

Children's Mental Health Work Group

Dec. 5, 1:00 – 5:00 pm
Hearing Room A
John L. O'Brien Building

Call information: 888-407-5039

Participant PIN: 92834822

Attendees:					
<input type="checkbox"/>	Representative Noel Frame	<input type="checkbox"/>	Lacy Fehrenbach	<input type="checkbox"/>	Steve Kutz
<input type="checkbox"/>	MaryAnne Lindeblad	<input type="checkbox"/>	Dr. Thatcher Felt	<input type="checkbox"/>	Amber Leaders
<input type="checkbox"/>	Randon Aea	<input type="checkbox"/>	Tory Gildred	<input type="checkbox"/>	Nickolas D. Lewis
<input type="checkbox"/>	Dr. Avanti Bergquist	<input type="checkbox"/>	Camille Goldy	<input type="checkbox"/>	Laurie Lippold
<input type="checkbox"/>	Ruth Bush	<input type="checkbox"/>	Libby Hein	<input type="checkbox"/>	Representative John Lovick
<input type="checkbox"/>	Representative Michelle Caldier	<input type="checkbox"/>	Dr. Bob Hilt	<input type="checkbox"/>	Joel Ryan
<input type="checkbox"/>	Diana Cockrell	<input type="checkbox"/>	Kristin Houser	<input type="checkbox"/>	Mary Stone-Smith
<input type="checkbox"/>	Senator Jeannie Darnielle	<input type="checkbox"/>	Avreayl Jacobson	<input type="checkbox"/>	Jim Theofelis
<input type="checkbox"/>	Peggy Dolane	<input type="checkbox"/>	Lonnie Johns-Brown	<input type="checkbox"/>	Dr. Eric Trupin
<input type="checkbox"/>	Jamie Elzea	<input type="checkbox"/>	Kim Justice	<input type="checkbox"/>	Senator Judy Warnick
<input type="checkbox"/>	Representative Carolyn Eslick	<input type="checkbox"/>	Judy King	<input type="checkbox"/>	Dr. Larry Wissow

No	Agenda Items	Time	Lead
1.	Introductions	1:00-1:10 pm	Rep. Noel Frame
2.	Agenda Review & Prioritization Strategy Handout 1: Mission/Vision (front); Target cover sheet (back)	1:10-1:25	Rep. Noel Frame
3.	Subgroup reports & recommendations: <i>15 min. for subgroups</i> <ul style="list-style-type: none"> Rates Laurie Lippold Handout 2: Behavioral Health Rates Recommendations Partnership Access Line Rep. Vandana Slatter/Laurie Lippold Prenatal to Five Relational Health Jamie Elzea Handout 3: Prenatal to Age 5 Recommendations Family-Initiated Treatment/HB 1874 Peggy Dolane Handout 4: 1874 Adolescent Behavioral Health Care Act – Follow-up Recommendations Workforce Laurie Lippold Handout 5: Workforce Recommendations Student Well-Being & School-based Connections to BH/IDD Services & Supports Camille Goldy & Lee Collyer Handout 6: Student Well-being & School-based Connections Recommendations 	1:25-2:55	Subgroup Leads
	BREAK	2:55-3:05	
4.	Prioritization results: Review, discussion, final decision-making	3:05-4:05	
5.	CMHWG reauthorizing legislation	4:05-4:15	Rep. Noel Frame
6.	Next steps	4:15-4:30	Rep. Noel Frame
7.	Ann Christian (Washington Council for Behavioral Health)	4:30-4:40	Ann Christian
8.	Public comment	4:40-5:00 pm	Rep. Noel Frame

Children's Mental Health Work Group

Vision: Washington's children, youth, and young adults have access to high-quality behavioral health care.

Mission: Identify barriers to and opportunities for behavioral health services and strategies for children, youth and young adults (prenatal to 25 years old) and their families that are accessible, effective, timely, culturally and linguistically relevant, supported by evidence, and incorporate tailored innovations as needed.

Authority: CMHWG authorized through December 30, 2020, with a report due December 1, 2020, to advise the Washington Legislature on barriers to and opportunities for children and families to access statewide behavioral health services. *Note: Work group participants have changed "mental health" to "behavioral health" to reflect that substance use disorder services have now been integrated into mental health services in Washington state. Furthermore, the work group has a stated preference to also include young adults (up to age 25), and clarified that "children" includes pre-natal.*

2019/2020 CMHWG Target “Cover Sheet”

Children’s Mental Health Work Group

Recommendations proposed from sub groups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Workforce (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Payment and funding (e.g. rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)
- Trauma informed care (e.g. trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma services – interventions that directly address trauma, such as Trauma Informed CBT [TF-CBT] among others)

Children’s Mental Health Work Group – Behavioral Health Rate Committee

GOAL: Advance timely and equitable access to behavioral health services grounded in best practices by ensuring that Medicaid rates are sufficient to increase access and support competitive salaries.

RECOMMENDATIONS:

- Require that proposals related to increasing Medicaid rates must be grounded within the rate-setting process for the provider type or practice setting (i.e. hospital, licensed behavioral health agency, outpatient network provider, FQHC, other primary care setting, etc.), incentivize preventive care, and recognize the shift toward value-based purchasing.
 - Any increase in Medicaid rates for behavioral health services must include a proportional increase to services with a case rate, with a priority on WISe. (Legislative directive to the HCA)

- Require the HCA, with respect to funds appropriated by the legislature for behavioral health, primarily with the intent of increasing Medicaid rates paid to providers, to work with stakeholders to establish/enhance transparency and accountability mechanisms that ensure these funds are used by HCA and MCOs for their intended purpose. The HCA shall report back to the appropriate committees of the legislature the mechanisms they have or intend to establish. (policy)

- Increase the following prioritized treatment codes (these will have the greatest impact to increase access for children and youth and address significant rate disparities) as follows: Increase by 8% OR the Medicare rate, whichever is higher for ALL settings. (\$\$\$)
 1. Behavioral Health Counseling and Psychotherapy – H0004, 90832, 90834, 90837, 99354, 99355, 90833, H0036
 2. Family Therapy – 90847
 3. Care coordination – H2015, H2021
 4. Peer Counseling/Peer Support Services – H0038
 5. Family Therapy without the Youth Present – 90846
 6. Group treatment — 90853, 90849
 7. Intake, Assessment, Treatment Planning – H0031, H0032
 8. Medication management – 99211, 99212, 99213, 99214, 99215

Additionally, direct the HCA to work with stakeholders to study the underlying salary assumptions and compare them to other market standards including Medicare, with the goal of creating a blueprint for future rate setting and achieving the goal as stated above.

**Source for determining most common mental health services and codes for serving children and youth: BEHAVIORAL HEALTH SERVICES DATA BOOK, July 27 2018, State of Washington, Mercer, pages 86-87.?

- Appropriate funding for partial hospitalization and intensive outpatient as an alternative to inpatient hospitalization and require reimbursement for these services. [PH and IOP allow children and adolescents to have their behavioral health needs met through intensive therapies up to 3-8 hours/day without requiring inpatient hospitalization.] \$4.6m
- Direct the HCA to build payment modes that adequately reimburse for multi-disciplinary team-base services, such as shared appointments, care conferences, and team meetings. (policy)

Medicare rates for comparable behavioral health codes are one key benchmark to be considered. The following table highlights just a few of the discrepancies between Medicare rates for adults and Medicaid rates for children for the same services delivered by physicians:

Treatment and code	Medicaid Rate (children)	Medicare Rate (adults)
Psychotherapy for 60 minutes (90837)	70.88	136.83
Psychiatric diagnostic evaluation (90791)	72.54	140.11
Family therapy for 50 minutes (90847)	59.29	114.52
E&M 30 minute medication management (99214)	86.94	110.51

Source of rate information:

<https://med.noridianmedicare.com/web/jfb/fees-news/fee-schedules/mpfs#2019> (maximum allowable cost as of July 2019)

<https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#claims> (maximum allowable cost for youth care, Oct 2019)

2019/2020 CMHWG Target “Cover Sheet”**Children’s Mental Health Work Group: Developmentally Appropriate 0-5 Mental Health Services**

Recommendations proposed from sub groups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

Prevention

Identification

Screening

X Assessment

X Treatment & Supports

Age continuum (check all that apply):

X Prenatal - 5

6-12

13-17

18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

Workforce (e.g., development, enhancement, inclusive of diversity and cultural relevance)

X Payment and funding (e.g. rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.

Quality of services and supports (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)

Cross-system navigation and coordination (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)

Trauma informed care (e.g. trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as Trauma Informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Policy Brief: Provide Developmentally Appropriate Mental Health Services for Children 0-5

Proposal from the Prenatal to Five Relational Health Committee

Our state has the opportunity to realign healthcare policy with best practice for serving very young children. Changes to our state's Medicaid policies for mental health assessment, diagnosis, and treatment of our youngest Washingtonians are needed to improve child and family outcomes, optimize practice conditions, and comply with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) federal benefit guidelines.

Recommendation: *Require the Health Care Authority (HCA) to analyze the fiscal impact of changing Medicaid policy to match best practices for mental health assessment and diagnosis of children birth through 5 years old.*

This fiscal analysis must include, but is not limited to, the impact of the following policy changes:

1. Allowing three to five sessions for intake and assessment of children 0-5
2. Allowing children 0-5 to be served in their home or other natural settings, and reimbursing clinicians for the necessary travel to natural settings
3. Requiring clinicians to use the developmentally appropriate standard of practice for diagnosing children 0-5, the [Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood](#) (DC:0-5)ⁱ, rather than the Diagnostic and Statistical Manual of Mental Disorders.

Cost Estimate: Less than \$100,000 for the HCA analysis

While our state has made important improvements to the behavioral health system, we are failing to provide basic mental health care for the youngest Washingtonians. Even very young children can suffer from mental health conditions, especially after experiencing trauma or cumulative stress. The last decades of research around brain science tells us that the right mental health treatments are highly effective at getting young children back on successful developmental trajectories, preventing many challenges later in life. However, young children served by Medicaid in Washington today are being deprived of effective, efficient treatment, for two reasons:

(1) Washington state Medicaid policy does not allow age-appropriate assessment of young children: Properly assessing children birth to five for mental health services requires more than a single assessment session.ⁱⁱ Without at least three assessment sessions, there is limited opportunity to build needed engagement of families or to determine child functioning across settings/caregivers. This makes misdiagnosis likely, including through inappropriate use of the DSM as a fallback.

State Medicaid policy also requires the enrolling client to be present for the single assessment session allowed. This is not always ethically or clinically appropriate with little children, because it exposes them to the unnecessary stress of hearing their caregiver share concerns related to the child's behaviors, emotions, and potential history of stressors and trauma; it places the caregiver in a position where they must expose their child to sensitive topics, such as domestic violence, or child welfare system involvement; it prevents the clinician from having the opportunity to observe the child and

caregiver interaction at their baseline during assessment, which could result in inaccurate diagnosis; and it prevents the clinician from exploring what supports the caregiver might need and how the caregiver's own behavioral health challenges and history may add complexity to the health of their child.

“A clinician or team needs a number of sessions to understand how an infant/young child is developing in each area of functioning. A few questions to parents or caregivers about each area may be appropriate for screening but not for a full evaluation. A comprehensive evaluation usually requires a minimum of 3 – 5 sessions of 45 or more minutes each.”

– ZERO TO THREE (2016). DC:0 – 5, p. 8.

Additionally, not reimbursing for and in some cases not allowing travel to natural settings for diagnosis similarly ignores needed information about child functioning at home and caregiver perspectives required to appropriately assess children.

(2) Washington State Medicaid policies do not require developmentally appropriate diagnoses: Use of the appropriate diagnostic manual for young children, the DC:0-5, is not required by HCA. The [DC:0-5](#), created by Zero to Three, is a developmentally aligned diagnostic manual for clinicians to identify disorders of early childhood. It describes signs and symptomatology at different ages from birth to five and incorporates the contextual factors within caregiver relationships to determine whether a child is experiencing a developmental disorder, mental health disorder, or should be seen by a physician to rule out a health condition. It is a nationally accepted standard and has been adopted in many states, e.g., Minnesota.ⁱⁱⁱ Not training clinicians in the DC:0-5 and not requiring use of the DC:0-5 creates three problems for our state's services to very young children:

- Without appropriate and accurate diagnoses, there is no basis for accurate treatment planning. Brain science tells us how much more successful the right treatments are in getting young children back on developmentally normative trajectories, but many children in Washington are being deprived of effective, efficient treatment. This creates risk for further complications in their care, including accumulating co-morbid conditions.
- In the absence of state policy to require use of DC:0-5, and related reimbursement, there is no incentive for providers to be trained in the developmentally sophisticated and appropriate diagnostic processes needed for young children. Unless the clinician or agency seeks training at a cost to themselves, their alternative is to use the DSM.
- The use of diagnoses from the DSM than age-appropriate diagnoses from the DC 0-5 is fraught with problems. Minimally, it may provide inaccurate care or unnecessarily prolong treatment. At worst, it substitutes the wrong treatment because the diagnosis was wrong in the first place, e.g., treating phantom ADHD or autism rather than trauma. This creates liability for providers with both the ethical commitments of their licensure as well as potential fraud.

Mental health agencies and clinicians are shouldering the cost of age-appropriate care. While the current system artificially registers that clinicians are using one session for assessment and diagnosing children using the DSM, in reality many clinicians are taking additional time to assess and diagnose clients, and using the DC:0-5, because they are committed to serve young children using developmentally appropriate tools and approaches. However, they can only informally note those

diagnoses. They must bill any additional assessment sessions under different, lower-paying codes, or use non-billable time to conduct additional assessments.^{iv} The difference between an assessment session reimbursement and an individual or family therapy code can be up to \$50 per session, depending on billing codes and negotiated rates, resulting in systemic loss of revenue for mental health providers. Additionally, continual work arounds in documentation, diagnosis and assessment add an additional barrier and weight to community mental health clinical practice, which has an impact on retention of skilled clinical staff.

Changing the allowable assessment sessions for children 0-5, allowing and reimbursing for travel to natural environments, and requiring the use of the DC: 0-5 for diagnosis of young children will help address the mental health needs of children from birth to five and their families, and move Washington State closer to best practice. Planning for these policy changes through assessing fiscal impact is a necessary first step towards better services for Washington's youngest children.

ⁱ The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood is found here: <https://www.zerotothree.org/resources/2221-dc-0-5-manual-and-training>. Additional information about the integration of the DC:0-5 into State Policy and Systems can be found here: <https://www.zerotothree.org/resources/2343-advancing-infant-and-early-childhood-mental-health-the-integration-of-dc-0-5-into-state-policy-and-systems#downloads>

ⁱⁱ Providers can currently only bill 90791 once per client per calendar year, a requirement included in Washington's Medicaid State Plan. June 2019 Maximum Allowable state cost schedule shows 90791 code max at \$69.36.

ⁱⁱⁱ Minnesota overview of the DC:0-5: <https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/diagnostic-assessment-young-children/>

^{iv} Typically Family with Patient Present code 90847 (shows in June 2019 max allowable state cost schedule as \$56.47), or Individual code 90837 (shows in June 2019 max allowable cost schedule as \$67.32)

2019/2020 CMHWG Target “Cover Sheet”

Children’s Mental Health Work Group: Maternal Medicaid

Recommendations proposed from sub groups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Identification
- Screening
- Assessment
- X Treatment & Supports

Age continuum (check all that apply):

- X Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Workforce (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- X Payment and funding (e.g. rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
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- Trauma informed care (e.g. trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as Trauma Informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Policy Brief: Fix the Medicaid Postpartum Cliff

A proposal from the Prenatal to Five Relational Health Committee

Extend Medicaid coverage to 365 days postpartum

Monthly Income	198% FPL
Pregnant individual	\$2,790
Expectant family of two	\$3,519

Medicaid pays for nearly half the births in our state. Pregnancy, delivery and up to three months postpartumⁱ are included for pregnant individuals up to 198% of the federal poverty level.

Our state supports pregnancies for low-income families but drops the ball postpartum.

Some postpartum individuals retain Medicaid by meeting eligibility requirements. However, an estimated 5,000 postpartum individuals lose coverage less than three months after their pregnancy ends. Medicaid currently expires for them during the newborn period when a birthing parent is still recovering from delivery and adjusting to taking care of a newborn. We should make keeping them covered as easy and seamless as possible during this time. Other coverage may be out of reach due to affordability or eligibility requirements resulting in an insurance gap. If other insurance is secured, continuity of care gaps may occur if their Medicaid providers are excluded from their new provider network.

The abrupt loss of coverage less than three months postpartum creates an unsafe gap for families.

Birthing people remain at risk for pregnancy-related mortality for an entire year postpartum; 13% of pregnancy related maternal deaths occur 42-365 days after delivery.ⁱⁱ Maternal death is tragic and grabs headlines, but maternal morbidity and complications are much more common. Complications needing care can arise well into the postpartum period after Medicaid has lapsed. Birthing parents may need therapy for depression, antibiotics for infections such as mastitis, and/or treatment for pelvic floor issues.

Evidence is mounting about the dangers of untreated behavioral health conditions for families with new babies, and their lasting impact.

Untreated postpartum depression interferes with a birthing parent's ability to connect with and care for their new baby and may cause the baby to have problems with sleeping, eating, and behavior as he or she grows.ⁱⁱⁱ Postpartum depression has been shown to affect an infant's brain development and cause problems with family relationships, breastfeeding and the child's medical treatment.^{iv} One of the most common, and costly, obstetric complications when left undiagnosed or untreated, behavioral health conditions were the leading cause of Washington's pregnancy-related deaths from 2014-2016.^v Every single one of these maternal deaths are preventable, yet four birthing parents will die per 100,000 live births in our state due to suicide or overdose. Pediatricians are encouraged to screen postpartum individuals for anxiety and depression, but we strip coverage from many before they even survive the challenging "fourth trimester." Extending Medicaid is one of the best tools to support increasing access to behavioral health care.

Leaving vulnerable families uninsured and without needed medical and behavioral health care is costly. A recent analysis found the total societal cost of untreated maternal mental health conditions in our state is \$304 million for all 2017 births when following the mother-child pair from birth until five years postpartum.^{vi} Nearly half (45%) of these total societal costs include child outcomes, stemming from the fact that children of birthing parents with perinatal mood and anxiety disorders have a higher risk of behavioral and developmental disorders. Early intervention in perinatal depression may prevent related child, adolescent, and adult mental health difficulties.^{vii} Healthy moms have a better chance of raising healthy babies.

Current practice is for birthing parents to have a six-week postpartum check. Unfortunately, fewer than 60% of our state's Medicaid birthing parents receive a postpartum check between 21-56 days postpartum^{viii}. This short window does not allow sufficient opportunity for patients to reconnect with their established medical provider. Reconnection is important for recovery, assessing mental health, breastfeeding, and healthy attachment with their infant. It is also critical for securing contraception, which has implications for a family's long-term physical and economic health. Extending coverage to 365 days allows time for a family to stabilize with a new baby and still access critical health resources.

Health disparities play a clear role in maternal and infant mortality. Our state's maternal mortality ratio is higher for non-white birthing parents, especially American Indian and Alaska Natives, and lowest for individuals with private health insurance. Infant mortality continues to be higher for American Indian and Alaska Native and black infants in our state. Health insurance coverage and access issues before and after pregnancy are higher for these communities.

States may submit waivers for federal matching funds to extend Medicaid for one-year postpartum. Illinois is preparing a waiver request to extend Medicaid coverage for 365 days postpartum; other states are exploring this option to enhance support for new families. Washington State has a chance to be a frontrunner in ensuring new families are safe and thriving.

ⁱ Birthing people are covered for 60 days postpartum, plus whatever days are left in the month in which the 60-day period ends, extending Medicaid coverage for up to three months postpartum.

ⁱⁱ Creanga AA, Syverson C, Seed K, Callaghan WM. Pregnancy-related mortality in the United States, 2011- 2013. *Obstet Gynecol.* 2017;130(2):366-73.

ⁱⁱⁱ National Institutes of Health. Postpartum Depression Facts.

<https://www.nimh.nih.gov/health/publications/postpartum-depression-facts/index.shtml>. Accessed 11/18/2019.

^{iv} American Academy of Pediatrics. Infants, Family are Affected by Mother's Perinatal Depression. Dec. 17, 2018.

<https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/Infants-Family-Are-Affected-by-Mothers-Perinatal-Depression.aspx>

^v Report to the Legislature. Washington State Maternal Mortality Review Panel: Maternal Deaths 2014-2016. October 2019. <https://www.doh.wa.gov/Portals/1/Documents/Pubs/141-010-MMRPMaternalDeathReport2014-2016.pdf>

^{vi} Luca DL, Gallow N, Staatz C, Margiotta C, Zivin K. Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in Washington. *Mathematica Policy Research. Issue Brief.* April 2019. <https://www.mathematica.org/our-publications-and-findings/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-washington>

^{vii} Goodman JH. Perinatal Depression and Mental Health. *Archives of Psychiatric Nursing.* 2019; 33(3): 217-224.

<https://doi.org/10.1016/j.apnu.2019.01.010>

^{viii} Centers for Medicare and Medicaid Services. Medicaid and CHIP Scorecard, Prenatal & Postpartum Care: Postpartum Care. <https://www.medicaid.gov/state-overviews/scorecard/postpartum-care/index.html>.

2019/2020 CMHWG Target “Cover Sheet”

Children’s Mental Health Work Group: MSS/ICM Training Funds

Recommendations proposed from sub groups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- X Prevention
- X Identification
- X Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- X Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- X Workforce (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Payment and funding (e.g. rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
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- Trauma informed care (e.g. trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as Trauma Informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Increase Perinatal and Infant Mental Health (IMH) Training

Proposal from the Prenatal to Five Relational Health Committee

\$200,000-\$400,000 for scholarship and training funds for Perinatal and Infant Mental Health for Maternity Support Service and Infant Case Management Providers across Washington in order to better address the specific mental health needs in pregnancy, infancy and early childhood

The foundations of life-long mental health are rooted in perinatal, infant and early childhood mental health

1 in 7 new moms , and up 38% of women of color will experience a perinatal mood or anxiety disorder. When a new parent struggles with mental health concerns it impacts the whole family. Maternal mental health problems represent the earliest adverse environmental exposures a child can experience and has life long implications for development. There are well researched associations between a parent's mood and outcomes such as preterm delivery, low birth weight, impaired postpartum infant growth, insecure infant-mother attachment and early cessation of breastfeeding.

Perinatal Mental Health refers to the mental health of new parents throughout the childbearing period (conception-1 year postpartum). Perinatal Mood and Anxiety Disorders (PMADs) refers to the spectrum of mood and anxiety disorders that parents may experience during this time, the most well-known of which is postpartum depression/anxiety. Infant mental health is the developing capacity of the child from birth to age three to experience, regulate and express emotions; form close and secure interpersonal relationships; and explore the environment and learn.

Professionals who work with families during pregnancy and in early childhood should have access to specific training and supports in mental health

Maternity Support Services (MSS) helps low income pregnant women have healthy pregnancies, providing health education and counseling during pregnancy until babies are two months old. MSS is a preventive health program that includes parent education, screening for health risk factors, brief solution-based counseling for identified risk factors and referral to community resources.

Infant Case Managers (ICM) provides support and guidance for families caring for new infants from the time babies are 2-3 months old through their first birthday (for those who qualify). ICM may also provide supportive referrals related to medical, mental health, social, educational, or other services the family might need.

MSS and ICM providers serve low-income families at a critical time. A child's earliest experiences shape their lifelong development and yet MSS and ICM providers are provided no evidenced based training in

either perinatal mental health or infant and early childhood mental health. MSS and ICM providers are uniquely situated to promote positive parent and infant mental health through both preventative and brief interventions as well as to screen and refer to higher levels of care but to do so would need greater access to training, which is not currently funded.

Increasing training in perinatal and infant mental health can improve effectiveness of current programs

MSS and ICM providers are currently tasked with screening and providing brief interventions for mental health concerns-- but without adequate training. MSS and ICM providers face significant barriers to addressing mental health concerns, due to Individual and cultural stigma around mental health disorders and limited public understanding of signs of perinatal and infant mental health concerns. And yet, early and effective screening for risk factors and/or current mental health systems and effective referral and intervention results in better health and wellbeing for families. With training, MSS/ICM providers can learn to effectively address stigma, educate about the importance of perinatal and infant mental health, and provide evidenced based brief interventions.

Scholarship and training funds can help advance the professional standing of infant case managers and maternity support service providers and help incentivize diversity in the field

Implementation of these funds can have significant impact in the field and should be considered a tool to promote equity. This includes ensuring that priority funding for training be given to organizations serving communities of color. In addition, the funds should include targeted outreach, funding of culturally competent/culturally specific training, training in multiple languages, and partnerships with organizations rooted in communities of color.

2019/2020 CMHWG Target “Cover Sheet”

HB 1874 and Family Initiated Treatment Data Tracking

Recommendations proposed from sub groups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

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1874 Adolescent Behavioral Health Care Act: Follow-Up Recommendations

Background

In 2018, the Parent Initiated Treatment Stakeholder Advisory Group recommended to expand parent's ability to access residential care and other less-restrictive alternatives in lieu of adolescent consent. The final version of HB 1874 did not include language regarding residential treatment.

This sub-group of the Children's Behavioral Health Work Group met three times during summer 2019 to review:

1. Whether to include access to "residential" level of care missed in the final version of HB 1874
2. Identify what information about medical necessity should be tracked for FIT in the next two years to inform recommendations.

Summary of Recommendations

1. Include **adolescent residential treatment** as a service that a parent can consent for under the Family Initiated Treatment section of RCW 71.34.600-670. Residential treatment facilities must be licensed under 246-337 WAC. Use the same monitoring and reporting guidelines and provider/facility safeguards for residential treatment that were established for Intensive Outpatient Program and Partial Hospitalization Program under HB 1874.
2. Task HCA to develop a data collection and tracking system for youth served under FIT to identify opportunities to fill gaps in care, expand services, and better understand the needs of our adolescent population as follows:
 - a. Data should be collected from **Facilities** for all youth admitted under FIT to acute inpatient mental health, secure withdrawal management and stabilization for substance use, or other approved inpatient substance use disorder treatment program, IOP/PHP for MH or SU or co-occurring disorders.
 - b. Data should be collected from **Parents and Youth** via an Adolescent Behavioral Health Help Line staffed during business hours to help families and youth who are trying to access behavioral health care.

Data to submit upon admission:

 - Facility Name, Type of Admission (MH, SU, Co-Occurring), Date of Admission
 - Guardianship Status (Parent(s), Legal Guardian, DCYF Case Worker)
 - Face Sheet (full demographics including First and last name, Date of birth, County of residence Insurance type, Parent/Guardian name, relationship, phone numbers, Language for care and if interpreter is needed)
 - Admission note (Including: Diagnosis & severity: DSM 5/ASAM Criteria, Presence of developmental disability/intellectual disability/ Autism spectrum disorder, Risk factors (danger to self, danger to others, grave disability), Age, race/ethnicity, gender, Before and after treatment interventions (i.e. history of outpatient, inpatient, WISE treatment prior to admission; disposition after residential treatment is completed; engagement in services post residential), If patient has prominent substance use issues

Data to submit upon discharge:

 - Date of Discharge
 - Discharge Summary (including disposition plan)
3. Identify Wraparound with Intensive Services (WISE) in the definition section of 71.34 as Intensive Outpatient Treatment for admission under Family Initiated Treatment. Exempt WISE from the monitoring and reporting guidelines and data tracking system, since there are already processes in place to gather and track youth in WISE.

Workforce Priorities

Possible Recommendations from the Workforce Committee:

The need for equitable and accessible behavioral healthcare services is growing in Washington. At the same time, our behavioral health workforce is suffering from critical shortages. In order to ensure Washington's behavioral health workforce is capable of meeting the growing demand for behavioral healthcare services – mental health and substance use disorder – we must reduce barriers that limit or delay entry into these professions, make strategic investments in career pathway development, and increase the diversity of the behavioral health workforce.

For these reasons, the Children's Behavioral Health Workgroup submit the following recommendations:

- Expand capacity of the Washington Student Achievement Council's Behavioral Health Conditional Scholarship Program that prioritizes services for high need populations and rural communities while building a more diverse workforce. Ensure that the policies regarding repayment do not make accessing conditional scholarships unrealistic for prospective students.[Recommendation to the legislature - \$2]
- Direct the Board of Community and Technical Colleges* to convene a workgroup of the relevant organizations and individuals, such as, the Dept. of Labor and Industries, the WA Student Achievement Council, WA College Grants, and the Workforce Training and Education Coordinating Board to develop a proposal regarding statewide implementation of apprenticeships within the field of behavioral health that prioritize a culturally diverse behavioral health workforce in high need communities beginning in 2021. [Recommendation to the legislature – May need some resources to do this work \$.]
- Provide the HCA with flexible funds to pass through (by way of the 9 Accountable Communities of Health?) to community-based organizations providing behavioral health services for training and mentoring for clinicians (including providers serving children 0-5). Direct the HCA to establish an advisory group, including but not limited to BH experts, providers and consumers, to develop guidelines for how the funds could be used, as well as a quality-monitoring infrastructure. [Recommendation to the Legislature -- \$500,000]
- Require all behavioral health professionals licensed under RCW 18.225, 18.205, 18.73, as part of their continuing education hours to complete 4 hours of continuing education on diversity, equity and inclusion. This training shall be focused on: understanding of the importance of diversity in

shaping life experiences in clinical practice; learning skills for engaging clients and constituencies as experts of their own experiences; and learning skills in awareness of one's own cultural background and values and in managing the influence of personal biases and values while working with diverse clients and constituencies. This requirement does not include physicians.

Elements of identity should include but not be limited to: Age, ethnicity/race, culture, country of origin, gender/sexual orientation, language, able-ness, religion/spirituality, socio-economic status, education, employment, health and immigration status. [Recommendation to the legislature.]

Recommendation to the Children's Behavioral Health Workgroup:

- Assess the feasibility of allowing behavioral health agencies to be credentialed. The Children's Behavioral Health Workgroup should work with the Department of Health and the Health Care Authority to assess options for streamlining the behavioral health credentialing process.
- The Children's Behavioral Health Workgroup should designate representatives to participate on the Workforce Board's Phase 2 subcommittee on background check.
- The Children's Behavioral Health Workgroup should designate representatives to participate on the Workforce Board's Phase 2 subcommittee on incentives for supervision of interns and trainees.
- The Children's Behavioral Health Workgroup should designate representatives to provide guidance and develop recommendations for the Department of Health as they draft rules related to paperwork reduction their potential impact on behavioral health services.

Please Note: Recommendations related to Rates, the most significant workforce issue, are included in the recommendations from the BH Rates Group.

*This has not been run by the SBCTC and it might be more appropriate to have the Dept. of Labor and Industries convene the group.

**Student Well-Being & School-Based Connections to BH/IDD Services and Supports
Children’s Mental Health Work Group**

Recommendations proposed from sub groups must either be legislatively directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

- Prevention
- Identification
- Screening
- Assessment
- Treatment & Supports

Age continuum (check all that apply):

- Prenatal - 5
- 6-12
- 13-17
- 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

- Workforce (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- Payment and funding (e.g. rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.
- Quality of services and supports (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)
- Cross-system navigation and coordination (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)

School-based Behavioral Health Subcommittee Recommendations, submitted 9/24/2019

Short Term Recommendations (for the 2020 leg session)

	Recommendation	Who has Authority?	Who is the Lead?	Who is responsible for implementation?	Deliverables	Accountability—what does success look like?	Policy Ask? (Identify RCW intended to change)	Budget Ask? (include cost)
1	<p>Establish in statute (as a subcommittee of the Children’s Behavioral Health Workgroup) The School-based Behavioral Health & Suicide Prevention Subcommittee.</p> <ul style="list-style-type: none"> • Establish staff support (at HCA and OSPI) • Set mission, define scope (all levels of care in the school setting (tiers 1, 2, 3)) • Define MTSS for WA and establish a WA-specific framework • Include suicide prevention, intervention, and postvention strategies • Require inclusive and participation from diverse set of stakeholders/partners (those who implement, including school-based health centers). • Outline that this will be the venue for big broad work beyond 	Legislature, Children’s BH Workgroup	Children’s BH Workgroup	Children’s BH Workgroup	<p>Once the subcommittee is established long-term, they will be responsible for the following:</p> <ul style="list-style-type: none"> • Define MTSS Framework, including guidance for data-based decision making for interventions and evaluation indicators • Identify needed resources • Identify funding models • Qualifying and quantifying what is happening and where the gaps are in K-12 and gaps in healthcare systems to promote 	<ul style="list-style-type: none"> • Data to advise policy and funding requests that can help districts where they are at. • Diverse student needs (SpEd, IDD). • Recommendations lead to a whole-child system with rapid identification of those in need of care through the development of comprehensive, tiered systems for getting students what they need and linking to community-based systems. • A robust system that can prevent, respond, and is inclusive. • Mirrors the integrated behavioral health system 	<p>SB 5903, (at one point, 5903 included creation of an MTSS workgroup, but it was taken out in final bill)</p> <p>HB 1541 Integrated Student Supports Protocol</p> <p>Connect with the Special Education Advisory Council’s recommendations</p>	<p>Staffing for workgroup: funding needed for agency’s responsible (and workgroup participation to cover the cost of travel and substitutes for educators?) will need to check with OSPI on costs for collecting data and reports required.</p>

	Recommendation	Who has Authority?	Who is the Lead?	Who is responsible for implementation?	Deliverables	Accountability—what does success look like?	Policy Ask? (Identify RCW intended to change)	Budget Ask? (include cost)
	the 2020 session recommendations				<ul style="list-style-type: none"> opportunities for continuity of care. • Equity of access • Identify systemic barriers • Guidance on HIPAA & FERPA • Catalog a curriculum of best-practices • Stigma-reduction work, including training for students, staff, and parents • Data collection 			
2	Build upon previous Suicide Prevention work in the broader work on school-based recognition and response to emotional and behavioral distress (HB 1336)—address the urgency of need across the K-12 system and foundational strength; include student voice.	Children’s Behavioral Health Workgroup	OSPI?	ESDs and School districts?	<ul style="list-style-type: none"> • Bolster school personnel supports, require all school staff to take the 3-hour suicide prevention training • Require counselors, psychs, social workers, and nurses to take an advanced course on crisis/safety planning on second round of training (every 3 years) and require 	<ul style="list-style-type: none"> • Identification and training of a strong champion at district level to lead this process. • Require districts to submit plans to OSPI for review or accompanying fidelity checklist to focus resources on districts lacking complete plans. • The inclusion of student voice in shaping the system. 	RCW 28A.320.127 from HB 1336 (2013), HB1216 HB 1221	Look at Navigator cost from fiscal note in HB 1216 and 1221 will need to check with OSPI on costs for collecting data and reports required.

	Recommendation	Who has Authority?	Who is the Lead?	Who is responsible for implementation?	Deliverables	Accountability—what does success look like?	Policy Ask? (Identify RCW intended to change)	Budget Ask? (include cost)
					<p>them to engage trusted adults in the development of a student-informed safety plan for students who are at risk for suicide (as part of the requirement for crisis planning)</p> <ul style="list-style-type: none"> • Training for family/parents and students • Build upon and refine what identification and referral should look like, clearly define roles, crisis safety plans, build up postvention. • Collect data on district implementation of RCW 28A.320.127; determine the need for resources to get to comprehensive implementation. • Identify district leads for suicide specific 			

	Recommendation	Who has Authority?	Who is the Lead?	Who is responsible for implementation?	Deliverables	Accountability—what does success look like?	Policy Ask? (Identify RCW intended to change)	Budget Ask? (include cost)
					crisis response and safety planning <ul style="list-style-type: none"> • Provide TA and training to district leads • Peer training and supports for students, parents, and staff • Determination of who's body of work this is, and what is taken off their plate to make room for it. • Promote Crisis Text Line, investigate how to get schools to put it their websites and student IDs • Require suicide threats are included in ESD safety center response models. 			
3	Fund ESD Navigators from HB 1216, further specify their role: <ul style="list-style-type: none"> • Define their scope of work • Determine credential requirement 	Legislature	OSPI and/or ESDs?	OSPI and ESDs	<ul style="list-style-type: none"> • OSPI report on Navigator impact, • Documentation of each district's completion of plan in RCW 28A.320.127 	<ul style="list-style-type: none"> • Navigators can provide training and technical assistance to each district in region, document each district's plan, be responsive in postvention, participation in regional 	HB 1216 already includes this position with brief	Look at OSPI 2020 decision package

	Recommendation	Who has Authority?	Who is the Lead?	Who is responsible for implementation?	Deliverables	Accountability—what does success look like?	Policy Ask? (Identify RCW intended to change)	Budget Ask? (include cost)
	<ul style="list-style-type: none"> • Require participation in regional healthcare coordination work at FYSPRTs and ACHs • Require oversight and support at OSPI to ensure consistency across the state. • Support the recommendations included in the leg. report due Dec 1, 2019 				<ul style="list-style-type: none"> • Documentation of training provided to school districts • Documentation of engagement in regional healthcare planning (school strategies showing up in ACH work). • Messaging and norming that accessing mental health prevention/intervention/treatment is supported 	healthcare partnerships to bridge the communication between healthcare and education.	job description . Provide language to refine job description and allowable activities. Need to add what is expected to be collected by OSPI	
4	Support state initiatives to integrate physical and behavioral health in the school setting (refer to broader recommendation from Dr. Cavens' group regarding a Community Care Coordination System for Integrated BH—see attached)	Legislature, Children's Behavioral Health Workgroup	Children's Behavioral Health Workgroup	Children's Behavioral Health Workgroup	<ul style="list-style-type: none"> • Include integration in health classes by giving parity to the social emotional health learning standards • Provide a library of curriculum/best practices • Promote school-based health centers 	<ul style="list-style-type: none"> • Workgroup develop recommendations for expanding school-based health centers in wA 		Staffing for workgroup

	Recommendation	Who has Authority?	Who is the Lead?	Who is responsible for implementation?	Deliverables	Accountability—what does success look like?	Policy Ask? (Identify RCW intended to change)	Budget Ask? (include cost)
					<ul style="list-style-type: none"> Promote strategies that support broader replication and improve sustainability of the school-based health center model. 			

Catalog of other initiatives that should be supported in 2020 Session:

1. Partnership Access Line (PAL) for Schools Pilot
2. Support [Staffing Enrichment Workgroup](#) Recs
3. [WA Mental Health Referral Service](#) pilot Extension and expansion (current pilot ends Jan 1, 2021)
4. Support recommendations from FYSPRSTs to expand WISE eligibility
5. Special Education Advisory Council’s recommendations related to students who need behavioral health services but services may not be in an IEP.
6. Support recommendations of the WA Action Alliance for Suicide Prevention from DOH.
7. Support/Track recommendations coming from the Center for the Improvement of Student Learning (leg. report due Dec 1, 2019)
8. Staff wellbeing initiatives (e.g.: Kaiser Thriving Schools RISE Index)

Long Term Recommendations (for once the group becomes formalized in 2020 leg session)

1. See [deliverables](#) for the School-based Behavioral Health & Suicide Prevention Subcommittee.
2. Bolstering the crisis response, triage, and postvention systems in schools.
3. Peer supports
4. Supports for educator secondary trauma

Long Term Next Steps:

1. Gather data:

- a. Big, medium, small districts from urban, suburban, and rural areas—what are their needs? What is working? What solutions do they recommend?
- b. Compare/contrast data from [JLARC Study](#) and [Kaiser Environmental Scan](#).
- c. School funding presentation—gain understanding of school staff roles, responsibilities, and allowable activities.