

The Dollars and Sense of Becoming a Medi-Cal Contracted Organization

Integrating EPSDT services into TAY foster care placements: Lessons learned



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Issue Brief

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Introduction

It was just a few weeks before Myeesha was set to graduate from San Francisco State University with her bachelor's degree—a time that should have been joyful. And yet, shortly after submitting her final paper, Myeesha began to exhibit serious signs of emotional distress and anxiety and had to be hospitalized for suicidal ideation.

“I'd realized nobody would be there to see me walk across the stage,” Myeesha said later, discussing factors that contributed to her anxiety. For her, like many young people who have grown up in foster care, it's not just the challenging moments but also the celebrations, especially those typically enjoyed by families, that are fierce reminders of being alone in the world.

Young people who grow up in foster care are among the country's most disconnected and at-risk populations. They typically have life experiences of chronic loss, trauma precipitated by interpersonal or family violence, and neglect, sometimes due to mental illness or addiction. All too often, they experience placement instability and frequent

disruptions once in foster care, sometimes related to the behavioral expressions of their emotional pain. As a result, foster youth experience fragmented attachments, repeatedly losing or being failed by the adults on whom they depend. Current and former foster youth are at an exceptionally high risk of behavioral and emotional disorders.

“Nobody would be there to see me walk across the stage.”

FOSTER YOUTH AND MENTAL HEALTH

One-third of all former foster youth have at least one mental health disorder; some of the most prevalent diagnoses include post-traumatic stress disorder (PTSD), depression, and anxiety, often with co-occurring substance abuse.* Symptoms can manifest as challenges navigating interpersonal relationships, tolerating distress, and regulating emotions.

The State of California has recognized the importance of behavioral health care for foster children and is working to integrate behavioral health interventions with foster care placement settings through an overhaul of the child welfare system known as the Continuum of Care Reforms (CCR), which impacts minors in the foster care system. Yet, for nonminor dependents—foster youth who have reached age 18 and are participating in extended foster care under the California Fostering Connections to Success Act—behavioral and mental health resources remain difficult to access.

*Courtney, M.E, et al. (2005). *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at 19*. Chicago: Chapin Hall at the University of Chicago. Retrieved at: https://www.chapinhall.org/wp-content/uploads/Courtney_Midwest-Evaluation-Adult-Functioning_Report_2005.pdf

THE WORK WE DO

First Place for Youth was founded in 1998 to develop and implement innovative solutions for young people at risk of homelessness, incarceration, and poverty after aging out of foster care. Our My First Place™ program serves youth ages 18 to 24 who are in or preparing to exit from the child welfare or probation systems, providing them with intensive case management services, including individualized employment and education supports, built on a foundation of secure, stable housing. The typical My First Place participant has been exposed to multiple traumatic events and has lived in six different placements. Most are between the ages of 18 and 21 and participating in the Transitional Housing Placement Program for Non-Minor Dependents (THPP-NMD, formerly THP+FC), a licensed placement in extended foster care.

Young people in our care make significant progress toward reaching their educational and employment goals, obtaining healthy living skills, and maintaining housing stability. Yet many of these young people suffer setbacks and barriers due to behavior health challenges that interfere with job attainment and retention, focus in school, and their capacity to navigate relationships with roommates, neighbors, landlords, and community members. Case management services at First Place are provided by master's-level clinicians equipped to assist young people in reducing or removing barriers to success, including those that stem from behavioral health concerns. Additional specialty services include employment and education coaching, and housing navigation support from trained specialists. Round-the-clock crisis management is available, but even with this, some youth require more intensive intervention to achieve success.



A NEW CHALLENGE

As we grew to serve a greater number of young people each year following the implementation of extended foster care, the behavioral health challenges experienced by foster youth became more evident. We realized that meeting their diverse needs requires the flexibility to tailor our services to each individual youth—making them more or less intense based on the youth’s unique needs, strengths, and behavioral or mental health challenges. Unfortunately, this task became increasingly difficult to accomplish within the constraints of the THPP-NMD rate. Recognizing the value of more carefully targeted supports, we began exploration of **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medi-Cal** as a source of funding to enable smaller caseloads and more intensive services for vulnerable young people.

In 2015, First Place initiated the process to become a Medi-Cal billable organization for EPSDT. At the outset, our goal was to achieve two related ends. First, we hoped this would enable us to provide enhanced behavioral health services even more individualized to meet youth needs. Second, we anticipated that this would allow us to meet budget shortfalls for behavioral health services we were already providing, thus decreasing our dependence on ever-uncertain private fundraising sources. We believed that this shift would increase placement stability, reduce unplanned exits from program, and support lasting outcomes in education, employment, housing stability, and healthy living skills.

EPSDT Fast Facts

- In 1967, Congress introduced the Medicaid benefit for children and adolescents, known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT).
- EPSDT is a federal entitlement that requires states to provide comprehensive and preventative health care services to low-income children under age 21 who are enrolled in “full-scope” Medicaid.
- The goal of EPSDT is to ensure that all children and adolescents receive age-appropriate preventative, dental, mental health, developmental, and specialty services.
- Medicaid is a healthcare program jointly funded by state and federal sources that assists low-income individuals and families in paying for medical costs. The federal government reimburses states for a specified percentage of program expenditures—the Federal Medical Assistance Percentage (FMAP)—typically around fifty percent.
- Medi-Cal is California’s Medicaid program serving low-income families and individuals—including seniors, persons with disabilities, pregnant women, and current and former foster youth up to age 26.

TAKING STOCK

In the end, First Place successfully procured an EPSDT contract for services in Contra Costa County, one of the six California counties in which First Place operates programs. We have been successfully providing EPSDT services to nonminor dependent foster youth in Contra Costa since July 2017. However, the fiscal and operational challenges we experienced along the way, as well as the significant barriers to EPSDT contract procurement, caused us to take a step back and reevaluate our strategy. Although we initially planned to expand EPSDT services to First Place programs in other counties, we are now proceeding with caution.

In this brief, we explore some of the challenges and barriers we faced along our journey to becoming an EPSDT provider. This brief is based largely on our own unique experience, but we hope that the lessons we learned along the way can be beneficial to our peer providers considering similar initiatives, and spark a conversation with stakeholders and policymakers interested in system reform.

In developing this brief, we partnered with ***i.e communications, LLC*** who identified and conducted interviews with key stakeholders in the field to get their perspectives on the challenges and opportunities involved in pursuing EPSDT to cover the costs of integrating behavioral health services into extended foster care placements. Although we have not included direct quotes or attributed specific recommendations to individual stakeholders, all interviews have been incorporated into the content of this brief, and we are deeply thankful for the insight and expertise of these generous interviewees.



Challenges, Opportunities, and Lessons Learned

Medi-Cal certification is county-specific, and the internal capacity that organizations must develop to become certified and provide EPSDT services is onerous, time-consuming, and incredibly complex. However, the operational challenges are not the only obstacles to overcome. In pursuing our strategy of using EPSDT to provide enhanced supports to youth in extended foster care and meet budget shortfalls, we identified two primary areas of challenge: (1) persistent barriers to contract procurement and (2) fiscal challenges related to costs, risks, and sustainability.

COUNTY CONTRACTING: Barriers, Breakthroughs, and Room to Grow

Possibly the most difficult hurdle to becoming an EPSDT provider is initiating the process and procuring the first contract. In our experience, and based on interviews with stakeholders consulted for this brief, the most persistent obstacles to contract procurement fall under four key areas:

- » Inconsistent policies and procedures across counties
- » Disadvantages for providers who are new to Medi-Cal
- » Barriers to initiating small contracts
- » Fiscal insecurities and uncertainties under realignment

You Know One County, You Know One County

Individual counties have significant discretion in EPSDT contracting, deciding what percentage (if any) of their EPSDT services will be provided via contract with private agencies, how such providers are selected, and what tools or systems providers must have in place in order to qualify. The lack of standardized, statewide procedures creates difficulties for providers seeking clear guidelines for certification and contracting. Additionally, Medi-Cal certification is only valid for one specific county, one specific location within that county, and one specific set of services. This presents challenges for organizations that must undertake the entire process separately for each county in which they operate.



PRACTICE TIP

For organizations new to Medi-Cal, it is advantageous to work with a consultant well-versed in its rules, particularly quality assurance requirements. Providers will gain essential guidance, and the consultant's relationships with local behavioral health agencies can help shape opportunities for a first contract.



PRACTICE TIP

Many counties provide education and training opportunities for providers looking to obtain EPSDT contracts. Look for trainings delivered by the specific county where you are pursuing certification so that you familiarize yourself with its unique policies and procedures.



POLICY POINT

Navigating the complicated world of Medi-Cal certification and billing requires more than just training, it requires ongoing coaching individualized to the organization. Counties that contract out a significant percentage of their EPSDT services should consider offering ongoing coaching to their provider partners, particularly providers that serve communities with previously unmet needs.

WHAT IS AN ELECTRONIC HEALTH RECORD (EHR) SYSTEM?

An EHR is essentially a digital version of a patient's paper chart maintained by a provider over the course of treatment and containing patient information, medical history, and progress notes. An EHR system is designed to make these records available to authorized users instantly and securely.

An additional challenge for providers working in multiple counties is the need to work effectively with each county's Electronic Health Records (EHR) system. Use of a HIPPA compliant EHR system is required for Medi-Cal service provision, but there is no statewide standard. A provider must decide between incurring the cost of adopting multiple systems, providing staff training on each one, or implementing an on-site system and uploading separately to the various county systems, which often means duplicative data entry.



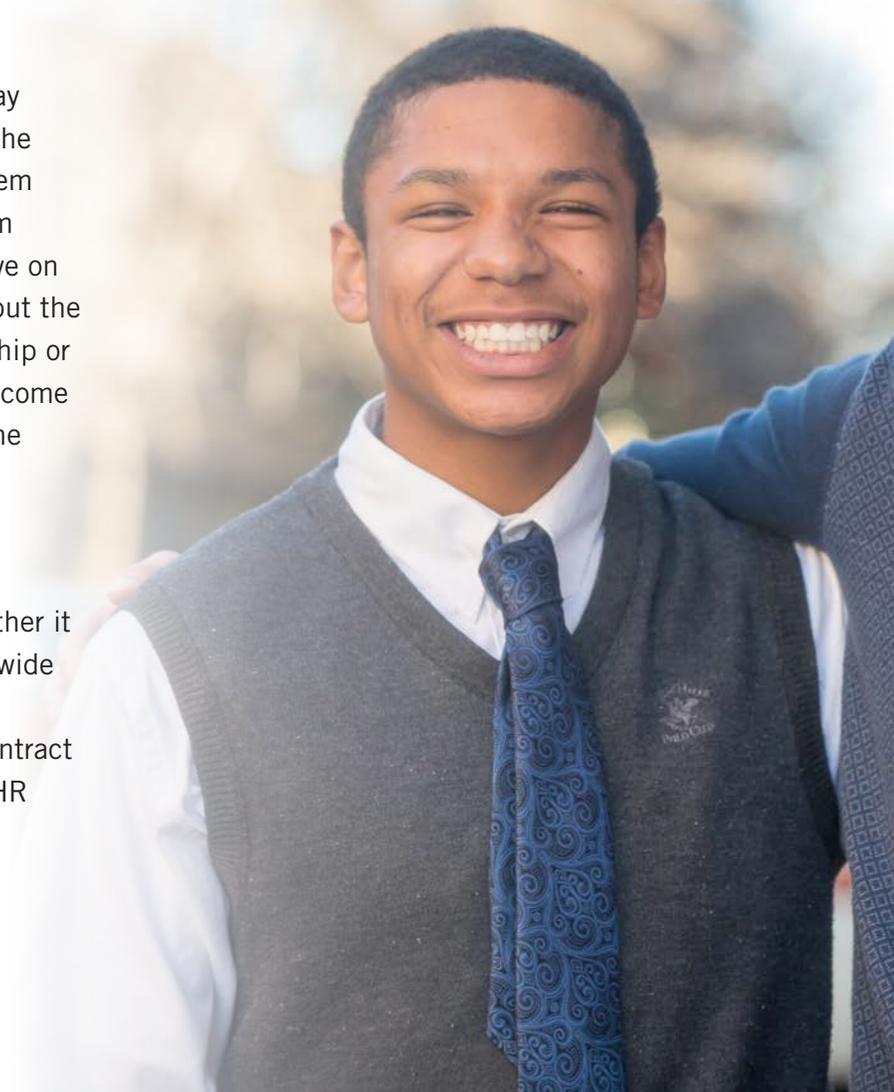
PRACTICE TIP

In some circumstances, providers may be able to reach an agreement with the county to use the county-owned system instead of adopting a separate system within the organization. This may save on costs and operational complexities, but the potential tradeoff is a lack of ownership or control over the notes, which may become county property once inputted into the EHR system.



POLICY POINT

Stakeholders should investigate whether it is feasible to establish uniform statewide standards, procedures, and tools for Medi-Cal certification and EPSDT contract procurement, including a uniform EHR system.



The Best Way to Get a Medi-Cal Contract is to Have a Medi-Cal Contract

An added barrier for providers that are new to Medi-Cal is that county contracting processes tend to favor providers with existing Medi-Cal contracts. During the contract bidding process, many counties inquire about prior experience, and award points based on existence of one or more Medi-Cal contracts. Thus, current and longtime providers are clearly advantaged to continue expanding, while others are at an immediate disadvantage.

Counties retain ultimate responsibility and bear the fiscal burden of disallowed services, so part of this preference stems from a legitimate desire to ensure that providers have the expertise and capacity to effectively implement and accurately bill for Medi-Cal services. This practice, however, may intentionally or unintentionally make it difficult for new organizations to enter the field, and can have a disproportionate impact on organizations that are smaller, more community-based, or which focus on specialty and/or under-represented communities.



PRACTICE TIP

Hiring staff or consultant(s) well-versed in behavioral health contracts can be instrumental in assuring counties that a new provider will have the capacity to manage, deliver, and accurately record and bill for Medi-Cal services. In-house expertise supporting quality assurance and compliance strategies also decreases agency risk and exposure during the learning phase.



POLICY POINT

Counties should rethink experience points and/or consider balancing these with points for organizations that serve or are operated by minority or underrepresented populations. In general, counties should apply a Diversity, Equity, and Inclusion (DEI) lens in their EPSDT contracting practices.



POLICY POINT

Stakeholders and local governments should explore reforms to ensure that procurement processes are administered with more transparency, clarity, accountability, and fairness, particularly toward new providers.



A Question of Scale

Counties often make contracting decisions from a macro perspective—considering the entire behavioral health system in that county, the range of contracted providers, and the availability of services for various populations. During the decision-making process, there are several overlapping factors that may influence county contracting preferences in a way that tends to disadvantage smaller providers. This is unfortunate, because many small or specialty providers intentionally focus on disenfranchised and vulnerable populations who are underserved and less likely to take advantage of traditional services.

First, county agencies may be reluctant to administer small contracts due to the relatively high administrative burdens these can entail, and the risks to the system if services are billed improperly.



PRACTICE TIP

Develop collaborative approaches with county partners. Ultimately, increasing collaboration between behavioral health departments, community-based organizations, and social services will result in better outcomes for transition-age foster youth and other at-risk youth.



POLICY POINT

Stakeholders and advocates should encourage counties to reserve a portion of contracts for agencies and community-based organizations that provide specialty services to otherwise underserved, vulnerable populations.

THE FLAT RATE ISSUE

The EPSDT-eligible population at First Place for Youth are those in THPP-NMD. During interviews, some stakeholders expressed concern that providers should be able to meet youth needs within the rates already available for THPP-NMD, and thus EPSDT funding could be better spent on another population. The THPP-NMD rate was originally intended to cover not just room and board, but also the full spectrum of services required by the program—services that promote positive outcomes and encourage successful transition to long term independence.

Part of the problem is that the THPP-NMD rate is the same in each county, and does not reflect regional housing costs. Increasingly, THPP-NMD providers are finding that the rising cost of housing is starving the portion of the rate that was intended for services. This is particularly acute for remote site (also known as scattered-site) providers in tight rental markets. In this model, providers or agencies lease apartments on the open market in various locations throughout the community. More and more, providers must compensate for rising rental costs by engaging in significant private fundraising and looking for opportunities for braided funding to provide necessary services—such as incorporating EPSDT. If the THPP-NMD rate were increased to address local housing costs, perhaps by reflecting the HUD Fair Market Rate (FMR), providers would have more funding available to provide necessary and enhanced mental and behavioral health services without looking to other sources.

Second, county contracting is often perceived as a winner-take-all game, meaning that if one provider—and their service population—receives an EPSDT contract, another will lose out. From this perspective, counties may be disinclined to award contracts to providers that serve a relatively narrow population, as opposed to those that can meet a broader range of community needs within one contract. There is a general perception that counties would rather give one contract to one general provider rather than multiple contracts to providers who support specific subpopulations.



PRACTICE TIP

Make a case for the needs of the provider's target population and how the program is a critical addition to the spectrum of available services. First Place was able to secure the Contra Costa contract in part due to a recognition on the part of county partners that transition-age foster youth are a particularly vulnerable population with unique service and access needs.



POLICY POINT

Counties should be accountable for identifying particular at-risk populations and ensuring that they have contracts within their array of providers that are designed specifically to meet those needs, including contracts with transition-age foster youth (TAY) providers.



Fiscal Concerns Under Realignment—Who Pays?

The EPSDT benefit is a federal entitlement, which means counties are required to provide these services to *all* eligible children, without caps. Counties are also required to have enough services available—either via contracts with private providers, or by providing them in-house—to meet the needs of the entire eligible population.

As a result, no counties explicitly cap the number of EPSDT contracts they enter into, nor the services they provide. However, in practice, many eligible youth are not able to access services, and observers note a reluctance on the part of counties to enter into new contracts with providers. Stakeholders and advocates have expressed concern that counties are limiting expenditures and treating EPSDT as a capped program in violation of federal law.

Many trace this problem to issues stemming from **2011 realignment** and growing fiscal concerns on the part of counties. Following realignment, counties have become increasingly concerned that the state will not continue to cover its share of EPSDT costs. In reaction, some county finance departments may be hesitant to expand EPSDT services.



POLICY POINT

Counties need clear guidance from the state affirming that EPSDT is an entitlement and guaranteeing that counties will be reimbursed for the state share when they exceed their allocation in providing medically necessary services to eligible children and youth. In other words, the state should assure counties that EPSDT service delivery will not become an unfunded mandate.

Realignment Fast Facts

- As part of the 2011–12 budget plan, the Governor and California State Legislature enacted a major shift—or “realignment”—of state responsibilities and revenues to local governments, primarily the state’s 58 counties.
- In total, realignment impacted over \$6 billion in funding and shifted responsibility for major criminal justice, mental health, and social services programs. The intent was to shift responsibility to the level of government that could best provide the services.
- Among the realigned services were public mental health programs, including the Medi-Cal EPSDT program.
- Under realignment, counties are responsible for delivering EPSDT services to Medi-Cal beneficiaries and funding the state share of program costs using dedicated state tax revenues allocated based on historical spending and demographics. The state, in turn, is responsible for reimbursing the federal share of county costs using federal Medicaid and state general funds.

Facing the uncertainty of ongoing state funding, counties may be disinclined to go into new contracts unless they are designed to meet a well-established and specifically demonstrated community need not addressed by the current continuum of services and providers. Developing relationships with county partners and educating them as to the importance of having a TAY-specific provider within the EPSDT continuum was an important part of First Place's success in procuring a contract in Contra Costa County.



PRACTICE TIP

Given this landscape, it is imperative for providers to make the case for why their organization should have an EPSDT contract. Think beyond the individual organization, do research, and be able to tell the county how contracting with your organization fits in the broader context and creates a better-rounded county continuum.



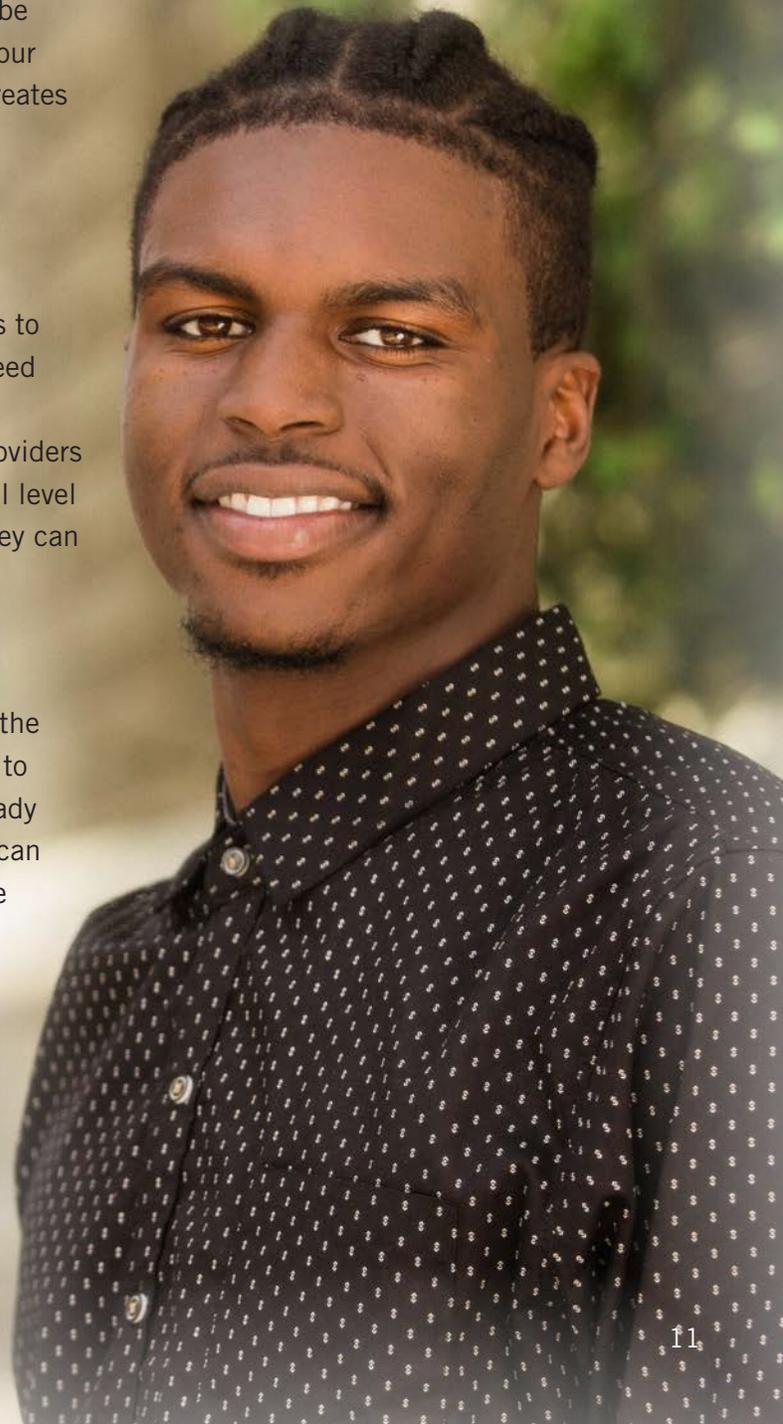
PRACTICE TIP

Relationships with the county are key. Build relationships and engage with county partners to make sure they understand the community need being met and the program's value to the full spectrum of county services. Counties and providers need to have good communication at the local level to understand what the needs are and how they can be met by the continuum of providers.



PRACTICE TIP

When making a pitch to the county, consider the county's needs and pressure points—namely, to increase service access and utilization. Be ready to demonstrate realistically how the program can assist the county in specifically meeting these goals.



FISCAL CHALLENGES: Costs, Risks, and Barriers to Sustainability

Jumping Into the Deep End

Initiating a behavioral health strategy supported by Medi-Cal billing requires significant investment of agency resources. There are substantial costs associated with feasibility, contract development, and site readiness. What makes these investments inherently risky is that most must be taken on with no guarantee of actually procuring an EPSDT contract.

In order to effectively compete for a contract in the first place, a provider must be ready to demonstrate their capacity to meet Medi-Cal certification requirements. Among other expenditures, this includes investing in necessary infrastructure, hiring appropriate licensed clinical staff and personnel to monitor compliance, and purchasing a HIPAA compliant EHR system that meets county specifications. Additionally, a prudent provider will set aside reserves to cover any gaps that emerge as a result of cost reconciliation during the first year of operation.

The prospect of covering these costs with no guarantee of actually procuring a contract is intimidating and may keep qualified providers from entering the field. Some of these risks, however, can be mitigated by partnering with outside funders and engaging in upfront conversations with potential county partners.

For First Place, the most critical support came from our partnership with the Walter S. Johnson Foundation. WSJF provided grant funding and access to subject-matter experts to support us as we completed feasibility, preparations, certifications, and early implementation. This partnership enabled First Place to mitigate the significant financial risks of pursuing an EPSDT contract and provide enhanced services that would otherwise have been out of reach.



PRACTICE TIP

Before beginning the contracting process, a prudent provider should preemptively identify administrative processes needed to accomplish enrollment, billing, and verification of services (quality assurance).



PRACTICE TIP

Philanthropic partnerships can provide instrumental support. Investment in planning and start-up grants enables providers to hone strategies without compromising existing services. Support might also be structured to leverage county funds, mitigating both provider and county risks while increasing accessible, high-quality services.



POLICY POINT

Counties typically do not have resources to float first-year or growth costs. However, public stakeholders should consider establishing a grant program to provide start-up funding to organizations looking to become Medi-Cal eligible. This could help level the playing field for smaller grassroots and community-based organizations and promote a greater diversity of provider types.

Conversations with Counties

For First Place, the path to becoming Medi-Cal billable truly began when we identified Contra Costa County as our target site and initiated active discussions with county officials. Medi-Cal certification is strictly required to procure an EPSDT contract. During these conversations, we reached an understanding that, once certified, First Place would receive an EPSDT contract to serve TAY. This informal understanding significantly lessened the financial risks we faced in pursuing certification.



PRACTICE TIP

In-depth conversations with representatives from county agencies—such as Children’s Behavioral Health Directors or TAY Services Coordinators—will assist a provider to submit a competitive bid demonstrating capacity and capability as well as positioning a bid to address an unmet need within the county’s array of services.



POLICY POINT

Stakeholders should explore whether it makes sense for counties to contribute to some of the start-up costs for providers that plan to serve populations with unmet needs in that county, so that provider agencies do not take on the risks and burdens alone.



The Long Haul – Barriers to Scale & Sustainability

During our financial planning processes, First Place determined that, in order for EPSDT to be fiscally sustainable for our organization, we would have to scale to multiple counties in which we operate, particularly those where we serve a higher concentration of EPSDT-eligible youth—those who are under age 21. We predicted that operating EPSDT contracts in multiple counties would make the project feasible by spreading out some of the one-time costs, including the significant infrastructure investments and the cost of hiring compliance staff.

In considering the costs and benefits of EPSDT contracting, it is important to remember that Medi-Cal certification is only valid for one specific county, one specific location (e.g. office) within that county, and one specific set of services. This means that an organization must undertake the entire certification process for each county in which it intends to operate. Given the barriers associated with obtaining contracts in each county, this can make it very difficult to reach the scale required to make fiscal sense for an organization. For First Place, the obstacles and challenges overviewed in this brief caused us to pause our original strategy of scaling to multiple counties.



PRACTICE TIP

Before beginning this process, providers should perform a thorough cost-benefit analysis for the organization. Consider each county in which the program operates, the size of the EPSDT-eligible population served in each county, and where—if anywhere—Medi-Cal contracts are pre-existing.



PRACTICE TIP

Proceed with caution: as part of their cost-benefit analysis, agencies should specifically consider the scale they would need to reach to achieve fiscal sustainability, and the likelihood of reaching that scale given the service type, eligible population, and various barriers to contract procurement.



Looking Back, Thinking Forward

Our journey to obtaining and implementing an EPSDT contract presented exciting opportunities as well as persistent challenges. When we started this journey, our goal was twofold. First, we hoped to provide enhanced behavioral health services that increase placement stability, reduce unplanned exits from program, and support lasting outcomes in areas associated with long-term independence and self-sufficiency. And second, we predicted that utilizing EPSDT as a funding source would allow us to meet budget shortfalls for behavioral health services we were already providing, thus decreasing our dependence on private fundraising.

As for our first goal, we were successful in procuring and implementing an EPSDT contract to benefit youth in Contra Costa County, and we have been providing EPSDT services to youth there since July 2017. It is still too soon to tell whether this mode of service delivery has enabled us to help youth achieve enhanced outcomes in education, employment, housing stability, and healthy living skills. However, we would welcome the opportunity to engage in more in-depth research on that question.

The second goal, related to fiscal sustainability, was dependent in part on our ability to expand EPSDT services to additional program sites, particularly in counties where we serve a higher percentage of EPSDT-eligible youth. As discussed in this issue brief, the fiscal, operational, and contracting challenges we encountered along the way have caused us to pause our initial strategy and proceed with additional caution moving forward.

There is great potential to use EPSDT funding to better integrate behavioral health care into extended foster care settings, improving services and outcomes for transition-age youth. However, tapping into that potential will be very difficult until there is broader systemic reform, particularly around contracting practices that unduly burden smaller organizations. We hope this issue brief highlights some of the drawbacks and challenges and sparks a conversation about the work that lies ahead.



About First Place for Youth

The mission of First Place is to help foster youth build the skills they need to make a successful transition to self-sufficiency and responsible adulthood. Founded in 1998 to address high rates of poverty, homelessness, and incarceration among former foster youth, First Place provides housing, intensive education and employment services, and life skills support to nearly 2,000 young people each year.

First Place operates direct service programs in six California counties—Alameda, Contra Costa, Los Angeles, San Francisco, Santa Clara, and Solano—and advocates for policies at the local, state and federal level to better meet the needs of transition-age youth in foster care. In 2017, First Place launched the My First Place™ Network to support other organizations as they implement the My First Place service model and otherwise expand and enrich their services for transition-age foster youth. First Place currently has partnerships with Hopewell, Inc., The Children’s Village, the Mississippi State Department of Child Protection Services, and the Jim Casey Youth Opportunities Initiative.

As an organization, First Place for Youth believes that more is possible for foster kids and has helped more than 10,000 young people on the path to brighter futures.

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