

## Children and Youth Behavioral Health Work Group (CYBHWG)

Friday, September 17, 2021  
8:00 am - Noon

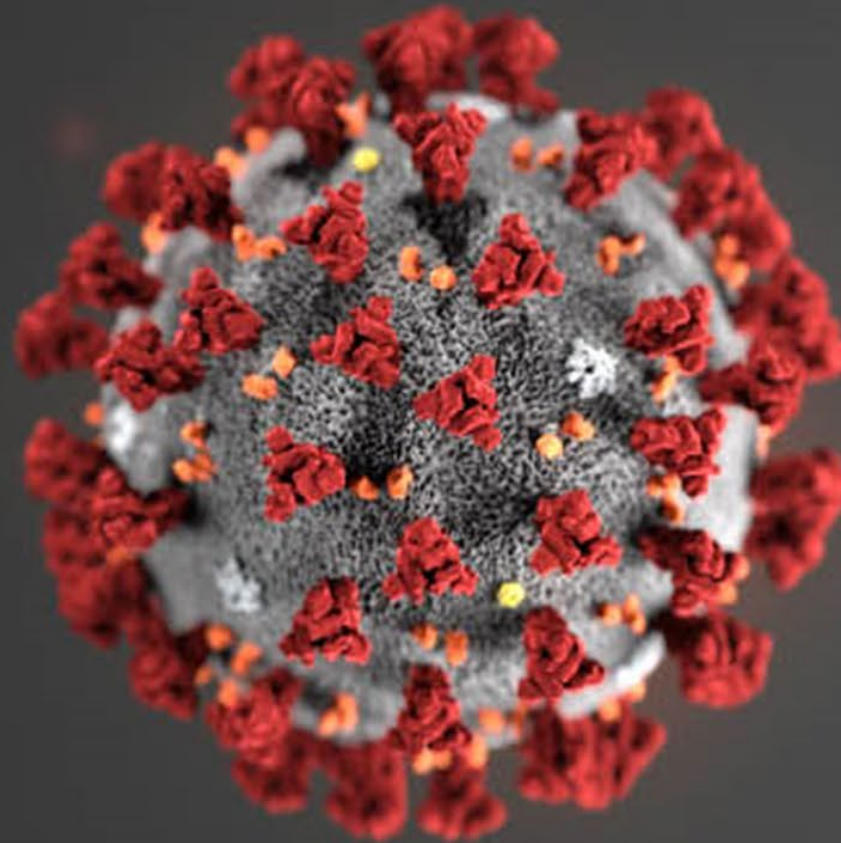
| Members                             |                                      |                                     |                             |                                     |                                       |
|-------------------------------------|--------------------------------------|-------------------------------------|-----------------------------|-------------------------------------|---------------------------------------|
| <input checked="" type="checkbox"/> | Representative Lisa Callan, Co-Chair | <input checked="" type="checkbox"/> | Dorothy Gorder              | <input type="checkbox"/>            | Cindy Myers                           |
| <input checked="" type="checkbox"/> | Keri Waterland                       | <input checked="" type="checkbox"/> | Summer Hammons              | <input checked="" type="checkbox"/> | Travis Sugarman (for Michele Roberts) |
| <input type="checkbox"/>            | Hannah Adira (non-voting)            | <input checked="" type="checkbox"/> | Dr. Robert Hilt             | <input checked="" type="checkbox"/> | Joel Ryan                             |
| <input checked="" type="checkbox"/> | Javiera Barria-Opitz                 | <input checked="" type="checkbox"/> | Kristin Houser              | <input type="checkbox"/>            | Noah Seidel                           |
| <input checked="" type="checkbox"/> | Dr. Avanti Bergquist                 | <input checked="" type="checkbox"/> | Avreayl Jacobson            | <input checked="" type="checkbox"/> | Mary Stone-Smith                      |
| <input checked="" type="checkbox"/> | Jane Beyer                           | <input checked="" type="checkbox"/> | Kim Justice                 | <input checked="" type="checkbox"/> | Representative My-Linh Thai           |
| <input type="checkbox"/>            | Tony Bowie                           | <input type="checkbox"/>            | Nichole Jensen (non-voting) | <input checked="" type="checkbox"/> | Jim Theofelis                         |
| <input checked="" type="checkbox"/> | Representative Michelle Caldier      | <input type="checkbox"/>            | Andrew Joseph, Jr.          | <input type="checkbox"/>            | Dr. Eric Trupin                       |
| <input checked="" type="checkbox"/> | Diana Cockrell                       | <input checked="" type="checkbox"/> | Michelle Karnath            | <input type="checkbox"/>            | Senator Judy Warnick                  |
| <input checked="" type="checkbox"/> | Lee Collyer                          | <input checked="" type="checkbox"/> | Judy King                   | <input checked="" type="checkbox"/> | Lillian Williamson                    |
| <input checked="" type="checkbox"/> | Representative Carolyn Eslick        | <input checked="" type="checkbox"/> | Amber Leaders               | <input checked="" type="checkbox"/> | Senator Claire Wilson                 |
| <input checked="" type="checkbox"/> | Dr. Thatcher Felt                    | <input checked="" type="checkbox"/> | Bridget Lecheile            | <input checked="" type="checkbox"/> | Dr. Larry Wissow                      |
| <input type="checkbox"/>            | Tory Gildred                         | <input checked="" type="checkbox"/> | Laurie Lippold              | <input checked="" type="checkbox"/> | Jackie Yee                            |

Staff: Rachel Burke, Cindi Wiek, and Cesar Zatarain, Jr.

Legislator(s): Rep. Lauren Davis, Rep. Carolyn Eslick, Rep. Mari Leavitt

| Agenda Items   | Notes  |
|--|--|
| Welcome / Co-chair nomination and approval                           | Decision: Keri Waterland approved as CYBHWG Co-chair.  |
| DOH Update: Forecast for children, youth and families/BH strike team | <p><b>Tona McGuire</b></p> <p><i>See page 3 for slides and TVW recording (35:06).</i></p> <p>Highlights:</p> <ul style="list-style-type: none"> <li>\$31M in federal funds to community BH providers – apps closed; expect to notify providers Oct. 1.</li> <li>Talking with BH providers to free up beds for youth (and get them out of EDs and hospital beds).</li> </ul> <p><i>See page 20 for information on Supporting Adolescents and Families Experiencing Suicidality (SAFES) grant.</i></p> |
| Update: CYBHWG mission/vision  | <p><i>See page 21 for CYBHWG mission and vision, and TVW recording (56:44)</i></p> <p>Issues raised:</p> <ul style="list-style-type: none"> <li>Want to make sure behavioral health services are developmentally relevant.</li> <li>Ensure that services are affirming of non-binary gender orientation.</li> <li>Ensure that services are tailored and aligned with community strengths and needs.</li> </ul>   |

|  |  |
|--|--|
| <p>HCA update: Recommendation implementation, decision packages</p> <p>State agency budget requests (called decision packages) are now available on <a href="#">OFM's website</a>.</p> | <p>See page 22 for a summary of recommendations for the 2021 legislative session and resulting legislation, and TVW recording (1:14:30).</p> <p>Additional instructions for accessing decision packages.</p> <ul style="list-style-type: none"> <li>• Use the <a href="#">OFM's website</a>.</li> <li>• Choose select option</li> <li>• Choose 2022 supplemental</li> <li>• Check the agencies and subcategories you want to see</li> <li>• Then search</li> </ul>   |
| <p>Legislative outlook</p>   | <p><b>Representative Lisa Callen</b><br/>See TVW recording (1:37:33)</p>   |
| <p>Subgroup updates</p>  | <p><b>Workforce &amp; Rates</b><br/>See TVW recording (1:43:36), and page 25 for additional materials</p> <p><b>Behavioral Health Integration</b><br/>See TVW recording (2:03:22); and page 26 for additional materials</p> <p><b>Prenatal through Five Relational Health</b><br/>See TVW recording (3:14:26), and page 29 for additional materials</p> <p><b>Youth and Young Adult Continuum of Care</b><br/>See TVW recording (2:39:12)</p> <p><b>School-based Behavioral Health &amp; Suicide Prevention</b><br/>See TVW recording (3:26:40), and page 32 for additional materials</p> <p><b>Additional Information:</b><br/><a href="#">State auditor's report on K–12 student behavioral health</a><br/><a href="#">WA Perinatal support line</a> or 1-888-404-7763</p> |
| <p>Presentation: Certified Community Behavioral Health Centers</p>   | <p><b>National Council for Mental Well-being</b><br/><b>Brett Beckerson, Director, Public Policy &amp; Advocacy</b><br/><b>&amp; Monika Witt, MSW, Project Manager</b></p> <p>See page 40 for slides and TVW recording (2:46:00).</p> <p><b>Additional Information:</b><br/><a href="#">How CCBHCs support the justice systems, including juvenile justice</a><br/><a href="#">Crisis response efforts with CCBHC and 988</a><br/><a href="#">May 2021 report with a lot of great data on the CCBHC model</a><br/><a href="#">All CCBHCs</a> (links to all states' CCBHCs)</p>   |
| <p>Public comment</p>  | <p>Sarah Rafton, Washington Chapter of the American Academy of Pediatrics</p> <ul style="list-style-type: none"> <li>• Would like to respectfully offer that the CYBHWG do a formal strategic planning process in the 2022 year to propose a holistic vision in 2023 for all parts of the system from prevention to treatment to acute and long-term needs.</li> </ul>   |
| <p>Wrap up/Next steps</p>  | <ul style="list-style-type: none"> <li>• Final recommendations due 10/11/21.</li> <li>• 10/15/21 CYBHWG Meeting to finalize recommendations.</li> </ul>  |



BEHAVIORAL HEALTH IMPACTS OF COVID-19  
**September Forecast and Impact on Youth  
2021 Update**

# Brief Overview: Development and Further Reading

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## Background:

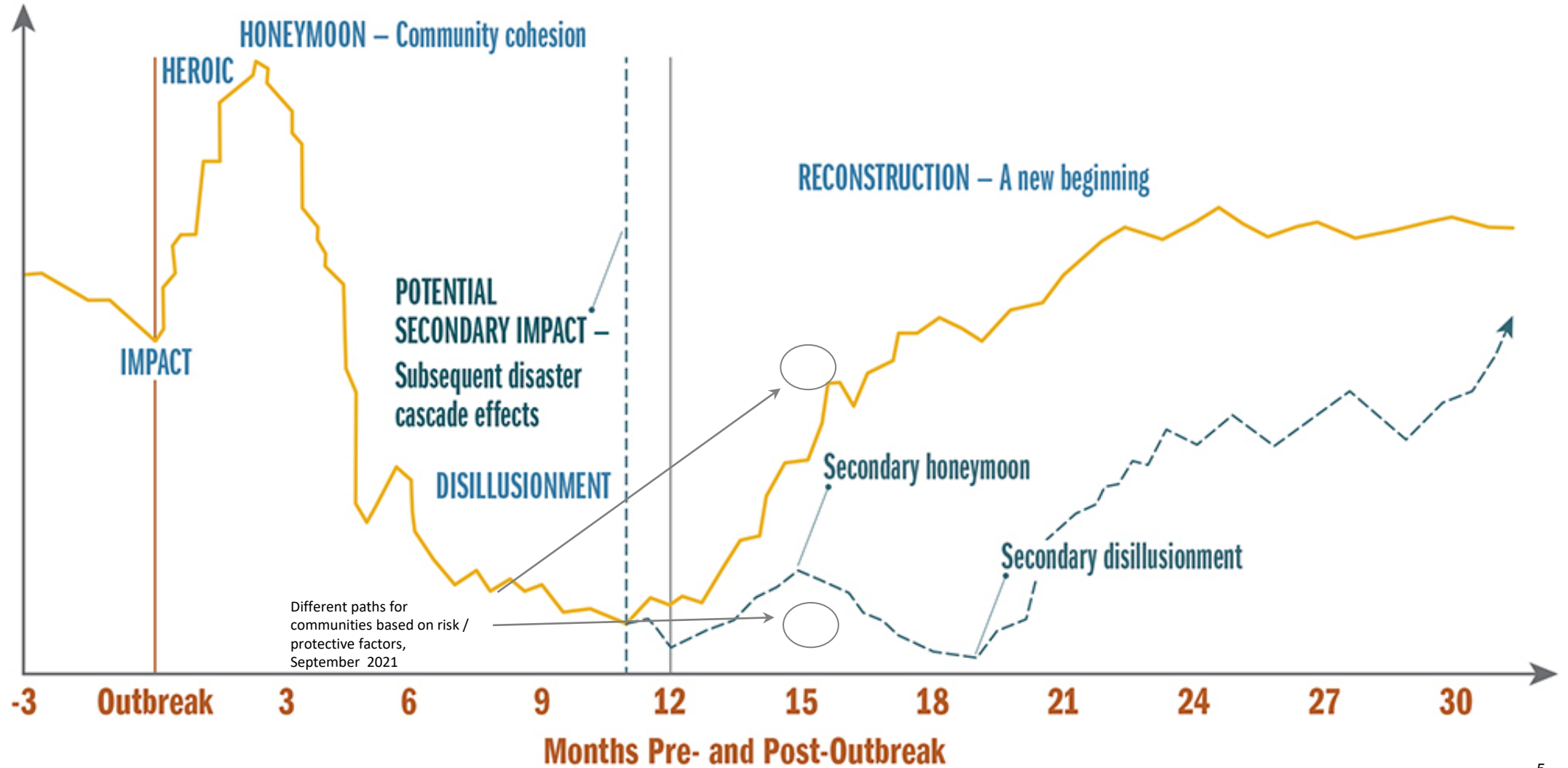
- Developed by combining academic literature, a wide variety of data sources, and the expertise of the DOH Behavioral Health Strike Team
- Highly subject to future waves, government actions, societal trends, social and economic impacts
- Continually informed by new research and data sources

## Further reading:

- Statewide Impact Forecast (*updated monthly*)
- Behavioral Health Situational Report (*updated weekly*)

# Reactions and Behavioral Health Symptoms in Disasters

Emotional Response – Lows to Highs



# Key Things to Know

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Areas of focus for September 2021:

- Back-to-classroom instruction for students around the state
  - Associated youth surge (there was no summer “slump” in Behavioral Health patterns for youth and adolescents)
  - Potential for school anxiety / refusal, behavioral acting out, withdrawal, regression
  - Parental / Caregiver anxiety about schools closing again, or having to balance work and childcare
- Expectations and associated anxiety around social participation and reconnection in the context of a pandemic that continues:
  - Anxiety about participation in social events.
  - Sense of overwhelm in crowds, or in groups.
  - Unsure of social dynamics, re-establishing and reconnecting with others, making small talk.
  - Fear of pressure to participate in things.

# Key Things to Know

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- “Return to workplace” shifts for many employers may also cause some unexpected behavioral health responses.
  - Some employees may be fearful about expectations, uncertain about in-office policies and procedures related to safety and health, frustrated by the addition of a commute, or confused as to their own mixed emotions about the ‘end’ of the pandemic and the opportunities and challenges associated with coming back to in-office work.
  - Interpersonal relationships in the workplace may also cause more frustration and anxiety for some in the workplace.
- **Members of the BIPOC community may be at higher risk of BH symptoms related to workplace return** if they are returning to environments where they have previously experienced (or are concerned about the ongoing or magnified experience of) discrimination, racism or microaggressions.

# Key Things to Know

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- As more and more people test positive for COVID, the long-term diagnostic sequelae are important to consider:
  - Long haul COVID – GI symptoms, exhaustion, respiratory sx are among the most common
  - Cognitive Dysfunction: UK study  
N = 81,337 participants (People who had recovered from COVID-19, including those no longer reporting symptoms), exhibited significant cognitive deficits versus controls when controlling for age, gender, education level, income, racial-ethnic group, pre-existing medical disorders, tiredness, depression and anxiety. The deficits were substantial for those who had been hospitalized as well as those who were not hospitalized who had biological confirmation of COVID-19 infection (N = 326).  
[https://www.thelancet.com/action/showPdf?pii=S2589-5370\(21\)00324-2](https://www.thelancet.com/action/showPdf?pii=S2589-5370(21)00324-2)
- Anxiety and depression (and a potential for an uptick in PTSD) may increase in the next few months related to variants of the virus, particularly Delta, but other variants of interest and concern as well. (Pulse survey shows potential return to baseline pre-covid)
- Vaccine efficacy / hesitancy/ breakthrough in context of variants: reinforcing ideas that are simple, consistent and reduce anxiety by focusing on actual risk (rather than perceived risk, which people consistently don't accurately determine).



# Potential for Violence and Aggression

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## ✧ Different viewpoints

Viewpoints are often held as “correct” or “incorrect” and as “Us vs Them”, leading to more rigidity, anger and judgment.

## ✧ Impulsivity & Emotion Dysregulation

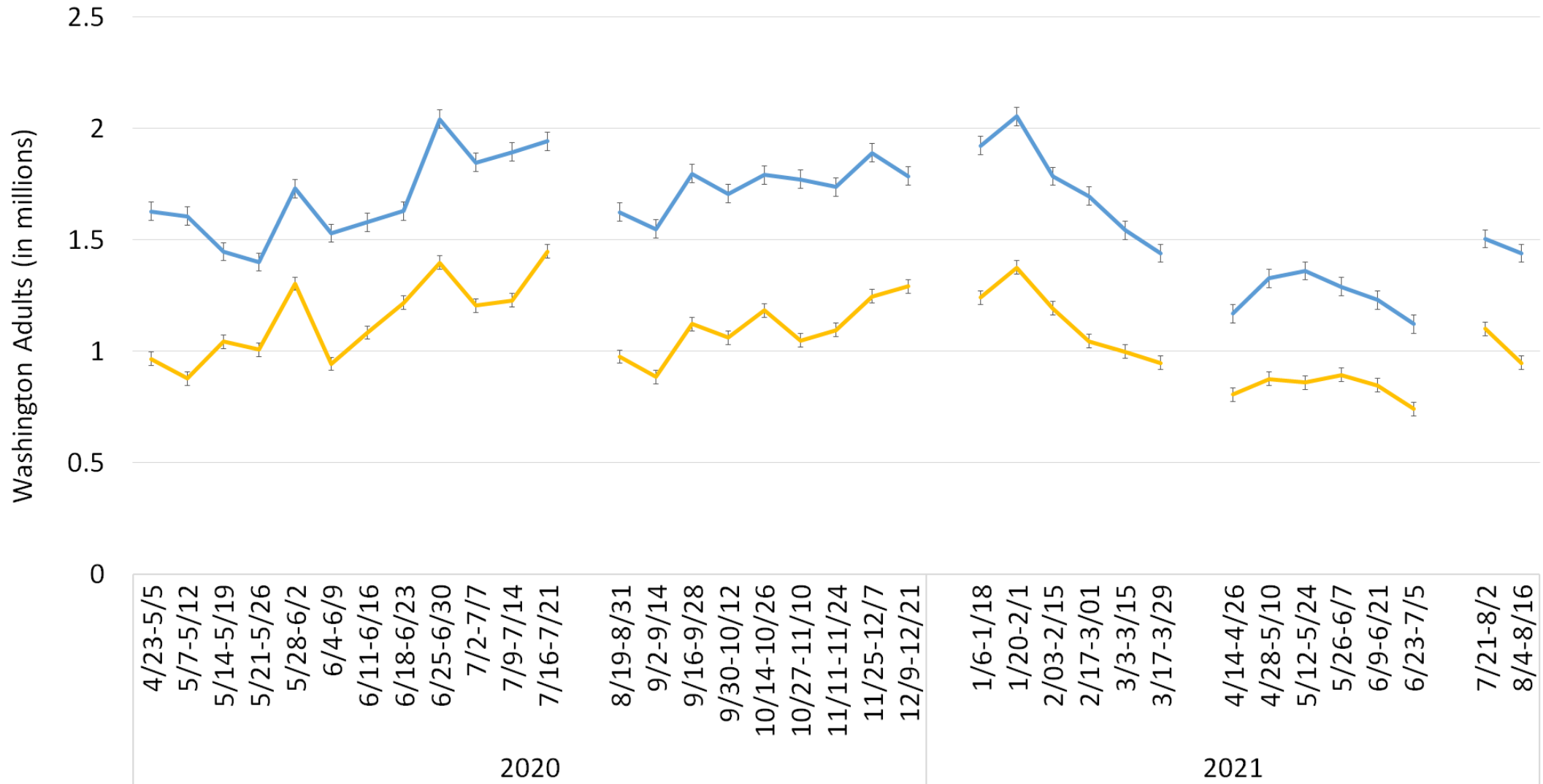
Impulsivity is still high.  
We have a harder time controlling our emotional responses.

## ✧ More contact

More in person social contact, more ambiguity about how to engage with others.

People can often respond differently or uncharacteristically (with more aggression or hostility) in crowds compared to small groups.

# Anxiety, Depression (Census Bureau)



—Anxiety: Feeling nervous, anxious, or on edge

—Depression: Feeling down, depressed, or hopeless

# Data Source & Definitions

The Department of Health collects syndromic surveillance data in near real-time from hospitals and clinics across Washington. The data are always subject to updates. Key data elements reported include patient demographic information, chief complaint, and coded diagnoses. This [data collection system](#) is the only source of emergency department (ED) data for Washington.

Visits of interest per 10,000 ED visits are utilized to measure 4 syndromic variables:

1. suicidal ideation,
2. suspected suicide attempt,
3. psychological distress, and
4. suspected all drugs overdoses.

Visits of interest per 10,000 ED visits can help provide insights into:

1. behavioral health impacts since the implementation of the “Stay Home, Stay Healthy” order from March 23, 2020 (CDC Week 13),
2. seasonal shifts year-over-year,
3. new visit trends due to COVID-19 symptoms and diagnosis,
4. perceptions of disease transmission and risk, as well as,
5. the relative frequency of these indicators for 2019, 2020, and 2021.

## Limitations:

Because the volume of visits across care settings varied widely during 2020 and to date in 2021, rates presented in this report may not reflect the true magnitude and direction of trends for behavioral health conditions and should be interpreted cautiously.

Furthermore, caution should be taken when evaluating data as fewer overall ED visits beginning in March 2020 (CDC Week 10-14) can skew results of data.

Furthermore, ED visits count for suicidal ideation, suspected suicide attempt, psychological distress, and suspected overdoses might show an increase in awareness in mental health experiences, thus taking a larger share of the total ED visits.

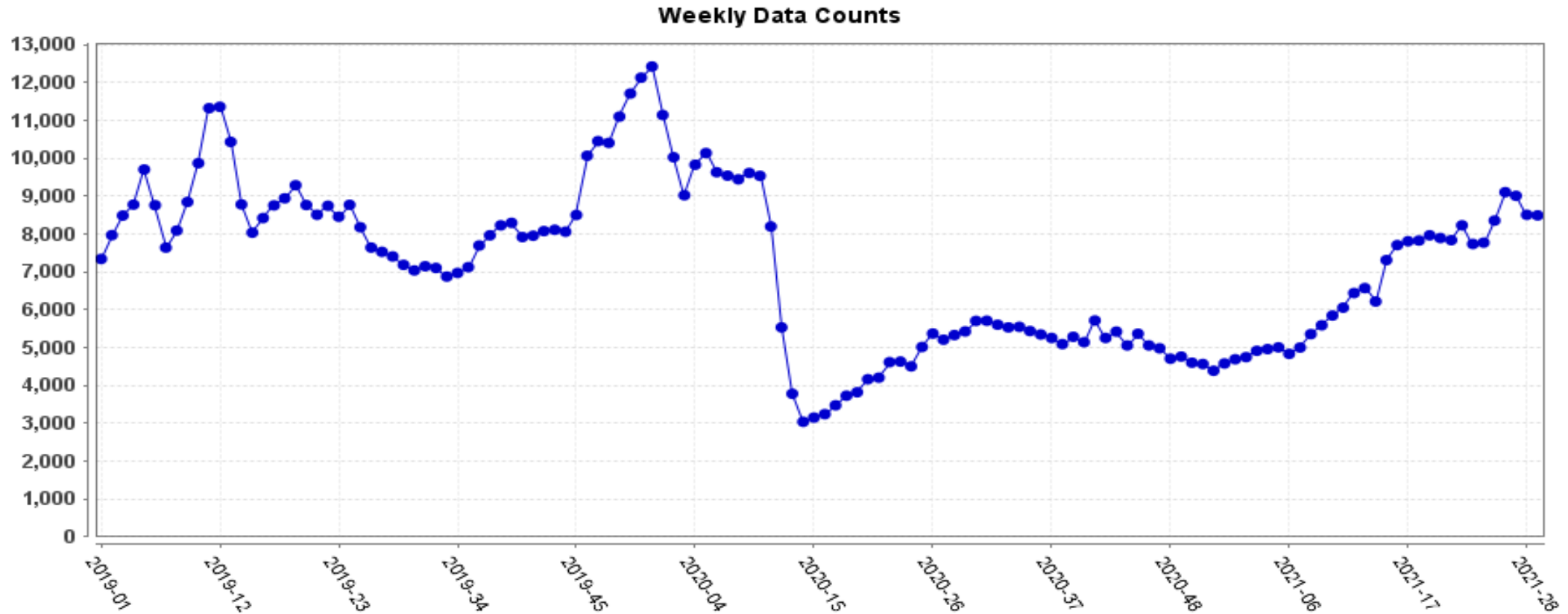
**Suicidal ideation:** Created by partners in the CDCs National Center for Injury Prevention to support states and jurisdictions to query visits related to suicidal ideation, or thoughts or plans of engaging in suicide-related behavior. Full details are available at <https://knowledgerepository.syndromicsurveillance.org/CDC-suicide-attempt-v1-syndromedefinitioncommittee>.

**Suspected suicide attempt:** Created by partners in the CDCs National Center for Injury Prevention to support states and jurisdictions to query visits related to a suicide attempt, or self-directed and potentially injurious behavior with any intent to die as a result of the behavior. Full details are available at <https://knowledgerepository.syndromicsurveillance.org/CDC-suicide-ideation-v1-syndromedefinitioncommittee>.

**Psychological distress:** This is a Syndrome Definition Committee community-developed syndrome definition for mental health conditions likely to increase in emergency department frequency during and after natural or human-caused disaster events. Full details are available at <https://knowledgerepository.syndromicsurveillance.org/disaster-related-mental-health-v1-syndromedefinitioncommittee>.

**Suspected all drugs overdoses:** This definition specifies overdoses for any drug, including heroin, opioid, and stimulants. It is indexed in the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) platform as CDC All Drug v1. Full details available at <https://knowledgerepository.syndromicsurveillance.org/cdc-all-drug-v1>.

# Weekly Data Counts for all ED Visits - 18 and under



## Key Points:

This graph represents weekly data counts of all ED visits in Washington state for people 18 and younger from Week 1 of 2019 to Week 29 of 2021 (week of July 18)

## Metrics:

Range: 1,777 to 12,420 ED visits.

## Limitations:

Caution should be taken when evaluating data as fewer overall ED visits beginning in March 2020 (CDC Week 10-14) can skew results of data.

## Limitations (additional):

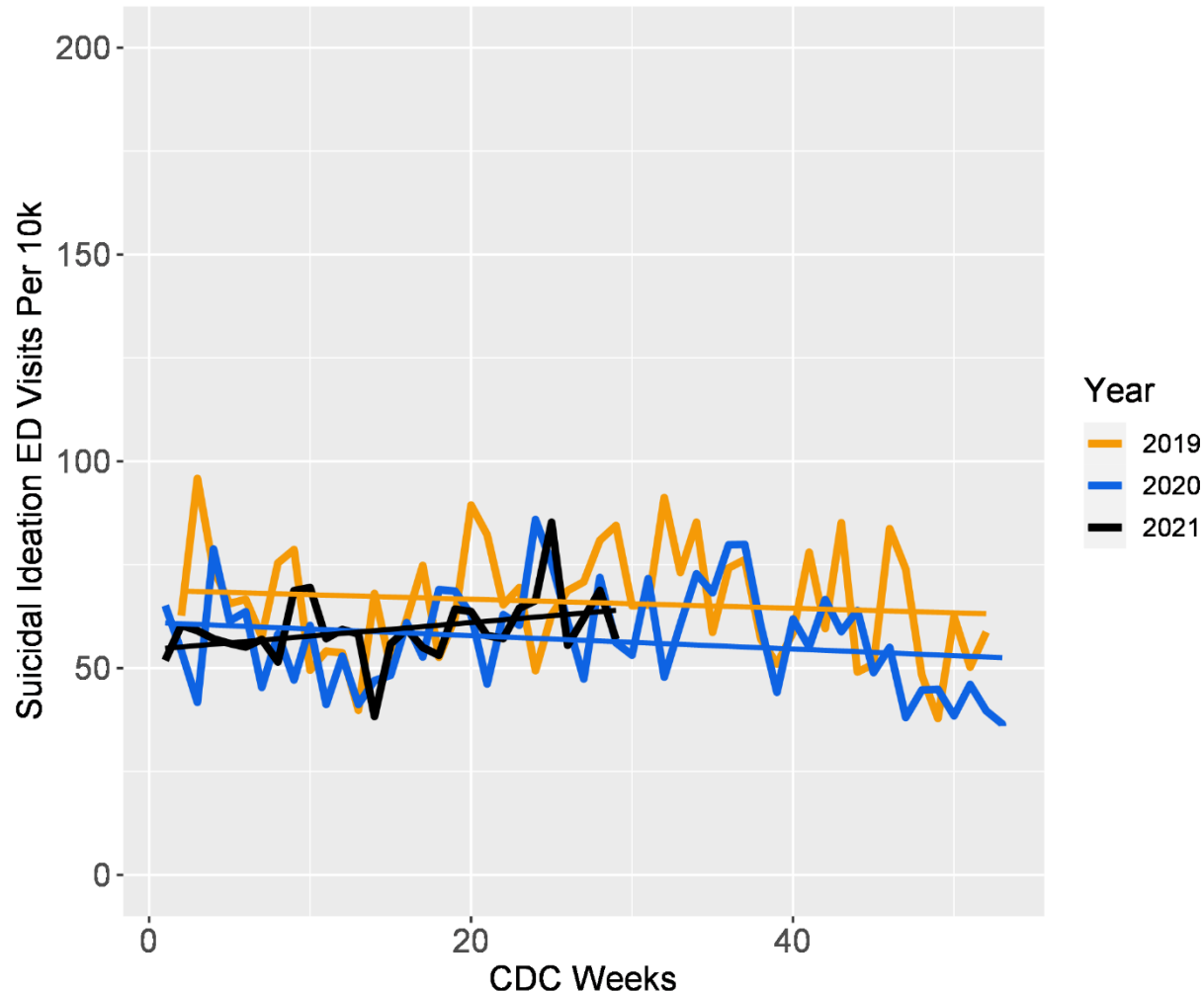
Because the volume of visits across care settings varied widely during 2020 and to date in 2021, rates presented in this report may not reflect the true magnitude and direction of trends for behavioral health conditions and should be interpreted cautiously.

Furthermore, ED visits count for suicidal ideation, suspected suicide attempt, psychological distress, and suspected overdoses might show an increase in awareness in mental health experiences, thus taking a larger share of the total ED visits.

# Suicidal Ideation – 18 and under

## Number of Suicidal Ideation Related Visits per 10,000 ED Visits

(limited to patients 18 years of age and under)

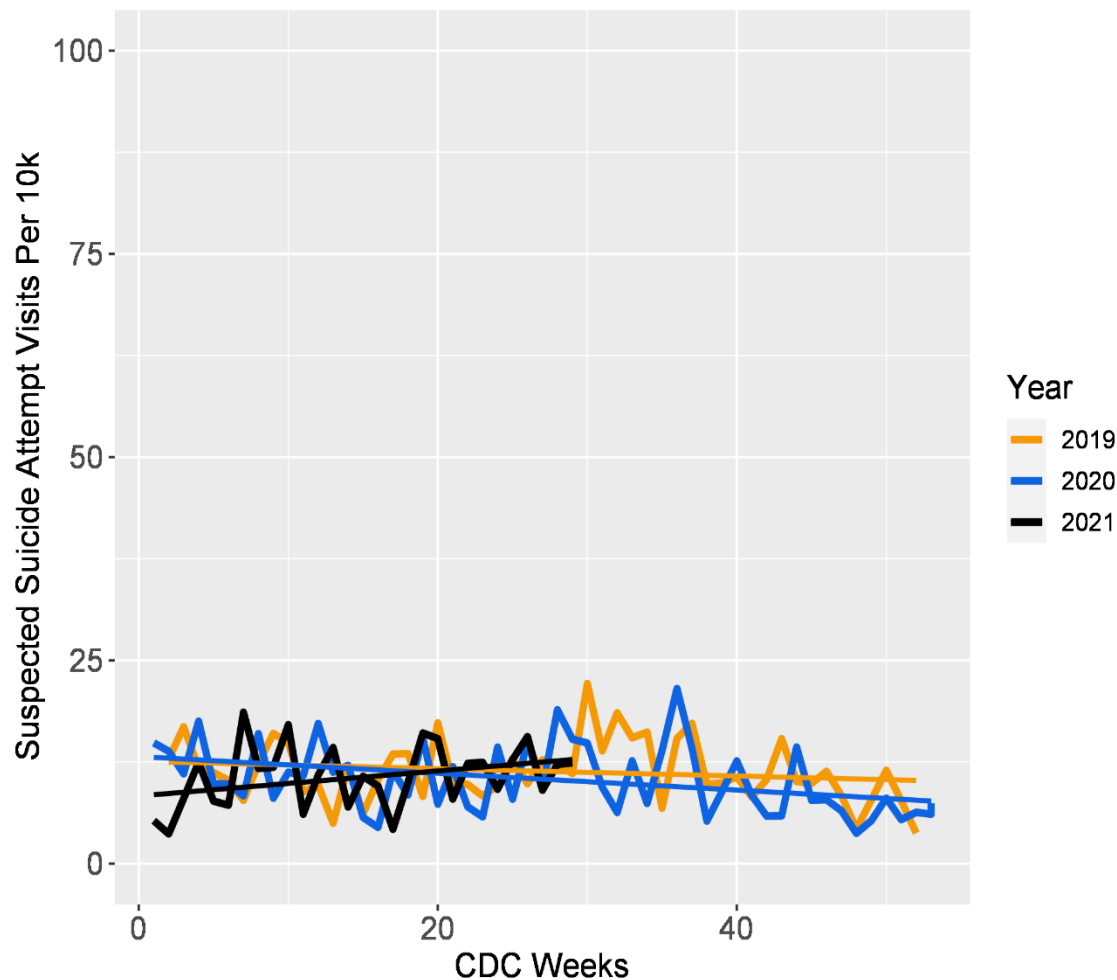


Average Weekly Difference Amongst Visit Counts: -42.6 per 10,000  
Source: CDC National Syndromic Surveillance Program

- The relative reported rate of ED visits for suicidal ideation among youth **decreased from the previous reporting period.**
- For the fifth reporting period in a row, **no statistical warnings or alerts were issued.**
- **Caution should be taken** when evaluating data
  - Fewer overall ED visits beginning in March 2020 (CDC Week 10-14) can skew results.
  - ED visits counts for behavioral health issues **might show an increase in awareness** in mental health experiences, thus taking a larger share of the total ED visits.

# Suspected Suicide Attempt – 18 and under

Number of Suspected Suicide Attempt Related Visits  
per 10,000 ED Visits  
(limited to patients 18 years of age and under)

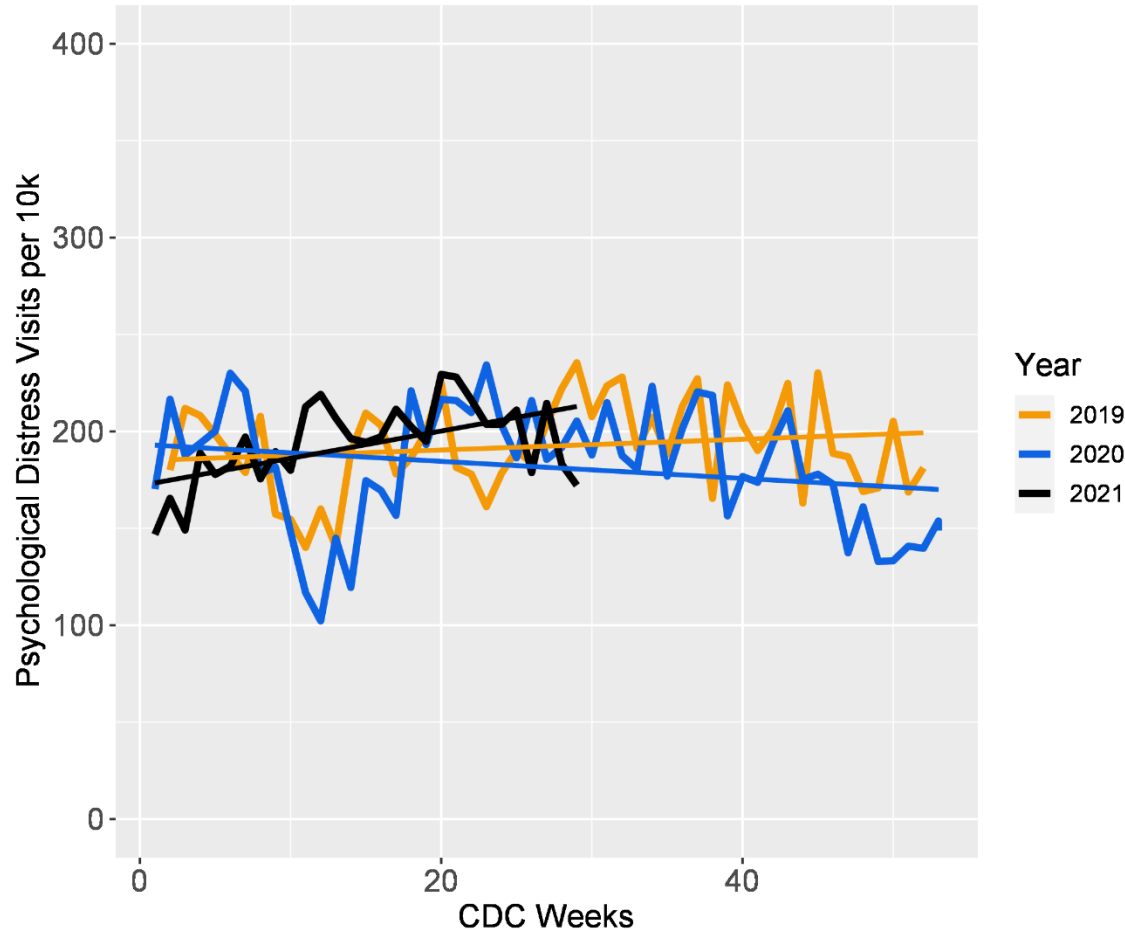


Average Weekly Difference Amongst Visit Counts: -7.4 per 10,000  
Source: CDC National Syndromic Surveillance Program

- The relative reported rate of ED visits for suspected suicide attempt among youth was **virtually unchanged from the previous reporting period.**
- For the fifth reporting period in a row, **no statistical warnings or alerts were issued.**
- **Caution should be taken** when evaluating data
  - Fewer overall ED visits beginning in March 2020 (CDC Week 10-14) can skew results.
  - ED visits counts for behavioral health issues **might show an increase in awareness** in mental health experiences, thus taking a larger share of the total ED visits.

# Psychological Distress – 18 and under

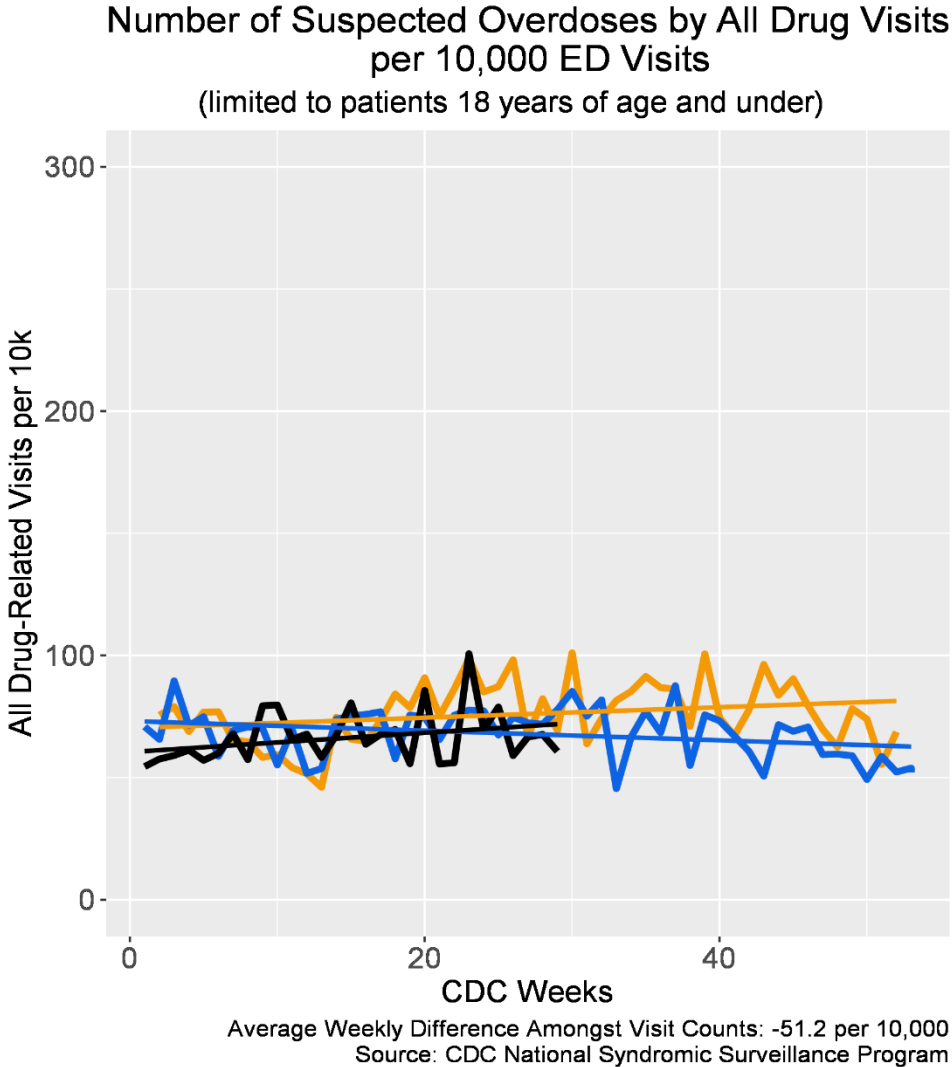
Number of Psychological Distress Related Visits  
per 10,000 ED Visits  
(limited to patients 18 years of age and under)



Average Weekly Difference Amongst Visit Counts: -119.2 per 10,000  
Source: CDC National Syndromic Surveillance Program

- The relative reported rate of ED visits for psychological distress among youth **decreased from the previous reporting period.**
- For the fifth reporting period in a row, **no statistical warnings or alerts were issued.**
- **Caution should be taken** when evaluating data
  - Fewer overall ED visits beginning in March 2020 (CDC Week 10-14) can skew results.
  - ED visits counts for behavioral health issues **might show an increase in awareness** in mental health experiences, thus taking a larger share of the total ED visits.

# Suspected Overdoses – 18 and under



- The relative reported rate of ED visits for suspected drug overdose among youth **decreased from the previous reporting period.**
- For the fifth reporting period in a row, **no statistical warnings or alerts were issued.**
- **Caution should be taken** when evaluating data
  - Fewer overall ED visits beginning in March 2020 (CDC Week 10-14) can skew results.
  - ED visits counts for behavioral health issues **might show an increase in awareness** in mental health experiences, thus taking a larger share of the total ED visits.



## Resources:

DOH - Forecast and situational reports, guidance and resources:

<https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020COVID19/HealthcareProviders/BehavioralHealthResources>

WA State – General mental health resources:

<https://coronavirus.wa.gov/information-for/you-and-your-family/mental-and-emotional-well-being>

**Looking for support?**  
Call Washington Listens at  
**1-833-681-0211**



Questions?





Washington State Department of Health is committed to providing customers with forms and publications in appropriate alternate formats. Requests can be made by calling 800-525-0127 or by email at [civil.rights@doh.wa.gov](mailto:civil.rights@doh.wa.gov). TTY users dial 711.

# Grant Awarded for Supporting Adolescents and Families Experiencing Suicidality (SAFES)

The federal Health Resources and Services Administration (HRSA) recently awarded the Washington State Department of Health (DOH) a [Pediatric Mental Health Care Access Grant](#) to increase the integration of telehealth resources into pediatric care. The SAFES project will create a crisis care consultation service for northeastern Washington through a partnership between DOH, Seattle Children's, and Frontier Behavioral Health.

The award of \$445,000 per year for five years will build on the existing [Partnership Access Line](#) (PAL) and [Behavioral Health Crisis Care Clinic](#) at Seattle

Children's. PAL provides mental health consultation to pediatric primary care providers (PCPs) statewide. This project will provide additional outreach to the pediatric primary care providers in the 10 counties in the Better Health Together and North Central Accountable Communities of Health (see map of regions served), in part to increase their use of PAL.

Seattle Children's will train and support a crisis care team at Frontier Behavioral Health in Spokane based on the Crisis Care Consultation Clinic model at Seattle Children's. This team will provide a combination of in-person and telehealth crisis support services to clients in the

region with suicidality crises and inadequate current supports. PAL will be used to triage referrals from PCPs that are appropriate to refer to the Frontier Crisis Care Team.

DOH's Children & Youth with Special Health Care Needs, Adolescent Health, and COVID Behavioral Health teams will coordinate this work as part of our ongoing efforts to improve child and adolescent health and address the mental health impacts of the COVID-19 pandemic. This funding is part of the American Rescue Plan Act. For more information, please contact Monica Burke at [monica.burke@doh.wa.gov](mailto:monica.burke@doh.wa.gov).



## Children and Youth Behavioral Health Work Group (CYBHWG)

**What's changed?** *Proposed 2021 changes are italicized.*

### Vision

*Each and every Washington child, youth and young adult, and their families are thriving.*

### Mission

Identify barriers and develop solutions and opportunities for *equitable, high quality* behavioral health services and strategies for children, youth and young adults (prenatal to age 25) and their families *through seeking deep and significant engagement of those receiving, delivering and funding the services. Ensure that all children, youth, and families have access to high-quality, equitable, well-resourced behavioral health education, care and supports when and where they need it.*

### Objectives

*Recommending legislation and other changes to ensure that behavioral health services for all of Washington's children, youth, young adults (prenatal to age 25) and their families are:*

- Accessible,
- *Affordable,*
- Effective,
- Timely,
- Culturally and linguistically relevant,
- *Engaging,*
- Supported by evidence,
- Incorporate tailored innovations, as needed,
- *Coordinated across sectors,*
- *Integrated whole-person care,*
- *Normalized as part of everyone's healthcare,*
- *Sustainable, with robust capacity and funding,*
- *Hold the promise of measurably improving health and outcomes, and*
- *Are amply resourced for all children, youth, and young adults.*

# Children and Youth Behavioral Health WorkGroup

## *Update: Recommendations for the 2021 legislative session*

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### Prioritized recommendations

#### Priority 1:

- ✓ Inclusion of the 2020 budget proviso [SB 6168, Sec. 211(78), 2020] to increase Medicaid rates for behavioral health services to retain workforce and ensure access. (Passed in 2020 legislative session for 2021 fiscal year; then vetoed as part of pandemic response.)  
*Senate Bill 5092 (operating budget):*
  - *\$6.5M General Funds-State (GFS)/\$17.509M total (includes federal funding through Medicaid). For children and adults, increases provider rates for behavioral health services by 15% (not to exceed the Medicaid rate) for individual, family and group therapy related to a primary medical diagnosis; assessment, and other behavioral health supports, effective October 1, 2021.*
  - *\$17.016M GFS/\$55.041M total. Continue 2% increase in Medicaid reimbursements that was provided in April 2021 to community behavioral health providers contracted through managed care organizations, with HCA employing mechanisms such as directed payment to assure that providers receive these increases.*
- ✓ Continue funding the “Washington State Mental Health Referral Service for Children and Teens” which helps families find providers that accept their insurance, and PAL for Moms, which supports physicians treating post-partum depression.  
*House Bill 1325 establishes these services as permanent programs.*

- ✓ **Priority 2:** Expand youth mobile crisis services statewide and ensure existing teams can meet increased demand.  
*Senate Bill 5092: \$25.848M GFS/\$38.579M total\* for adult and youth mobile crisis services. A minimum of 6 new youth teams will be established so each region has at least one by June 30, 2022.*

- ✓ **Priority 3:** Change Medicaid policy to match best practices for mental health assessment and diagnosis of children 0-5, including allowing 3-5 sessions for intake/assessment, in children’s homes and other natural settings.  
*House Bill 1325 and Senate Bill 5092: \$1.079M GF/\$1.257M Total.*

- ✓ **Priority 4:** Establish a workgroup to develop a behavioral health teaching clinic enhancement rate.  
*Senate Bill 5092: \$150K GFS/Total. HCA to convene a work group to develop a recommended teaching clinic enhancement rate for behavioral health agencies training and supervising students and those seeking their certification or license.*

#### Priority 5:

- ✓ Expand the Student Loan Repayment Program and reduce existing barriers within the program.  
*Senate Bill 5092: \$8.25M GFS/Total. Provides additional funds for behavioral health students.*
- ✓ Preserve and expand existing investments in infant and early childhood mental health consultation.  
*Senate Bill 5092 and the Fair Start Act (Senate Bill 5237): \$2.4M GFS/Total. Adds 6 additional mental health consultants.*
- ✓ Establish a complex needs fund to expand access to consultant support for behavioral health challenges of children ages 0-5.  
*Senate Bill 5092 and the Fair Start Act (Senate Bill 5237): \$5.07 GFS/\$9.674 Total. Includes support for childcare and ECEAP, and early ECEAP providers.*

- ✓ **Priority 6:** Direct the Health Care Authority (HCA) to explore Medicaid waiver options for respite care for youth with behavioral health challenges, without adversely impacting the respite waivers for children and youth in the foster care system and for children and families enrolled with the Developmental Disabilities

Administration (DDA).  
*Senate Bill 5092: \$150,000 GFS/Total.*

- **Priority 7:** Expand availability of youth and family peer services across the continuum of care, reduce barriers to entry and retention, enhance diversity, and ensure peers are supported in their recovery.

*Senate Bill 5092 provides the following (with no specifications around adult vs. children, youth and family peer services).*

- *\$1.762M in one-time funding to maintain and increase resources for peer support programs (adult and youth) and for HCA to contract with an organization to assist with recruitment with a specific focus on black, indigenous and people of color communities.*
- *\$250,000 for HCA to contract for the development of a specialized 40-hour crisis response training curriculum and conduct at least one statewide training session in FY 2022 and one statewide training session in FY 2023.*
- *\$500,000 to establish an emotional support program for individuals employed as peer specialists.*

### Statements of support and CYBHWG work *(not prioritized)*

- ✓ Work with the Behavioral Health Apprenticeship Coalition to develop and implement a registered behavioral health apprenticeship model.  
*Senate Bill 5092: \$1.6M GFS/Total for Labor and Industries, in coordination with the Washington State Apprenticeship Training Council, to establish behavioral health apprenticeship programs.*
- Engage with and support the Workforce Training and Education Coordinating Board's efforts to address barriers to employment created by background checks.  
*Senate Bill 5092: \$100,000 GF-Federal for HCA to convene a task force to examine impacts and changes proposed to the use of criminal background checks in behavioral health settings, with the goal of reducing barriers to developing and retaining a robust behavioral health workforce while maintaining patient safety measures.*
- Remove clinical barriers to postpartum mood and anxiety screening by supporting the Washington Chapter of the American Academy of Pediatrics' "learning collaborative".  
*Legislation not required; work is underway.*
- Support the Multi-tiered Systems of Support (MTSS) decision package submitted by the Office of Superintendent of Public Instruction (OSPI).  
*Senate Bill 5092: \$760K GFS/Total (partial funding).*
- Increase staffing levels in schools to support students' social-emotional health by supporting the "Building Staffing Capacity to Support Student Well-Being" decision package submitted by OSPI.  
*Senate Bill 5092: \$51.568M (partial funding). Funding for an additional .5 FTE per prototypical school for high-needs schools, beginning in the 2022-2023 school year.*
- Improve transitional care for youth discharging from inpatient behavioral health and juvenile justice settings by supporting the work of the Senate Bill 6560 work group.  
*No legislation introduced in 2021 legislative session.*
- ✓ Support efforts to ensure that quality, affordable childcare is available and accessible (workforce issue).  
*Senate Bill 5092 and the Fair Start Act (Senate Bill 5237):*
  - *Progressively expand eligibility for families for the Working Connections Child Care Program (WCCC) over a six-year period.*
  - *Progressively lowers families' copayments based on income for WCCC over a two-year period.*
  - *As of July 1, 2021, increases childcare subsidy base rates to the 85<sup>th</sup> percentile of market for licensed or certified providers.*
  - *As of July 1, 2026, expands eligibility for the Early Childhood Education and Assistance Program (ECEAP).*
  - *For the 2021-22 school year, ECEAP rates must be set at a level at least 10% higher than 2019-21 rates.*
- ✓ Support development of a state implementation plan for the national 988 behavioral health crisis line, scheduled to go live in Washington in July 2022.
- ✓ Support current efforts to assess and improve telehealth, including audio-only, to reduce racial and income

disparities in behavioral health service access and ensure that virtual services are clinically effective and provide relief to children and families. Recommend review of data and research focused on prenatal to age 25 and development of standards of practice, with stakeholders, as well as a requirement that providers publicize the Washington Lifeline. The Washington Lifeline program offers free wireless services and cell phones to low-income families and individuals.

*Budget bill (): \$410,000 for telehealth work group to establish best practices.*

- ✓ Support legislation requiring continuing education for behavioral health professionals in the provision of culturally responsive treatment.  
*Senate Bill 5229: \$187K GFS/Total. Requires professions licensed under Title 18 RCW to complete health equity continuing education training at least once every 4 years, using standards and criteria based on available research and evidence.*
- Support HB 1349 to create a Peer Support Specialist credential, allowing peers to serve individuals with commercial insurance and work directly for hospitals and correctional institutions. *Not passed; work in progress.*
- ✓ The CYBHWG continues to support learning from the current partial hospitalization (PH) and intensive outpatient (IOP) pilot about how they may become part of the service continuum. (Added 12/23/2020.)  
*Budget bill (): 1.8M GFS/Total to continue(?); \$8.5M to expand.*



**Workforce/Rates Subcommittee  
Preliminary Recommendations  
Sept. 17, 2021**

**Joint recommendations with the BH Integration Subcommittee:**

- Behavioral Health Integration – Start Up Funds
- Reimbursement for non-Licensed Staff (in Primary Care Settings)

**Joint recommendations with the Council of Behavioral Health Agencies:**

- Medicaid Rate Increase (TBD but at least 5%)
- Provide necessary language and funding for the HCA to secure federal funding to adopt the CCBHC model through its existing 1115 waiver/SPA and develop a plan for a statewide initiative.

**Still exploring:**

- Issues related to supervision/licensing
- Issues related the credentialing process for behavioral health agencies

**Possible Support items:**

- Recommendations from the Workforce Board
- Recommendations related to portability and/or reciprocity

*Thank you!*

### Recommendations to CYBHWG September 2021

**Priority 1:** Provide start-up funds to clinics which demonstrate objective and specific readiness to build collaborative care behavioral health integration programs in primary care settings.

**Ask:** Provide \$2 million to fund eligible clinics to put integrated care programs in place and for training and technical assistance provided by clinical programs which have established pediatric BHI in primary care to advise on start-up activities. Based on experience of several existing programs, \$200,000 in start-up funds is needed for a clinic to establish an integrated behavioral health program, including necessary training.

Eligibility for funding would be targeted at those clinics deemed by HCA to have a viable plan for implementation of integrated care, that includes, but would not be limited to, the following:

- A primary care champion or proponent of the program
- Support for implementation at the highest level of clinic leadership
- A behavioral health professional located at the clinic
- An arrangement for psychiatric consultation and supervision
- A registry tracking the symptoms of patients
- A team approach to care
- Universal screening for behavioral health issues and social determinants of health
- Provision of care coordination, including coordination with schools, ED's, hospitals, and other points of care
- Family and child engagement
- The ability to bill under the collaborative care codes (this is not to preclude billing under other codes in addition, such as those for psychotherapy)
- Ensuring "closed-loop" referrals and engagement in specialty behavioral health care when indicated

Start-up costs covered would include:

- Training, including in such operational elements of integration as developing work flows to ensure that team-based care is provided, and in evidence-based practices, including brief interventions for children with mild to moderate behavioral health challenges
- Development of reliable and systematic workflows, including a multi-disciplinary team approach to screening parents post-natally and children and teens ages 11 and older as indicated by Bright Futures standard of care
- Commitment to monitor screening rates and modify workflows as needed to ensure universal screening
- On-boarding of behavioral health professional, with salary support while developing a caseload
- On-boarding of psychiatric support person (M.D. or ARNP), including initial salary support
- Clinical oversight
- Development of partnerships with community mental health centers for referral of patients with higher level needs
- IT infrastructure, including necessary EHR adjustments and creation of a registry

### Recommendations to CYBHWG September 2021

- Space needs for additional staff

#### Recommendation re BHI Training Centers

The subgroup recognizes that there are organizations with significant expertise based on experience in setting up BHI programs tailored to the unique needs of pediatric populations, that are evidence-based and effective. We believe that there will be significant benefits, including cost-savings, from supporting centralized training and technical assistance to clinics in implementing pediatric-specific BHI programs.

**Priority 2:** Reimbursement for non-licensed staff like Community Health Workers, navigators and care coordinators to support kids' behavioral health.

**Ask:** Fund per member per month for children insured on Apple Health adequate for clinics to provide these critical support services.

#### ***Specific Activities that a non-licensed support staff does or should do to support BH in primary care***

- 1- Support families to connect with and access services for specific family needs, including:
  - Financial, food, housing, and other social determinants of health resources
  - Insurance coverage enrolling/reenrolling
  - WIC and newborn resources
  - ABA, birth to three referrals, early intervention
  - Child Find, ECAEP, Head Start, school district services
  - Postpartum resources
- 2- Support care navigation process for primary care, mental health care, schools, or care elsewhere, such as:
  - Coordinate scheduling for appointments and services
  - Remind patients of upcoming appointments
  - Connect with patients after appointments to determine and remind of next steps, as needed
  - Follow families after specialty mental health care at 30, 60, and 90 days
  - Coordinate PCP appointments, collaborating with patients to access PCP scheduling and addressing barriers and concerns
  - Collaborate with DDA case managers to help families seek resources for in home services or determine who their case worker is
  - Follow up on birth to three referrals to ensure connection for children needing early intervention.
  - Refer to school districts and educate parents on Child Find services as well as ECAP and Head start
  - Obtain releases of information to obtain records from school and other providers
  - Communicate updates to behavioral health provider, psychiatrist
- 3- Offer specific patient education
  - What to do in crisis situations
  - Basic mental health coping strategies for parents and children

**Recommendations to CYBHWG September 2021**

***Specific Activities that a non-licensed support staff does or should do to support BH in primary care (cont.)***

- Parenting strategies and skills
- 4- Oversee monitoring, communication, and outreach related to
  - Community availability of health and mental health resources
  - Registries of families who have not connected with care teams
  - High-risk families who do not show for appointments
- 5- Complete screenings and forms as needed, including:
- 6- Identify behavioral, developmental, and/or social determinants of health using a validated instrument
- 7- Document referrals and connection to services in the electronic health record
- 8- Administrative support for Licensed Mental Health Professional
- 9- Transmit time-sensitive documents at the request of LICSW managing CPS cases, school coordination, CoCM, and all other records requests.
- 10- Organize, scan and track all documents including but not limited to: school release (ROI's), completed rating scales (e.g. Vanderbilt, SDQ, SMFQ, SCARED), and any documents that arrive from CPS or foster care.
- 11- Manage and support LICSW BHIP and psychiatry schedule as directed by LICSW after full assessment and triage is completed by LICSW.
- 12- Organize, manage, schedule, and facilitate Care Management meetings with pediatric and family physicians. Manage patient list as directed by entire team.
- 13- Work weekly and closely with LICSW to work BHIP/SW/Psychiatry queue

**Children & Youth Behavioral Health Work Group – Prenatal-5 Relational Health Subgroup (P5RHS)**  
**DRAFT ABBREVIATED Recommendations Brief – PREGNANT & EARLY PARENTING MENTAL HEALTH**  
**HELPLINE (09-15-21)**

**Budget Recommendation: Expand the Parent Support Warm Line**

**Invest in the Parent Support Warm Line so un- and under served expectant and new parents have equitable access to mental health services through peer-to-peer engagement and increased public awareness.**

**Perinatal mental health issues are common, yet often untreated:** Drs. Pilyoung Kim and Sarah Watamura at the University of Denver call the transition to parenting a time of “two open windows,” an exceptionally sensitive period when both infant and parent are highly receptive to being shaped by their environments and mutual interactions. This transition, from pregnancy through the first year postpartum, is often referred to as the “perinatal” period. It can be a time of tremendous joy and connection, and a time when parents are overloaded as they respond to their child’s needs and hold everything else together.

Because the transition to parenting can be so stressful, post-partum depression is experienced by 1 in 7 new moms, 1 in 10 dads, and 1 in 8 adoptive mothers and many other types of caregivers

experience anxiety and other behavioral health disorders.<sup>i</sup> The impacts of behavioral health conditions disproportionately impact families that are already experiencing hardship. Addressing perinatal mental health has a two generational impact and those with the biggest risk and prevalence are the least seen and served by the behavioral health system. Some studies show approximately 50% of low-income women reporting elevated (clinically significant) depressive symptoms.<sup>ii</sup> However, relatively few can access support. Only 38.1% of referred women had at least one mental health appointment, and only 6% of those needing help received sustained treatment according to a recent study of pregnant and postpartum women screened for psychiatric distress in a publicly funded clinic and referred for mental health treatment.<sup>iii</sup>



**The risks of untreated perinatal mood and anxiety disorders (PMADs) are significant for caregivers, children, and families – but we have the knowledge and tools to treat, and sometimes prevent, undue hardship. We can provide better access to perinatal mental health support for the 80,000+ people each year who have babies in Washington State by expanding the [Perinatal Support Washington Warm Line](#).** The Warm Line is staffed by peers with relevant lived experience, including English and Spanish speakers, who are trained to reduce stigma and to identify essential services for parents in need. Investments in the Warm Line would increase access to mental health services for parents in un- and under-served racial, ethnic, linguistic, and geographic communities by:

- Adding staff coordinators for the Warm Line from priority communities
- Increasing public awareness to be sure priority communities know about the warm line and related services

**Mental health supports are not readily available to Washington parents – especially parents of color:**

Ranked 46<sup>th</sup> of 50, Washington State is one of the worst states in the nation for mental health care and has even fewer resources for specialized mental health care during pregnancy and postpartum.<sup>iv</sup> Additionally, there are not enough providers. According to a survey by the University of Washington, 30

of our 39 counties have fewer than 10 perinatal mental health providers of any kind.<sup>v</sup> The number of providers is woefully insufficient for a state with more than 80,000 births per year and an estimated 16,000 parents in need of perinatal mental health support.<sup>vi</sup> *More than 80% of those seeking mental health support are covered by Medicaid only,*<sup>vii</sup> *however, less than 20% of self-identified perinatal mental health providers in the UW survey said they accept public insurance leaving the vast majority of parents without access to perinatal mental health services.*

**Disparate care during pregnancy is a contributing factor for mental health conditions:** People who are Black, Indigenous, and other People of Color (BIPOC) are less likely to have access to mental health services, less likely to receive needed care, more likely to receive poor quality of care, and more likely to end services prematurely than their white peers.<sup>viii</sup> The long-term psychological toll of racism puts Black, Indigenous, and other women of color at higher risk for a range of medical conditions that threaten their lives and their infants' lives, including mental health conditions.<sup>ix</sup> In fact, mothers of color experience higher rates of PPD, even when controlling for contextual factors.<sup>x</sup>

**What is the impact on the state budget and society?** Un- and under-treated parent mental health challenges during pregnancy and postpartum have an enormous toll on families and society, from productivity loss and unemployment to preterm birth and maternal health conditions. Writ large, PMADs had a total estimated six year (prenatal to age 5) societal cost of *\$304 million for mothers and children* born in Washington in 2017<sup>xi</sup> even after accounting for children's resilience. This cost is repeated for every year's births, so every year, Washington state is faced with an additional \$300+ million in costs for that year's births and corresponding untreated parental mental health conditions.

There is also a human cost that cannot be monetized undiagnosed and/or untreated conditions, resulting in greater family mental health challenges and increased health disparities. One of the most significant impacts of parent mental health disorders is on children. *The science is clear – parents and infants develop together.* Research shows that parent mental health issues affect the likelihood of secure infant-mother attachment.<sup>xii</sup>

**The Parent Support Warm Line bridges the gap between need and support, with trained peers answering the phones and helping parents access support while addressing feelings of shame and stigma:** The Warm Line peer support staff provides parents with information and education about the types of support that are available and works with parents until they find the support they need. A pilot study published by 2020 Mom and partners concluded that peer support care models alleviate the burden of mental health both on individuals and the U.S. healthcare system in a number of ways, including: decreasing stigma and increasing cultural relevance; providing cost-effective services; and overcoming mistrust of clinical settings that some Black, Indigenous, and People of Color (BIPOC) experience as a result of systemic racism.<sup>xiii</sup> The Warm Line here in Washington State has already contributed to health equity for expectant and new parents. In fact, 42 percent of Warm Line callers who shared demographic information self-identified as parents of color.

We have the opportunity to invest in and grow the [Perinatal Support Washington Warm Line](#) for more pregnant and parenting people and their loved ones. This expansion will help reduce maternal morbidity and mortality, reduce the cost of untreated mental health to the state and society, and in the long term, promote healthy child development. It will support more parents, regardless of their preferred language, race, income, and insurance status, by ensuring they are connected with relevant and appropriate mental health supports. With funding, additional staff can be hired and public awareness can be increased.

The Prenatal through 5 Relational Health Subgroup (P5RHS) has prioritized policy recommendations based on these criteria:

1. **COMMUNITY-INFORMED** - Prioritizes approaches and ideas that strengthen child and family well-being, as shared by members of impacted communities and those that serve them
2. **CENTERS & ADVANCES EQUITY** – Holds the promise to measurably closes the gaps in health access and outcomes
3. **REALISTIC ACHIEVABLE** – Size and scope are appropriate for Washington’s budget context policy landscape
4. **CAPACITY** – Implementation could be described and executed well and quickly
5. **STRENGTHENS/TRANSFORMS** – Helps to build, sustain, or transform foundational systems
6. **FIT** – Fits within the P5RHS and CYBHWG scope, and avoids duplicating the work of other groups

<sup>i</sup> Mott, S.L., Schiller, C.E., Richards, J.G., O’Hara, M.W., Stuart, S. (August 2011). Depression and anxiety among postpartum and adoptive mothers. *Archives of Women’s Mental Health*. 2011 Aug; 14(4): 335–343.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3433270>

<sup>ii</sup> Chaudron, LH, Szilagyi, PG, Tang, W, Anson, E, Talbot, NL, Wadkins, HIM, Tu, X and Wisner, KL. (2010). Accuracy of depression screening tools for identifying postpartum depression among urban mothers. *Pediatrics*, 125(3), e609-e617. DOI:

<https://doi.org/10.1542/peds.2008-3261>

<https://pediatrics.aappublications.org/content/125/3/e609> and Chung EK, McCollum KF, Elo IT, Lee HJ, & Culhane JF. (2004).

Maternal depressive symptoms and infant health practices among low-income women. *Pediatrics*, 113(6):e523-9. doi:

10.1542/peds.113.6.e523. PMID: 15173532.

<https://pediatrics.aappublications.org/content/113/6/e523>

<sup>iii</sup> Smith, M. V., Shao, L., Howell, H., Wang, H., Poschman, K., & Yonkers, K. A. (2009). Success of mental health referral among pregnant and postpartum women with psychiatric distress. *General Hospital Psychiatry*, 31(2), 155-162.

<https://doi.org/10.1016/j.genhosppsych.2008.10.002>

<sup>iv</sup> <https://www.mhanational.org/issues/ranking-states#one>

<sup>v</sup> Moms Access Project Report, January 2019, UW Medicine School of Psychiatry (Amritha Bhat, Deb Cowley, unpublished data)

<sup>vi</sup> According to Postpartum Support International, 15 to 20% of women experience significant mental health symptoms

postpartum. <https://www.postpartum.net/learn-more/>

<sup>vii</sup> Washington 2018 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting Measures,

<https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Washington-2018.pdf>

<sup>viii</sup> Perzichilli, Tahmi, “The Historical Roots of Racial Disparities in the Mental Health System,” *Counseling Today*, May 7<sup>th</sup> 2020,

<https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/>

<sup>ix</sup> Taylor, J., Novoa, C., Hamm, K., and Phadke, S. (May 2, 2019). Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint. Retrieved from:

<https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/#fn-469186-12>

<sup>x</sup> Gress-Smith, J. L., Luecken, L. J., Lemery-Chalfant, K., & Howe, R. (2012). Postpartum depression prevalence and impact on infant health, weight, and sleep in low-income and ethnic minority women and infants. *Maternal and Child Health Journal*, 16, 887–893. doi:10.1007/s10995-011-0812-y

<https://pubmed.ncbi.nlm.nih.gov/21559774/> and Ceballos, M., Wallace, G. & Goodwin, G. (2017). Postpartum depression

among African-American and Latina mothers living in small cities, towns, and rural communities. *Journal of Racial and Ethnic Health Disparities*, 4, 916–927. <https://doi.org/10.1007/s40615-016-0295-z>

<https://link.springer.com/article/10.1007/s40615-016-0295-z>

<sup>xi</sup> Luca, D.L., Garlow, N., Staatz, C., Margiotta, C., Zivin, K. (April 19, 2019). Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in Washington. Cambridge, MA: Mathematica Policy Research.

<https://www.mathematica.org/our-publications-and-findings/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-washington>

<sup>xii</sup> Atkinson, L., Paglia, A., Coolbear, J., Niccols, K., Parker, K.C., Guger, S. *Clinical Psychology Review*. Volume 20, Issue 8, November 2000, Pages 1019-1040. <https://www.sciencedirect.com/science/article/pii/S0272735899000239>

<sup>xiii</sup> “A significant Solution for Maternal Mental Health: Certified Peer Specialists” from 2020 Mom. <https://www.2020mom.org/issue-brief-download>

# School-based Behavioral Health and Suicide Prevention Subcommittee

Priorities Survey  
September 2021



# System Barriers

# What are the top five barriers?

1. There are not enough behavioral health professionals in schools
2. The system is fragmented or not a system
3. There are not enough behavioral health professionals in the community
4. Educators do not receive adequate training to support student behavioral health
5. Funding is inadequate

# Tentative Recommendations and Rankings

These are the results of an on-line survey, which will be discussed at the October 1<sup>st</sup> subcommittee meeting

# #1: Support for MTSS Implementation in Schools

- There are currently seven Regional Implementation Coordinators (RICs) funded by federal grant funds (2 through FFY 2023; 5 through FFY 2025)
- 2021-23 provisos provided support for:
  - Two additional MTS RICs
  - One MTSS Data Analyst
  - Establishing a database to track technical assistance to districts and fidelity of implementation
- The RICs will support 28 districts in the first cohort, 2021-22

## #2 Staffing enhancements

- Increase staffing levels in schools for:
  - Counselors
  - Social Workers
  - Nurses
  - School Psychologists

(OSPI has requested increased funding specifically for school nurse positions in 2022-23. Legislature funded increase in counselor positions for high poverty schools, beginning in 2022-23)

## #3 Funding to support Interconnected Systems Framework

- Because Medicaid and private insurance plans typically don't reimburse behavioral health providers to engage in collaboration with educators, including consultation, training, or participation in MTSS teams or IEP meetings

## #5: State funding for portion of FTE: School-based BH providers

- Fund 50% of positions with state funds
- Districts provide remainder through district funds and/or Medicaid billing
- Allows clinicians to engage in non-billable activities to support students: consultation, training of staff, and participation in MTSS and IEP teams, etc.

# #4: Funding for training on culturally-responsive behavioral health supports for students, including suicide prevention

- Need to specify audience and funding source/type/amount



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# Certified Community Behavioral Health Clinics

Overview for the Children and Youth Behavioral Health Work  
Group for the State of Washington

September 17, 2021

**CCBHC** SUCCESS CENTER



# What Goes into Being a CCBHC?

## CCBHC Criteria

- Organizational Authority
- Staffing
- Access to Care
- Scope of Services
- Care Coordination
- Quality Reporting

## CCBHC Payment

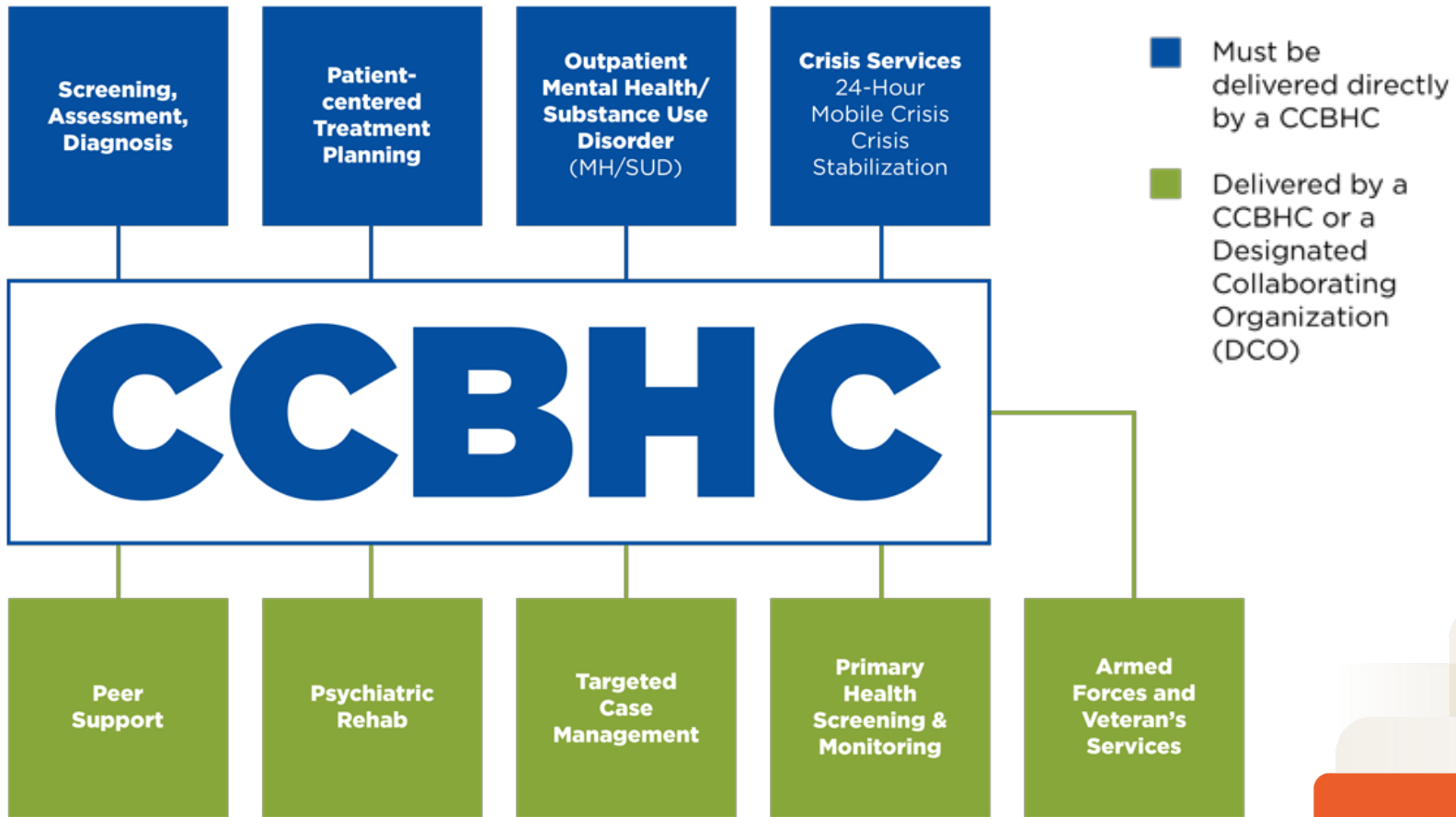
- Cost-related Medicaid reimbursement rate (demonstration participants)

OR

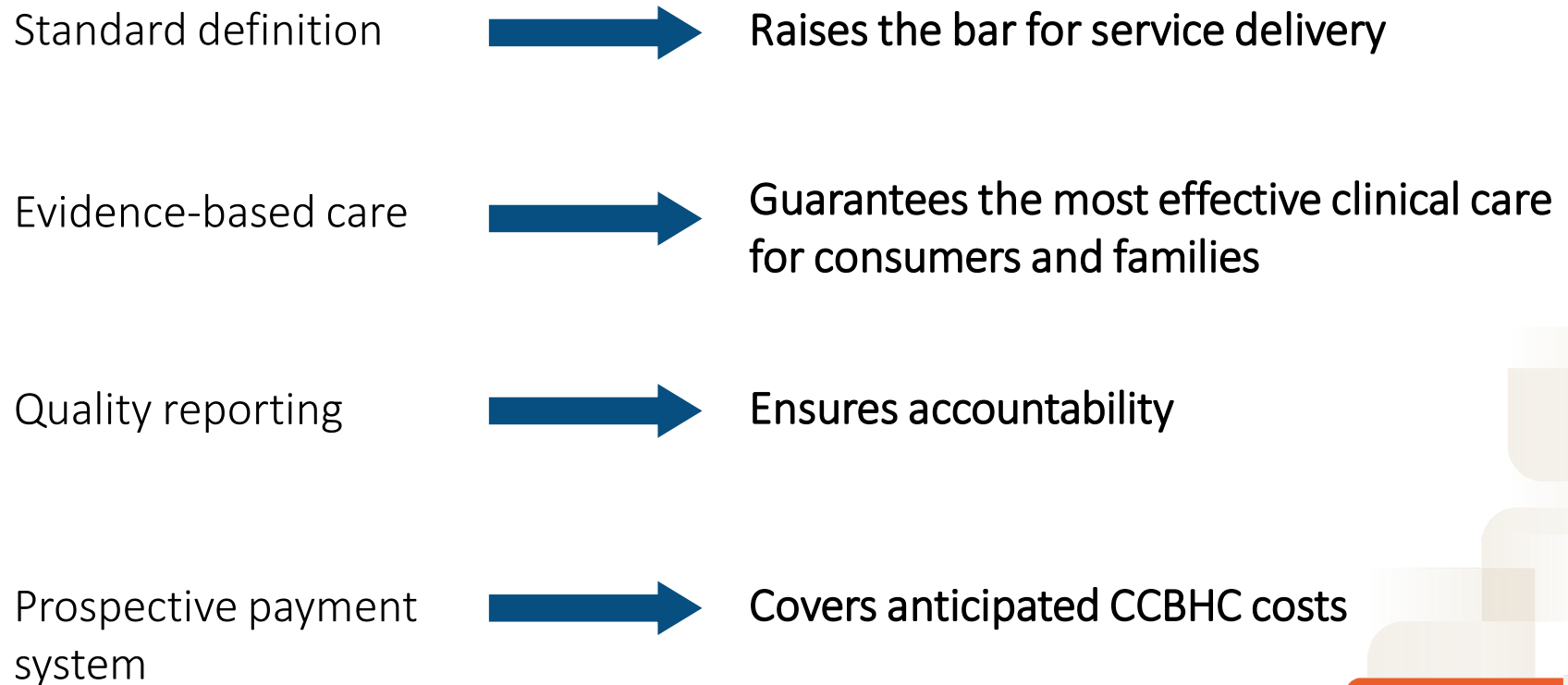
- Grant funds: \$2 million/year for 2 years (expansion grantees)

Note: This presentation contains a summary of selected CCBHC certification criteria. To view the full criteria: [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/ccbhc-criteria.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf)

# CCBHC Scope of Services



# CCBHCs: Supporting the Clinical Model with Effective Financing



# Breaking through Old Limitations

**Services are not confined to delivery within the 4 walls of a clinic**

- Think creatively!
- In-home services for newly placed foster youth?
- Pre-release assessment in jails?
- Outreach to homeless populations?
- And more...



# CCBHCs Provide a Financial Foundation to...

## Participate in value-based payment

- Data infrastructure
- Electronic health records and health information exchanges
- Assertive care coordination
- Population health management
- Sophisticated management of clinic finances

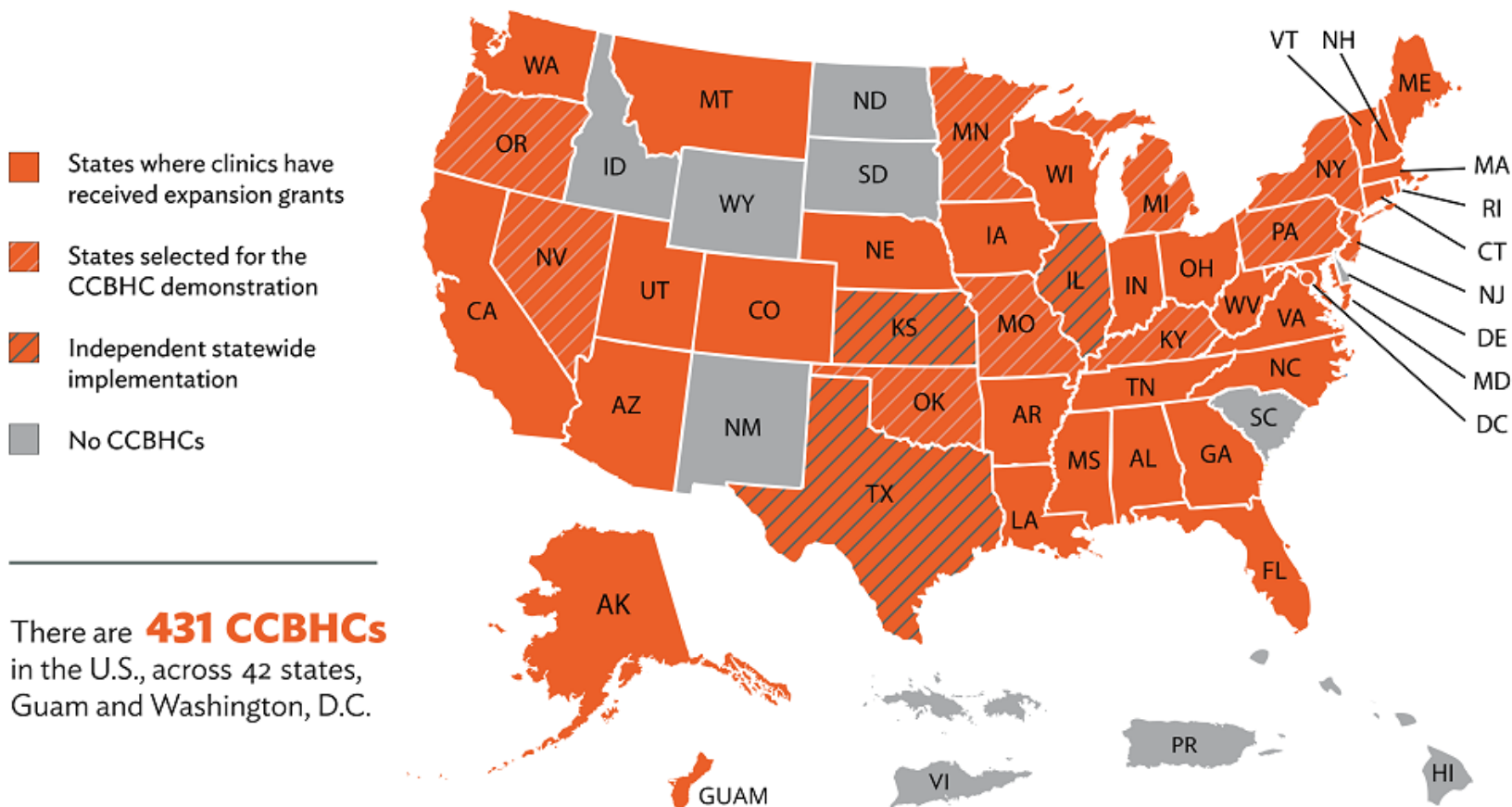
## Alleviate the crisis in access

- Workforce expansion
- Access supported by technology
- Increased service capacity
- Increased access to substance use treatment
- Evidence-based, non-billable activities

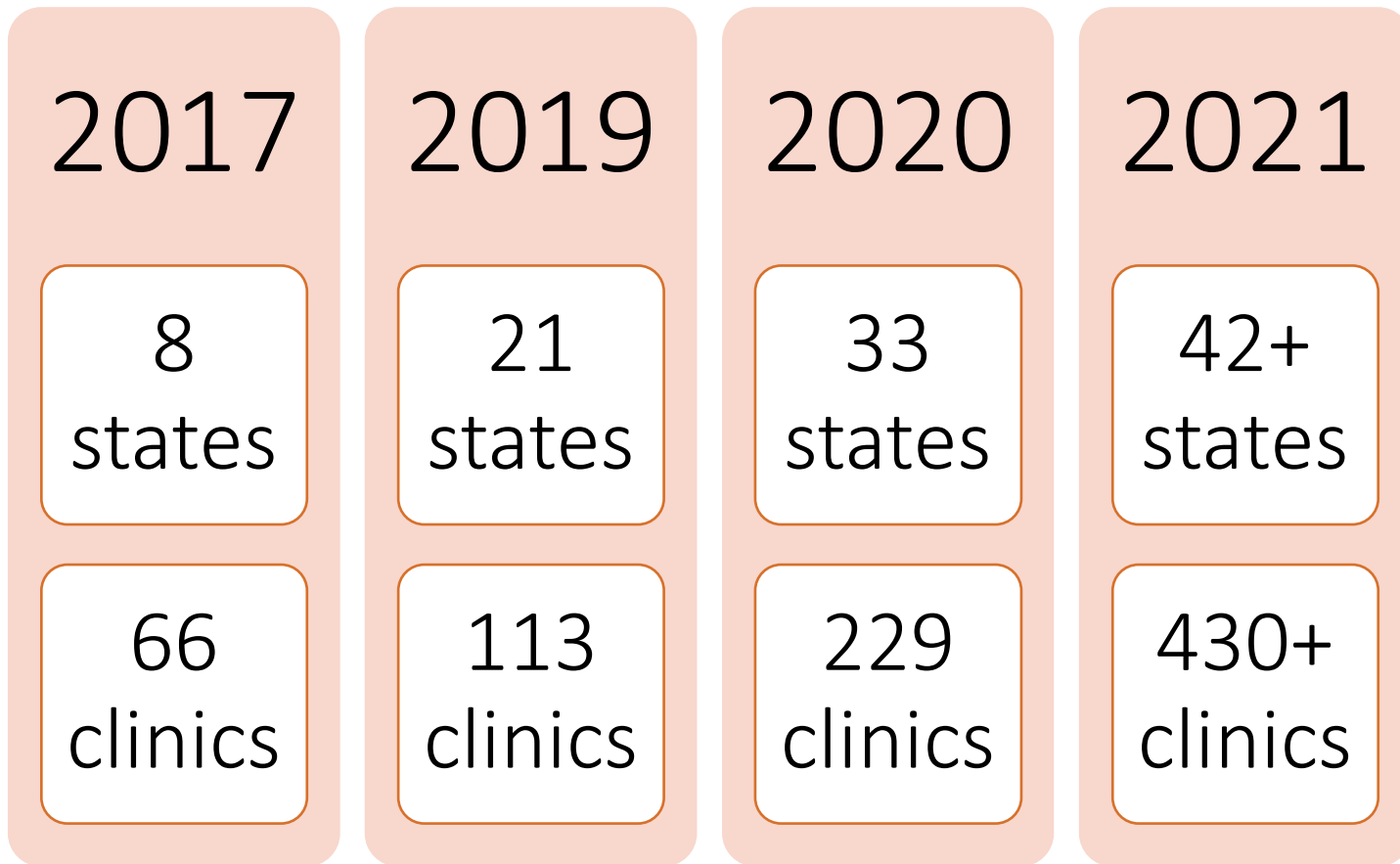
# History of Sister Safety-Net Systems

- The **community mental health centers program**, the **program for migrant health centers and community health centers** were both established in the 1975 amendments to the Public Health Services Act (PL 94-63).
- This Act established comprehensive community based behavioral health and primary care centers supported by federal funding, with a goal of providing access to all.
- However, in the 1980s, the community mental health portion was ‘deregulated’ and block-granted to the states, resulting in the loss of a federal definition, and a dramatic reduction in federal funding.
- This is one reason community behavioral health agencies are so heavily dependent (85-95%) upon Medicaid reimbursement even compared to our sister safety net system (52%).

## Status of Participation in the CCBHC Model



# Incredible Growth in Only 4 Years!





# CCBHCs' Successes, 4 Years In

- Increased hiring / recruitment
- Greater staff satisfaction & retention
- Redesigning care teams
- Improved access to care
- Launch of new service lines to meet community need
  - New initiatives designed to reach target populations or address key Medicaid agency goals
- Deploying outreach, chronic health management outside the four walls of the clinic
- Improved partnerships with schools, primary care, law enforcement, hospitals
- Reduction in hospitalizations/ED visits
- Improvements in physical health indicators

# Investing in the Workforce

- **5,200+** staff hired at 128 CCBHCs in 4 years
  - Average = 41
  - **Psychiatrists** and **peer support professionals** among most commonly added staff

“CCBHC status has allowed us to court and hire more highly qualified candidates, because we can now offer more competitive salaries.”

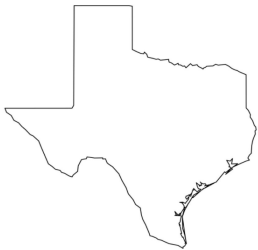
“Who we employ is equally as important as who we serve. Since April 2017, we’ve hired 38 new staff within our CCBHC services; **88% of whom are from communities of color**—similar percentages to our client populations.”

# CCBHCs' State Impact Over Time



## Missouri

- Hospitalizations **dropped 20%**, ED visits **dropped 36%** at 3 years
- Access to BH care **increased 23%**, with 19% increase with veteran services in 3 years
- **In 1 year, 20% decrease** in cholesterol; **1.48-point Hgb A1c decrease**
- Justice involvement with persons with BH needs **decreased 55%** in 1 year



## Texas

- The CCBHC model in Texas is projected to save **\$10 billion by 2030**
- In 2 years, there were **no wait lists** at any CCBHC clinic
- **40% of clients** treated for cooccurring SUD & SMI needs, only 25% of other clinics



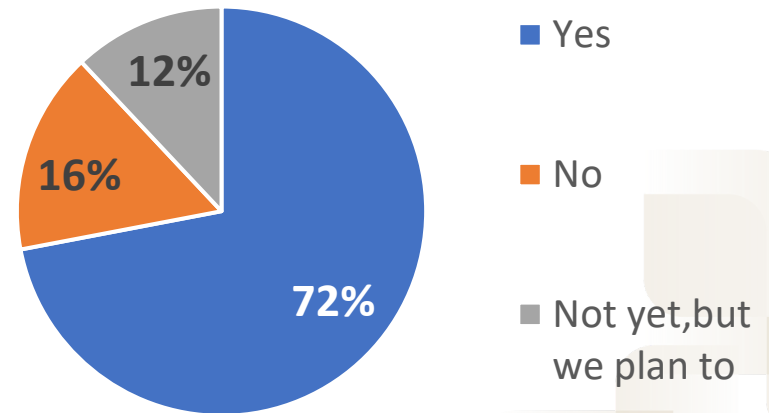
## New York

- All-cause readmission dropped **55%** after year 1
- BH inpatient services show a **27% decrease** in monthly cost
- BH ED services show a **26% decrease** in monthly cost
- Inpatient health services **decreased 20%** in monthly cost
- ED health services **decreased 30%** in monthly cost
- **24% increase** in BH services for children and youth

# Meeting Children, Youth and Families Where They Are

- **84%** of CCBHCs provide direct services on site in schools or plan to
- **63%** engage in suicide prevention efforts targeted to children/youth
- **42%** provide Mental Health First Aid training to middle or high school teachers and staff
- **20%** provide Mental Health First Aid training to middle or high school students

CCBHCs Providing Direct Services on Site at Elementary, Middle, and High Schools



# Spotlight On: Partnerships with Schools

“The closest psych hospital for kids is over an hour away. We have had to send kids up to 4 hours away to find a bed. 41% of admits to the local ED were for children with psychiatric needs. The school-based crisis clinician position was developed to address this need.”



For school year 2018-2019:

- **156 crisis screenings** were conducted
- Of these, **122 children (72%)** were diverted from the ED

**94%** of CCBHCs have a partnership with local schools, and **72%** deliver direct services in schools.

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53

# State Legislative Advancements



## Kansas

- State legislators in Kansas crafted [HB 2208](#) which required the State to allocate funding to develop the CCBHC model.
- The legislation was part of a broad effort to increase access to care in rural areas



## Illinois

- State legislators crafted [SB2294](#) which included the CCBHC as part of a larger health care bill for their state.



## Maine

- Maine [appropriated funding](#) to support the state's Medicaid and Behavioral Health leadership could hire staff to support a CCBHC SPA process.



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## Recommendation for the CYBHWG

- Washington should pursue the CCBHC model as a potential long-term solution for stabilizing the public behavioral health system and its workforce.
- It can do so by supporting a budget provision that would authorize HCA to explore how to adopt the CCBHC model through a Medicaid State Plan Amendment or 1115 Medicaid waiver, and develop a plan for a statewide initiative.



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## QUESTIONS??

Need More Information?

Contact the Washington Council for Behavioral Health

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Joan Miller: [jmiller@thewashingtoncouncil.org](mailto:jmiller@thewashingtoncouncil.org)