



# THE CHILDREN'S MENTAL HEALTH WORK GROUP

FINAL REPORT AND RECOMMENDATIONS

SUBMITTED TO THE GOVERNOR AND THE LEGISLATURE

DECEMBER 2016



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## TABLE OF CONTENTS

I)	INTRODUCTION AND WORK GROUP REQUIREMENTS.....	3
II)	WORK GROUP MEMBERS AND REPRESENTATED ORGANIZATIONS.....	4
III)	WORK GROUP MEETINGS AND ACTIVITIES.....	7
IV)	STATEMENT OF INTENT.....	14
V)	2016 FINAL REPORT RECOMMENDATIONS.....	15
VI)	ACRONYM GLOSSARY.....	20
APPENDIX A	ADDITIONAL RECOMMENDATIONS FROM SENATOR JUDY WARNICK AND REPRESENTATIVE TOM DENT	23
APPENDIX B	ADDITIONAL RECOMMENDATIONS FROM DR. ROBERT HILT AND LAURIE LIPPOLD	25
APPENDIX C	ADDITIONAL RECOMMENDATIONS FROM DR. ERIC TRUPIN	34
APPENDIX D	PROPOSAL FOR PEDIATRIC BEHAVIORAL HEALTH CARE SYSTEM, DR. PHYLLIS CAVENS & KRISTIN HOUSER	35
APPENDIX E	JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE: STUDENT MENTAL HEALTH SERVICES INVENTORY EXECUTIVE SUMMARY	40
APPENDIX F	CHILDREN'S MENTAL HEALTH WORK GROUP: WORK PLAN	41
APPENDIX G	CHILDREN'S MENTAL HEALTH WORK GROUP: RECOMMENDATIONS SUBMITTED BY MEMBERS	43

## I. INTRODUCTION AND WORK GROUP REQUIREMENTS.

In 2016, the Children's Mental Health Work Group (Work Group) was established in Engrossed Second Substitute House Bill 2439 (E2SHB 2439), relating to increasing access to adequate and appropriate mental health services for children and youth. The Work Group was established to identify barriers to accessing mental health services for children and families, and to advise the Legislature on statewide mental health services for this population.

The Work Group was required to review the barriers that exist to identifying and treating mental health issues in children with a particular focus on birth to age five and to conduct the following tasks:

- Review and recommend developmentally, culturally, and linguistically appropriate assessment tools and diagnostic approaches that managed care plans and behavioral health organizations should use as the mechanism to establish eligibility for services;
- Identify and review billing issues related to serving the parent or caregiver in a treatment dyad and the billing issues related to services that are appropriate for serving children, including children birth to five;
- Evaluate and identify barriers to billing and payment for behavioral health services provided within primary care settings in an effort to promote and increase the use of behavioral health professionals within primary care settings;
- Review workforce issues related to serving children and families, including issues specifically related to birth to five;
- Recommend strategies for increasing workforce diversity and the number of professionals qualified to provide children's mental health services;
- Review and make recommendations on the development and adoption of standards for training and endorsement of professionals to become qualified to provide mental health services to children birth to five and their parents or caregivers;
- Analyze, in consultation with the Department of Early Learning, the Health Care Authority, and the Department of Social and Health Services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool; and
- Identify outreach strategies that will successfully disseminate information to parents, providers, schools, and other individuals who work with children and youth on the mental health services offered through the health care plans, including referrals to parenting programs, community providers, and behavioral health organizations.

The legislation required the Work Group to report its findings and recommendations to the appropriate committees of the Legislature by December 1, 2016. The Work Group expires on December 1, 2017.

## II. WORK GROUP MEMBERS AND REPRESENTED ORGANIZATIONS.

As provided in E2SHB 2439, the Work Group is comprised of the following members representing the following entities or organizations.

Member	Representing	E2SHB 2439
Senator Jeannie Darneille	Washington State Senate, District 27	The President of the Senate shall appoint one member and one alternative member from each of the two largest caucuses of the Senate.
Senator Judy Warnick	Washington State Senate, District 13	
Representative Tana Senn (Co-chair)	Washington House of Representatives, District 41	The Speaker of the House of Representatives shall appoint one member and one alternative member from each of the two largest caucuses in the House of Representatives.
Representative Tom Dent	Washington House of Representatives, District 13	
Greg Williamson	Department of Early Learning	The Governor shall appoint at least one representative from each of the following: The Department of Early Learning, the Department of Social and Health Services, the Health Care Authority, the Department of Health, and a representative of the Governor.
Tina Burrell	Department of Social and Health Services	
MaryAnne Lindeblad (Co-chair)	Health Care Authority	
Lacy Fehrenbach	Department of Health	
Andi Smith	Office of the Governor	
Dr. Mona Johnson	Office of Superintendent of Public Instruction	The Superintendent of Public Instruction shall appoint one representative from the Office of the Superintendent of Public Instruction.
Nickolaus D. Lewis	Tribal Council Representative from the Lummi Nation	The Governor shall request participation by a representative of tribal governments.
Steve Kutz	Tribal Council Representative from the Cowlitz Indian Tribe	
Kathleen Crane	King County Behavioral Health Organization	The Governor shall appoint one representative from each of the following: Behavioral health organizations, community mental health agencies, Medicaid managed
Mary Stone-Smith	Catholic Community Services of Western Washington	
Christi Sahlin	Molina Healthcare	

Dr. Bob Hilt	Seattle Children's Hospital	care organizations, pediatricians or primary care providers, providers that specialize in early childhood mental health, child health advocacy groups, early learning and child care providers, the managed health care plan for foster children, the evidence-based practice institute, parents or caregivers who have been a recipient of early childhood mental health services, and foster parents.
Dr. Sabine Thomas	Washington Association for Infant Mental Health	
Laurie Lippold	Partners for Our Children	
Tatsuko Go Hollo	Children's Alliance	
Joel Ryan	Washington State Association of Head Start & ECEAP	
Ruth Bush	Apple Health Foster Care	
Dr. Eric W Trupin	Evidence Based Practice Institute, University of Washington	
Kristin Houser	Parent Representative	
Ann Marie Henninger	Foster Parent Representative	

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The Work Group elected Representative Tana Senn and MaryAnne Lindeblad as co-chairs. Administrative support and staffing was provided by the House Office of Program Research, Senate Committee Services, and the Office of Financial Management.

Members of the Work Group consulted with Lonnie Johns-Brown from the Washington State Office of the Insurance Commissioner.

Presentations were made by: Barbara Lucenko, Department of Social and Health Services Research and Data Analysis Division; Chris Imhoff, Department of Social and Health Services Division of Behavioral Health and Recovery; Greg Williamson, Department of Early Learning; Veronica Santangelo, Department of Early Learning; Scott Hanauer, Community Youth Services; Alicia Ferris, Community Youth Services; Dr. Sabine Thomas, Washington Association for Infant Mental Health; Kristin Schutte, Olympic ESD 114; Erin Riffe, Capitol ESD 113; Mick Miller, NorthEast Washington ESD 101; Dr. Megan Beers, Wellspring Family Services; Bevette Irvis, Wellspring Family Services; Jenn Sparr, Wellspring Family Services; Peggy Dolane, parent representative; Laura Ruderman, parent representative; Roseann Martinez, parent representative; Lonnie Johns-Brown, Washington State Office of the Insurance Commissioner; Sharon Shadwell, Department of Health; Gail Kreiger, Health Care Authority; Kristin Houser, King County Behavioral Health Advisory Board; Dr. Francie Chalmers, Washington Chapter AAP; Libby Hein, Children's Home Society of Washington; Todd Slettvet, Health Care Authority; MaryAnne Lindeblad, Health Care Authority; Barb Putnam, Department of Social and Health Services; Dr. Mona Johnson,

Office of Superintendent of Public Instruction; Joel Ryan, Washington State Association of Head Start and ECEAP; Laurie Lippold, Partners for Our Children; and Dr. Bob Hilt, Seattle Children's Hospital.

Public comments were received from: Libby Hein, Children's Home Society of Washington; Sharon Grier, Lummi Behavioral Health; Dr. Phyllis Cavens, Child and Adolescent Clinic; Christi Colvin, Cowlitz County Youth Suicide Prevention Program; Alicia Ferris, Community Youth Services; Katrina Hanawalt, Center for Human Services; Dominica Myers, Kinship Adoptive Parent; Lou Olson, Hope Sparks Children's Developmental Services; Mackenzie Dunham, Child & Adolescent Clinic; Melanie Smith, Wellspring Family Services; Fran Williams, Child Care Action Council; and Peggy Dolane, National Alliance on Mental Illness, Seattle.

### III. WORK GROUP MEETINGS AND ACTIVITIES.

The Work Group convened five official meetings over the course of the 2016 interim, occurring on June 21, September 8, September 28, October 13, and November 1. Summaries of the meetings are not designed to be comprehensive or a complete transcription of the meetings, but rather a discussion of the presentations and a brief summary of the agenda items. All meetings were open to the public and included time allotted for public comments. Information from the meetings, including documents and agendas, was published to the public website.<sup>1</sup>

The Work Group formed three teams led by Work Group members to seek input and participation from a broad group of stakeholders interested in the improvement of statewide mental health services for children and families. Each team focused on different requirements set forth in E2SHB 2439 and reported their findings and recommendations back to the Work Group. All the teams held numerous meetings, met with a diverse group of stakeholders, presented findings to the Work Group, and submitted recommendations for the final report.<sup>2</sup> The teams include the:

- Child Care and Education Team, co-chaired by Dr. Mona Johnson and Joel Ryan;
- Workforce Team, co-chaired by Laurie Lippold and Dr. Bob Hilt; and
- Assessment, Eligibility, and Billing Team, co-chaired by MaryAnne Lindeblad and Barb Putnam.

#### i. **Work Group Meeting on June 21, 2016.**<sup>3</sup>

The enabling legislation, E2SHB 2439, directed the Work Group to choose two co-chairs, one from among its legislative membership and one representative of a state agency. Representative Tana Senn and MaryAnne Lindeblad, representing the Health Care Authority, were selected as co-chairs. Staff from the House Office of Program Research provided an overview of the Work Group's purpose and duties, as set forth in E2SHB 2439. The Work Group adopted a work plan that outlined their meeting schedule and agenda topics.<sup>4</sup>

**Children's Mental Health Services.** Staff from the Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) provided an overview of children's behavioral health services in Washington State, including a data summary, overview of services delivered, and a continuum of care framework. The data summary analyzed 1,602,745 children ages 0-17 in State Fiscal Year (SFY) 2015, and found that 64% received at least one service from the DSHS or the HCA and 51% of these children were enrolled in Medicaid. Furthermore, behavioral health treatment needs varied by services used, with 17% of children with HCA medical coverage demonstrating a mental health or substance use treatment need, and that rate increased to 55% of children in foster care and 87% of children in juvenile rehab services. In 2013, the DSHS and the HCA reported that approximately 40% of children on Medicaid with mental health treatment needs were receiving services.

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<sup>1</sup> Children's Mental Health Work Group Website: <http://leg.wa.gov/JointCommittees/CMH/Pages/default.aspx>

<sup>2</sup> See Appendix G.

<sup>3</sup> Meeting materials from June 21, 2016:

<https://app.leg.wa.gov/CMD/agenda.aspx?agency=4&year=2016&cid=24093&mid=25322>

<sup>4</sup> See Appendix F.

**Trauma and Mental Health Treatment Needs.** Study findings were presented to the members that examined the relationship between Adverse Childhood Experiences (ACEs) and health risk behavior in adulthood.<sup>5</sup> ACEs are defined as traumatic events that can have negative, lasting effects on health and well-being. These experiences could include exposure to childhood physical, emotional, or sexual abuse, homelessness, death or incarceration of a parent, or other experiences. The DSHS and HCA reported that mental health treatment needs rose from 11%, for youth (ages 12-17) reporting no ACEs, to 44% for youth reporting five or more ACEs. Additionally, staff presented data findings on the higher rates of emergency room use, criminal justice system involvement, and increased risk for homelessness for children with mental health service needs. Staff finished their presentation with a summary of the continuum of care for children in Washington State.

**School- and Early Learning-based Services.** Staff from the Office of Superintendent of Public Instruction (OSPI) provided an overview of children's mental health services available through K-12 public schools, including a data summary, guidance on counseling programs, and an overview of other projects related to social-emotional learning and mental health services.

Staff from the Department of Early Learning (DEL) provided an overview of the early intervention services they offer for infants and young children, including:

- Early Support for Infants and Toddlers (ESIT);
- Early Childhood Intervention Prevention Services (ECLIPSE);
- Home visiting services;
- Homeless child care;
- Early Childhood Education and Assistance Program (ECEAP); and
- Early Achievers infant-toddler consultation services.

## ii. **Work Group Meeting on September 8, 2016.**<sup>6</sup>

At the September 8th meeting, members received background information on workforce, child care, and education issues as they relate to children's mental health services; and members participated in round table discussion on those issues. Topics discussed included:

- Workforce development and gaps, including an overview of survey results on the shortages that exist in community mental health and potential solutions;
- Creating diversity in the mental health workforce;
- Infant mental health and the services provided by professionals with an Infant Mental Health Endorsement (IMH-E®);
- Mental health services provided through K-12 public schools and early learning programs and strategies for addressing children's mental health needs in Washington State;
- School-based support and the ability of Educational Service Districts to provide mental health services in K-12 public schools; and

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<sup>5</sup> Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., & Edwards, V. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, 14, 245-258.

<sup>6</sup> Meeting materials from September 8, 2016:

<https://app.leg.wa.gov/CMD/document.aspx?agency=4&year=2016&cid=24093&mid=25387&hid=194370>

- Trauma-informed care as a mechanism to reduce the rate of preschool expulsions.

The Workforce Team and the Child Care and Education Team provided members with a progress update and an overview of their work for the final report.

**Creating Workforce Diversity and Addressing Workforce Shortages.** The Work Group discussed the issue of workforce diversity and found that a lack of data exists on the diversity of practitioners in the mental health field. The Work Group recommended that the final recommendations request a study be conducted that analyzes the current diversity in the children's mental health field, and how that workforce mirrors the diversity of the children and families served.<sup>7</sup> The Work Group also discussed including children's mental health in the definition of basic education.

Alicia Ferris and Scott Hanauer, representatives from Community Youth Services, provided survey results on the current workforce shortage in community mental health agencies. 86% of the survey respondents reported having ever been employed at a community mental health agency, however, only 43% of those surveyed still worked at a community mental health agency. The top cited reasons for leaving employment with a community mental health agency were low pay (17.3%), overworked (15.6%), poor management (12.6%), and too much paperwork (12.0%). The top reasons study participants provided for never working at a community mental health agency were low pay (40%) and overworked/high case load (36%). A number of solutions were discussed with the Work Group including efforts to increase Behavioral Health Organization (BHO) and Managed Care Organization (MCO) reimbursement rates, lifting the state set indirect and administrative cap of 10%, reducing paperwork and relying on evidence-based practices (EBPs) for quality assurance.

**Infant and Early Childhood Mental Health.** Dr. Sabine Thomas, Executive Director of the Washington Association for Infant Mental Health, provided an overview on infant mental health and the work of professionals with an IMH-E®. Dr. Thomas defined infant mental health as "the developing capacity of the child from birth to three to: experience, regulate and express emotions; form close and secure interpersonal relationships; and explore the environment and learn, all in the context of family, community, and cultural expectations." She discussed how the IMH-E® could be used as an innovative solution to address the current workforce shortage and provide an interdisciplinary, professional development system to expand and recognize competency in the field of early childhood and infant mental health.

**Themes in Addressing Children's Mental Health.** The co-chairs of the Child Care and Education Team conducted an informal survey on strategies for addressing children's mental health in Washington State. The team received over 900 responses and the following themes emerged from the data set:

- Provide sustainable funding;
- Provide onsite mental health services in early learning and K-12 settings;

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<sup>7</sup> See recommendation K in section V of this report.

- Require increased collaboration across early learning, Educational Service Districts (ESDs), K-12 schools, and community mental health organizations;
- Increase access to quality care;
- Increase parent support and engagement;
- Invest in prevention and intervention services by supporting a continuum of care;
- Address provider shortages; and
- Increase the use of EBPs.

**ESD Panel: School-based Mental Health.** Representatives from three ESDs - Olympic ESD 114, Capitol ESD 113, and NorthEast Washington ESD 101 - each discussed school-based mental health services and the number of students enrolled in K-12 who are experiencing significant mental health issues. The representatives discussed how school-based support is a critical element of the full continuum of care for mental health, and how the ESDs have a history of facilitating the rollout of statewide initiatives, and are prepared to do so with mental health in schools.

Director Kristin Schutte from ESD 114 provided a summary of the 2015-16 School-Based Mental Health Program, which served over 350 high school students and 230 elementary students. She stated that 89% of educators surveyed in regard to this program reported significant improvements in the classroom and school climate. Director Erin Riffe reported that ESD 113 is the first ESD in Washington to be dually licensed to provide both mental health and substance abuse clinical treatment services, and they are currently piloting a comprehensive school-based mental health service model. Assistant Superintendent Mick Miller reported that ESD 101 received a USDE School Safety Grant, which was used to fund mental health therapists (8 FTE) to provide year-round mental health services in four school districts and 15 schools. The ESD representatives recommended that the Work Group make recommendations in their final report to fund ESDs to establish school-based mental health services.

**Trauma-Informed Child Care.** Representatives from Wellspring Family Services - Dr. Megan Beers, Bevette Irvis, and Jenn Sparr - discussed trauma-informed child care with the Work Group. Wellspring's Early Learning Center serves children ages one through five who are currently homeless or have a recent history of homelessness. A significant proportion of these children have experienced a high number of ACEs and intergenerational trauma. Wellspring has a non-expulsion policy at their Early Learning Center. In order to provide a system of supports and care for high-needs children, Wellspring implements policies and procedures that: 1) avoid re-traumatizing children and families; 2) place a high value on the relationship with the child and family; and 3) support staff in meeting the needs of children who have experienced trauma. Wellspring staff provided the following recommendations to promote trauma-informed care at early learning centers across the state:

- Create and promote training on trauma-informed care for providers enrolled in Early Achievers;
- Fix the Early Achievers rating process to remove the current disincentives to take children with social and emotional problems;
- Provide a system of support to providers who serve children with greater social and emotional needs; and
- Increase the capacity for providers to access mental health consultation for both program-level and child specific needs.

### iii. Work Group Meeting on September 28, 2016.<sup>8</sup>

Members received background information on assessment, eligibility, and billing issues as they relate to children's mental health services; and members participated in round table discussion on those issues.

Topics discussed included:

- Barriers to billing and payment under Medicaid and other coverages;
- Billing for confidential services for minors;
- A summary of infant and early childhood mental health screening, assessment, and evaluation tools;<sup>9</sup>
- Reimbursement for maternal depression screenings under Medicaid; and
- Care coordination in the pediatric behavioral health care system.<sup>10</sup>

The Assessment, Eligibility, and Billing Team provided members with a progress update and an overview of their work for the final report.

**Barriers to Treatment.** A panel of three parents - Peggy Dolane, Laura Ruderman, and Roseann Martinez - provided information on their experiences with the children's mental health system and the barriers they faced while trying to find appropriate and adequate care. All three families had commercial insurance. Several common barriers emerged from the presentations and Work Group discussion including: insurance coverage gaps for specialized mental health services; lack of an intensive in-home treatment and support option for children and youth experiencing a mental health crisis and their families; an adequate and appropriate referral and outreach system for mental and behavioral health services; a lack of treatment options for children and youth presenting with mental health symptoms that are not considered severe enough to warrant immediate treatment; and difficulties initiating mental health treatment for youth over the age of 13 who do not consent.

**Confidential Billing.** Lonnie Johns-Brown, Legislative Director for the Washington State Office of the Insurance Commissioner, provided an overview on billing for confidential services for minors. RCW 26.28.010 outlines the circumstances under which a minor can access medical services without parental consent. Services commonly considered confidential are: outpatient mental health services and inpatient mental health services;<sup>11</sup> outpatient substance abuse treatment and inpatient substance abuse treatment;<sup>12</sup> prenatal care services; abortion services; birth control services; Sexually Transmitted Disease (STD) testing and treatment (including HIV); and emergency medical services.

Health carriers and insurers are required to adopt policies and procedures to conform administrative, business, and operational practices to protect an enrollee's right to privacy or right to confidential health care services granted under state or federal law. Lonnie Johns-Brown reported that the Office of

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<sup>8</sup> Meeting materials from September 28, 2016:

<https://app.leg.wa.gov/CMD/agenda.aspx?agency=4&year=2016&cid=24093&mid=25392>

<sup>9</sup> See chart: [file:///C:/Users/paintner\\_as/Downloads/Sharon%20Shadwell,%20DOH-%20Chart%20handout%209-28-16%20\(1\).pdf](file:///C:/Users/paintner_as/Downloads/Sharon%20Shadwell,%20DOH-%20Chart%20handout%209-28-16%20(1).pdf)

<sup>10</sup> See Appendix D.

<sup>11</sup> For inpatient mental health services, a parent or guardian must be notified.

<sup>12</sup> For inpatient substance abuse treatment, a parent or guardian must be notified.

the Insurance Commissioner is currently working on R 2013-11 in response to a request from a stakeholder coalition who expressed concerns that insurance companies sometime disclose information regarding one family member's health care services (often through an Explanation of Benefits<sup>13</sup>) to other family members who are on the same policy. She explained that private insurers currently use an opt-in system for youth who are at the age of consent, therefore, youth age 13 and over must notify their insurance plan if they want their mental health records to remain private from their parent or guardians. The Work Group discussed the challenges faced in regard to privacy and additional strategies for addressing confidentiality concerns.

**Maternal Depression Screening and Treatment.** Gail Kreiger, a representative from the HCA, discussed some of the billing options and codes available under Medicaid for services provided to the parent in order to benefit the child. She provided information on how Medicaid can reimburse for a maternal depression screening under the child's insurance.

**Care Coordination.** Kristin Houser, Dr. Francie Chalmers, and Libby Hein presented a proposal for the pediatric behavioral health care system.<sup>14</sup> The proposal focused on the following key components of an effective, accessible system: an emphasis on prevention and early intervention; care coordination; access to treatment through either primary care or mental health providers; annual screens for child and adolescent mental health needs; maternal depression screening at well child visits; shared treatment plans among providers; access to psychiatric consultation services; ability to maintain treatment with same provider; and evidence based and cost effective care.

The presenters stated that the goal for a model system should be for children to receive early identification of behavioral health needs and timely, supportive help in accessing appropriate care to meet these needs and realize the best possible outcomes. Kristin Houser explained that care coordination should be the "glue" that holds the system together and discussed several key responsibilities of their proposed care coordinator model. She also discussed the importance of psychiatric consultation services for primary care providers, and the need for uniformity of providers in public programs so children are not forced to change providers.

#### iv. Work Group Meeting on October 13, 2016.<sup>15</sup>

The October 13th meeting was reserved for the Work Group to present and engage in round table discussion of the draft recommendations. The Work Group heard recommendations from the:

- Assessment, Eligibility and Billing Team;
- Child Care and Education Team; and
- Workforce Team.

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<sup>13</sup> An Explanation of Benefits (common referred to as an EOB) is a document from a health insurance plan to an enrollee with a description of the care provided, the charges that were submitted to the insurer, the amount covered by insurance, the amount not covered and the policyholder's or patient's remaining financial responsibility, if any.

<sup>14</sup> See Appendix D.

<sup>15</sup> Meeting materials from October 13, 2016:

<https://app.leg.wa.gov/CMD/agenda.aspx?agency=4&year=2016&cid=24093&mid=25399>

Following the meeting, and as a result of the group discussion, the teams made revisions and submitted their agreed upon recommendations to staff.<sup>16</sup> Staff compiled the recommendations into a matrix and sent the recommendations and matrix to the Work Group.

**Medicaid Billing in Schools.** Staff from the HCA presented a brief overview of Medicaid billing options in K-12 schools. Behavioral health services are available to all Medicaid eligible children aged 0-20 through Apple Health MCOs, or through BHOs. Examples of covered mental health services include crisis intervention, counseling, outpatient and inpatient services, and psychological testing. Members received information on the following options for school districts to provide mental health services:

- School-Based Health Care Services;
- Medicaid Administrative Claiming;
- School-Based Health Centers; or
- Centers for Medicare and Medicaid Services Free Care Policy.

Data presented showed that four school districts in Washington state consistently bill Medicaid for mental health services, resulting in just over \$100,000 in Medicaid expenditures annually which is approximately 1% of the School-Based Health Care Services budget. Staff stated that many school districts do not have qualified staff to meet program requirements in order to bill for mental health services.

**v. Work Group Meeting on November 1, 2016.<sup>17</sup>**

On November 1, 2016, the Work Group discussed and voted on recommendations to be included in the final report to the Legislature. Recommendations offered by individual Work Group members and the matrix developed from the recommendations submitted by the teams were discussed and voted on.<sup>18</sup> Members approved 21 total recommendations and prioritized five (see section IV of this report).<sup>19</sup>

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<sup>16</sup> See Appendix F.

<sup>17</sup> Meeting materials from November 1, 2016:

<https://app.leg.wa.gov/CMD/agenda.aspx?agency=4&year=2016&cid=24093&mid=26450>

<sup>18</sup> Matrix: [file:///C:/Users/paintner\\_as/Downloads/FINAL%20CMHWG%20Matrix.pdf](file:///C:/Users/paintner_as/Downloads/FINAL%20CMHWG%20Matrix.pdf)

<sup>19</sup> Prioritized Recommendations: [file:///C:/Users/paintner\\_as/Downloads/Prioritization%20voting%20results.pdf](file:///C:/Users/paintner_as/Downloads/Prioritization%20voting%20results.pdf)

#### IV. STATEMENT OF INTENT.

Representative Senn and MaryAnne Lindeblad, the Work Group's co-chairs, submitted the following statement of intent:

The three subcommittees generated dozens of ideas on how to improve mental health delivery for children. Some important common themes emerged.

- **System Capacity:** The goal of our work is to increase mental health care access for children. But whether it is done in the doctor's office, school setting or elsewhere, there is a shortage of mental health providers at all levels from child psychiatrist to mental health social worker. There are many reasons for this shortage (low pay, high-stress, few residencies) and addressing it is a clear priority. In particular, the lack of training and providers focused on infant mental health is troubling. When addressing these workforce shortages, not only is it important to build in screening capacity, but the ability to provide appropriate diagnostics and treatment is also essential.
- **Culturally and Linguistically Appropriate Services and Assessments:** One major barrier to mental health services is a lack of culturally and linguistically appropriate services. Assessments are often only performed in English with limited access to interpreters with a mental health background, and may not recognize different cultural norms. The lack of diverse providers creates another barrier for patients to access treatment, and stigma in almost all cultures remains.
- **Collaboration across health care, early learning and education:** Care coordination is critical to ensure that patients' physical and mental health needs are treated in tandem. Prescribing by more than one provider may create health dangers. The education system and health care delivery system rarely coordinate, leading to missed warning signs and opportunities. Early learning providers do not have the resources or incentives to help the children in the greatest need. And a 'warm hand-off' to referrals is needed but often not available.

Below are the recommendations that received clear priority and broad support from the workgroup. However, the subsequent recommendations have additional, and often targeted, recommendations that can make a marked impact on the delivery system as well.

For instance, it is not surprising that a recommendation such as "reduced paperwork" did not receive the highest of priority, but the benefits may prove significant, achievable and low-cost.

## V. 2016 FINAL REPORT RECOMMENDATIONS.

The Work Group was required to identify barriers to accessing mental health services for children and families, and to advise the Legislature on statewide mental health services for this population in a report due to the Legislature on December 1, 2016. On November 1, 2016 the work group voted on and approved 21 total recommendations, and voted to prioritize the top five recommendations in the following order of priority.<sup>20</sup>

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### Prioritized Recommendations

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#### *Relating to Medicaid Rates.*

1. The Legislature should provide funding to increase Medicaid rates to achieve equity with Medicare rates, in order to increase the number of providers who will serve children and families on Medicaid.

After the rate increases have been implemented for two years, the Legislature should require an outcome-based study on providers, analyzing the impact on the workforce and the number of providers who serve children and families on Medicaid.

#### *Relating to Screening and Assessment.*

2. The Legislature should require the Health Care Authority (HCA) and the Division of Behavioral Health and Recovery (DBHR) to assemble a work group or work groups<sup>21</sup> to:
  - Identify a standardized list of culturally and developmentally appropriate screening tools for children aged 0-20, for use by all primary care practitioners whether covered by Medicaid or commercial insurance;
  - Identify standardized mental health assessment, outcome, and diagnostic tools that are culturally and developmentally appropriate for children aged 0-5 that support access to Behavioral Health Organization (BHO) services, and clearly delineate what substantive mental health challenges look like in young children. Identify billing options and propose coverage for a new or redefined code with an adequate reimbursement rate for the following services performed during an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visit, or other primary care office visit for a child:
    - Maternal depression screening, to be provided when children are aged 0-5; and
    - Behavioral health screening, including depression screening, for children aged 0-20.

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<sup>20</sup> Recommendations 1 and 2 tied for priority one with 8 votes each, and recommendations 4 and 5 tied for priority three with 6.5 votes each. The voting breakdown for the prioritized recommendations can be found here:

[file:///C:/Users/paintner\\_as/Downloads/Prioritization%20voting%20results.pdf](file:///C:/Users/paintner_as/Downloads/Prioritization%20voting%20results.pdf)

<sup>21</sup> The work group(s) should be composed of a diverse membership, including representatives from early learning and K-12 education.

*Relating to Children's Mental Health Workforce Supports and Incentives.*

3. The Legislature should provide a tuition loan repayment program targeted for child psychiatrists, therapists, and clinicians working for BHO- or MCO-funded agencies that serve a high percentage of children, youth, and families on Medicaid. The tuition loan repayment program should be directed at professionals in the above fields who make a commitment to work for 5 years in the public sector setting, working more than 20 hours per week on average. Loan repayment amounts should be commensurate with the average training costs for the respected specialties.

*Relating to Mental Health Service Delivery and Care Coordination.*

4. The Legislature should:
  - Fund an FTE mental health lead at each of the nine Educational Services Districts (ESDs) and a coordinator in the Office of Superintendent of Public Instruction (OSPI). The mental health leads will help coordinate Medicaid billing, mental health services, and other system level supports;
  - Create 2-3 regional pilot projects to fund a provision of mental health services in school districts struggling to address mental and behavioral health needs in K-12; and
  - Fund one “lighthouse” ESD, which has experience with providing mental health services to serve in an advisory role for the other districts. The “lighthouse” ESD will have experience with providing mental health services and billing through Medicaid.
5. The Legislature should require the HCA to incorporate care coordination into larger primary care provider practices. The care coordination model must:
  - Use a psychiatric registered nurse or master’s level mental health clinician with specified knowledge and training in mental health care, including but not limited to mental health screening, motivational interviewing, suicide prevention.
  - Provide advocacy and engagement services which foster warm hand-offs to mental health professionals, tracks compliance with recommendations and referrals, facilitates communication between health care providers, and provides education to children and families.

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## Supported Recommendations

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The following recommendations approved by the Work Group are not listed in any order of priority, but are organized by topic.

### *Relating to Network Adequacy.*

- A. In addition to the network adequacy reporting requirement established in E2SHB 2439 and other federal requirements, state agencies should ensure network adequacy and promote continuity of care in multiple care settings for both commercial and Medicaid coverages by:
  - i. Performing quarterly evaluations of network adequacy;
  - ii. Encouraging MCOs to contract with private behavioral health providers who are part of the BHO;
  - iii. Increasing primary care provider and care coordinator awareness of the Partnership Access Line (PAL) consultative services; and
  - iv. Facilitating or requiring provision of telephonic or telemedicine consultations with psychiatric care.
  
- B. The HCA should establish performance measures for MCOs relating to the delivery of:
  - i. Developmental screenings;
  - ii. Behavioral health screenings for children aged 5-12;
  - iii. Adolescent depression screenings; and
  - iv. Maternal depression screenings.

### *Relating to Screening and Assessment.*

- C. The Legislature should:
  - i. Require the HCA and the DBHR to provide outreach and education to primary care practitioners and mental health providers regarding:
    - a. Expectations of services to be performed during an EPSDT exam;
    - b. Maternal depression or other contributing mental health conditions that directly impact the child in the child's treatment plan; and
    - c. Billing requirements for mental health screening and referrals to mental health services, including new billing and coverage options developed pursuant to recommendation #2 from the prioritized list.
  - ii. Identify a full complement of medically necessary behavioral health services to be covered by all commercial carriers.
  
- D. The Legislature should enlist local health districts and other appropriate venues and providers to provide behavioral health screening for all children aged 0-20.

### *Relating to Paperwork Reduction.*

- E. In accordance with the federal Paperwork Reduction Act of 1995, state agencies should reduce the amount of paperwork required by clinicians providing mental health services to children on Medicaid by replacing current rules with regulations that focus on the use of best practices for age-appropriate, strength-based psychosocial assessments, including current needs and relevant

history in areas such as behavioral/emotional, mental health safety/risk, and functional impairment.

State agencies should eliminate duplicate documentation requirements in state rules for provider agencies, except when this documentation is required for medical necessity or meeting access-to-care standards.<sup>22</sup>

- F. State agencies should review the E3SHB 1713 Sec. 533(4) report and the Workforce Training and Education Coordinating Board 2017 report regarding paperwork reduction, and suspend the development of any new rule changes related to behavioral health until rule integration is finished in 2017.

*Relating to Medicaid Rates.*

- G. State agencies should remove limitations on treatment options focused on treating the family dyad or a particular familial relationship.
- H. The Legislature should provide increased funding for specialized children's mental health services and training including, but not limited to:
  - i. Infant mental health services and training (IMH-E®, Level 3);
  - ii. Early interventions for treating psychosis;
  - iii. Wraparound with Intensive Services (WISe);
  - iv. Treatment for eating disorders; and
  - v. Interventions and services that are culturally and linguistically appropriate.

*Relating to Children's Mental Health Work Force and Incentives.*

- I. The Legislature should incentivize clinical supervision of therapists working in MCO or BHO agencies through individual agency contracts, by restricting counselor-to-supervisor ratios in contracts with MCOs and BHOs, and/or by capping the caseload size for supervisors to be consistent with recommendations from evidence-based and research-based practices.

*Relating to Recruiting and Maintaining a Diverse Workforce.*

- J. The Legislature should increase options for payments and increase the variety of professionals who can help provide mental health interventions, such as parent-family partners and peer support in communities and non-traditional locations, including settings such as primary care, education, child welfare, and juvenile justice, in order to increase the diversity of the settings in which mental health settings can be provided.
- K. The Legislature should require the Washington State Institute for Public Policy, or a similar organization, to conduct a study in collaboration with interested stakeholders and communities to evaluate the children's mental health system and available workforce. At a minimum the study should evaluate:
  - i. The number of mental health providers serving children, including children birth to age 5 and those on Medicaid;

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<sup>22</sup> This recommendation shall be integrated with the rule changes and integration in 2017.

- ii. The demographics of providers and their clients including, but not limited to, race and ethnicity, languages services are provided in, ages of children served, the use of screening tools and assessments that are culturally and linguistically appropriate, and the level of cultural competency training received by providers;
- iii. The availability of culturally and linguistically diverse services and providers.

The study should also review the public mental health services available to children and the corresponding child outcomes in order to determine where racial and ethnic disparities exist and the severity of those disparities. Racial and ethnic disparities should be monitored on an ongoing basis.<sup>23</sup>

*Relating to Child Care Services.*

- L. State agencies should provide at least 12 months of stable child care through the Working Connections Child Care (WCCC) program for children involved in the child welfare system or who are homeless, regardless of the employment status of their parents or guardians.
- M. The Legislature should require the Department of Early Learning (DEL) to reinstate and expand mental health consultation and coaching for child care providers who care for children with behavioral health needs.
- N. The DEL Early Achievers program should provide funding to assist participating child care providers in meeting the necessary training and supervision requirements for an Infant Mental Health Endorsement (IMH-E®) at the infant family associate or specialist levels to serve children birth to age three.

*Relating to Mental Health Training and Education.*

- O. The Legislature should fund development of expanded behavioral health training and coaching opportunities for early learning through K-12 providers, educators, administrators, and parents, which are culturally competent and utilize multiple approaches including employment of paraprofessionals and peers.
- P. The Legislature, state agencies, and school districts should implement developmentally and culturally appropriate K-12 Social Emotional Learning (SEL) standards and competencies to complement existing early learning SEL standards, using the proposed SEL framework outlined in the October 1, 2016, Legislative report, "Addressing Social Emotional Learning in Washington's K-12 Public Schools."

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<sup>23</sup> Consultation with affected communities should take place during the development and implementation of the study. Collaboration with other states or the National Conference of State Legislatures to make comparisons of service delivery systems for behavioral health services for children across states.

## VI. ACRONYM GLOSSARY.

### **ACEs**

Adverse Childhood Experiences; Potentially traumatic events experienced by a child that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian.

### **BHO**

Behavioral Health Organization; BHOs purchase and administer public mental health and substance use disorder treatment under managed care on a regional basis for individuals enrolled in Medicaid.

### **DBHR**

Division of Behavioral Health and Recovery; The DBHR is part of the Behavioral Health Administration within the Department of Social and Health Services.

### **DEL**

Department of Early Learning; The DEL provides voluntary, comprehensive, high-quality early learning programs and support to families and early learning professionals.

### **DSHS**

Department of Social and Health Services; The DSHS provides services for Washington's most vulnerable residents through behavioral health and developmental disability services, aging and long-term care and child and family support, juvenile rehabilitation, and food and cash assistance.

### **EBP**

Evidence-Based Practice; EBP is the integration of clinical expertise, patient values, and the best research evidence into the decision making process for patient care.

### **ECEAP**

Early Childhood Education and Assistance Program; ECEAP is Washington's pre-kindergarten program for low-income 3- and 4-year-old children and their families.

### **ECLIPSE**

Early Childhood Intervention and Prevention Services; ECLIPSE is a center-based intervention and preventative services program serving children from 0-5 years of age who have experienced certain types of trauma and require family centered, child focused mental health services.

### **EOB**

Explanation of benefits; An EOB is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf.

**EPSDT**

Early and Periodic Screening, Diagnostic, and Treatment; The EPSDT benefit provides comprehensive and preventive health care services for children under 21 who are enrolled in Medicaid.

**ESDs**

Educational Service Districts; In Washington state, there are nine ESDs that oversee a total of 295 school districts.

**ESIT**

Early Support for Infants and Toddlers; The Department of Early Learning's ESIT program provides services to children birth to age 3 who have disabilities or developmental delays.

**HCA**

Health Care Authority; The HCA serves more than 2 million Washington residents through the Apple Health (Medicaid) program and the Public Employees Benefits Board (PEBB) Program.

**IMH-E®**

Infant Mental Health Endorsement ®; IMH-E® is a recognized endorsement for culturally sensitive relationship focused practice promoting infant mental health, that validates a provider's education, qualifications, practical and reflective experiences promoting infant mental health interventions.

**MCO**

Managed Care Organization; Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that accept a set per member per month (capitation) payment for these services.

**OSPI**

Office of Superintendent of Public Instruction; The OSPI is the primary agency charged with overseeing K-12 public education in Washington state.

**PAL**

The Partnership Access Line; PAL is a telephone-based child mental health consultation system for primary care providers.

**SEL**

Social-Emotional Learning;

**SFY**

State Fiscal Year; In Washington state, the SFY is a 12-month period extending from July 1 of one calendar year to June 30 of the next calendar year.

**WCCC**

Working Connections Child Care; The WCCC program offers subsidies for child care to eligible low-income families in Washington state.

**WISe**

Wraparound with Intensive Services; WISe is designed to provide comprehensive behavioral health services and supports to Medicaid eligible individuals, up to 21 years of age, and their families, with complex behavioral health needs

APPENDIX A



**Washington State Legislature**

November 22, 2016

Governor Jay Inslee  
Office of the Governor  
PO Box 40002  
Olympia, WA 98504-0002

Secretary of the Senate  
Hunter Goodman  
P.O. Box 40482  
Olympia WA 98504-0482

Office of the Chief Clerk of the House of Representatives  
Barbara Baker, Chief Clerk  
P. O. Box 40600  
Olympia, WA 98504-0600

To Whom It May Concern:

As members of the Children's Mental Health Work Group (Work Group)<sup>1</sup>, we respectfully submit this letter detailing our specific recommendations to be made in addition to the official Children's Mental Health Work Group report and its appendices.

We commend the Work Group for its diligence and thoroughness in identifying existing barriers to accessing children's mental health services. The Work Group intently studied the complexities of mental health service delivery and billing, and was able to author a report that provides a thorough picture of the state of children's mental health services in Washington. However, the report lacked clear focus on the immediate need facing children's mental health services: workforce and workforce development.

**It is our position that the lack of workforce is the primary barrier obstructing access to children's mental health services, particularly in rural areas. We need concrete, practical solutions to simultaneously address the current workforce crisis and look ahead to the shortages we will face in the coming years. This crisis has a multitude of root causes, some of which stem from low pay, difficult caseloads and excessive paperwork requirements. Let's first work to retain our existing providers.**

We must focus on increasing the availability of the existing children's mental health provider workforce in order to best serve the children and families who need services now. When our mental health service providers are encumbered by high caseloads and burdensome paperwork requirements, our children cannot access services.

There are a few practical, commonsense solutions that would help free up availability of our existing providers, thereby removing barriers to service delivery. First, reducing required clinical paperwork in

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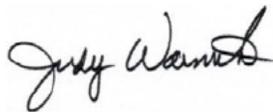
<sup>1</sup> Engrossed Second Substitute House Bill 2439 (E2SHB 2439) passed in 2016, creating the Children's Mental Health Work Group.

accordance with the federal Paperwork Reduction Act of 1995<sup>2</sup> is a simple, concrete way to alleviate the heavy workload of our clinicians. We must encourage state agencies to amend their administrative codes and internal policies to eliminate unnecessary and burdensome paperwork requirements. Second, we should increase our workforce by empowering existing health providers, such as local health departments, to provide depression screenings and referral services for children and families. Finally, utilizing telemedicine is an efficient and inexpensive way to increase access to services. Telemedicine is proving to be particularly useful in rural and remote areas of our state, which are very often the areas with the fewest providers. Each of these solutions are practical ways to address the current provider shortage, and would help alleviate the workload currently placed on our providers.

While we have an immediate workforce crisis, we must also look into ways to increase the children's mental health workforce in the long term. We affirm the need for a tuition loan repayment program targeted for child psychiatrists, therapists, and clinicians working for BHO or MCO-funded agencies that serve a high percentage of children, youth and families on Medicaid<sup>3</sup>. In addition to a tuition loan repayment program, due consideration must be given to alternative credentials and education programs to funnel workforce into the mental health system. The Work Group discussed the creation of additional educational programs to increase the availability and use of child psychiatric nurses and nurse practitioners to provide critical mental health services. These suggestions could help address our growing provider need.

We are pleased with the effort the Work Group members and staff put into the creation of the final report. We must keep a narrow focus on workforce issues in the 2017 legislative session.

Respectfully submitted,



Senator Judy Warnick  
State Senator  
13th Legislative District



Rep. Thomas Dent  
State Representative  
13th Legislative District

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<sup>2</sup> Work Group Final Report Recommendation E, pages 17-18 of Final Report.

<sup>3</sup> Work Group Final Report Recommendation #3, page 16 of Final Report.

## APPENDIX B



Governor Jay Inslee  
P.O. Box 40002  
Olympia, WA 98504-0002

November 21, 2016

Barbara Baker  
Chief Clerk  
P. O. Box 40600  
Olympia, WA 98504-0600

Hunter Goodman  
Secretary of the Senate  
P. O. Box 40482  
Olympia, WA 98504-0482

Dear Governor Inslee, Chief Clerk Baker, and Secretary of the Senate Goodman:  
An important provision of the Children’s Mental Health Bill HB 2439 is to “Evaluate and identify barriers to billing and payment for behavioral health services provided within primary care settings in an effort to promote and increase the use of behavioral health professionals within primary care settings.”

The current report does not adequately address this provision.

Primary Care Behavioral Health involves embedding a behavioral health specialist (masters or doctorate trained) within a primary care team to provide high volume, brief, and episodic care. Access to this service is same-day, provided in concert with a primary care provider or adjacent to the primary care service. This care can be both proactive and reactive and is specific to the unique needs of the patient. We have identified barriers to billing which inhibit the ability of primary care implementing this model. We have learned that the E3SHB Behavioral Health Regulatory Alignment Task Force (report due Dec 15, 2016) has identified some of the barriers to billing and payment for behavioral health specialists embedded in primary care settings. Their draft report acknowledges that there needs to be improved structure in place for billing for behavioral health services provided within primary care. This task force recognizes that there are challenges with “same day” billing prohibition which limits ability to bill for primary care service and mental health service within the same visit and that it is necessary for the State to clearly define billing codes, similar to Oregon.

1. We endorse and support these aforementioned recommendations and ask that these recommendations are added to the Children’s Mental Health Workgroup report: that the billing structure be improved to support provision of same-day



behavioral health and primary care services provided in the primary care setting, and be codified like in Oregon.

In addition, we know that requiring physician prior authorization before mental health services may be provided is counter to the model of Primary Care Behavioral Health. In a Primary Care Behavioral Health model, behavioral health services are provided in real time; it is truly the right care in the right place at the right time. Behavioral health specialists supplement primary care providers in the moment; prior authorization defeats the efficacy of this model – makes this model impossible to implement.

2. We request that the Children’s Mental Health Workgroup report identify prior authorization of a primary care provider as a barrier to effective behavioral health integration within primary care and recommend that prior authorization requirements for mental health care be eliminated.

Finally, it is important that documentation for behavioral health services within primary care is not overly burdensome and matches the documentation standards typical of primary care, typical of medical care. Currently, there documentation requirements in place that suggest *what* elements (e.g. treatment plan, assessment, etc.) are necessary and also *how* these elements need to be documented. This requirement is especially tied to practices that are utilizing mental health CPT codes (e.g. 90832, 90834, etc.) and has led to rejected fee-for-service claims in Washington.

3. We request that the regulations on *how* the elements are documented be eliminated to allow for behavioral health services to be delivered effectively and efficiently in a primary care setting. Oregon Senate Bill 832 (passed in July 2015) allows for any code to be billed and reimbursed in any setting (including primary care) by any independently licensed mental health provider (e.g. psychologist, social worker, licensed mental health counselor). The ability for practices to bill and receive payment for fee-for-service encounters is essential to short-term fiscal sustainability of Primary Care Behavioral Health while longer-term strategies of pay-for-performance are finalized and implemented across the state. In essence, we cannot expect practices to incur a financial loss for integrating behavioral health until alternative payment structures are in place. Paying for fee-for-service claims in the interim would eliminate this barrier.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read 'R. Hilt'.

Dr. Robert Hilt

A handwritten signature in black ink, appearing to read 'Laurie Lippold'.

Laurie Lippold

November 21, 2016

Governor Jay Inslee  
P.O. Box 40002  
Olympia, WA 98504-0002

Barbara Baker  
Chief Clerk  
P. O. Box 40600  
Olympia, WA 98504-0600

Hunter Goodman  
Secretary of the Senate  
P. O. Box 40482  
Olympia, WA 98504-0482

Dear Governor Inslee, Chief Clerk Baker, and Secretary of the Senate Goodman:

We are writing to request that the attached document be included in the final report of the Children's Mental Health Workgroup.

The Workgroup, convened as a result of HB 2439 (passed by the legislature in 2016), did a tremendous amount of work during the interim and came up with 22 priorities that were then further prioritized. The Child Mental Health Workgroup identified 5 top priorities, and they are delineated in the overall report due to the legislature on Dec. 1<sup>st</sup>.

Beyond the recommendations included in that report, as co-chairs of the Work Force Sub-Committee of the Child Mental Health Workgroup, it is our hope that the attached additional list of all other recommendations developed by our Sub-Committee be included as an appendix. Our Work Force Sub-Committee identified many more specific recommendations that we feel could be valuable as a reference for others working on these issues over the coming years. We do not want the group's work and recommendations to get lost.

Additionally, we were asked by Rep Senn to outline further one of the recommendations pertaining to child psychiatrists that was not fleshed out by the Committee, but is incredibly important and relevant to work force issues and concerns. Washington has a severe shortage of child psychiatrists, which yields either very long waits for access or no access at all for our sickest children. The University of Washington has the only child psychiatrist training program in the state, currently graduating 5 new child psychiatrists each year via a 2-year fellowship program for board eligible adult psychiatrists. This rate of graduation is insufficient to expand our state's workforce or to resolve the access to care problem.

One of our workgroup's ideas was to increase the state's child psychiatrist workforce by paying for one more child psychiatrist to be graduated here in Washington every year. If state dollars were to be directed toward increased child psychiatrist training, our suggestion was that it go toward funding a new and specific "public sector" child psychiatry fellowship training position. These particular trainees would gain additional experience and engagement with serving Medicaid and Foster Care clients by spending additional time working in public sector focused clinical sites like community mental health agencies to both give back to the state and to build their interest and engagement with the public sector for their future life work. It was estimated by the UW training directors that such an initiative would cost ~\$195,000 per year (paying for two positions in a 2 year program, graduating one every year).

Please let us know if you have questions or need more information. We were honored to be part of this extremely important effort and look forward to working towards implementation of the recommendations in order to establish an accessible and quality children's mental health system.

Thank you for your attention.

Sincerely,



Dr. Robert Hilt



Laurie Lippold

## **Issues and Recommendations from the Workforce Team, Not already in the Child Mental Health Workgroup's Final Report**

### **Strategies to Reduce Mental Health Agency Paperwork Burdens**

**Issue:** In a recent survey of over 200 master's-level therapists across Washington, survey respondents clearly indicated "too much paperwork" as one of the primary drivers to workforce turnover. Time spent completing excessive paperwork results in reduced time each week doing direct services, reduced availability of staff to be responsive to the needs of their clients, and an inefficient use of existing funding for mental health services.

#### **Other Recommendations not in the CMHWG Final Report:**

1. Exempt provider agencies using evidence- and research-based practices (EBPs/RBPs) from current documentation Washington Administrative Codes (WACs) when that EBP already requires documentation of that element of treatment: assessments (except for meeting access to care standards and medical necessity), crisis/safety plans, treatment/service planning, tracking of progress/outcomes (treatment/service plan review), and discharge/transition plans.
2. In lieu of WAC documentation, allow the provider agency to produce an active certification from an EBP and a summary of the quality assurance processes covered by the contracted EBP organization.
3. Clarify WACs that allow for any documentation requirement to be considered met if it is demonstrated or included within the clinical file, rather than within a particular document within the file.
4. Institute a procedure rule that ALL audits by local or state agencies must look at the full file.
5. Give providers the option of either including proof of training and active consultation in the full file or documenting the use of approved treatment elements in the progress notes.
6. Audits done of programs utilizing EBPs/RBPs to fidelity would be done either by auditors trained in or familiar with that particular model or with support from an expert in that model.
7. Ensure that WISE be reviewed by those familiar with the specific requirements and expectations of this legally mandated and manualized service area.
8. Work towards outcomes instead of regulating process. And, replace audits intending to evaluate quality through process and compliance with audits that evaluate quality through outcomes over the course of treatment, by discharge, such as:
  - a. Remain in the home and community with their family;
  - b. Improve school attendance and achievement;
  - c. Stabilization in child care (i.e. prevent expulsion);
  - d. Reduce/resolve legal involvement or criminal activity;
  - e. Reduce or eliminate drug/alcohol use;

- f. Increase safety as evidenced by: reduce or eliminate mental health emergencies resulting in CLIP, psychiatric hospital stays, referrals to crisis services, ER visits due to MH.
- 9. Consider exempting agencies involved in the Children’s Mental Health Quality and Performance Pilot program through the University of Washington Evidence-Based Practice Institute from all WAC documentation requirements during the course of the pilot (projected to last one year in 2017).
- 10. Consider exempting agencies conducting research to develop evidence-based practices that are effective, valid, and acceptable for children from diverse populations.
- 11. Exempt organizations providing the full complement of WISE (Wraparound Intensive Services). WISE consists of three required components: 1. Intensive services; 2. 24/7-crisis response; and 3. Wraparound facilitation.
- 12. Ensure consistent interpretation of the WACs between DBHR and the BHOs.
- 13. Direct DBHR to determine (and act on) if audits of mental health providers and agencies can be coordinated.
- 14. Require auditors to produce source documentation to the final written audit or review when articulating findings. This would include both federal and/or state requirements, and any local requirements added (such as via the contract).

**Strategies to Improve Our Workforce via Medicaid Rates**

**Issue:** Low rates paid to providers (or to BHOs who then pay providers) for serving children/families on Medicaid has lead to poor access, low pay, provider turnover, and the potential for lower quality services. Because Medicaid is the main funder of community mental health services, Medicaid capitation rates are a primary determinant of community-based Medicaid providers’ ability to recruit and retain a qualified workforce.. Medicaid rates are only about 2/3 of Medicare rates for the same units of service, highlighting care inequities between children and adults within our system.

**Other Recommendations not in the CMHWG Final Report:**

- 1. Move Medicaid rates from the bottom of the rate bands so providers can offer competitive clinical salaries, which will support recruitment and retention.
- 2. Institute an incentive plan for paying providers for performance outcomes on top of Medicaid rate (i.e., do not withhold funding in order to pay for performance). This is in line with the EBPI Pay for Performance pilot.
- 3. Establish parity between the BHO and MCO rates (go to the higher level).
- 4. Embark upon an in-depth study of the rates to determine what the rates will ultimately need to be to have enough providers, including child psychiatrists, to adequately serve the Medicaid population. Include in the study an analysis of the connection between rates and provider pay, the impact of any initial enacted Medicaid rate increase on provider enrollment, increased access to care for children/youth as a result of the rate increase, and a review of other states to determine what their rates are in order to have an adequate workforce.

5. Review recommendations from the Governor’s Behavioral Healthcare Workforce Task Force related to Medicaid rates.
6. Revise HCA (and other) policies as needed to clearly delineate what substantive mental health challenges look like in a young child AND remove limitations on family treatment/treatment focused on a particular dyad or relationship.
7. Review existing Medicaid waiver, clarify policies, and standardize billing for home-based services so that providers are able to implement best practices.
8. Explore replication of innovative prevention strategies that address parental mental health such as Ohio’s Maternal Depression Screening and Response Program (required in all OH home visiting).
9. Increase rates for provision of evidence or research based treatment modality over ‘treatment as usual’ to allow for the additional time and effort needed to maintain fidelity to model.
10. Incentivize the development of and support for supervisors skilled in IECMH Reflective Supervision (RS). Such supervisors will be beneficial within the MH services system and increase revenue potential for MHI agencies as they are contracted by early learning entities to provide this service.

**Addressing Workforce Problems Through Loan Repayment, Training, and Other Support**

**Issue:** Washington has a chronic and not improving shortage of child psychiatrists, pediatric psychiatric nurse practitioners, and therapists skilled in the delivery of evidence based practices. Improvements in training, recruitment and retention of workers is one of the keys to improving care for our young people.

**Other Recommendations not in the CMHWG Final Report:**

1. Cap caseload size for therapists consistent with the average number of cases directed by the specific EBP/RBP being used, as well as any needed supplementation of assessment and diagnosis approaches that incorporate a clinical review of culturally relevant factors.
2. Adequately pay for specialized services where needed (such as infant mental health, early intervention for psychosis, WISe, or eating disorders, as well as interventions and services that are culturally and linguistically appropriate).
3. Work with the higher education community around incorporating training on EBPs/RBPs in their master’s level programs and ensure that trainings prepare providers to deliver information and services in a culturally sensitive and appropriate manner.
4. Develop a Washington “certificate” program in EBPs/RBPs for child mental health, with salary incentives made available both for agencies who enroll their providers in the certificate program and for individuals who receive these certificates and commit to at least 2 years of continued service to children, youth, and families in the public mental health system.

5. Explicitly assume training as part of the costs associated with doing business (which is the current BHO practice) and build training costs into the contracts providers have with the BHOs/MCOs, and ensure that trainings prepare providers to deliver information and services in a culturally sensitive and appropriate manner.
6. Fund 2 additional child psychiatry residency training positions at UW (yielding one new child psychiatrist graduate every year) under a new “public sector psychiatry” training pathway. This new pathway would be designed to yield graduates specifically primed for public sector service within our state. Additional investments would be required in mental health training sites and supervisors beyond existing UW training systems for child psychiatrists.
7. Increase the number of family psychiatric nurse practitioner training positions in Washington, and re-open a pediatric psychiatric nurse practitioner pathway at one of the training sites.
8. Without adding burdensome paperwork, require that providers with contracts with the BHO and/or MCO report on the use of EBP’s and incent their use through higher rates.
9. Use peer support specialists (and ensure that they can bill) to expand what a fully licensed therapist can deliver.
10. Incentivize clinical supervision of therapists in MCO/BHO agencies through individual agency contracts, restricting counselor to supervisor ratio in contracts with MCOs/BHOs, and/or by capping the caseload size for supervisors to be consistent with that which a particular EBP/RBP recommends.
11. Increase the state plan’s 10% cap for administrative expenses for BHO contracted agency services, OR supplement funding to compensate for this cap.
12. Build capacity to provide effective IECMH services for young children and their families by:
  - Conducting Diagnosis Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5) training that supports best practice in diagnosing mental health challenges in young children. Such training though need is not covered in MSW (or other) program.
  - Providing training for existing IECMH providers in mental health consultation to childcare and in the context of primary care settings.
  - Incentivizing participation in the endorsement process via supporting portfolio processing fees, and/or release time to participate in portfolio development and review, and/or engagement of vetted IMH Reflective Supervisors.
  - Providing Group Reflective Supervision Consultation Training aligned with endorsement™

**Diversity**

**Issue:** Children of color are 30-50% less likely to receive mental health care as white children. They are also more likely to receive treatment that is inappropriate or inadequate. A diverse workforce is needed to better ensure that children and families receive the most appropriate services, delivered in a linguistically and culturally competent manner.

**Other Recommendations not in the CMHWG Final Report:**

1. Increase payment for those providing culturally and linguistically appropriate services to Medicaid children/families.
2. Increase payment for interventions that reflect the families' explanations of the causes of mental health issues, incorporate cultural values throughout the intervention, and engage youth and families in the process.
3. Increase access to trained interpreters to ensure linguistic access to services, and ensure that interpreters are adequately reimbursed.
4. Increase payment for providers offering interventions in community locations, including primary care, education, child welfare and juvenile justice and ensure that payment can be made when providing services in non-traditional settings by a variety of professionals.
5. Conduct a review of public mental health agency procedures, referrals and services to explore whether services are provided in an equitable and appropriate fashion across youth from different racial/ethnic backgrounds.
6. Conduct a review of the provision of public mental health services to children, as well as child outcomes, to determine where racial and ethnic disparities exist and the severity of those disparities. Monitor racial and ethnic disparities on an ongoing basis to track progress and refine approaches.
7. Ensure that payment can be made when providing services in non-traditional settings by a variety of credentialed professionals.
8. Offer training in provision of IECMH services for mental health providers and provide training in research and Evidence Based Treatments across the state in order to reduce inequities in access to trained providers for children in rural areas. Additionally, training should include outreach to insure maximal inclusion of providers of color.
9. Increase access to long-term culturally informed and appropriate professional development opportunities vs. short-term diversity trainings for all childhood mental health therapists.
10. Conduct cross-institutional trainings (DBHR/DEL/DOH/HCA...) on tenets of IECMH mental health as they pertain to diverse clients.

November 2016

APPENDIX C

# UW Medicine

DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

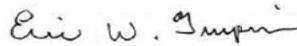
11/22/2016

Dear Governor, Chief Clerk of the House and Secretary of the Senate,

In addition to the excellent recommendations that have been proposed and voted on by the Children's Mental Health Work Group, I would like to further suggest the inclusion of the two recommendations below related to training a workforce to fulfill the proposed improvements in the mental health system:

1. Work with the higher education community around incorporating training on EBPs/RBPs in their master's level programs and ensure that trainings prepare providers to deliver information and services in a culturally sensitive and appropriate manner.
2. Develop a Washington "certificate" program in EBPs/RBPs for child mental health, with salary incentives made available both for agencies who enroll their providers in the certificate program and for individuals who receive these certificates and commit to at least 2 years of continued service to children, youth, and families in the public mental health system.

Regards,



Eric W. Trupin, Ph.D.  
Professor & Vice Chairman  
University of Washington School of Medicine  
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## APPENDIX D

### **Proposal for Pediatric Behavioral Health Care System September 28, 2016**

#### INTRODUCTION

What we have now in Washington State is not a coordinated public mental health system. Rather, it is a collection of mental health providers who take Medicaid, ranging from solo practitioners to mental health clinics to complex health care systems, with BHO's and insurance companies (the "plans") layered above the providers as the entities through which payments flow, and the state perched on top as rule-maker. This "system" is so fragmented and complicated that it is very difficult for children and families to gain access to services that are often desperately needed.

At the same time, there is a fair amount of consensus around what the building blocks of a real system with access and accountability should look like. They include:

- An emphasis on prevention and early intervention
- Care coordination to provide a "door" into the system and an engaged human being for children and families to communicate with when they are in need of services, and to follow up to ensure the care has been provided
- Availability of behavioral health care through both primary care providers, mental health clinics, and individual behavioral health professionals depending on client preference and level of need.
- Communication and coordination among primary care providers, mental health providers, and schools
- Access to psychiatric consultation services for primary care providers and mental health counselors to assist with diagnosis and treatment plans in difficult cases and to assist with medication plans
- Arrangements between Apple Health plans and BHO behavioral health providers, so that seamless transitions in care can occur when clients need more or less intense levels of care in the course of their treatment
- Cost effective and efficient care – upstream investment with outcome measures

Important work has already been done to put these building blocks in place. However, there is a great deal of variability throughout the state and too often, progress is made only in a single health care system or in a particular region, without generalizing it to the population, which remains largely bewildered by the process of accessing care.

#### GOAL

Our goal is for children to receive early identification of behavioral health needs and for those who need it to receive timely, supportive, effective, and coordinated care so that they can realize the best possible outcomes.

## PROPOSAL

We propose that the following be required of the plans, with adequate funding provided, in the delivery of behavioral health services to their members. It appears likely that these goals can be best achieved by working with the BHO's.

### 1. Survey of Available Providers

As a starting point, the plans need to prepare an inventory of the providers with whom they contract to provide behavioral health services to children and youth. That survey should include, at a minimum, contact information for each provider, their training and credentials, and the age-appropriate, evidence-based approaches to treatment that they follow as well as their ability to serve patients insured by Medicaid. This information should be made available on each MCO/BHO Provider Directory.

### 2. Care Coordinators

Research demonstrates that interventions are most successful when a child or adolescent interacts and engages with a caring, trained individual. Thus, we propose that care coordinators be placed in clinical settings.<sup>1</sup> Estimates of the incidence of significant behavioral health issues among children on Medicaid are in the range of 20%. It seems reasonable to require the plans to fund one care coordinator for every 2000 children covered by that plan. One possibility for helping these care coordinators to become integrated with the work of healthcare homes is to have this role proportionally supported by the plans which are active in that region, so that a practice would work with fewer coordinators who would then support all the Apple Health Plans.<sup>2</sup>

- a. Training – Care coordinators should be RN or master's level clinicians, with training and/or experience in working with behavioral health conditions. They should be further trained in
  - Screening for behavioral health issues, using screening tools proven to be effective
  - Motivational interviewing
  - Identification of suicidality and suicide prevention

- b. Responsibilities

- “Warm hand-off,” whenever possible, to mental health provider
- Providing advocacy and assistance with system navigation
- Ensuring family engagement
- Documentation and reporting of time between referral date and first visit date, as well as the failure of engagement between a consumer who has sought care and a mental health provider

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<sup>1</sup> It has been suggested that the plans already provide care coordination or can provide it through their employees. It is our belief that youth and families do not typically turn to their insurance provider for assistance when in crisis, nor do children and youth form the kind of relationships necessary for care coordination to be successful with an employee of an insurance company who they can only have contact with over the phone or by email.

<sup>2</sup> We are not proposing that care coordinators be put in every clinical setting, but in a primary care or mental health clinic in the region served; the care coordinator would coordinate care with providers throughout the region.

- Obtaining releases so that health care information can be shared between primary care provider, behavioral health provider, school counselor, and counselors in the juvenile justice system where appropriate
- Ensuring that the primary care provider is kept informed of the referral and that a copy of the chart notes from the initial assessment and discharge follow up plan are sent to the PCP
- Ensuring that the behavioral health provider is kept informed of the medications and other treatment provided by the PCP
- Ensuring that the PCP is kept informed of the medications and other treatment provided by the behavioral health provider, including when the child is discharged from the care of that behavioral health provider
- Ensure patient has had Well Child Care in the past 12 months and diagnosis and treatment plan shared with the mental health provider
- Coordination and communication with school counselors, counselors in juvenile detention centers, and behavioral health providers
- Providing care tracking functions, such as brief symptom/function check-ins over the phone which are then relayed to the care team
- Tracking each Apple Health child for whom care is sought, whether by the child or youth, a parent, or a provider, and providing the Plan and the State with information as to the contact and the disposition of each case
- Providing further education to patients and families on underlying causes, sharing information and reaffirming management strategies recommended by the provider
- Helping patients and families make it to their appointments and connecting them with local social and support services

### 3. Child and Adolescent Behavioral Health Screening

Behavioral health disorders affect one in five children and adolescents, but their problems are not being reliably identified or treated in the US health system. Fewer than 1 in 8 children with identified mental health problems receive treatment. There is a strong consensus that we identify children and youth with behavioral health needs as early as possible, in the context of their primary care, in order to provide services as soon as possible and promote the best outcomes. In December 2015, the American Academy of Pediatrics recommended children and youth ages 11 – 18 be screened annually for depression.

It is critically important that such screening is systematic and reliable, using a standardized tool, such as the PHQ-9, Ages & Stages, Social/Emotional, and Rapid Assessment of Adolescent Preventive Services (RAAPS). Doing so requires compensation for the time necessary to implement a standardized screening and discuss the results with the patient and family. Moreover, should a child or adolescent be found in need of services the primary care provider needs to invest appropriate time and resources to refer and communicate with specialty providers. Current well-child reimbursement under Apple Health is not sufficient to implement a standardized measure, explain the results to the patient, and potentially seek referral resources.

We propose annual behavioral health early identification and intervention screening, ages 3-18.

#### 4. Maternal Depression Screening

Adverse Childhood Experiences (ACES), including abuse and neglect, can cause trauma that interferes with healthy brain development in children. This trauma leads to health and development issues well into adulthood, and can be responsible for difficulty in school, chronic disease, mental illness and violence. Persistent maternal depression without intervention can result in ACES and have a lasting negative impact on children. Well-child visits offer a timely opportunity to screen mothers for depression. Early identification of children whose mothers may need treatment is critical to protect children from exposure to ACES. Pediatric health care providers are well-positioned to screen mothers and connect them to resources at the earliest opportunity.

The Centers for Medicare and Medicaid Services (CMS) has stated that maternal depression can have a substantial negative impact on the health and well-being of both mothers and children, and can lead to increased related health costs, negative social consequences and impeded child development. CMS considers maternal depression screening during the well-child visit a pediatric best practice and makes it clear that states may cover maternal depression screening for both Medicaid eligible and non-Medicaid eligible mothers during the well-child visit

We propose maternal and developmental early identification and intervention screens, at birth and annually until age 3.

#### 5. Psychiatric Consultation Service

The Partnership Access Line (PAL), run out of Children's Hospital has achieved real success in supporting primary care providers who are treating children in their practices. The major areas where assistance has been sought are on diagnosis, treatment plans, and medication choice and management. While legislation was passed to provide additional funding to extend these services in one area of the State, there should be access by all primary care providers and mental health counselors in the state to effective back-up for care in more complex or difficult cases. It should include:

- a. Psychiatrists designated for each region to be available for telephone consultation by providers, and to provide clinical support (targeted consults and caseload reviews) for the care coordinator role. This might occur at the level of 1.0 FTE for a psychiatrist for every 25,000 children on Apple Health, depending on the degree of clinical assignments to the role
- b. Access to regionally-based psychiatric providers either in person or by tele-medicine service for assessment in difficult or complex cases
- c. Tracking of services provided to Apple Health recipients at the State level to ensure that consultations are occurring and that they are effective.

#### 6. Consistency of providers between health plans and BHO's

At the present time, health care plans and RSN's are not required to and often do not contract with the same providers of behavioral health services, even when the provider's practice covers mild, moderate and serious clinical conditions. Thus, children can see providers who have contracted with the BHO when they have serious behavioral health conditions, and if they improve to a mild to moderate level, they may see a completely different provider, thus breaking the continuity of care that had been working for them. This is

not effective care and it is particularly ineffective with children for whom personal engagement and positive relationships are essential to successful treatment.

We propose that the plans and BHO's be required to collaborate in the contracting process and, to the extent possible, that they contract with the same providers for children's behavioral health care so that care transitions can be seamless and without disruption when the patient's condition is getting either better or worse. Not only will better care be provided to consumers, but therapists will also likely have greater job satisfaction if they are treating patients across the spectrum of symptom severity. This, in turn, could contribute to less turnover among mental health providers.

#### 7. Funding

We appreciate that this is the most difficult aspect of our proposal. However, it is a modest proposal, a beginning of an integrated system that can be built on as different pieces of the system learn to work together and the political will is summoned to fund and support a fully integrated and effective system of behavioral health care. At this point, it likely will be necessary to braid together funds from Medicaid reimbursement, Medicaid waivers, state only funding, and MIDD revenues, to make this basic level of integration possible. Another option may be to obtain Federal Health Home funding with state match for top 5% high risk, high cost children. Clearly, for Washington to build an effective, integrated system of care, paying adequate rates to providers for prevention, including behavioral health screening, and for treatment will be critical.

It is critical for Washington to build a cost-effective and efficient integrated system of behavioral health care, paying adequate (covering the cost of care) Fee for Service rates for Evaluation and management codes, plus a Per Member Per Month Pay for Performance to providers for maternal/developmental/behavioral health screening, care coordination, and urgent care, to ensure 24/7/365 access to behavioral health care, and adequate capacity to give behavioral health care.

Some sources for this proposal are as follows:

Richardson, et al, *Collaborative Care for Adolescents With Depression in Primary Care*, JAMA 2014;312(8):809-816

Hilt et al., *The Partnership Access Line*, JAMA Pediatrics 167 (No. 2), Feb. 2013

SAMHSA-HRSA, Center for Integrated Health Solutions, *Integrating Behavioral Health and Primary Care for Children and Youth*, July 2013

NAMI, *Integrating Mental Health and Pediatric Primary Care, A Family Guide* 2011

Kuo, et al. *Comparison of Health Care Spending and Utilization Among Children with Medicaid Insurance*, Pediatrics 2015;136:1521, November 16, 2015

Washington State Healthy Youth Survey 2014, WA Department of Social and Health Services

Chun, et al, *Evaluation and Management of Children and Adolescents with Acute Mental Health or Behavioral Problems. Parts 1 and 11*, Pediatrics 2016; 138;3; September 2016.

## APPENDIX E



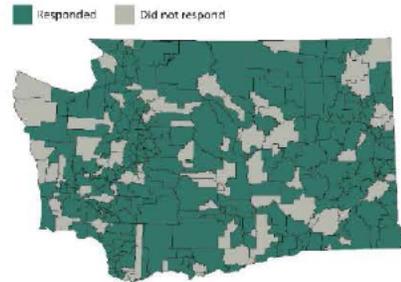
### Briefing Report Overview: Student Mental Health Services Inventory

State of Washington Joint Legislative Audit and Review Committee

October 2016

At the Legislature's request, staff of the Joint Legislative Audit and Review Committee (JLARC) inventoried mental health services available to students through schools, school districts, and educational service districts (ESDs). JLARC staff completed the inventory primarily through a survey of school districts, supplemented by interviews and analysis of existing data. The survey asked questions about what services are provided, who provides them, where they are provided, and who pays.

Three-quarters of school districts (218 of 295) completed the survey. The data in the inventory represent 85% of enrolled students and 83% of public schools (1,985 of 2,392) in Washington.



#### Access the inventory through JLARC's online report

The online report includes summary information and topic-specific tables. These tables include data about multi-tiered systems of support, service models, funding, and barriers. Comments from districts and ESDs provide additional context. Readers can sort, filter, and review the data, or download the complete data files. The report is online at <http://bit.ly/JLARCmInventory>.

#### Inventory highlights

- 191 districts report that some or all of their schools have a basic level of mental health services that focuses on prevention and promoting positive behaviors (65% of all districts).
- Districts report that screening for mental health concerns occurs in 1,844 schools (77% of all schools).
- Districts report that students receive mental health services, such as therapies, in their communities and in schools:
  - At 1,411 schools, services are provided in the community (59% of all schools).
  - At 796 schools, services are provided in the school by a community provider (33% of all schools).
  - At 448 schools, services are provided in the school by a district or ESD employee (19% of all schools).
- Districts report that funding comes from a variety of sources, regardless of where service is provided:
  - Private insurance funds services for students at 942 schools (39% of all schools).
  - Medicaid funds services for students at 863 schools (36% of all schools).
  - Other: Levy dollars fund services for students at 240 schools and dedicated county sales taxes fund services for students at 221 schools.
- Districts report that students experience various barriers to accessing mental health services. Barriers include transportation, lack of providers, and affordability of private insurance co-pays.

#### Medicaid funds some school-based mental health services

In 2015, of the 1.1 million students in public schools, 55,000 (5%) received Medicaid-funded mental health services. Most of these students were served outside their schools through managed care plans and publicly-funded mental health and substance abuse treatment centers. Approximately 10,000 of the students (1%) received Medicaid-funded mental health services in their schools. School districts receive reimbursement from Medicaid for certain services through contracts with the Health Care Authority.

Joint Legislative Audit & Review Committee, 1300 Quince St SE, Olympia, WA 98501  
(360) 786-5171 • (360)786-5180 (fax) • JLARC@leg.wa.gov • www.jlarc.leg.wa.gov  
Keenan Konopaski, Washington State Legislative Auditor

## APPENDIX F

### Children's Mental Health Work Group: Work Plan

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The Children's Mental Health Work Group is tasked with identifying barriers to accessing mental health services for children and families, and to advise the Legislature on statewide mental health services for this population.

#### 1.1 INITIAL MEETING: TUESDAY, JUNE 21ST 9:00AM - 12:30PM

- Location: HHR A JLOB Olympia, WA
- Published Agenda:
  - Welcome and introductions;
  - Background and overview of E2SHB 2439;
  - Appoint co-chairs and adopt work plan;
  - Overview of children's mental health services in WA State (HCA and DSHS);
  - Overview of children's mental health services available through public schools, preschools, and child care (OSPI and DEL);
  - Public comment;
  - Next steps.

#### 1.2 WORKFORCE, CHILD CARE & EDUCATION: THURSDAY, SEPTEMBER 8TH 9:00AM - 3:00PM

- Location: HHR A JLOB Olympia, WA
- Presentations from the Workforce Team and others covering the following:
  - Review workforce issues related to serving children and families, including issues specifically related to birth to five (See 2439 Sec. 2(3)(d));
  - Recommend strategies for increasing workforce diversity and the number of professionals qualified to provide children's mental health services (See 2439 Sec. 2(3)(e)); and
  - Review and make recommendations on the development and adoption of standards for training and endorsement of professionals to become qualified to provide mental health services to children birth to five and their parents or caregivers (See 2439 Sec. 2(3)(f)).
- Presentation from the Child Care & Education Team and others covering the following:
  - Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool (See 2439 Sec. 2(3)(g)); and
  - Identify outreach strategies that will successfully disseminate information to parents, providers, schools, and other individuals who work with children and youth on the mental health services offered through the health care plans, including referrals to parenting programs, community providers, and behavioral health organizations(See 2439 Sec. 2(3)(h)).
- Review and discussion.
- Public comment.

#### 1.3 ASSESSMENT, ELIGIBILITY, & BILLING: WEDNESDAY, SEPTEMBER 28TH 8:30AM - 12:30PM

- Location: HHR A JLOB Olympia, WA
- Presentation from the Assessment, Eligibility, & Billing Team and others covering the following:

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Revised: August 25, 2016

Prepared by: Ashley Paintner, OPR, 360-786-7120  
WA State House of Representatives, ELHS Committee

- Review and recommend developmentally, culturally, and linguistically appropriate assessment tools and diagnostic approaches that managed care plans and behavioral health organizations should use as the mechanism to establish eligibility for services (See 2439 Sec. 2(3)(a));
  - Identify and review billing issues related to serving the parent or caregiver in a treatment dyad and the billing issues related to services that are appropriate for serving children, including children birth to five (See 2439 Sec. 2(3)(b)); and
  - Evaluate and identify barriers to billing and payment for behavioral health services provided within primary care settings in an effort to promote and increase the use of behavioral health professionals within primary care settings (See 2439 Sec. 2(3)(c)).
- Review and discussion.
  - Public comment.

#### 1.4 RECOMMENDATIONS: THURSDAY, OCTOBER 13TH 8:30AM - 12:30PM

- Location: HHR A JLOB Olympia, WA
- Recommendations: Presentations from the three teams.
- Review and discussion of the report.
- Public comment.

#### 1.5 FINAL REPORT RECOMMENDATIONS: TUESDAY, NOVEMBER 1ST 10:00AM - 2:00PM

- Location: HHR A JLOB Olympia, WA
- Final Report Recommendations: Discussion and public comment.
- Draft report distributed to the Work Group on November 15th for final comment.
- Final comments due to staff by November 22nd.

#### 1.6 FINAL REPORT DUE TO THE LEGISLATURE: THURSDAY, DECEMBER 1ST (NO MEETING)

APPENDIX G

PRIORITIZED RECOMMENDATIONS	RANKING
<p><b>A. <u>Standardized Screening and Assessment Tools and Maternal Depression Screening</u></b></p>	2
<p>I. Identify a standardized list of screening tools for use by all primary care practitioners that are culturally and developmentally appropriate for all children (0-20). A small committee of physicians, mental health practitioners, DBHR, CA, DOH and HCA staff will convene to identify and publish the standardized tools by April 1, 2017.</p>	3
<p>II. Identify standardized mental health assessment and outcome diagnostic tools for all children 0-5 that supports access to BHO services. DBHR is responsible for working with BHO's to establish and implement standardized mental health assessment and outcome diagnostic tools. Lessons from this activity may be used for developing assessment and outcome diagnostic tools for children 6-20 years of age.</p>	2
<p>III. Identify a billing option for maternal depression screening performed during an EPSDT, or "other" child's primary care office visit and propose coverage for a new code(s) with adequate reimbursement rate.</p>	1
<p><b>B. <u>Outreach and Education to PCP and MH providers and Childrens Mental Health and Maternal Depression Screening</u></b></p>	3
<p>I. Provide outreach and education to PCPs regarding:  a. Expectations of the services to be performed during an EPSDT exam; and  b. Billing for mental health screens and referral for mental health services; and  c. Maternal depression or other contributing mental health conditions that are directly impacting the child in the child's treatment plan.</p>	2
<p>II. Provide outreach and education to MH providers (BHO, Managed Care, Fee-for-Service) regarding:  a. Maternal depression or other contributing mental health conditions that are directly impacting the child in the child's treatment plan; and  b. Billing requirements.</p>	3
<p>III. Propose coverage, identify a new code, and seek funding with adequate reimbursement for the following services performed during and EPSDT, or "other" child's primary care office visit:  a. Maternal depression screening, for children 0-5; and  b. Behavioral health screening, including depression screening, for children 0-20.</p>	1

<p><b>C. <u>Care Coordination, Network Adequacy, and Value Based Purchasing</u></b></p>	<p>1</p>
<p>I. Incorporate care coordination into larger PCP practices by:</p> <ul style="list-style-type: none"> <li>○ Supporting a care coordinator model with one psychiatric RN or master's level mental health clinician, trained and knowledgeable in mental health care. <ul style="list-style-type: none"> <li>● Care Coordinator Training and Knowledge: <ul style="list-style-type: none"> <li>▪ Screening for mental issues using proven effective screening tools</li> <li>▪ Conducting a motivational interview</li> <li>▪ Identifying suicidality and suicide prevention</li> <li>▪ Understanding family/dyad</li> <li>▪ Experience in care coordination</li> </ul> </li> <li>● Care Coordinator Responsibilities: <ul style="list-style-type: none"> <li>▪ Foster warm hand-off to MHP</li> <li>▪ Advocate and system navigator</li> </ul> </li> <li>▪ Facilitate and Track: <ul style="list-style-type: none"> <li>○ Family engagement</li> <li>○ Document and report time between referral date and 1<sup>st</sup> visit date</li> <li>○ Obtain releases for communicating PHI, as indicated</li> <li>○ Communication between all medical and mental health providers, parents, caregivers, and other practitioners (e.g.: juvenile detention centers, and school counselors)</li> <li>○ Compliance with health care visits for youth and parent/caregiver and assist parents and families making appointments and connecting to local services</li> <li>○ Compliance with care and treatment plan (brief telephonic system function check in)</li> </ul> </li> <li>▪ Provide managed care plans with information as to the contact and the disposition of each case</li> <li>▪ Provide further education to parents and families</li> </ul> </li> </ul>	<p>1</p>
<p>II. Ensure network adequacy and promote continuity of care</p> <ul style="list-style-type: none"> <li>○ Continue to evaluate and confirm network adequacy quarterly through HCA</li> <li>○ Foster managed care organization contracting for mental health services with providers who have a private practice but are also part of the BHO.</li> <li>○ Increase PCP's and Care Coordinators awareness of PAL consultative services</li> </ul>	<p>2</p>
<p>III. Provide psychiatric care consultations via telemedicine or telephonically Enhance the HCA's value based purchasing efforts in PCP settings to promote the delivery of the quality of care via performance measures for the following services:</p> <ul style="list-style-type: none"> <li>○ Developmental screening</li> <li>○ Adolescent depression screening</li> <li>○ Maternal depression screening</li> </ul>	<p>3</p>

## Children's Mental Health Work Group: Report Recommendations

This form is to be used as a guide when submitting report recommendations to the Children's Mental Health Work Group. Please fill out as much of the form as is appropriate given the specific recommendation and return to staff by October 25, 2016.

The following timeline applies for submitting report recommendations:

- **October 13, 2016 8:30am-12:30pm:** Presentation of recommendations by the three teams and discussion;
- **October 25, 2016 (no meeting):** Recommendations due to staff and distributed to Work Group for review;
- **November 1, 2016 10:00am-2:00pm:** Discussion of recommendations and voting;
- November 15, 2016 (no meeting): Draft report distributed to Work Group for final review;
- **December 1, 2016 (no meeting):** Final report due to the Legislature.

<b>Team: Assessment, Eligibility and Billing Team</b>	<b>Date: October 25, 2016</b>
<b>Team Members:</b> MaryAnne Lindeblad (HCA), Barb Putnam (DSHS/CA), Stephen Kutz (DOH), Ruth Bush, Christi Sahlin, Tatsuko Go Hollo (DOH), Kathleen Crane, Melanie J Smith, Phyllis Cavens, Jill Klenota, Tina Burrell (DSHS/BHA), Andy Toulon, Kevin Black, Devon Nichols (OFM), Stacey Bushaw (HCA), Mackenzie Dunham Ashley Paintner, Krista Houser, Senator Judy Warnick, Laurie Lippold, K Campbell, Mary Stone-Smith, Christi Sabine, Tom Dent, Peter Dolan, Hannah Castro, Lin Payton (HCA), Eric Trupin, Robert Hilt, Greg Williamson (DEL), Veronica Santangelo (DEL), Libby Hein, Alicia Ferris, Katrina Hanawalt, Sarah Rafton Chris Imhoff (DSHS/BHA), Ray Hsiao, Michael Langer (DSHS/BHA), Paul Davis (DSHS/BHA), Tory B. Gildred, Bethany Larsen (ChildHaven), Christy Arenson (CFCS), Darlene Darnell (CFCS), Manuel Villafan, George, Gail Kreiger (HCA), Kathleen Boyle, Lonnie Johns-Brown (OIC), Peggy Dolane, Rashi Gupta	
<b>Others Participating:</b>	
<b>Report Recommendation:</b>  <b><u>Standardized Screening and Assessment Tools and Maternal Depression Screening</u></b> <ul style="list-style-type: none"> <li>● Identify a standardized list of screening tools for use by all primary care practitioners that are culturally and developmentally appropriate for all children (0-20). A small committee of physicians, mental health practitioners, DBHR, CA, DOH and HCA staff will convene to identify and publish the standardized tools by April 1, 2017.</li> <li>● Identify standardized mental health assessment and outcome diagnostic tools for all children 0-5 that supports access to BHO services. DBHR is responsible for working with BHO's to establish and implement standardized mental health assessment and outcome diagnostic tools. Lessons from this activity may be used for developing assessment and outcome diagnostic tools for children 6-20 years of age.</li> <li>● Identify a billing option for maternal depression screening performed during an EPSDT, or "other" child's primary care office visit and propose coverage for a new code(s) with adequate reimbursement rate.</li> </ul> <p style="text-align: right; margin-top: 10px;"><b>Work Group Priority Level Assigned:</b> _____</p>	

Children's Mental Health Work Group website: <http://leg.wa.gov/JointCommittees/CMH/Pages/default.aspx>

1

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<p><b>Description of Issue:</b></p> <p>Physicians do not have a list of validated tools to screen children for mental health and support appropriate referrals. Without a resource list for a PCP to refer to children are not getting consistently screened. Opportunities for communication and care coordination between PCPs and MH providers are being missed. Therefore children are not receiving timely interventions with optimal benefits. With this, we are recommending a small committee of subject matter experts to discuss and identify a list of standardized screening tools with the ultimate goal of publishing by April 1, 2017.</p> <p>There are significant inconsistencies across the BHOs related to access to services and service delivery including:</p> <ul style="list-style-type: none"> <li>• Unknown and inconsistent criteria for level of care determination.</li> <li>• Some BHOs deny the existence of MH disorders in children under 6 attributing symptoms primarily to physical or developmental issues. The current DC03 and DSM 5 diagnostic crosswalk is not utilized in most BHOs to make a MH diagnosis in children 0-3. There is no reassurance that the move to the DC05 will improve access and consistency without policy and procedures.</li> <li>• Some BHOs do not connect the child's presenting symptoms and behavior to the caregiver's contributing mental health conditions which could be addressed in the child's treatment plan with familial interventions.</li> </ul> <p>Maternal depression is a growing concern recognizing the impact it has on the child's social and emotional growth, development, and parental bonding. There are currently no expectations of the PCP related to performing maternal depression screening in well child visits. CMS has provided guidance to states encouraging coverage including billing for non-Medicaid covered parents under the child's Medicaid coverage. Some PCPs may be unwilling to administer a screen without reimbursement.</p> <p><i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i></p>
<p><b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed):</b></p> <p>Review and recommend developmentally, culturally and linguistically appropriate assessment tools and diagnostic approaches that managed care plans and behavioral health organizations should use as the mechanism to establish eligibility for services <i>(2439, Sec 2 (3)(a))</i>.</p> <p><i>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i></p>
<p><b>Population(s) Impacted:</b></p> <p>Children ages 0-20; parents/caregivers; PCPs; Mental Health providers; DBHR; CA; HCA; DOH; DEL; schools; child care providers; etcetera.</p> <p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEL, OSPJ, etc.), K-12 teachers, mental health providers, etcetera.")</i></p>
<p><b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b></p> <p>HCA needs authority and funding to implement and reimburse for maternal depression screening.</p>

Children's Mental Health Work Group website: <http://leg.wa.gov/JointCommittees/CMH/Pages/default.aspx>

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**Relevant Background Information:**

Within the current system of care, families face barriers to receiving a full range of needed services for children experiencing mental health problems. Early and accurate recognition of mental health issues coupled with appropriate and timely intervention enhances health outcomes while minimizing overall expenditures. Early intervention services for children and families at high risk for adverse childhood experience help build secure parent-child attachment and bonding, which allows young children to thrive and form strong relationships in the future. Early identification and intervention is critical for children exhibiting aggressive or depressive behaviors indicative of early mental health problems.

Primary care providers use a range of screening and assessment tools subsequently there is inconsistent access to adequate, appropriate, and culturally responsive mental health services for children. Additionally, families and children ages birth to five experience vast differences between access to services and service delivery.

**Additional Information:**

**CMHWG Members Abstaining/Opposed (for staff only):**

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## Children's Mental Health Work Group: Report Recommendations

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<b>Team: Assessment, Eligibility and Billing Team</b>	<b>Date: October 25, 2016</b>
<b>Team Members:</b> MaryAnne Lindeblad (HCA), Barb Putnam (DSHS/CA), Stephen Kutz (DOH), Ruth Bush, Christi Sahlin, Tatsuko Go Hollo (DOH), Kathleen Crane, Melanie J Smith, Phyllis Cavens, Jill Klenota, Tina Burrell (DSHS/BHA), Andy Toulon, Kevin Black, Devon Nichols (OFM), Stacey Bushaw (HCA), Mackenzie Dunham Ashley Paintner, Krista Houser, Senator Judy Warnick, Laurie Lippold, K Campbell, Mary Stone-Smith, Christi Sabine, Tom Dent, Peter Dolan, Hannah Castro, Lin Payton (HCA), Eric Trupin, Robert Hilt, Greg Williamson (DEL), Veronica Santangelo (DEL), Libby Hein, Alicia Ferris, Katrina Hanawalt, Sarah Rafton Chris Imhoff (DSHS/BHA), Ray Hsiao, Michael Langer (DSHS/BHA), Paul Davis (DSHS/BHA), Tory B. Gildred, Bethany Larsen (ChildHaven), Christy Arenson (CFCS), Darlene Darnell (CFCS), Manuel Villafan, George, Gail Kreiger (HCA), Kathleen Boyle, Lonnie Johns-Brown (OIC), Peggy Dolane, Rashi Gupta	
<b>Others Participating:</b>	
<b>Report Recommendation:</b>  <b><u>Outreach and Education to PCP and MH providers and Children's Mental Health and Maternal Depression Screening</u></b> <ul style="list-style-type: none"> <li>○ Provide outreach and education to PCPs regarding:                     <ul style="list-style-type: none"> <li>• Expectations of the services to be performed during an EPSDT exam; and</li> <li>• Billing for mental health screens and referral for mental health services; and</li> <li>• Maternal depression or other contributing mental health conditions that are directly impacting the child in the child's treatment plan.</li> </ul> </li> <li>○ Provide outreach and education to MH providers (BHO, Managed Care, Fee-for-Service) regarding:                     <ul style="list-style-type: none"> <li>• Maternal depression or other contributing mental health conditions that are directly impacting the child in the child's treatment plan; and</li> <li>• Billing requirements.</li> </ul> </li> </ul>	

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<ul style="list-style-type: none"> <li>○ Propose coverage, identify a new code, and seek funding with adequate reimbursement for the following services performed during and EPSDT, or “other” child’s primary care office visit: <ul style="list-style-type: none"> <li>● Maternal depression screening, for children 0-5; and</li> <li>● Behavioral health screening, including depression screening, for children 0-20.</li> </ul> </li> </ul>
<b>Work Group Priority Level Assigned:</b>
<b>Description of Issue:</b>  Maternal depression is a growing concern recognizing the impact it has on the child’s social and emotional growth, development, and parental bonding. There are currently no expectations of the PCP related to performing maternal depression screening in well child visits. CMS has provided guidance to states encouraging coverage including billing for non-Medicaid covered parents under the child’s Medicaid coverage. Most PCPs are unwilling to administer a screen without reimbursement.  Lack of outreach and education has resulted in providers being unaware of what is allowable, what is reimbursable and how to bill appropriately. This results in children being treated in a vacuum or not at all.  Confusion exists in the mental health community regarding allowable CMS rules around treatment that can be provided to a child, and the child’s parent or guardian, if the treatment is directly related to the child’s care and is medically necessary.  <i>(e.g., “The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.”)</i>
<b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed):</b>  Identify and review billing issues related to serving parent or caregiver in a treatment dyad and the billing issues related to services that are appropriate for serving children birth to five <i>(2439, Sec 2(3)(b))</i> .  <i>(e.g., “E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.”)</i>
<b>Population(s) Impacted:</b>  Children ages 0-20; parents/caregivers; PCPs; Mental Health providers; DBHR; CA; HCA; DOH; DEL; schools; child care providers; etcetera.  <i>(e.g., “Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEL, OSPI, etc.), K-12 teachers, mental health providers, etcetera.”)</i>
<b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b>  HCA needs authority and funding to implement and reimburse for: <ul style="list-style-type: none"> <li>● Maternal depression screening; and</li> <li>● Additional Behavioral health screening for children.</li> </ul>
<b>Relevant Background Information:</b>  Maternal depression is a serious and widespread condition that not only affects the mother, but may have a lasting, detrimental impact on the child’s health. Maternal depression presents a significant early risk to proper child development, the mother-infant bond, and the family. Maternal depression screening and treatment is an important tool to protect the child from the potential adverse physical and developmental effects of maternal depression.

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According to the AAP, "If the maternal depression persists untreated and there is not intervention for the mother and the dyadic relationship, the developmental issues for the infant also persist and are likely to be less responsive to intervention over time." 6 Recent research shows promising results for intensive interventions that focus specifically on mother-child interactions, suggesting that treatments designed to improve child well-being must attend both to relieving the mothers' depression and focus on interactions with the child as central dimensions of the interventions.

Mental health screening for children is important to conduct starting in the early development years to identify conditions which would benefit from mental health interventions.

Performing mental health screening for children and maternal depression screening without positive findings requiring a referral is not Medicaid reimbursable. Therefore, providers may be unwilling to perform these screenings as part of an EPSDT or office visit. Providers need to be supported in implementing these screening tools into their delivery of care. These screenings with positive findings requiring a referral are a billable service but providers seem unaware. Provider outreach and education will include appropriate use of codes, documentation requirements and billing procedures.

**Additional Information:**

**CMHWG Members Abstaining/Opposed (for staff only):**

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<b>Others Participating:</b>	
<b>Report Recommendation:</b>  <b><u>Care Coordination, Network Adequacy, and Value Based Purchasing</u></b> <ul style="list-style-type: none"> <li>● Incorporate care coordination into larger PCP practices by:                     <ul style="list-style-type: none"> <li>○ Supporting a care coordinator model with one psychiatric RN or master's level mental health clinician, trained and knowledgeable in mental health care.                             <ul style="list-style-type: none"> <li>● Care Coordinator Training and Knowledge:                                     <ul style="list-style-type: none"> <li>▪ Screening for mental issues using proven effective screening tools</li> <li>▪ Conducting a motivational interview</li> <li>▪ Identifying suicidality and suicide prevention</li> <li>▪ Understanding family/dyad treatment</li> <li>▪ Experience in care coordination</li> </ul> </li> <li>● Care Coordinator Responsibilities:                                     <ul style="list-style-type: none"> <li>▪ Foster warm hand-off to MHP</li> <li>▪ Advocate and system navigator</li> <li>▪ Facilitate and Track:   <ul style="list-style-type: none"> <li>○ Family engagement</li> </ul> </li> </ul> </li> </ul> </li> </ul> </li> </ul>	

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- Document and report time between referral date and 1<sup>st</sup> visit date
  - Communication between all medical and mental health providers, parents, caregivers, and other practitioners (e.g.: juvenile detention centers, and school counselors)
  - Compliance with health care visits for youth and parent/caregiver and assist parents and families making appointments and connecting to local services
  - Compliance with care and treatment plan (brief telephonic system function check in)
  - Provide managed care plans with information as to the contact and the disposition of each case
  - Provide further education to parents and families
- Ensure network adequacy and promote continuity of care
    - Continue to evaluate and confirm network adequacy quarterly through HCA
    - Foster managed care organization contracting for mental health services with providers who have a private practice but are also part of the BHO
    - Increase PCP's and Care Coordinators awareness of PAL consultative services
    - Provide psychiatric care consultations via telemedicine or telephonically
- Enhance the HCA's value based purchasing efforts in PCP settings to promote the delivery of the quality of care via performance measures for the following services:
    - Developmental screening
    - Adolescent depression screening
    - Maternal depression screening

Work Group Priority Level Assigned:

Description of Issue:

Mental health providers who render services to Medicaid covered children and families range from private offices to community mental health centers serving individuals with complex health care needs. Mental health services for some children are fragmented and the system is complicated, making it difficult for children and families to gain access to services that are medically necessary.

PCP's who performing mental health screenings and are not confident about appropriate next steps if results show further services may be necessary. Interventions are most successful when a child or adolescent interacts and engages with a caring, trained individual. An experienced and trained care coordinator knowledgeable of available resources and supports who has developed rapport with the primary care provider, mental health provider, school counselor, juvenile detention center, and the child and the caregiver can play a key role in the delivery of care for better outcomes.

An adequate network of credentialed and qualified mental health providers is essential to improving the delivery of mental health care. Although this group of health care professionals is limited in areas of the state, children must have timely access to services in a network that supports continuity of care. It is imperative to optimize resources within the network in all regions of the state and using technology and integrated models.

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<p>Committee members recognize the value of providing services in the home setting. There currently is no restriction on place of service and providing services described in these recommendations in the home. However, CMS does not allow federal Medicaid funding to be used for travel of a provider and the rule for establishing Medicaid reimbursement rate doesn't provide an option for including additional dollars to that rate to pay for travel time and costs.</p> <p><i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i></p>
<p>Section of E25HB 2439 Addressed (if applies, or issue/gap addressed):</p> <p>Evaluate and identify barriers to billing and payment for behavioral health services provided within primary care settings in an effort to promote and increase the use of behavioral health professionals within primary care settings (2439, Sec 2 (3)(c))</p> <p><i>(e.g., "E25HB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i></p>
<p>Population(s) Impacted:</p> <p>Children ages 0-20; parents/caregivers; PCPs; Mental Health providers; DBHR; CA; HCA; DOH; DEL; schools; child care providers; etcetera.</p> <p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEL, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</i></p>
<p>Current Law(s) and/or Rule(s) that needs to be changed, if any:</p> <p>While there is no law or rule that requires change, HCA needs to explore incorporating this service into the scope of work of the managed care contracts and complete the analysis on the managed care rate.</p>
<p>Relevant Background Information:</p> <p>HCA's vision for a healthier Washington is an integrated delivery system, "one stop shopping" delivery of care where clients can access needed mental health services as well as general medical care.</p> <p>Practitioners on the committee have varying experience with an integrated model. One committee member has had the opportunity to implement an integrated care coordination model and reports the benefits could be as follows:</p> <ul style="list-style-type: none"> <li>• An emphasis on prevention and early intervention.</li> <li>• Care coordination to provide a "door" into the system and an engaged human being for children and families to communicate with when they are in need of services, and to follow up to ensure the care has been provided.</li> <li>• Availability of behavioral health care through both primary care providers and mental health clinics, depending on client preference and level of need.</li> <li>• Communication and coordination among primary care providers, mental health providers, and schools</li> <li>• Access to psychiatric consultation services for primary care providers, by mental health counselors, and psychiatrists to assist with diagnosis in difficult cases and assist with medication plans.</li> <li>• Arrangements between Apple Health plans and BHO behavioral health providers, so that seamless transitions in care can occur when clients need more or less intense levels of care in the course of their treatment.</li> <li>• Cost effective and efficient care – upstream investment with outcome measure.</li> </ul>

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<p>HCA conducts a quarterly network adequacy review for each managed care plan to determine clients have access to services. Mental health services are available via the BHO system, managed care, and fee-for-service with the high level acuity services being provided in the BHO system and lower acuity services being provided in the managed care and fee-for-service system. Clients may move within these systems to receive appropriate services at the appropriate time for the appropriate severity. Consequently, there can be a disruption in the continuity of care if a provider is not a member of these three models allowing the child to receive services from one provider. This result in care that is not effective and it is particularly ineffective with children for whom personal engagement and positive relationships are essential to successful treatment.</p> <p>HCA is incorporating value based purchasing into its managed care delivery system. Defined performance measures are included in the managed care contracts with the expectation that the plans will incentivize the providers to deliver services in a manner that increases the plan’s performance for each measure. Increased performance contributes to quality of care with positive health outcomes. Consequently, reducing costs over time and supporting financial stability with predictable variance.</p>
<p>Additional Information:</p>
<p>CMHWG Members Abstaining/Opposed (for staff only):</p>

Early Learning and K-12 Team Recommendations

October 24, 2016

Recommendation	Priority Level	Timing of Implementation	Cost (No, Low Moderate or High)
1. Improve mental health service delivery in schools by: a) Instating a FTE mental health lead at each of the nine ESDs and one OSPI coordinator, and b) Launching 2-3 regional pilot projects to fund mental health services in school districts struggling to address mental/behavioral health needs in K-12 school. c) Provide funding for one "lighthouse" ESD who has experience in this arena to help advice others.	High	Short to mid-term	Moderate to high fiscal impact.
2. Recommend that most high needs child welfare system & homeless children receive stable child care for at least one full year.	High	Short term	Low fiscal impact
3. Reinstate and expand child care mental health consultation	High	Mid-term	Moderate fiscal impact.
4. Development of additional mental/behavioral health training and coaching for early learning through k12 providers, educators, administrators and parents.	High	Mid to long-term	High fiscal impact.
5. Support implementation of developmentally and culturally appropriate K-12 social emotional learning standards/competencies to compliment the early learning SEL standards currently in existence.	High	Mid-term	Low fiscal impact.
6. Support exploration of a professional infant mental health endorsement.	High	Mid-term	Low fiscal impact.

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<b>Team:</b> Early Learning & K-12 Education Team	<b>Date:</b> 10/25/2016
<b>Team Members:</b> Dr. Mona Johnson – Co Chair Joel Ryan – Co chair Nickolaus Lewis Representative Tana Senn Greg Williamson Laurie Lippold Sabine Thomas	
<b>Others Participating:</b> Veronica Santangelo Melanie Smith Megan Hale Mick Miller Kristin Schutte Mike Hickman Erin Riffe	
<b>Report Recommendation:</b>  #1. Improve mental health service delivery in schools by: <ul style="list-style-type: none"> <li>a) Instating a FTE mental health lead at each of the nine ESDs and one OSPI coordinator, and</li> <li>b) Launching 2-3 regional pilot projects to fund mental health services in school districts struggling to address mental/behavioral health needs in K-12 school.</li> </ul>	

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c) Provide funding for one “lighthouse” ESD who has experience in this arena to help advise others.

Work Group Priority Level Assigned: High

**Description of Issue:**

Schools and school districts around the state are trying to provide mental health services for its students. Some are able to cobble together grants and public funds. Others are connected with a medical clinic on campus. Too many are unable to provide any.

However, we know that 1 in 5 children suffer from some mental illness and many children have multiple ACEs (Adverse Childhood Experiences) that may get in the way of their learning, socializing, success and happiness.

If educational outcomes are truly what we are aiming for, we must address mental health issues for students where they are most of the day—at school.

The nine Educational Service Districts (ESDs) are a great resource for the 295 school districts across the state. They can serve as Medicaid billing entities, coordinate federal, state and private grants, explore MIDD funding through counties, contract directly with medical providers and more.

This is just a first step, but an important one to begin to build capacity across our state for providing mental health referrals and services for our youth.

*(e.g., “The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.”)*

**Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed):**

Analyze, in consultation with DEL, HCA, and DSHS, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool (2439 Sec. 2(3)(g));

Identify outreach strategies that will successfully disseminate information to parents, providers, schools, and other individuals who work with children and youth on mental health services offered through the health care plans, including referral to parenting programs, community providers, and behavioral health organizations (2439 Sec. 2(3)(h)).

*(e.g., “E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.”)*

Children’s Mental Health Work Group website: <http://leg.wa.gov/JointCommittees/CMH/Pages/default.aspx>

2

Staff: Ashley Paintner, OPR, (360) 786-7120/[ashley.paintner@leg.wa.gov](mailto:ashley.paintner@leg.wa.gov); Kevin Black, SCS, (360) 786-7747/[kevin.black@leg.wa.gov](mailto:kevin.black@leg.wa.gov); Devon Nichols, OFM, (360) 902-0582/[devon.nichols@ofm.wa.gov](mailto:devon.nichols@ofm.wa.gov)

<p><b>Population(s) Impacted:</b></p> <ul style="list-style-type: none"> <li>• School children &amp; families in K-12</li> <li>• School &amp; school district administrators needing help figuring out mental health delivery and/or referral in their schools.</li> </ul> <p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEL, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</i></p>
<p><b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b></p> <p>N/A</p>
<p><b>Relevant Background Information:</b></p> <p>Our vision is that all children with mental health issues receive the support and services needed to be successful in school and life. We know that a child’s success in school at any age is directly linked to their mental health &amp; well-being.</p> <p>We believe that a new, more robust mental system is required for our children—one that screens all children for mental health issues, integrates best practices and the highest impact professional development, provides coaching, training and on-site services, and referrals to children that need help. We need a system that is coordinated and well executed. We believe that no early learning and K–12 system is complete and will be successful without social emotional learning and professional development being integrated into mental health (and all other) work utilizing a cultural relevant and racial equity lens.</p> <p>We believe it is critical to address the lack of funding currently available within the early learning and K-12 school systems. It is no longer possible to piece children’s mental health services together with a handful of state, federal, and private grants. Nor can we tip the scales simply through investments in targeted early learning programs such as home visiting services or ECEAP. Right now, school funding is too restrictive and wholly insufficient while the current Medicaid reimbursements rates make it impossible to attract quality services and providers for families in need of services. Thus, we conclude that to achieve our goal of ensuring that all children succeed in school and life we need a comprehensive system that is financed with a more robust and significant investment.</p>
<p><b>Additional Information:</b></p> <p>Timing of implementation: Short to mid-term  Cost: Moderate to high fiscal impact.</p> <p>Note: JLARC’s 2016 report on mental health services in schools may be a valuable resource.</p>

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CMHWG Members Abstaining/Opposed (for staff only):

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## Children's Mental Health Work Group: Report Recommendations

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- **December 1, 2016 (no meeting):** Final report due to the Legislature.

<b>Team: Early Learning &amp; K-12 Education Team</b>	<b>Date: 10/24/16</b>
<b>Team Members:</b> Dr. Mona Johnson – Co Chair Joel Ryan – Co chair Nickolaus Lewis Representative Tana Senn Greg Williamson Laurie Lippold Sabine Thomas	
<b>Others Participating:</b> Veronica Santangelo Melanie Smith Megan Hale Mick Miller Kristin Schutte Mike Hickman Erin Riffe	
<b>Report Recommendation:</b>  <p style="text-align: center;"><b>#2. We recommend that our most high needs children receive stable child care for at least one full year.</b></p> <p style="text-align: right; font-size: small;"><b>Work Group Priority Level Assigned: High</b></p>	
<b>Description of Issue:</b>  Specifically, we recommend that children within the child welfare system and homeless children have access to the working connections child care program regardless of the employment status of their parents and/or guardians.	

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<p><i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i></p>
<p><b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed);</b></p> <p>Analyze, in consultation with DEL, HCA, and DSHS, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool (2439 Sec. 2(3)(g));</p> <p>Identify outreach strategies that will successfully disseminate information to parents, providers, schools, and other individuals who work with children and youth on mental health services offered through the health care plans, including referral to parenting programs, community providers, and behavioral health organizations (2439 Sec. 2(3)(h)).</p> <p><i>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i></p>
<p><b>Population(s) Impacted:</b></p> <p>Children &amp; families within the child welfare system; homeless children &amp; families</p> <p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEL, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</i></p>
<p><b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b></p> <p>N/A</p>
<p><b>Relevant Background Information:</b></p> <p>Our vision is that all children with mental health issues receive the support and services needed to be successful in school and life. We know that a child’s success in school at any age is directly linked to their mental health &amp; well-being.</p> <p>We believe that a new, more robust mental system is required for our children—one that screens all children for mental health issues, integrates best practices and the highest impact professional development, provides coaching, training and on-site services, and referrals to children that need help. We need a system that is coordinated and well executed. We believe that no early learning and K–12 system is complete and will be successful without social emotional learning and professional development being integrated into mental health (and all other) work utilizing a cultural relevant and racial equity lens.</p> <p>We believe it is critical to address the lack of funding currently available within the early learning and K-12 school systems. It is no longer possible to piece children’s mental health services together with a handful of state, federal, and private grants. Nor can we tip the scales simply through investments in targeted early learning programs such as home visiting services or ECEAP. Right now, school funding is too restrictive and wholly insufficient while the current Medicaid reimbursements rates make it impossible to attract quality services and providers for families in need of services. Thus, we conclude that to achieve our goal of ensuring that all children succeed in school and life we need a comprehensive system that is financed with a more robust and significant investment.</p>

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<p><b>Additional Information:</b></p> <p>Timing of implementation: Short term  Cost: Low fiscal impact.</p>
<p><b>CMHWG Members Abstaining/Opposed (for staff only):</b></p>

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## Children's Mental Health Work Group: Report Recommendations

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Team: <b>Early Learning and K-12 Education Team</b>	Date: <b>10/24/16</b>
<b>Team Members:</b> Dr. Mona Johnson – Co Chair Joel Ryan – Co chair Nickolaus Lewis Representative Tana Senn Greg Williamson Laurie Lippold Sabine Thomas	
<b>Others Participating:</b> Veronica Santangelo Melanie Smith Megan Hale Mick Miller Kristin Schutte Mike Hickman Erin Riffe	
<b>Report Recommendation:</b>  <div style="text-align: center;"><b>#3. Reinstate and expand child care mental health consultation</b></div> <div style="text-align: right; font-size: small; margin-top: 10px;"><b>Work Group Priority Level Assigned: High</b></div>	
<b>Description of Issue:</b>  The Department of Early Learning once funded a cadre of mental health coaches that supported local child care providers that were dealing with children with behavioral and mental health issues. Funding for this was discontinued. We are asked that this program be reestablished and funded. It was a terrific resources for providers and families.	

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<p>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</p>
<p>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed);</p> <p>Analyze, in consultation with DEL, HCA, and DSHS, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool (2439 Sec. 2(3)(g));</p> <p>Identify outreach strategies that will successfully disseminate information to parents, providers, schools, and other individuals who work with children and youth on mental health services offered through the health care plans, including referral to parenting programs, community providers, and behavioral health organizations (2439 Sec. 2(3)(h)).</p> <p>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</p>
<p>Population(s) Impacted:</p> <p>Child care and early learning settings</p> <p>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEL, OSP), etc.), K-12 teachers, mental health providers, etcetera.")</p>
<p>Current Law(s) and/or Rule(s) that needs to be changed, if any:</p>
<p>Relevant Background Information:</p> <p>Our vision is that all children with mental health issues receive the support and services needed to be successful in school and life. We know that a child's success in school at any age is directly linked to their mental health &amp; well-being.</p> <p>We believe that a new, more robust mental system is required for our children—one that screens all children for mental health issues, integrates best practices and the highest impact professional development, provides coaching, training and on-site services, and referrals to children that need help. We need a system that is coordinated and well executed. We believe that no early learning and K-12 system is complete and will be successful without social emotional learning and professional development being integrated into mental health (and all other) work utilizing a cultural relevant and racial equity lens.</p> <p>We believe it is critical to address the lack of funding currently available within the early learning and K-12 school systems. It is no longer possible to piece children's mental health services together with a handful of state, federal, and private grants. Nor can we tip the scales simply through investments in targeted early learning programs such as home visiting services or ECEAP. Right now, school funding is too restrictive and wholly insufficient while the current Medicaid reimbursements rates make it impossible to attract quality services and providers for families in need of services. Thus, we</p>

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conclude that to achieve our goal of ensuring that all children succeed in school and life we need a comprehensive system that is financed with a more robust and significant investment.
<p><b>Additional Information:</b></p> <p>Timing of implementation: Mid-term  Cost: Moderate fiscal impact.</p>
CMHWG Members Abstaining/Opposed (for staff only):

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<b>Team: Early Learning &amp; K-12 Education Team</b>	<b>Date: 10/24/16</b>
<b>Team Members:</b> Dr. Mona Johnson – Co Chair Joel Ryan – Co chair Nickolaus Lewis Representative Tana Senn Greg Williamson Laurie Lippold Sabine Thomas	
<b>Others Participating:</b> Veronica Santangelo Melanie Smith Megan Hale Mick Miller Kristin Schutte Mike Hickman Erin Riffe	
<b>Report Recommendation:</b>  #4. Development of additional mental/behavioral health training and coaching for early learning through k12 providers, educators, administrators and parents.	
<b>Work Group Priority Level Assigned: High</b>	
<b>Description of Issue:</b>  We believe that any coaching and professional development should include cultural competency, racial equity, and be delivered in multiple approaches such as paraprofessionals and peer to peer.	

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(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")

**Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed);**

Analyze, in consultation with DEL, HCA, and DSHS, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool (2439 Sec. 2(3)(g));

Identify outreach strategies that will successfully disseminate information to parents, providers, schools, and other individuals who work with children and youth on mental health services offered through the health care plans, including referral to parenting programs, community providers, and behavioral health organizations (2439 Sec. 2(3)(h)).

(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")

**Population(s) Impacted:**

Early learning through k12 providers, educators, administrators, parents, children & youth.

(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEL, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")

**Current Law(s) and/or Rule(s) that needs to be changed, if any:**

**Relevant Background Information:**

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We believe that a new, more robust mental system is required for our children—one that screens all children for mental health issues, integrates best practices and the highest impact professional development, provides coaching, training and on-site services, and referrals to children that need help. We need a system that is coordinated and well executed. We believe that no early learning and K–12 system is complete and will be successful without social emotional learning and professional development being integrated into mental health (and all other) work utilizing a cultural relevant and racial equity lens.

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**Additional Information:**

Timing of implementation: Mid to long-term  
Cost: High fiscal impact.

**CMHWG Members Abstaining/Opposed (for staff only):**

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<b>Others Participating:</b> Veronica Santangelo Melanie Smith Megan Hale Mick Miller Kristin Schutte Mike Hickman Erin Riffe	
<b>Report Recommendation:</b>  #5. Support implementation of developmentally and culturally appropriate K-12 social emotional learning standards/competencies to compliment the early learning SEL standards currently in existence.   <div style="text-align: right;"><b>Work Group Priority Level Assigned: High</b></div>	
<b>Description of Issue:</b>	

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<p>To implement SEL effectively and equitably schools will need to (1) start by evaluating and building school and classroom environments that are conducive to SEL; (2) incorporate principles of universal design for learning when adapting SEL curricula to their unique climate; (3) emphasize equity in the selection and implementation of curriculum; and (4) take a holistic approach, understanding that each person (child and adult) will start at different places and progress in different ways along an SEL continuum. To ensure school districts have tools to do this work, we recommend the Legislature adopt the proposed Social Emotional Learning Framework, including the guiding principles, standards, and benchmarks for K-12 students in Washington outlined in the October 1, 2016 Legislative report.</p>
<p><i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i></p>
<p>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed):</p> <p>Analyze, in consultation with DEL, HCA, and DSHS, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool (2439 Sec. 2(3)(g));</p> <p>Identify outreach strategies that will successfully disseminate information to parents, providers, schools, and other individuals who work with children and youth on mental health services offered through the health care plans, including referral to parenting programs, community providers, and behavioral health organizations (2439 Sec. 2(3)(h)).</p>
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<p>Population(s) Impacted:</p> <p>K-12 educators, administrators, parents, children and youth</p> <p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEL, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</i></p>
<p>Current Law(s) and/or Rule(s) that needs to be changed, if any:</p> <p>N/A</p>
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**Additional Information:**

Timing of implementation: Mid-term  
Cost: Low fiscal impact.

Note: October 1, 2016 Legislative Report from the Office of Superintendent of public Instruction titled: Addressing Social Emotional learning in Washington’s K-12 Public Schools will be helpful.

CMHWG Members Abstaining/Opposed (for staff only):

## Children's Mental Health Work Group: Report Recommendations

This form is to be used as a guide when submitting report recommendations to the Children's Mental Health Work Group. Please fill out as much of the form as is appropriate given the specific recommendation and return to staff by October 25, 2016.

The following timeline applies for submitting report recommendations:

- **October 13, 2016 8:30am-12:30pm:** Presentation of recommendations by the three teams and discussion;
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- November 15, 2016 (no meeting): Draft report distributed to Work Group for final review;
- **December 1, 2016 (no meeting):** Final report due to the Legislature.

<b>Team: Early Learning &amp; K-12 Team</b>	<b>Date: 10/24/16</b>
<b>Team Members:</b> Dr. Mona Johnson – Co Chair Joel Ryan – Co chair Nickolaus Lewis Representative Tana Senn Greg Williamson Laurie Lippold Sabine Thomas	
<b>Others Participating:</b> Veronica Santangelo Melanie Smith Megan Hale Mick Miller Kristin Schutte Mike Hickman Erin Riffe	
<b>Report Recommendation:</b>  # 6. Support exploration of a professional infant mental health endorsement.	
<small>Work Group Priority Level Assigned: High</small>	
<b>Description of Issue:</b>  We recommend that Early Achievers provide funding for participating child care providers to develop an online portfolio to obtain endorsement as an Infant Family Associate or Specialist. This is relatively inexpensive and excellent credentialing opportunity for providers working with infants and young children and their families.	

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1

Staff: Ashley Paintner, OPR, (360) 786-7120/[ashley.paintner@leg.wa.gov](mailto:ashley.paintner@leg.wa.gov); Kevin Black, SCS, (360) 786-7747/[kevin.black@leg.wa.gov](mailto:kevin.black@leg.wa.gov); Devon Nichols, OFM, (360) 902-0582/[devon.nichols@ofm.wa.gov](mailto:devon.nichols@ofm.wa.gov)

<p>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</p>
<p>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed);</p> <p>Analyze, in consultation with DEL, HCA, and DSHS, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool (2439 Sec. 2(3)(g));</p> <p>Identify outreach strategies that will successfully disseminate information to parents, providers, schools, and other individuals who work with children and youth on mental health services offered through the health care plans, including referral to parenting programs, community providers, and behavioral health organizations (2439 Sec. 2(3)(h)).</p> <p>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</p>
<p>Population(s) Impacted:</p> <p>Professionals interested in receiving/obtaining an infant mental health endorsement</p> <p>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEL, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</p>
<p><b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b></p>
<p>Relevant Background Information:</p> <p>Our vision is that all children with mental health issues receive the support and services needed to be successful in school and life. We know that a child’s success in school at any age is directly linked to their mental health &amp; well-being.</p> <p>We believe that a new, more robust mental system is required for our children—one that screens all children for mental health issues, integrates best practices and the highest impact professional development, provides coaching, training and on-site services, and referrals to children that need help. We need a system that is coordinated and well executed. We believe that no early learning and K–12 system is complete and will be successful without social emotional learning and professional development being integrated into mental health (and all other) work utilizing a cultural relevant and racial equity lens.</p> <p>We believe it is critical to address the lack of funding currently available within the early learning and K-12 school systems. It is no longer possible to piece children’s mental health services together with a handful of state, federal, and private grants. Nor can we tip the scales simply through investments in targeted early learning programs such as home visiting services or ECEAP. Right now, school funding is too restrictive and wholly insufficient while the current Medicaid reimbursements rates</p>

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2

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<p>make it impossible to attract quality services and providers for families in need of services. Thus, we conclude that to achieve our goal of ensuring that all children succeed in school and life we need a comprehensive system that is financed with a more robust and significant investment.</p>
<p><b>Additional Information:</b></p> <p>Timing of implementation: Mid-term  Cost: Low fiscal impact.</p>
<p><b>CMHWG Members Abstaining/Opposed (for staff only):</b></p>

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<b>Team:</b> Workforce	<b>Date:</b> 10-25-16
<b>Team Members:</b> (includes both members of the MH Workgroup and others)	
<p>Alicia Ferris</p> <p>Bob Hiit (robert.hiit@seattlechildrens.org)</p> <p>Cantore, Victoria</p> <p>Carroll, Leslie M (DOH)</p> <p>Caruso, Julie</p> <p>Chris Kaasa</p> <p>Dakoda Foxx (daxjustice@gmail.com)</p> <p>Darlene Darnell</p> <p>Dolan, Peter</p> <p>Donna Christianson (aol.com)</p> <p>Dr. Ray Hsiao</p> <p>Eric Trupin (uw.edu)</p> <p>Greg Williamson (greg.williamson@del.wa.gov)</p> <p>Gupta, Rashi</p> <p>Joan Miller (thewashingtoncouncil.org)</p> <p>Johns-Brown, Lonnie (OIC)</p> <p>Kathryn Kolan</p> <p>Kevin Black (Black.Kevin@leg.wa.gov)</p> <p>Laurie Lippold (lippoldlau@aol.com) (gmail.com)</p> <p>Lelach Rave (via Google Docs) (wcaap.org)</p> <p>Mackenzie Dunham (candac.com)</p> <p>Mary Stone Smith</p> <p>Matthew Thompson (kidsclinicmail.com)</p> <p>Michael Langer</p> <p>Nicholas Kasovac</p> <p>Nova Gattman</p> <p>Paintner, Ashley</p>	

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Phyllis Cavens (pacifier.com) Rep. Tom Dent (tom.dent@leg.wa.gov) Sabine Thomas (wa-aimh.org) Scott Hanauer Shadwell, Sharon R (DOH) Tatsuko Go Hollo (childrensalliance.org) <input type="checkbox"/>
<b>Others Participating:</b>
<b>Report Recommendation:</b> <u>PAPERWORK</u>  #1 - In accordance with the Federal Paperwork Reduction Act, and to efficiently and effectively use our strained financial resources in providing mental health services to children on Medicaid, the current WACs should be replaced with the following language: Use Best Practices for age-appropriate, strength-based psychosocial assessments, including current needs and relevant history in the following areas: Behavioral/Emotional, Mental Health Safety/Risk, and Functional Impairment (family/relationships, school/work, living skills/self-care, legal, medical/physical, addiction/substance use, and caregiver needs/strengths, as applicable).  <div style="text-align: right;">Work Group Priority Level Assigned: #1 in this category</div>
<b>Description of Issue:</b>  Assessments (as currently required for licensed community behavioral health agencies) are immensely time-consuming and thus a costly and inefficient use of our funds. When using Best Practices to do a full psychosocial assessment, overregulation of what is included in an assessment is unnecessary. One section on Needs and History in these areas would be sufficient, in addition to an auditor's own review of adequate level of services provided around coordination of care based on individual need. The burden to show this in the clinical file should fall on the provider agency. The focus of the audits should be on demonstrated outcomes using tools appropriate for assessing quality of care and client improvement. A pilot being conducted by the UW in 2017 is researching the feasibility of these tools for performance monitoring.]  <i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i>
<b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed);</b> New Section 2 (3)(d)  <i>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i>
<b>Population(s) Impacted:</b> MH providers  <i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEI, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</i>
<b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b>

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<p>Unsure at this time.</p>
<p><b>Relevant Background Information:</b></p> <p>Burdensome and duplicative paperwork was identified as one of the primary barriers to having an adequate provider network.</p>
<p><b>Additional Information:</b></p>
<p><b>CMHWG Members Abstaining/Opposed (for staff only):</b></p>

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<b>Team Members:</b>	
Alicia Ferris Bob Hilt (robert.hilt@seattlechildrens.org) Cantore, Victoria Carroll, Leslie M (DOH) Caruso, Julie Chris Kaasa Dakoda Foxx (daxjustice@gmail.com) Darlene Darnell Dolan, Peter Donna Christianson (aol.com) Dr. Ray Hsiao Eric Trupin (uw.edu) Greg Williamson (greg.williamson@del.wa.gov) Gupta, Rashi Joan Miller (thewashingtoncouncil.org) Johns-Brown, Lonnie (OIC) Kathryn Kolan Kevin Black (Black.Kevin@leg.wa.gov) Laurie Lippold (lippoldlau@aol.com) (gmail.com) Lelach Rave (via Google Docs) (wcaap.org) Mackenzie Dunham (candac.com) Mary Stone Smith Matthew Thompson (kidsclinicmail.com) Michael Langer Nicholas Kasovac Nova Gattman Paintner, Ashley	

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<b>Others Participating:</b>
<b>Report Recommendation: Paperwork</b>  Exempt provider agencies using evidence- and research-based practices (EBPs/RBPs) from current documentation WACs when that EBP already requires documentation of that element of treatment: assessments (except for meeting access to care standards and medical necessity), crisis/safety plans, treatment/service Planning, tracking of progress/outcomes (treatment/service plan review), and discharge/transition plans.
<b>Work Group Priority Level Assigned: #2 in this category</b>
<b>Description of Issue:</b> EBPs as quality assurance, rather than asking EBPs to adapt to audits around the WACs, would also reduce unnecessary paperwork burden that exists solely to pass audits. An additional benefit would be to increase agencies and provider willingness to adopt and continue using EBPs.]  <i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i>
<b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed):</b> New Section 2 (3)(d)  <i>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i>
<b>Population(s) Impacted:</b> MH providers  <i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEI, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</i>
<b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b> Unsure

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<b>Relevant Background Information:</b>
<b>Additional Information:</b>
<b>CMHWG Members Abstaining/Opposed (for staff only):</b>

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<p><b>Others Participating:</b></p>
<p><b>Report Recommendation: Paperwork</b></p> <p>Review the 1713 Task Force report and the Behavioral Health Care Work Force Task Force regarding paperwork reduction, and suspend making any behavioral health WAC changes until the integration WAC committee completes its work during the 2017 legislative session. This will help avoid duplication or create parallel efforts within the same timeframes.</p> <p style="text-align: right;"><b>Work Group Priority Level Assigned: #3 in this category</b></p>
<p><b>Description of Issue:</b></p> <p>It was agreed that we need to review the work of these other groups so that the recommendations can be as consistent as possible.</p> <p><i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i></p>
<p><b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed):</b></p> <p><b>New Section 2 (3)(d)</b></p> <p><i>(e.g., "E2SHB 2439 Sec. 2(3)(d): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i></p>
<p><b>Population(s) Impacted:</b></p> <p>HCA, DBHR, Health Plans, Providers</p> <p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEL, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</i></p>

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<p><b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b>  <b>Unsure</b></p>
<p><b>Relevant Background Information:</b></p>
<p><b>Additional Information:</b></p>
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<b>Others Participating:</b>
<b>Report Recommendation: RATES</b>  Move Medicaid rates from the bottom of the rate bands so providers can offer competitive clinical salaries, which will support recruitment and retention.
<b>Work Group Priority Level Assigned: #1 in this category</b>
<b>Description of Issue:</b>  Low rates paid to providers (or to BHOs who then pay providers) for serving children/families on Medicaid lead to poor access, low pay, provider turnover, and the potential for lower quality services. Because Medicaid is the main funder of community mental health services, Medicaid capitation rates are a primary determinant of community-based Medicaid providers' ability to recruit and retain a qualified workforce. This is even more apparent in rural areas. Qualified people choose to opt out of serving Medicaid clients, and many are taking private pay only. Medicaid rates are only about 2/3 of Medicare rates for the same units of service, highlighting care inequities between children and adults within our system.  Payment rate levels do not match best practices for IECMH service provision, the intensity and/or duration of services required, the geographic location (rural rates don't account for further travel requirements, or the dyad for whom the service is being provided. For example, for IECMH providers, rate is established to provide home based services, in King County base on severity and not where it is delivered, in Snohomish County the rate for home based services is higher only for the fee for service.  <i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i>
<b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed);</b> <b>New Section 2 (3) (b) and (d)</b>

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<p>(e.g., "E25HB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</p>
<p><b>Population(s) Impacted:</b>  <b>MH providers</b></p> <p>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEI, OSP), etc.), K-12 teachers, mental health providers, etcetera.")</p>
<p><b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b>  <b>Budget issue</b></p>
<p><b>Relevant Background Information:</b></p>
<p><b>Additional Information:</b></p>
<p><b>CMHWG Members Abstaining/Opposed (for staff only):</b></p>

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## Children's Mental Health Work Group: Report Recommendations

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<b>Team: Workforce</b>	<b>Date: 10-25-16</b>
<b>Team Members:</b>	
Alicia Ferris Bob Hiit (robert.hiit@seattlechildrens.org) Cantore, Victoria Carroll, Leslie M (DOH) Caruso, Julie Chris Kaasa Dakoda Foxx (daxjustice@gmail.com) Darlene Darnell Dolan, Peter Donna Christianson (aol.com) Dr. Ray Hsiao Eric Trupin (uw.edu) Greg Williamson (greg.williamson@del.wa.gov) Gupta, Rashi Joan Miller (thewashingtoncouncil.org) Johns-Brown, Lonnie (OIC) Kathryn Kolan Kevin Black (Black.Kevin@leg.wa.gov) Laurie Lippold (lippoldlau@aol.com) (gmail.com) Lelach Rave (via Google Docs) (wcaap.org) Mackenzie Dunham (candac.com) Mary Stone Smith Matthew Thompson (kidsclinicmail.com) Michael Langer Nicholes Kasovac Nova Gattman Paintner, Ashley	

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Phyllis Cavens (pacifier.com) Rep. Tom Dent (tom.dent@leg.wa.gov) Sabine Thomas (wa-aimh.org) Scott Hanauer Shadwell, Sharon R (DOH) Tatsuko Go Hollo (childrensalliance.org)	
<input type="checkbox"/>	From Laurie Lippold <laurielippold@gmail.com> CcBcc
<input type="checkbox"/>	
<b>Others Participating:</b>	
<b>Report Recommendation:</b> Increase the Medicaid rate to achieve equity with the Medicare rate to make it more attractive to provide services to individuals/families on Medicaid.	
Work Group Priority Level Assigned: Tied for #2 in the rate category	
<b>Description of Issue:</b>  Low rates paid to providers (or to BHOs who then pay providers) for serving children/families on Medicaid lead to poor access, low pay, provider turnover, and the potential for lower quality services. Because Medicaid is the main funder of community mental health services, Medicaid capitation rates are a primary determinant of community-based Medicaid providers' ability to recruit and retain a qualified workforce. This is even more apparent in rural areas. Qualified people choose to opt out of serving Medicaid clients, and many are taking private pay only. Medicaid rates are only about 2/3 of Medicare rates for the same units of service, highlighting care inequities between children and adults within our system.	
<i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i>	
Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed);	

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<p><b>New Section 2 (3) (b) an (d)</b></p> <p><i>(e.g., "E25HB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i></p>
<p><b>Population(s) Impacted:</b>  <b>Provider and consumers</b></p> <p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEI, OSP), etc.), K-12 teachers, mental health providers, etcetera.")</i></p>
<p><b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b>  <b>Budget item</b></p>
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<p>Others Participating:</p>
<p>Report Recommendation: Rates</p> <p>Revise ACS and HCA policy as needed to clearly delineate what substantive mental health challenges look like in a young child AND remove limitations on family treatment/treatment focused on a particular dyad or relationship.</p>
<p style="text-align: right;">Work Group Priority Level Assigned: Tied for #2 in this category</p>
<p>Description of Issue:</p> <p>There has been considerable confusion about what services, provided by whom and to whom, can be billed/paid. Current standards and practices regarding the 'patient' have precluded parents with very young children from receiving the services they need.</p> <p><i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i></p>
<p>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed);</p> <p>New Section 2 (3) (b) and (d)</p> <p><i>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i></p>
<p>Population(s) Impacted:</p> <p>Infants/young children, parents, providers</p>

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<p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEI, OSP), etc.), K-12 teachers, mental health providers, etcetera.")</i></p>
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<b>Others Participating:</b>
<b>Report Recommendation: Loan Repayment, Training, Other Supports</b>  Provide tuition loan repayment for child psychiatrists, therapists, and clinicians working for BHO- or MCO-funded agencies that serve a high percentage of Medicaid children/youth/families. Loan repayment support for child psychiatrists or for therapists/clinicians would be over the course of 5 years of greater than 50% of full-time work in a public sector setting. Loan repayment amounts would be commensurate with average training costs for the specialties.
<b>Work Group Priority Level Assigned: #1 in this category</b>
<b>Description of Issue:</b>  Training to become a child psychiatrist is lengthy and costly, consisting of 4 years of college, 4 years of medical school, 3 to 4 years of adult psychiatry residency, and then 2 years of child psychiatry residency. Few are able or willing to make this kind of commitment, which contributes to a national shortage of psychiatrists focusing specifically on children and youth. (Note: Washington produces 5 new child psychiatrists every year, and about half remain in the state to practice.)  Other professions serving this population are facing similar shortages. For example, there is no longer a pediatric psychiatric nurse program (NP) in Washington and only those completing a family psychiatry NP specialization are learning to support children, which in reality might be just a small portion of their caseload.  <i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i>

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<p><b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed);</b>  <b>New Section 2 (3)(d)</b></p> <p><i>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i></p> <p><b>Population(s) Impacted:</b></p> <p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEI, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</i></p> <p><b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b>  <b>Maybe need to review professions eligible for current loan repayment.</b></p> <p><b>Budget item</b></p>
<p><b>Relevant Background Information:</b></p>
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<p><b>Others Participating:</b></p>
<p><b>Report Recommendation:</b> Loan Repayment, Training, Other Supports</p> <p>Adequately pay for specialized services where needed (such as infant mental health, early intervention for psychosis, WISe, or eating disorders, as well as interventions and services that are culturally and linguistically appropriate).</p> <p style="text-align: right;"><b>Work Group Priority Level Assigned:</b> #2 in this category</p>
<p><b>Description of Issue:</b></p> <p>Payment rate levels do not match best practices for IECMH service provision, the intensity and/or duration of services required, the geographic location (rural rates don't account for further travel requirements, or the dyad for whom the service is being provided. For example, for IECMH providers, rate is established to provide home based services, in King County base on severity and not where it is delivered, in Snohomish County the rate for home based services is higher only for the fee for service.</p> <p>Additionally, most Washington universities and colleges report that they are not teaching EBPs as part of their master's level programs. This impacts the quality of services available. Multiple efforts have occurred over the years to train providers systematically at community mental health agencies on specific practices, such as trauma-focused Cognitive Behavioral Therapy. Unfortunately, effectiveness has been limited by high staff turnover rates (staff are trained, practice for a short time, and leave—often for higher pay elsewhere), as well as the extra time it requires to supervise and support the use of ongoing EBPs in an agency.</p> <p><i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i></p>
<p><b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed);</b>  <b>New Section 2 (3) (b), (d)</b></p> <p><i>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i></p>
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<p>Rep. Tom Dent (tom.dent@leg.wa.gov)</p> <p>Sabine Thomas (wa-aimh.org)</p> <p>Scott Hanauer</p> <p>Shadwell, Sharon R (DOH)</p> <p>Tatsuko Go Hollo (childrensalliance.org)</p> <p><input type="checkbox"/></p>
<p><b>Others Participating:</b></p>
<p><b>Report Recommendation: Loan Repayment, Training, Other Supports</b></p> <p>Incentivize clinical supervision of therapists in MCO/BHO agencies through individual agency contracts, restricting counselor to supervisor ratio in contracts with MCOs/BHOs, and/or by capping the caseload size for supervisors to be consistent with that which a particular EBP/RBP recommends.</p> <p style="text-align: right;"><b>Work Group Priority Level Assigned: # 3 in this category</b></p>
<p><b>Description of Issue:</b></p> <p>The ratio of supervisors to clinicians is high, making it very difficult to provide appropriate levels of supervision.</p> <p><i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i></p>
<p><b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed):</b></p> <p><b>New Section 2 (3)(d)</b></p> <p><i>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i></p>
<p><b>Population(s) Impacted:</b></p> <p>Providers and ultimately children and families</p> <p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEI, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</i></p>
<p><b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b></p> <p><b>Unsure</b></p> <p><b>Budget item</b></p>

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<b>Relevant Background Information:</b>
<b>Additional Information:</b>
<b>CMHWG Members Abstaining/Opposed (for staff only):</b>

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## Children's Mental Health Work Group: Report Recommendations

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The following timeline applies for submitting report recommendations:

- **October 13, 2016 8:30am-12:30pm:** Presentation of recommendations by the three teams and discussion;
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- **November 15, 2016 (no meeting):** Draft report distributed to Work Group for final review;
- **December 1, 2016 (no meeting):** Final report due to the Legislature.

<b>Team:</b> Workforce	<b>Date:</b> 10-25-16
<b>Team Members:</b> Alicia Ferris Bob Hilt (robert.hilt@seattlechildrens.org) Cantore, Victoria Carroll, Leslie M (DOH) Caruso, Julie Chris Kaasa Dakoda Foxx (daxjustice@gmail.com) Darlene Darnell Dolan, Peter Donna Christianson (aol.com) Dr. Ray Hsiao Eric Trupin (uw.edu) Greg Williamson (greg.williamson@del.wa.gov) Gupta, Rashi Joan Miller (thewashingtoncouncil.org) Johns-Brown, Lonnie (OIC) Kathryn Kolan Kevin Black (Black.Kevin@leg.wa.gov) Laurie Lippold (lippoldlau@aol.com) (gmail.com) Lelach Rave (via Google Docs) (wcaap.org) Mackenzie Dunham (candac.com) Mary Stone Smith Matthew Thompson (kidsclinicmail.com) Michael Langer Nicholas Kasovac Nova Gattman Paintner, Ashley Phyllis Cavens (pacifier.com)	

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<p>Rep. Tom Dent (<a href="mailto:tom.dent@leg.wa.gov">tom.dent@leg.wa.gov</a>)  Sabine Thomas (<a href="mailto:wa-aimh.org">wa-aimh.org</a>)  Scott Hanauer  Shadwell, Sharon R (DOH)  Tatsuko Go Hollo (<a href="http://childrensalliance.org">childrensalliance.org</a>)  <input type="checkbox"/></p>
<p><b>Others Participating:</b></p>
<p><b>Report Recommendation: Diversity</b></p> <p>Increase payment for providers offering interventions in community locations, including primary care, education, child welfare and juvenile justice and ensure that payment can be made when providing services in non-traditional settings by a variety of professionals.</p>
<p style="text-align: right;"><b>Work Group Priority Level Assigned: #1 in this category</b></p>
<p><b>Description of Issue:</b></p> <p>Children of color are 30-50% less likely to receive mental health care as white children. They are also more likely to receive treatment that is inappropriate or inadequate. A diverse workforce is needed to better ensure that children and families receive the most appropriate services, delivered in a linguistically and culturally competent manner. Lack of accessibility of appropriate services and a shortage of culturally and linguistically competent providers, among other issues, including inappropriate referrals and variations in cultural norms and stigmas, present significant barriers to communities of color in need of behavioral health services. Further, there is a lack of men, particularly men of color, providing early childhood mental health services to communities in need.</p> <p>It is critical that in addition to having a diverse work force, services can be provided and billed for in settings that are relevant to the population being served.</p> <p><i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i></p>
<p><b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed):</b>  <b>New Section 2 (3) (e)</b></p>

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<p>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</p>
<p><b>Population(s) Impacted:</b>  Children and families of color; providers</p> <p>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEI, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</p>
<p><b>Current Law(s) and/or Rule(s) that needs to be changed, if any:</b></p> <p><b>Budget</b></p>
<p><b>Relevant Background Information:</b></p>
<p><b>Additional Information:</b></p>
<p><b>CMHWG Members Abstaining/Opposed (for staff only):</b></p>

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<p><b>Team Members:</b></p> <p>Alicia Ferris</p> <p>Bob Hilt (robert.hilt@seattlechildrens.org)</p> <p>Cantore, Victoria</p> <p>Carroll, Leslie M (DOH)</p> <p>Caruso, Julie</p> <p>Chris Kaasa</p> <p>Dakoda Foxx (daxjustice@gmail.com)</p> <p>Darlene Darnell</p> <p>Dolan, Peter</p> <p>Donna Christianson (aol.com)</p> <p>Dr. Ray Hsiao</p> <p>Eric Trupin (uw.edu)</p> <p>Greg Williamson (greg.williamson@del.wa.gov)</p> <p>Gupta, Rashi</p> <p>Joan Miller (thewashingtoncouncil.org)</p> <p>Johns-Brown, Lonnie (OIC)</p> <p>Kathryn Kolan</p> <p>Kevin Black (Black.Kevin@leg.wa.gov)</p> <p>Laurie Lippold (lippoldlau@aol.com) (gmail.com)</p> <p>Lelach Rave (via Google Docs) (wcaap.org)</p> <p>Mackenzie Dunham (candac.com)</p> <p>Mary Stone Smith</p> <p>Matthew Thompson (kidsclinicmail.com)</p> <p>Michael Langer</p> <p>Nicholas Kasovac</p> <p>Nova Gattman</p> <p>Paintner, Ashley</p> <p>Phyllis Cavens (pacifier.com)</p>	

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<p><b>Others Participating:</b></p>
<p><b>Report Recommendation: Diversity</b></p> <p>Conduct a survey of mental health providers serving children, including children birth –five, on Medicaid, including demographics and culturally and linguistically diverse services available. At a minimum, the survey should include: race/ethnicity, languages (of providers) spoken, ages served, use of screening tools and assessments that are culturally and linguistically valid and appropriate, and level of cultural competence training received.</p>
<p style="text-align: right;"><b>Work Group Priority Level Assigned: #2 in this category</b></p>
<p><b>Description of Issue:</b></p> <p>At present there is very little information available regarding the make-up of the workforce. DBHR recently conducted a survey of the chemical dependency workforce but not the mental health workforce. DBHR's study found that a significant majority of CD clinical staff are white (approx. two-thirds), while half of the youth they serve are people of color. For example, more than one in five youth CD clients are Latino, compared to just 6% of CD clinical staff.</p> <p><i>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</i></p>
<p><b>Section of E2SHB 2439 Addressed (if applies, or issue/gap addressed):</b></p> <p><b>New Section 2 (3)(e)</b></p> <p><i>(e.g., "E2SHB 2439 Sec. 2(3)(g): Analyze, in consultation with the department of early learning, the health care authority, and the department of social and health services, existing and potential mental health supports for child care providers to reduce expulsions of children in child care and preschool.")</i></p>
<p><b>Population(s) Impacted:</b></p> <p>Communities of color, parents/children, providers</p>

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<p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEI, OSP), etc.), K-12 teachers, mental health providers, etcetera.")</i></p>
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<p><b>Others Participating:</b></p>
<p><b>Report Recommendation: Diversity</b></p> <p>Conduct a review of the provision of public mental health services to children, as well as child outcomes, to determine where racial and ethnic disparities exist and the severity of those disparities. Monitor racial and ethnic disparities on an ongoing basis to track progress and refine approaches.</p>
<p style="text-align: right;"><b>Work Group Priority Level Assigned: #3 in this category</b></p>
<p><b>Description of Issue:</b></p> <p>Children of color are 30-50% less likely to receive mental health care as white children. They are also more likely to receive treatment that is inappropriate or inadequate. A diverse workforce is needed to better ensure that children and families receive the most appropriate services, delivered in a linguistically and culturally competent manner. Lack of accessibility of appropriate services and a shortage of culturally and linguistically competent providers, among other issues, including inappropriate referrals and variations in cultural norms and stigmas, present significant barriers to communities of color in need of behavioral health services. Further, there is a lack of men, particularly men of color, providing early childhood mental health services to communities in need.</p> <p>At present there is very little information available regarding the make-up of the workforce. DBHR recently conducted a survey of the chemical dependency workforce but not the mental health workforce. DBHR's study found that a significant majority of CD clinical staff are white (approx. two-thirds), while half of the youth they serve are people of color. For example, more than one in five youth CD clients are Latino, compared to just 6% of CD clinical staff.</p> <p><small>(e.g., "The expulsion rate in state-funded preschools in Washington is higher than the national average with approximately nine of every 1,000 children being removed from care due to their behavior.")</small></p>

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<p><b>Population(s) Impacted:</b>  HCA, Plans, DBHR, children and families of color, providers</p> <p><i>(e.g., "Parents of children in preschool, preschool children, preschool teachers and child care providers, state (DEI, OSPI, etc.), K-12 teachers, mental health providers, etcetera.")</i></p>
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