IMPLEMENTING HEALTHY FAMILIES PROJECT: YEAR TWO

INTRODUCTION

This report is an interim report on the activities of the *Implementation of Healthy Families Project* (the *Project*) funded by the David and Lucile Packard Foundation. (Grant #98-1789). The *Project* has completed two years of work under the auspices of this grant. While enrollment has increased significantly in the Healthy Families Program (HFP) and currently is over 450,000 (April 2001), the utilization of the Seriously Emotionally Disturbed (SED) benefit for children remains far below preliminary estimates. In April 1999, the Foundation granted an additional year of funding to CIMH to continue work in the areas of enrollment and utilization of the SED benefit portion of the HFP and in the area of administrative procedures of the program.

The SED benefit, as structured, is a joint private public union that requires communication and cooperation between County Mental Health Systems, Health Plans and two governmental agencies, the California State Department of Mental Health (DMH) and Managed Risk Medical Insurance Board (MRMIB). The depth and complexities related to this benefit structure have been more profound than CIMH understood during the planning and early stages of this *Project*. However, as the state has gained experience with the HFP, and we have learned more about the dynamics impacting the mental health benefits, CIMH has been able to respond by shifting the attention and emphasis of the *Project* to reflect this understanding.

The *Project* identified the barriers to enrollment, referral, and communication as so significant that the decision was made to direct attention almost solely to these areas. This report will discuss the steps taken to addresses these identified barriers and is divided into four sections.

Section One describes the information gathering stage of the work in which Health Plans, County Mental Health Departments (the Counties), MRMIB and DMH personnel were interviewed and surveyed regarding perceptions of the program overall, the working relationships between each entity and the experience with the referral processes, and coordination of care. The purpose of this phase was to attempt to understand, from the perspective of all parties involved, the nature of the barriers and to fully delineate these difficulties.

Section Two outlines the outcomes and actions generated by the information gleaned from these interviews. After gathering extensive information, the *Project* was able to devise specific responses to address many of the identified barriers.

Section Three describes the *Project's* ongoing work in the area of administrative procedures. This includes completion of the Memorandum of Understanding (MOU)

process between the Counties and Health Plans, creation of a Dispute Resolution Agreement and continued work on Anticipatory Guidelines for physicians.

Section Four describes the current status of the ongoing activities of the *Project* and future plans.

SECTION ONE: INFORMATION SEEKING

Based on earlier work, the *Project* had established that the referrals to County Mental Health systems and subsequent utilization of the SED benefit were far below anticipated levels, originally targeted to be 3-5% of all HFP enrollees. As of July 2000, data generated by the DMH confirmed a utilization rate of under .01%. (Developing data indicates that there may be a significant improvement in this rate.) Additionally, the rate of increase in the SED benefit did not appear to be growing at a pace consistent with the rapidly climbing numbers of overall enrollment in the HFP. The goal of the *Project* in this phase of the grant was first to understand more clearly the reasons for under utilization of the SED benefit, then to develop and, when possible, implement strategies to address this.

The HFP as implemented in California is modeled on the state employee benefit program. The Health Plans administer the basic Mental Health benefit (twenty outpatient visits, thirty days of hospitalization) while the Counties administer the SED benefit. This means that two large disparate systems interact smoothly and closely when managing referrals and coordinating care. The *Project* took a targeted look at a small number of Health Plans and the Counties to better identify the barriers to effective coordination of the SED benefit. We found that basic information was not available across the agencies, key processes had not been negotiated, and negative beliefs across the two systems inhibited attempts to solve existing problems.

To begin, the *Project* examined two areas of potential referrals:

- Developing an in-depth understanding of the referral and care coordination process between Health Plans and the Counties.

- Tracking Healthy Families eligible and/or enrolled children, who have SED, and may be receiving services through the Health Plan and/or the County, but in the latter case, not being billed through the HFP.

Health Plans and County Mental Health Systems were identified and contacted regarding working with the *Project* on these issues. Three large Health Plans agreed to work with the *Project*. At the same time, four Counties interested in increasing the SED benefit utilization and willing to commit the resources and staff to work with the *Project* agreed to participate.

The *Project* undertook a series of meetings, structured interviews and focus groups with three Health Plans; Blue Cross (its subsidiary Well Point Behavioral Health) Health Net and LA Care (these three entities serve over 50% of the Healthy Families enrollees), and three Counties, Los Angeles, San Mateo and Stanislaus (a fourth county, Riverside, participated in a later phase of the *Project*). These particular Counties were each chosen for a specific reason. Los Angeles has the highest HFP enrollment. San Mateo, one of the earliest Counties to implement Children's System of Care (CSOC), has a well-developed children's Mental Health system able to accurately track its clients, and Stanislaus is a rural county that expects a proportionately large Healthy Families SED utilization. The particular issues addressed in the interviews and surveys were those identified previously in the work of the *Project*.

The *Project* sought information about:

- The availability of information necessary for effective monitoring and oversight of Mental Health benefits

- The referral process between the Health Plans and the Counties and efforts to coordinate care

- The Counties' ability to identify current Mental Health clients eligible for, but not enrolled and/or billed, through the HFP

Major Findings

After extensive interviews and surveys regarding the referral and care coordination processes between Health Plans and the Counties, the findings identified the following problem areas:

1. There exists a significant cultural and knowledge gap between Healthy Families Health Plans and the Counties, which affects every interaction in the system.

2. The Counties and Health Plans do not have necessary information and processes for communications.

3. The initial assumptions regarding the goal of Healthy Families SED benefit utilization warrant more detailed analysis, given the experience of the first two years of the program.

1. Cultural and Knowledge Gaps Between the Health Plans and the Counties

Health Plans and Counties face dramatically different incentives and are held accountable by different stakeholders. The significant cultural and expectation gaps between Healthy Families Health Plans and the Counties affect interactions at every level in the system. In the HFP, these two systems have very little knowledge of each other's practices and procedures, with resultant confusion and misunderstanding. For example, the *Project* found that Health Plans and Counties alike lack specific information that would ease their communication with each other. Both report not knowing whom to call about what issues. In the Counties we found confusion about the role of Behavioral Health providers that compromise the Health Plans' networks, and at the Health Plans we found confusion about the role of access teams and enrollment procedures.

2. Necessary Information is not Retained and Processes for Communication have not been Developed

In the HFP, a child may, or may not, be receiving services under the basic benefit of the Health Plan, but may meet the criteria for SED referral to the County Mental Health Plan for more intensive services. An HFP beneficiary may be referred to the Counties for SED assessment from a variety of sources that include the Health Plan, a provider, another child service system, or by self-referral. This creates a difficult environment to track referrals and coordinate care.

Protocols for coordination of the referrals and care have been developed by this project, endorsed by the California Mental Health Directors Association and MRMIB staff and disseminated to all Health Plans and Counties. However, Health Plans and the Counties have not actively formalized or disseminated these protocols in some Counties. At times, this leads to problems with referrals, a lack of feedback between Counties and Health Plans when referrals do occur, and other problems, such as a lack of coordination of care.

Health Plans do not have access to clear, easy to use contact information about the Counties or information about the roles of different people in public health systems. Counties do not have clear current information on how or where to refer people eligible for Healthy Families, whom to contact at Plans for different issues, or access to easy-to-use information on benefits and eligibility. The overall result of these difficulties in communication is directly affecting the referral processes between the two entities.

Health Plans:

In many of the Health Plans, there are not processes for early identification of youth who meet the criteria for and need an SED referral, who are being served via the basic benefit by network therapists or by primary care physicians. In some instances, identification of

these clients is not made in a timely manner. Frequently, the referrals to the county for SED services are made only after a youth experiences a psychiatric crisis and has been hospitalized.

The Counties:
The *Project* has offered a significant amount of training to the County Mental Health systems regarding the referral protocols and the Counties' responsibilities under the HFP. Over the course of time, County staff who had been trained moved to different positions or left County services. Because there were so few referrals, the knowledge of the referral process and the Program became diluted or lost completely. This often resulted in misinformation, inappropriate refusal of referrals; and inability to bill correctly. This *Project* has worked as liaison between Health Plans and the Counties when difficulties arise. In the majority of these situations, the difficulty can be attributed to lack of knowledge of the HFP/SED benefit, referral protocol, and MOU responsibilities by either the County personnel or the Health Plan personnel involved.

3. Lack of Effective Collection and Reporting of Basic Data

Both the Counties and Health Plans have difficulty collecting and analyzing necessary data related to the utilization of HFP mental health benefits. Without this information, it is difficult, if not impossible, to understand the current state of utilization, identify problem areas, and assess the impact of strategies implemented to impact utilization.

Health Plans:
With respect to the Health Plans, many plans do not/are not able to collect data on the number of enrollees receiving the basic mental health benefit. This is a function of the environment of private Health Plans. For example, capitated systems do not collect encounter data. Secondly, the Program was modeled on the PERS benefit and Health Plans were encouraged to treat the Healthy Families population as a commercial population. Some Health Plans do not differentiate Healthy Families from their other "lines" of insurance, and thus, do not have the capability to easily separate data regarding Healthy Families utilization from other utilization data. This is exacerbated by the fact that the Healthy Families Mental Health benefit is, by comparison, a small portion of the overall Healthy Families benefit. There is little financial incentive to separate the basic Mental Health benefit utilization numbers.

Other reasons the Health Plans do not have accurate information about the utilization of the basic Mental Health benefits include services delivered by primary care physicians. Mental Health care and benefits, such as prescription of medication, (stimulants/anti-depressants), are provided by primary care physicians, but are not recorded as Mental Health services. At this time, the Health Plans are not able to document how much Behavioral Health care primary care physicians are delivering. A further complicating aspect of this program is that many of the Health Plans delegate management and risk for

Behavioral Health benefits to subsidiary Behavioral Health organizations, companies specializing in management of behavioral care, further diluting the ability to accurately track these services.

County Mental Health:
The Counties have difficulty identifying, tracking, and billing for Healthy Families clients for a number of reasons, as well. Initially, the information systems were complicated and confusing. Identifying a Healthy Families youth required that the County search the MEDS file, the large data file that lists all eligible Medi-Cal recipients in a County system. As a result of our early efforts to work with this information system, DMH has refined and simplified this process by designing an extract file that lists only eligible Healthy Families recipients in a particular County. However, this remains a large data file that many Counties have not yet developed expertise to manage effectively.

Healthy Families information in the form of claims paid data indicates low numbers of clients being billed, and/or reimbursed, to the County Mental Health systems. On the other hand, the data systems indicate a larger number of Healthy Families youth enrolled and receiving services than are accounted for in the claiming system. Thus, the number of clients enrolled in the SED programs and the number of client services that are being billed to HFP do not reconcile at this time. The actual number of Healthy Families beneficiaries receiving services is not clear, but both data sets reflect relatively low numbers of Healthy Families clients.

Currently, efforts are under way to resolve the problems. The *Project*, working with the Counties and the DMH, has uncovered the source of some of the inconsistencies in the eligibility/billing systems. For example, one important finding was a substantial amount of duplication of clients listed with both Healthy Families and Medi-Cal at the same time. While duplicate enrollment is not allowed, the data systems are not currently able to accurately reflect the exclusive enrollment of some beneficiaries who transfer between Medi-Cal and HFP enrollment.

Some Healthy Families beneficiaries were also found listed simultaneously under the Individualized Educational Plan (IEP) services given by Counties and under Healthy Families. This group is composed of children who have been declared SED by Special Education standards and who have a special IEP in place. Services under this program are frequently billed through the Medi-Cal process, or through a special mandates claiming process or often not billed at all. The *Project* is continuing to work with the Counties and the DMH in efforts to establish processes to gather more accurate information about the Healthy Families youth being seen in the County Mental Health systems.

In summary, the *Project* found many of the basic functions of the HFP were being compromised by confusion and lack of understanding of the program by both Health Plans and the Counties. The *Project* identified multiple problems at many levels in all of the systems involved in the HFP. The problems identified were clearly impeding the referral and delivery of the SED benefit. For a complete review of these findings the executive summary is attached (Attachment 1).

SECTION TWO: PROJECT RESPONSE TO INITIAL FINDINGS

In response to these findings, it was clear a significant amount of education of all parties was needed, and a detailed strategy was developed to begin to address these problems. The *Project*, in conjunction with the CIMH Implementing Healthy Families Advisory Committee, MRMIB staff, the DMH, Health Plans, and the Counties, developed a comprehensive strategy that involved education, training, research and outreach. In this second phase of the *Project's* efforts to increase utilization of the SED benefit, three areas were targeted for activity and specific actions were outlined. These were:

1. An information campaign

2. A training program

3. A study group to research the utilization and penetration issues

1. INFORMATION CAMPAIGN

The *Project's* Information Campaign utilized a variety of formats to provide key information to relevant audiences. The goal of the effort has been to deliver information frequently and continually, to keep issues relevant to HFP Mental Health benefits current, to present the information in "easy to digest" brief components, and to target information to specific audiences. The campaign utilized a newsletter, a listserve, troubleshooting and technical assistance, a resource binder, and other product services in this effort. Additionally, the *Project* used established forums and meetings to keep the awareness of the HFP current at all times.

Healthy Families Bulletins

The *Project* began publishing quarterly informational bulletins that were specifically designed to be brief and easy to read, contain practical information, and target different information to specific audiences. The purpose of this newsletter was to bring basic information regarding the program to all the parties involved in the Healthy Families SED benefit. These bulletins were designed to be useful and informative to county mental health line staff and administrators, as well as Health Plan liaisons and administrators, with separate pages and information for each of these groups. This bulletin was designed for ease of reproduction and distribution. To date, the bulletins have been distributed statewide to all interested stakeholders and have been very well-received. Information for the newsletters was developed both during the work with the participating Counties and as a result of questions and problems resulting from calls to the *Project* for technical assistance. Topics covered have included information about the responsibilities of the Counties and Health Plans, referral processes, billing information, and contact information. Data regarding enrollment figures is also included in these bulletins. The *Project* has also posted these bulletins on the CIMH website (Attachment 2).

Troubleshooting and Technical Assistance

One finding of the *Project* was the lack of a centralized resource from which the Healthy Families partners could seek assistance and information. The *Project*, in conjunction with the DMH and MRMIB staff, provided this service, offering technical assistance in response to requests for information, clarification of policies and requirements, and assistance with disputes between the Counties and Health Plans. In this capacity, the *Project* began to detail issues involved, identify key individuals across the state, and address questions on a case-by-case basis. Questions range from procedural issues, billing issues, and clarification of policy issues to County-specific problems. Health Plans also began to contact CIMH for assistance. Often these requests necessitated direct contact between Health Plans and the Counties. As a result of these conversations between the *Project*, Health Plans and the Counties, the *Project* was able to bring problems to the attention of DMH and MRMIB, which assisted their development of solutions and responses.

Listserve

CIMH also utilized a listserve to respond to questions about the HFP. The listserve has proved to be a popular and easy way to disseminate information and answer questions about many issues. The *Project,* upon receiving a question and developing a response, forwards the information via e-mail to a list of individuals who have asked for these updates. The feedback to CIMH has been that the listserve is a useful practical tool that reaches a wide audience.

Healthy Families Resource Binder

The *Project* began work on the creation of a Healthy Families Resource Binder. The purpose of this binder was to provide administrators and line staff information regarding Healthy Families in a format that was practical and easily accessible. This handbook contains County-specific inserts, rules, and regulations; numbers to call of Health Plan Liaisons; flow charts for SED referrals and billing processes; DMH information notices; a copy of Title X legislation; and copies of the Healthy Families Bulletins. The Healthy Families Resource Binder is intended as a basic resource for the Counties and is scheduled for statewide dissemination September 30, 2001.

Task Force

At the same time, the *Project,* at the request of the DMH, participated in a task force that was concentrating on improving data services regarding the HFP to the Counties by the DMH. On this task force, CIMH was involved in the process of creating a Frequently Asked Questions paper and a revised, simplified billing report format for the HFP (Attachment 3). Participation on this task force was helpful for CIMH in that the *Project* gained knowledge of some of the technical aspects of the program and was able to, in turn, answer questions for the Counties.

Forums

CIMH also participates regularly in several statewide forums. These include the California Mental Health Children's System of Care Coordinators (CSOC), the California Mental Health Directors Association (CMHDA), and the Small Counties Regional Meetings. In these forums and meetings, CIMH began reporting regularly on the status of the HFP. These reports served several functions. The most immediate was to bring to the attention of the participants the status of the Healthy Families SED benefit and to keep attention focused on the HFP. Regularly, statistics regarding enrollment and services were discussed. At the same time comments and feedback were solicited from the Counties. The overall goal was to bring to the Mental Health leaders knowledge about the HFP, as well as to inform them of strategies for increasing enrollments of the HFP. Concurrently, CIMH was made aware by these management level participants of difficulties being experienced by their individual Counties in implementing the HFP. Concerns from the Counties' perspective regarding Health Plans' response were also brought to the attention of CIMH. In the role of intermediary, CIMH was then able to go to the Health Plans with these concerns. An ongoing dialogue between all of these parties was established and maintained.

Brochure

As reported previously, the *Project* developed and disseminated a Healthy Families SED benefit brochure. After the English version of the brochure was completed, it was translated into Spanish, Vietnamese, and Chinese. These versions of the brochure are now on the CIMH website in PDF format available for downloading and printing. In addition, the English version of the SED brochure has been made available from the MRMIB website. The brochures have been distributed throughout the state. The *Project* also worked with **School Connections**, another Packard Foundation project involved in the HFP, in an effort to distribute these brochures to school counselors.

2. TRAINING COMPONENT

Working with the pilot Counties, the *Project* utilized the information and technical assistance products developed for training and planning meetings, involving the Health Plans and the Counties. The meetings served as a forum to actively educate relevant parties about HFP Mental Health benefits, assist with the establishment of processes for communication regarding referrals and coordination of care, and supported relationship building between Health Plans and the County staff that will assist with obstacles related to the cultural differences between the two systems.

The training was tested in two of the original three pilot Counties, Los Angeles and Stanislaus. A third, Riverside, was substituted for San Mateo County, as there is a large Healthy Families population in Riverside and in adjoining San Bernardino County. Key Health Plan representatives, County Mental Health staff and Behavioral Health staff attended. The training was well received, therefore, the outline and supporting materials

have been packaged within the Healthy Families Resource Binder. The *Project* will be encouraging other Counties to use this resource to schedule similar meetings and CIMH will offer to facilitate these meetings, as requested.

3. WORK GROUP

The *Project* convened a work group and began to examine in more detail the issue of the under utilization of the SED benefit, in light of early estimates of expected Healthy Families SED referrals to the county programs. As noted, preliminary estimates of the SED potential referrals were based upon prevalence estimates in the general population and then benchmarked to the EPSDT penetration rate in the County Mental Health systems statewide approximately 4%. In addition to the difficulties noted earlier in this report, the work group identified several other barriers to both referral and utilization that may be affecting the benefit.

A significant factor is the newness of the HFP and the amount of time new programs need to build. Recent research indicates many low income families potentially eligible for Healthy Families do not either know of the program or in the case of the SED benefit; may have Healthy Families Insurance, but not know of the SED benefit. (The Urban Institute 2001) A lack of knowledge on the part of providers as well, may contribute to low participation (Kaiser Family Foundation, 2001).

The work group identified the referral process by which youth may have to move from one therapist providing basic benefits through the Health Plan to the County for Behavioral Health services as a potential problem for some clients. This process could be difficult for some youth to negotiate. Other impediments include the fact that some number of SED-eligible children may be receiving services through involvement with social services, which would automatically disqualify them for Healthy Families insurance because they have Medi-Cal. The work group outlined questions that may exist regarding the direct comparison between EPSDT and Healthy Families SED benefit. Clearly, there are several issues affecting the referral rate to the SED benefit that have yet to be resolved and continue to be the focus of work for the *Project*.

SECTION THREE: ADMINISTRATIVE PROCEDURES

The *Project* continued work in three areas of administrative procedure: Memorandum of Understanding (MOUs) between Health Plans and the Counties, Dispute Resolution and Anticipatory Guidance.

MOU:

The *Project* had proposed to provide technical assistance to support the development of new MOUs between the Counties and Health Plans. Subsequent to that, the *Project* intended to support training and assistance regarding the new MOU. However, the plan to

develop a new MOU has not developed because problems regarding completion of the initial MOU have continued. Thus, the *Project* has continued work to assist with the completion of the first MOU. This required negotiation between the parties, explanations in the case of parties who were new to the process and, in some cases, revitalizing the process that had become dormant in some Counties. Complications included confusion over who was responsible to sign, turnover in county staff, i.e., different county counsels, and at times, some very real disagreement with provisions of the MOU. CMHDA re-emphasized support and agreement to the MOU as written and the *Project* made a concentrated effort to finalize the MOUs. To date, the majority of the MOUs have been signed with all the major Health Plans, with the exception of the Kaiser Health Plan, and the majority of the Counties. The MOU process between the Kaiser Health Plan and the twenty-four Counties with Kaiser Plans is unique, in that the Kaiser Plan had originally not participated in the MOU process. This however, is nearing completion, pending final approval from the Kaiser Plan, CMHDA, and DMH.

Dispute Resolution:

A second administrative task the *Project* took on was the drafting and finalizing of a dispute resolution protocol. A task force was formed comprised of representatives from MRMIB staff, DMH, Health Plans, Counties, and consumers. The draft protocol currently in development is divided into an administrative section and a clinical section. After extended negotiations, the first section of this protocol is in a format acceptable to all parties. However, agreement on dispute resolution regarding clinical matters is pending decisions by MRMIB regarding format for these decisions. The *Project* is continuing to work on this protocol.

Anticipatory Guidance:

The *Project* also undertook the task of developing anticipatory guidance tools, similar to those in use in the Medi-Cal population.

The overall goal of the Anticipatory Guidance Project is to improve the ability of Health Plans and their contracted primary care practitioners to target Behavioral Health (Mental Health and Alcohol/other Drug) problems in their Healthy Families patients, ask relevant questions to determine the need for Behavioral Health services, and make appropriate referrals to Behavioral Health specialty providers. A related goal is to enable primary care practitioners to "anticipate" Behavioral Health problems that may arise in the various developmental stages of children and adolescents, and intervene accordingly. The impetus to this project has been concerns of many Behavioral Health specialists, supported by research, that many primary care practitioners are not equipped or trained to provide high quality Behavioral Health assessments, interventions, and appropriate referrals when indicated.

Numerous stakeholders were contacted in meeting these objectives, including County Medical Directors, the Counties, Primary Care Physicians, Health Plans, State Department of Health Services, State County Medical Service Plan, State Department of Mental Health, and the MRMIB, among others. In addition, a work group of primary care practitioners, public Health Planners, and County Mental Health representatives reviewed

existing Anticipatory Guidance protocols and assessment tools. The full report of this work group is attached (Attachment 4).

Finally, the *Project* Advisory Board, after reviewing the work group's findings, decided to not recommend new procedures at this time. In the interim, MRMIB has reported that HEDIS measures are being upgraded, and it was the consensus that requesting more Anticipatory Guidance measurements was not practical at this time, given the movement at the national level regarding NCQA standards being changed.

SECTION FOUR: ONGOING PROJECTS

The *Project* is continuing to work in several areas at this time and has the following plans for the remainder of the grant.

Through the work with the pilot Counties, and the information supplied by the DMH, it is clear the Counties are seeing more Healthy Families children than original data indicated. The *Project* has identified several different sources of error in the data systems. Discrepancies in the eligibility processes, enrollment and disenrollment files, and billing systems have been uncovered. These findings have statewide implications and, if not corrected could have acted to discourage Counties from seeking HFP enrollees. The DMH is currently working to correct the information system problems. At the same, time the *Project* is working actively with the DMH and with the Counties to identify eligible children who are not enrolled in the HFP, currently being served by the Counties. To this end, the *Project* has designed an "in reach" report that will use financial information gathered at intake to identify potential HFP beneficiaries. This report is being tested in the pilot Counties. Now that several sources of the enrollment/reimbursement discrepancies have been illuminated, the *Project* will help the DMH disseminate this information to the Counties, using all of the resources listed earlier in this report (HF Bulletins, Listserve, Forum, and Trainings).

The *Project* will continue to press for utilization data of the basic Mental Health benefit from the Health Plans. A key difficulty in deriving accurate estimates of the potential SED utilization rate is the effect of the HFP's split benefit structure. Without basic benefit utilization data from the Health Plans, it is difficult to determine expected referral numbers to the county services. In the meantime, the work group continues to address the issue of clarifying the comparison of EPSDT Medi-Cal children with HFP children receiving County services. The *Project* has designed two reports to compare the HFP children to EPSDT children currently receiving County Mental Health services. The DMH has agreed to generate these reports. The work group will use these reports in attempting to formulate a more accurate comparison to use in analysis of the SED benefit. If these reports are found to be useful, the *Project* will refine the report format and make them available statewide. The *Project* will also begin looking at trend lines in the pilot Counties in order to determine if the efforts made thus far have been productive.

The *Project* will attempt to determine if the rate of increase in utilization in these pilot Counties differs from the state average trend line.

As the next step in the training process, the *Project* has begun exploring the possibility of expanded Healthy Families trainings via teleconferencing facilities. Using this modality, the *Project* is preparing to bring trainings on identifying SED children to Primary Care Physicians. The *Project*, acutely aware of the difficulty in reaching this busy group of practitioners, is negotiating with a group that offers Telemedicine training to rural physicians. These trainings will offer CMEs to the physicians who train regularly on this rural Telemedicine network and, thus, would be more likely to attend such training. These trainings are tentatively scheduled for early 2002. The *Project* is also planning Healthy Families SED training via teleconferencing facilities to rural and/or small north state Counties.

CONCLUSION

The *Project* has completed two years of work under the auspices of this grant. Previously, the *Project* noted that barriers to enrollment, referral, and communication between Health Plans and County Mental Health systems were a top priority. The different perspectives, goals, mandates and understanding of all of the stakeholders involved make HFP a complicated program that demands collaboration at many levels. The *Project* has concentrated in these areas and over the past year has made significant progress in illuminating and helping to eliminate many of the original problems noted. Several areas were targeted by the *Project,* including an extensive information campaign, a training component, and work at the county level on data/billing systems. The *Project* also became very actively involved in facilitating discussions between County Mental Health Departments and Health Plans on a variety of issues ranging from procedural (MOU/Dispute Resolution) to problem solving on a case-by-case basis.

The *Project* has had to work within the realities of a system compromised of major entities that did not understand or trust each other. The most important product of the *Project* thus far, has been understanding and then addressing this disconnection between the Health Plans and the County Mental Health systems. As the Counties and Health Plans have gained experience with the HFP and working with each other, many of the original problems have been resolved. It is our belief that the communication and referral process between the Counties and the Health Plans has significantly improved. It is encouraging to note recent data from the DMH indicate SED benefit enrollment and utilization is growing and expanding. Although much more remains to be completed in this area, substantial progress has been made.

For the remainder of the grant, the *Project* will concentrate its energy on structural aspects of the HFP, such as finalization of the MOU and Dispute Resolution documents. The *Project* will also continue its work on the data/information systems. Once these problems have been clearly outlined and resolved, the solutions will be circulated to the

County departments through the Healthy Families Bulletins and expanded trainings. The *Project* will continue to educate all stakeholders about the HFP and SED benefit.

ATTACHMENTS

1. Executive Summary
2. HF Bulletins
3. FAQ Document
4. Anticipatory Guidelines
5. Sample HF Data Reports
6. Training Module
7. Utilization Group Roster
8. Anticipatory Guidance Group Roster

REFERENCES

1. The Urban Institute: How Familiar are Low-income Parents with Medicaid and SCHIP: Kenney, Haley, Dubay

2. Kaiser Family Foundation: S-CJHIP Implementation in California, April 2001.