Children and Youth Behavioral Health Work Group – Behavioral Health Integration (BHI) Subgroup

July 8, 2025

Glossary of Terms

B&O: Business and Occupation
CHW: Community Health Worker
CCBHC: Certified Community Behavioral Health Clinics
EPSDT: Early and Periodic Screening, Diagnostic, and Treatment
HCA: Health Care Authority
MCO: Managed Care Organization
PAL: Partnership Access Line

Meeting Topics

Current Draft of BHI Inputs for Strategic Plan Overview and Feedback
Work on Legislative Recommendations
Possible future BHI Initiatives
Next Steps & Wrap Up

Discussion Summary

Current Draft of BHI Inputs for Strategic Plan Overview and Feedback

Kristin Houser, BHI Lead, shared the most current draft of the document and solicited feedback from the group on how to improve content and language used. The leads built the draft to be intersectional with "Strategic Imperative 2: Build out Comprehensive Offerings" from the Washington Thriving Strategic Plan. Key points that were outlined during the meeting are:

1. Behavioral health services should be integrated into primary care clinics (pediatricians' offices and family practice clinics.
2. The state should heavily invest into the BH integrated care for longevity and accessibility in order to help achieve several objectives in:
    a. Early Life Course
        i. Support for perinatal behavioral health, inclusive of both mental health and substance use.
        ii. Infant and early childhood developmental support
        iii. Behavioral Health in schools and the school environment
        iv. "Third place" promotion and prevention strategies for school-aged youth (6-12, 13 17)
        v. Transition-Age Youth (TAY) service set (adolescents 13-17 and young adults 18-25)
        vi. Support during life events and circumstance-based milestones at all ages

   b. Gaps in Treatment Continuum
      i. Creating seamless supportive ecosystems around young people and their caregivers/family
      ii. Expanding middle-intensity services before intensive services are needed
      iii. Develop crucial missing specialized care options for underserved populations
      iv. Continue investment in crisis and residential service expansion for youth with housing insecurity
      v. Strengthen stabilization and ongoing wellness supports
3. Feedback of note from the subgroup participants in response to the draft that was presented:
   a. Including specialized language to include primary care and family as a system as support for youth with behavioral health needs and avoiding viewing children in isolation.
   b. Addressing that parents and family need mental/behavioral health support to properly support the behavioral health needs of youth.
   c. A "whole-person integrated system" involves the family
   d. Look at the nine core components of Certified Community Behavioral Health Clinics (CCBHCs) for language about integrating across the lifespan.
4.

The most up-to-date version of the BHI Inputs to Recommendations document will be available for review at the next BHI subgroup meeting.

Legislative Recommendations Discussion

1. The group discussed how to best begin preparation for the upcoming legislative session, a topic that was raised was BHI for preventive service in early childhood. The group decided to convene a smaller subcommittee to explore preparations for the 2026 Legislative session. Topics that were briefly discussed were:
   a. Gaps in prevention, coaching, and support for families who are experiencing behavioral health issues before they arise to the level of diagnoses (diagnostic codes) and being able to have them reimbursed by insurance
   b. In terms of insurance coverage, there isn't a way for a primary care provider to refer families to a specialist without a diagnosis already in place.

Possible Future BHI Initiatives

1. Discussions of topics that may not be developed enough to make legislative recommendations for this year included
   a. Improving the ability of primary care to provide first line treatment for families where children experience emotional/behavioral difficulties associated with atypical development
      i. Pediatrics often have limited bandwidth for follow up after complex behavioral/neuro-diagnosis. Some solutions that came up were strengthening case management, and making referrals to specialists easier for families and providers (increasing specialist care access included).
      ii. Increasing knowledge of neurodiversity in primary care and behavioral health that specifically addresses neurodivergent needs can help across a spectrum, allowing for preventative care for families before crisis' take place.

iii. Someone flagged discrimination based on atypical neuro-diagnosis. An example being that it can be difficult for families to find a primary-care doctor to treat their behavioral/neurodivergent children (because of their diagnosis).
    1. How can we help primary care feel confident in serving the behavioral/neurodiverse population and ensure behavioral/neurodiverse youth receive ALL the care they need?

iv. If there is no diagnosis in place, families can "ping-pong" between providers and not really find the support they need. Even when there is a diagnosis in place, they might not be able to find the totality of supports that they might qualify for. Primary care, as their medical home and with care coordination services might be able to help families navigate getting support more effectively.

Next Steps & Wrap Up

1. The BHI leads will be convening a sub-committee to strategize for future BHI efforts in preparation for 2026 Legislative Recommendations.
2. Thank you to everyone who has provided feedback on our inputs for Washington Thriving. If you're interested in assisting with the Strategic Plan inputs or 2026 Legislative Recommendations, please email info@bhcatalyst.org, khouser206@outlook.com, and lawrence.wissow@seattlechildrens.org.
3. The subgroup will next meet on Tuesday, July 22nd from 1-2:30pm. *If you are not already on the BHI mailing list and would like to be added, you can email cybhwg@hca.wa.gov indicating your preference.*