of MCPs and school systems are entering into contractual relationships to work together for the first time. Interviewees for this report described the significant challenges to successfully implement SBHIP, including any new technology-based solutions, with the most significant challenge being the complexity of the Medi-Cal behavioral health care delivery system and the historical divide between health care, behavioral health, and education service providers (see Figures 4 and 5). Other significant challenges include the following:

Overburdened schools. Both MCPs and LEAs expressed concerns about adding a new initiative to schools' plates, given how stretched they are with responding to new COVID-19 variants, masking requirements, vaccine mandates, and school safety and violence concerns. This is all on top of the growing behavioral health crisis SBHIP is aiming to address, with LEAs often having to look to immediate, short-term solutions to address the real-time concerns of suicidal ideation, self-harm, and illicit drug use. School providers and staff have limited capacity to both meet the day-to-day requirements and implement new initiatives and technologies.

Parachuting in solutions. MCPs and educational entities are wary of investing in and implementing solutions that are simply "parachuting" into a school, creating more confusion than good. For example, educational entities reported "screening exhaustion" with an immense amount of screening already being conducted and the need to be more thoughtful about when and where to screen for potential mental health concerns. They also noted new technology can often be disruptive and labor intensive for school staff, providers, and educators. MCPs stressed the need for local partnerships and deferring to schools and community leaders as the experts to avoid forcing an ill-fitting one-size-fits-all approach on schools. MCPs recognized that their role with SBHIP is to be a helpful facilitator and engaged partner, but not the leader. Partnership Health Plan has worked closely with local schools to empower decisionmaking and ensure SBHIP interventions are homegrown solutions. (See Figure 3, above.)

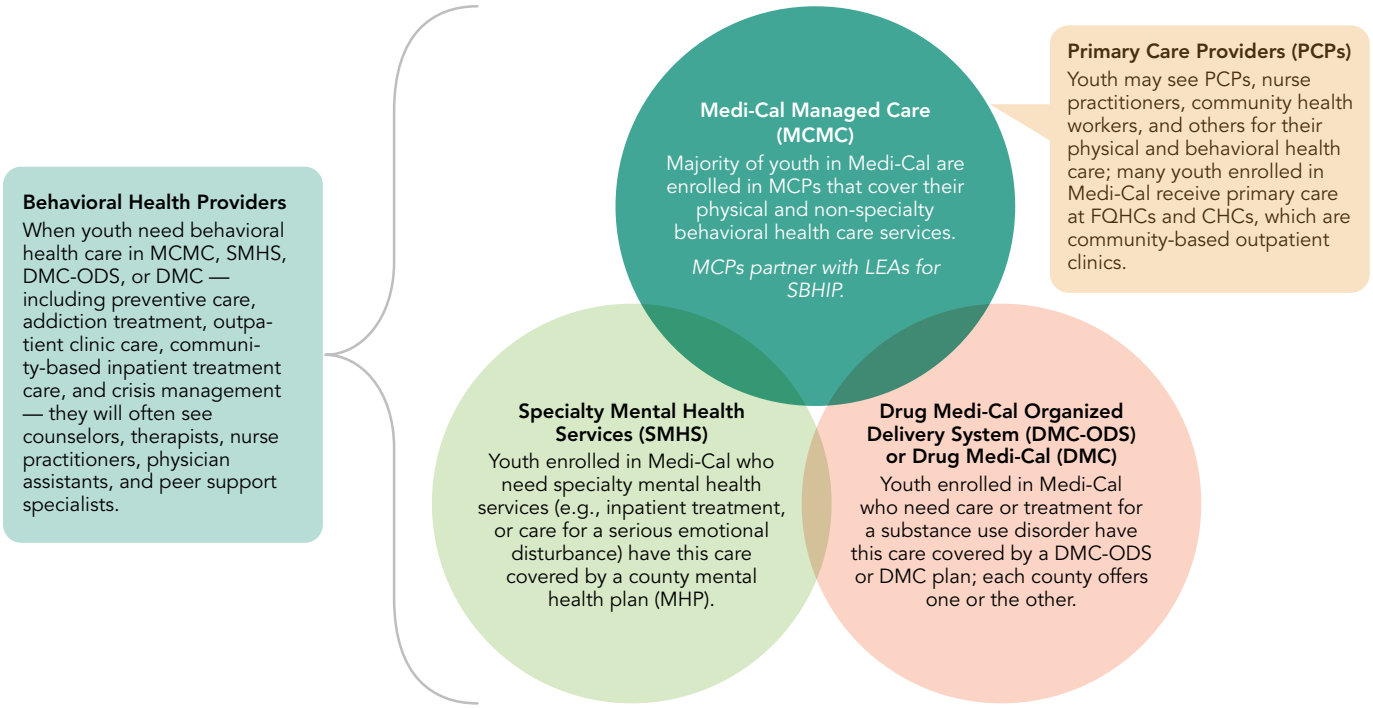
Funding cliff. MCPs noted that SBHIP funding concludes in December 2024, creating a potential funding cliff after three years of supporting and building out SBHIP interventions. The uncertainty of a funding commitment from DHCS for additional funds or an extended timeline makes both MCPs and LEAs hesitant to dive in fully to SBHIP. Similarly, LEAs expressed concerns about the costs of technologies, with the Community Health Care Network noting that "LEAs are VERY concerned about additional costs/mandates" given the staff training and infrastructure building needed to implement SBHIP interventions with only three years of guaranteed funding.

Data sharing and legal concerns. MCPs and schools are concerned with the lack of existing IT integration to facilitate data sharing across MCPs, schools, and providers. Blue Shield of California Promise Health Plan noted that "the wide array of platforms used by different facilities and providers makes data interface and integrity challenging." In this same vein, both entities are concerned about meeting compliance requirements across HIPAA (Health Insurance Portability and Accountability Act), which protects the privacy of patients' sensitive health information, and FERPA (Family Educational Rights and Privacy Act), which protects the privacy of students' educational records, and the need to comply with both laws.

The Most Significant Challenge: The Medi-Cal and Education Ecosystems in California

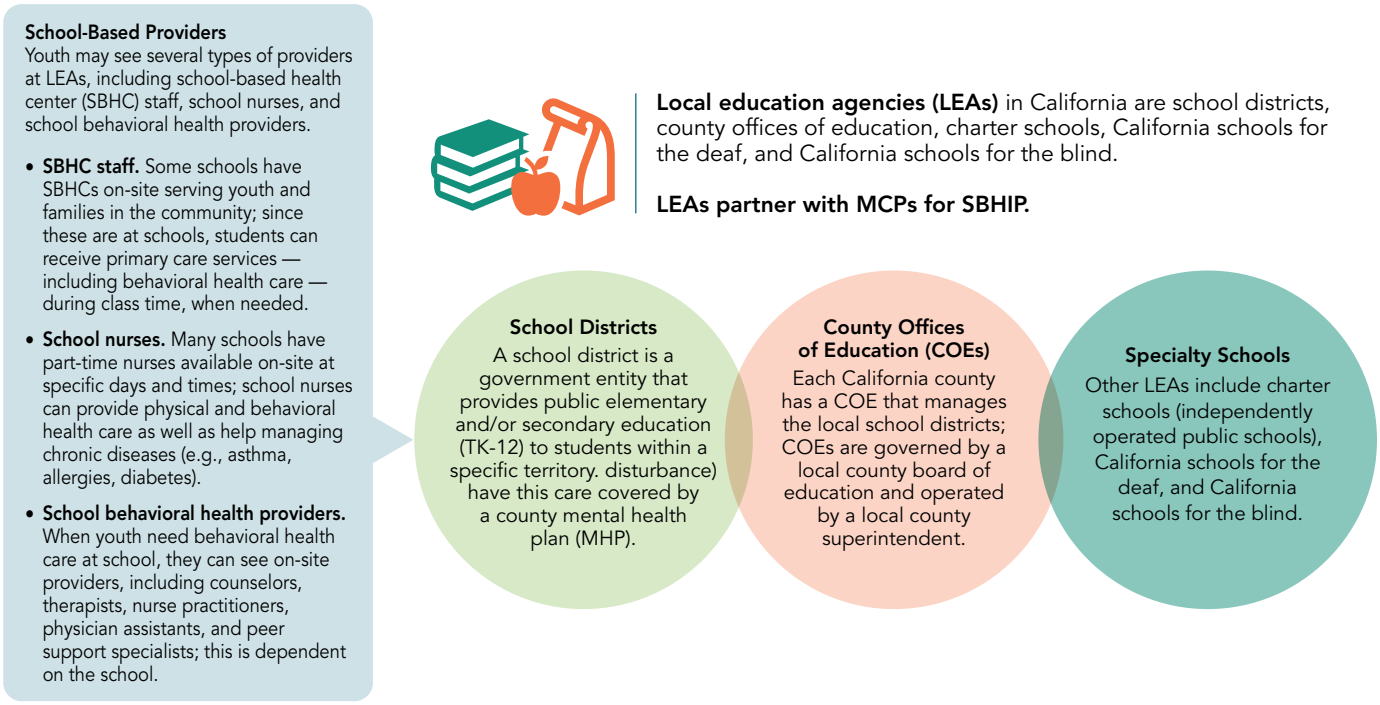
The behavioral health care system in California is fragmented and complex, with different players responsible for providing care in a range of locations, including schools, medical offices, Federally Qualified Health Centers (FQHCs), community health centers (CHCs), and hospitals. Providers in these organizations do not always communicate with each other or coordinate care in a meaningful way. Traditionally, funding, decision-making, and information are siloed, and bureaucratic processes make it challenging for two big systems — education and health care — to partner. SBHIP aims to incentivize MCPs and LEAs to partner to support students more directly, on-site at schools.

Figure 4. The Medi-Cal Ecosystem



Source: Graphic of the Medi-Cal ecosystem, based on internal expertise and research in health care and education, Manatt Health, 2022.

Figure 5. The Education Ecosystem



Notes: *TK* is transitional kindergarten.

Source: Graphic of the education ecosystem, based on internal expertise and research in health care and education, Manatt Health, 2022.

Conclusion

SBHIP provides a unique, timely, and much needed opportunity for MCPs and LEAs to engage in mitigating California's youth behavioral health crisis. All interview and survey participants reported an eagerness to dive into this new partnership opportunity to support youth. One interviewee noted "we already feel the silos crumbling," and another said that LEAs were hesitant to partner with MCPs prior to SBHIP and that SBHIP has created positive momentum for future partnerships.

Findings also point to important barriers:

- Schools are overburdened and under-resourced, and any new initiative drains resources in the short term.
- With funding guaranteed for three years only, long-term sustainability of SBHIP interventions is not certain.
- Data sharing between schools, MCPs, and technology vendors raises concerns about data security and confidentiality.

- While there is real interest in leveraging technology solutions for SBHIP, there is also a paralysis for many about "where to start," what technology solutions best meet the needs, and how to integrate them into school operations with minimal disruption.

California health plans, behavioral health care providers, and school systems are in the very early days of knowing how to coordinate services for youth, and their ability to extend scarce resources by leveraging technology effectively will not come quickly. The recent experiences of MCPs and LEAs offer some guidance for making progress over time:

- Prioritize developing authentic partnerships and common objectives among organizations at the local level.
- Use SBHIP as a learning laboratory to share ideas, track outcomes, and lift challenges to a broad, statewide audience.
- Look for opportunities to test and try technology-based solutions to supplement existing resources and build on capabilities that work incrementally over time.

Appendices

Appendices to this report offer some additional basic information to help MCPs and LEAs cope with being overwhelmed by the number and opaque nature of behavioral health solutions on the market.

Appendix A. Survey and Interview Participants shows which interviewees shared their thoughts on SBHIP and the opportunity to partner to address the growing need and demand for youth behavioral health interventions.

Appendix B. Select Providers of Technology-Based Behavioral Health Solutions for Youth is a noncomprehensive list of companies working on technology-based solutions to improve the experiences of youth with or at risk of facing behavioral health challenges in their lives.

Appendix C. Select Providers of Technology-Based Behavioral Health Solutions for Youth offers a list of basic questions for MCPs and LEAs to ask potential partners and a set of performance metrics to judge impact over time.

Managed Care Plans	Educational Entities
Survey Respondents (June–July 2022)	
• Blue Shield of California Promise Health Plan (three surveys submitted) • CenCal Health • Central California Alliance for Health • Community Health Center Network (on behalf of Alameda Alliance and Anthem) • Health Plan of San Joaquin • Inland Empire Health Plan • L.A. Care Health Plan • Molina Healthcare of California • Partnership Health Plan of California	• Lassen County Department of Education • Mendocino County Department of Education • Modoc County Department of Education • Shasta County Department of Education • Solano County Department of Education • Sonoma County Department of Education
Interviewees (March–May 2022)	
• Beacon Health Options • Health Plan of San Mateo • Molina Healthcare of California • Partnership HealthPlan of California	• California School-Based Health Alliance • Fresno County Office of Education • Los Angeles County Office of Education • San Bernardino County Superintendent of Schools • Santa Clara County Office of Education

Appendix B. Select Providers of Technology-Based Behavioral Health Solutions for Youth

Company	Technology-Based Solution	Outcomes	Partners	Available in CA	Reimbursed by Medicaid
Akili Interactive	Improves attention function in children age 8–12 with inattentive or combined-type ADHD through an FDA-authorized digital therapeutic video game. Presents specific sensory stimuli and simultaneous motor challenges designed to target neural systems in the brain related to attentional control.	Five clinical trials including 600+ children with ADHD across 15 states. Published STARS-ADHD study reported to improve objective attention in 8- to 12-year-old children: 56% of parents noticed their child's attention improved after one month; one in three children no longer had an attention deficit on at least one measure of attention; and 73% of children said they could more easily pay attention after one month of treatment.	Providers	Yes	—
Bamboo Health	Enables health care providers and payers with software, information, and insights across the physical and behavioral health care continuum. Enables integration into EHRs (e.g., Allscripts, Athena, Cerner, Epic); interoperability between data sources; and access to real-time data, patient-level analytics, decision support, and communication and patient referral tools.	Objectives: Reduce ED onboarding, reduce LOS, and reduce per capita overdoses and suicides.	Providers, payers, FQHCs, state government, and direct to consumers	Yes	Yes
BeMe Health	Mobile mental health platform integrating social, gaming, and streaming engagement with human coaching and clinical care for teens age 13+. Resources ranging from self-guided activities, trackers, self-assessments, and interactive modules to skills-based live coaching delivered via synchronous and asynchronous text-based sessions, and access to trained clinicians who provide real-time support and evidence-based, virtual care to teens.	Objectives: Healthy problem-solving behaviors and goal setting to foster improved functioning in teens' everyday lives.	California, Indiana, Iowa, Kansas, Mississippi, Texas, Colorado, Medicaid, TRICARE, commercial partners	Yes	Yes

Company	Technology-Based Solution	Outcomes	Partners	Available in CA	Reimbursed by Medicaid
Brightline	Provides virtual and behavioral health services to children age 18 months to 17 years, including web-based app with access to videos, interactive exercises, tips and guides, and chat with coaches to help kids build skills; 30-minute coaching sessions for parents and youth age 6–17 with programs on managing stress and anxious thoughts, getting on track with school, and boosting confidence; licensed clinicians for therapy, evaluation, and medication support to help youth manage anxiety, depression, behavior issues, ADHD, and other common conditions; and speech therapy (18 months–11 years).	80% of parents or caregivers reported their child's disruptive behavior improved significantly, 70% reported their child's anxiety showed significant clinical improvement, and 70% reported their child's depression improved significantly.	Employers, health plans, direct to consumers	Yes	No
Care Solace	Web-based care navigation system connecting students and families to mental health resources via access to a database including psychiatry and psychology providers, crisis intervention, and telehealth providers. Automated matching backed by live team available 24/7/365 to help families and staff through the process of accessing community-based mental health programs and resources or telehealth services.	In a case study with Chico Unified School District, since implementing Care Solace in December 2019, the service has resulted in more than 636 connections to community-based care.	Fresno Unified School District, Irvine Unified School District, Chicago Unified School District, Placerville Unified School District, Perris Union High School District, San Pasqual Unified School District, Torrance Unified School District	Yes	Yes
Daybreak	Delivers online school-based counseling platform for youth age 11–19 by partnering with schools and pediatric groups. Services include live video sessions, messaging with licensed therapists, and well-being tools with support ranging from stress and mindfulness to nutrition. Average length of treatment is 12–20 weeks. Psychiatric assessment and FDA-approved medication prescriptions are available.	Simi Valley schools case study: four days from referral to appointment; 80% of students improved on the GAD, PHQ, or WHO scale; and school staff reported satisfaction ratings of 4.75/5.	School districts in California (over 100 schools), Texas, Washington, Oregon, Ohio, and Florida; health plans including Cigna and Health Net	Yes	No (expected in the next six months)

Company	Technology-Based Solution	Outcomes	Partners	Available in CA	Reimbursed by Medicaid
DotCom Therapy	Online therapy for speech, occupational, and mental health issues for students in K-12 schools. Speech-language pathologists conduct evaluations of skills, develop individualized treatment plans, facilitate parent coaching and training, and deliver continuation of school-based services. Occupational therapists conduct task analysis and holistic evaluations and provide recommendations for learning. LCSWs treat mental health issues, provide crisis intervention, and lead behavioral educational initiatives through trauma-informed, evidence-based care.	350K+ sessions completed since 2015; 91% of patients progressing toward goals, and 97% provider retention.	OSF Healthcare, Dignity Health, Prince George's County Public Schools	Yes	Yes
Equip	Virtual eating disorder recovery app for youth age 6–24. Uses family-based treatment and virtual five-person provider care team, including a therapist, medical provider, family mentor, peer mentor, and registered dietitian. Treats coexisting conditions like anxiety, depression, OCD, ADHD, and trauma. Treatment includes a research-backed body image program created by Stanford-trained clinicians that reduces eating disorder symptoms and increases positive body image and self-esteem.	After treatment, Equip families report the following: 1.1 lb. per week average weekly weight gain for 75% of patients, in first four weeks; 65% reduction in eating disorder symptoms and two-thirds reporting improvements in mood, in the first eight weeks; 54% of patients with depression no longer depressed, and 73% of parents feel more confident in caring for their child, after 16 weeks.	Aetna, Magellan, Cigna, Optum Moda Health, United, Partnership Health Plan of California, Pacific-Source Health Plan, Horizon	Yes	Yes
Floreo	VR/AR-based therapy for neurodiverse youth age 5+, with a focus on autism. Develops virtual reality lessons designed to help behavioral therapists, speech therapists, special educators, and parents who work with autistic children. Almost 200 virtual reality lessons are designed to help children build social skills and train for real-world experiences (e.g., crossing the street or choosing where to sit in the school cafeteria).	Published study on feasibility of using Floreo's Joint Attention Module in school-age children with autism in a special education setting reported the following: 95.4% of the time participants tolerated the headset, 95.4% of the time participants seemed to enjoy using Floreo's platform, and 95.5% of the time the VR experience was reported as valuable.	Ochsner Health, Children's Hospital of Philadelphia, California Psychcare	Yes	Yes

Company	Technology-Based Solution	Outcomes	Partners	Available in CA	Reimbursed by Medicaid
Hazel Health	On-demand telehealth service designed specifically for K-12 schools and youth age 5–18. The school counselor or nurse uses an iPad to connect the student directly with a Hazel therapist over live video. Students can also connect directly with a Hazel therapist through their phone or computer. Follows school district policies, complies with FERPA and HIPAA, and is available at school during regular school hours to support students with depression, trauma, self-harm, grief, anger management, and bullying issues. Currently serving over 2 million students across 12 states, with 67% of Hazel therapists identifying as people of color and 32% of them speaking multiple languages.	Hazel students have regained over 70,000 hours of school time, and schools using Hazel see a 40% reduction in health-related absences.	School districts: San Bernardino Unified School District, Denver Public Schools; payers: Aetna, Anthem, Centene, United	Yes	Yes
Manatee	Provides therapy and coaching to kids, teens, and their families via an online telehealth platform. Services include live, 30-minute video therapy sessions with children receiving homework assignments to complete in between sessions; live, 30-minute video coaching sessions; and access to mobile app with resources for journaling, goal setting, courses, assessments, and an AI-powered chatbot to provide cognitive behavioral therapy and mindfulness exercises. Also offers parental coaching, progress tracking, treatment updates, and instant messaging to access care team.	76% of families report seeing clinical improvement after their child completes the six-week program.	Children's Hospital Los Angeles, Children's Hospital of Wisconsin, Children's Hospital Colorado	Yes	No
MindRight	On-demand text services, with coaches checking in daily, and real-time alerts in escalated and crisis situations. Focus on low-income youth of color, age 13–25. Coaches are young professionals, former teachers, community members, and college students.		Schools and state Medicaid programs: Amerihealth Caritas DC, Horizon Blue Cross Blue Shield of NJ, Kaiser Permanente, Newark Public Schools, and Gary, Indiana School District	No	Yes

Notes: *ADHD* is attention deficit hyperactivity disorder. *AI* is artificial intelligence. *ED* is emergency department. *EHR* is electronic health record. *FDA* is Food and Drug Administration. *FERPA* is Family Educational Rights and Privacy Act. *FQHC* is Federally Qualified Health Center. *GAD* is generalized anxiety disorder. *HIPAA* is Health Insurance Portability and Accountability Act. *LCSW* is licensed clinical social worker. *LOS* is length of stay. *OCD* is obsessive-compulsive disorder. *PHQ* is Patient Health Questionnaire. *VR/AR* is virtual reality/augmented reality. *WHO* is World Health Organisation.
Source: AVIA Health conducted research and interviews with behavioral health companies and hospital systems.

Appendix C. Assessing Potential and Progress of Technology-Based Behavioral Health Solutions for Youth

Solution Category	Questions for Solution Vendors	Criteria for Setting Goals and Measuring Progress
Education and wellness	• Where is your solution commonly used (e.g., school, home, provider office)? • How does your solution adjust its content based on the age of the user? • How does the solution identify and manage people who need higher levels of care? • How does the solution ensure parents/guardians/care givers are alerted if the user expresses thoughts of self-harm or harm to others? • Is your solution reimbursed by Medicaid?	# of users and duration of engagement over time % reduction in incidence of BH symptoms % of users referred/connected to BH providers % decrease in unnecessary health care utilization
Screening for BH needs	• Which evidence-based assessments can your solution administer? • Is the solution patient/consumer-facing or provider/educator/care team–facing, and how is it administered (e.g., phone only, omnichannel)? • How does the tool share data with care teams, families, educators? • What escalation protocols are in place? • Can the solution refer patients to appropriate resources based on the outcome of the screen? • Is your solution reimbursed by Medicaid?	% decrease in time to identify at-risk patients % decrease in time to complete patient intake % decrease in time to treatment
Care navigation and referrals	• Who is able to make referrals — the end user, care team, educator? • How does the solution connect individuals to BH services and help patients navigate care? • Does the solution notify appropriate parties when the referral is accepted and completed? • Who is responsible for building the referral networks? • How does the solution verify that patients are being referred to credible resources? • Is your solution reimbursed by Medicaid?	% of patients and families receiving timely access to BH and social services % decrease in time to treatment
Clinical care and supplemental support	• How does a user access therapy (e.g., in a school-based setting by an educator, at home by patient)? • Are your providers employed or contracted? What types of provider licenses and levels of care do they offer? • Who captures clinical information and/or progress over time? How is that information shared? • How does the solution meet critical HIPAA and FERPA requirements? • What is your experience partnering with school districts, managed care plans, and provider organizations? • Who is responsible for intake, consent, and billing? • Is your solution reimbursed by Medicaid?	% utilization, no shows, missed appointments % reduction in incidence of BH symptoms % improvement in social outcomes (e.g., days in school) % increase in medication and treatment plan adherence

Notes: *BH* is behavioral health. *FERPA* is Family Educational Rights and Privacy Act. *HIPAA* is Health Insurance Portability and Accountability Act.
Source: AVIA Health conducted research and interviews with behavioral health companies and hospital systems.

About the Authors

This issue brief was prepared by Claudia Page, senior advisor, and Madeleine Toups Tranchina, manager, at Manatt Health. Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the health care system. Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, and its consulting subsidiary, Manatt Health Strategies, is passionate about helping our clients advance their business interests, fulfill their missions, and lead health care into the future.

Information in this brief characterizing the types of technology-based solutions available to address youth behavioral health needs and descriptions of specific companies in this space, was provided by AVIA. A leading digital transformation partner for health care organizations, AVIA provides unique market intelligence, proven collaborative tools across a network of 50+ leading health systems, and results-based consulting to help solve health care's biggest strategic challenges.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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