

Prenatal to Five Relational Health Subgroup Meeting

July 14, 2020

Agenda Items	Summary Meeting Notes
New Co-Chair!	<ul style="list-style-type: none"> • Welcome new co-chair – Representative Debra Entenman (47th district). ☺
Overview	<ul style="list-style-type: none"> • Initial recommendations due to CYBHWG Sept. 18; final recommendations due Oct. 13. • Reminder: Changing environment – pandemic, state budget. Consider what the Legislature is being asked to do overall regarding revenue and providing services.
Issue Groups (1-hour)	<p>Members joined issue groups dedicated to the top 3 priority areas identified at the last meeting. These issue groups will continue to meet to develop recommendations in each priority area. At this first meeting, the groups took a first look at these questions:</p> <ul style="list-style-type: none"> • What is the issue? • What is the problem and how does it affect children, families, and communities? • What is the impact on state budget and society? • What options do we have to change this? • Why is taking the recommended action a smart move? • Anything to let legislators know between now and January?
Issue Group Reports <i>Telehealth</i>	<p>See 07-14-20 Issue Group Notes (attached).</p> <p>Discussion:</p> <ul style="list-style-type: none"> • Discussed parity issue – same rate as in-person visits – a lot of this allowed, but people may not know how to bill. • Behavioral Health Institute report/recommendations – lots there. • How to coordinate with other behavioral health groups working on telehealth? • Need to home in on specific P to 5 issues that other groups may not be addressing.
<i>Infant & early childhood mental health consultation</i>	<p>See 07-14-20 Issue Group Notes (attached).</p> <p>Discussion:</p> <ul style="list-style-type: none"> • Who might be better to help parents recognize that they need help, and who might be better to navigate getting help? Roles for master’s level clinicians, roles for peers. • Emphasize importance of parent peers – building a network for mental health support.
<i>Enhanced funding for developmentally appropriate assessment & care</i>	<p>See 07-14-20 Issue Group Notes (attached).</p> <p>Discussion:</p> <ul style="list-style-type: none"> • Inadequate reimbursement leads to access barriers, quality of care issues, and inequity issues. • Providers can’t take the time to do assessment because they can’t get reimbursed. • Workforce is being asked to practice in a non-evidence-based way, leading to risks of poor outcomes for children, disincentives for staff to continue, leading to higher turnover.

Prenatal to 5
Relational Health
Subgroup

July 14, 2020 Meeting



Agenda

- ✓ Welcome
 - ✓ Introductions
- ✓ Recommendations Brief Template
- ✓ Break Outs – Issue Groups
 - ✓ Review last meeting's content
 - ✓ Discussion and action
 - ✓ Schedule of meetings
 - ✓ Assignments
- ✓ Report Out
- ✓ Next Steps





Welcome & Introductions

Highlighted individuals participated in all or part of the meeting

1. Fathiya Abdi
2. Endelkachew Abebaw
3. Camela Atherley-Quinones
4. Amritha Bhat
5. Jessica Box
6. Rachel Burke
7. Rep. Lisa Callan
8. Victor Cardenas
9. Simrun Chhabra
10. Christopher Chen
11. Haruko Watanabe Choosakul
12. Diana Cockrell
13. Brent Collett
14. La'Quonia Cooper
15. Ben Danielson
16. Darlene Darnell
17. Mia Edidin
18. Jamie Elzea
19. Rep. Debra Entenman
20. Areceli Escarzaga
21. Janet Fraatz
22. Kim Gilsdorf
23. Dorothy Gorder
24. Becca Graves
25. Zach Hall
26. Erica Hallock
27. Katrina Hanawalt
28. Kim Harris
29. Libby Hein
30. Lauren Hipp
31. Julie Hoffman
32. Nucha Isarowong
33. Avreayl Jacobson
34. Judy King
35. Elizabeth Krause
36. Jodi Kunkel
37. Garrison Kurtz
38. Erin Lee
39. Hannah Lidman
40. MaryAnne Lindeblad
41. Laurie Lippold
42. Edna Maddalena
43. Sandy Maldonado
44. Alicia Martinez
45. Michelle Martinez
46. Kathryn McCormick
47. Sally Mednansky
48. Lou Olson
49. Monica Oxford
50. Dila Perera
51. Ryan Pricco
52. Sarah Rafton
53. Jennifer Rees
54. Joel Ryan
55. Rep. Tana Senn
56. Sharon Shadwell
57. Mary Smith
58. Paula Steinke
59. Anne Stone
60. Ashley Taylor
61. Beth Tinker
62. Cynthia Turrietta
63. Megan Veith
64. Kristin Wiggins
65. David Willis
66. Mary Ann Woodruff
67. Liv Woodstrom

Zoom Tip Share your name and organization

1. Click on "Participants" from the black menu at the bottom of your Zoom window
2. Find your name
3. Click "More"
4. Click "Rename"
5. Enter your name

Welcome to our new Co-Chair



Interests:

- Passion for early education and educational and economic opportunity
- Impact of policy on the African American community (Started the Black Members' Caucus)
- Elevating family and consumer voice about how policies and programs affect them

Welcome our new members

Jessica Box

Rep. Callan

Dr. Christopher Chen

Camela Atherley-Quinones

Araceli Escarzaga

Dorothy Gorder

Nucha Isarowong

Jodi Kunkel

Erin Lee

Dr. David Willis



Color Brave Space Norms

From [Equity Matters Northwest](#)

- 1. Put Relationships First** – *Work to build community and trust with an awareness of power dynamics.*
- 2. Keep Focused on Our Common Goal** – *We care deeply about [insert your mission], especially those who are directly impacted by racism.*
- 3. Notice Power Dynamics in the Room** – *Be aware of how you use your privilege: From taking up too much emotional and airtime space or disengaging.*
- 4. Create Spaces for Multiple Truths and Norms** – *– Speak your truth, and seek understanding of truths that differ from yours, with awareness of power dynamics.*
- 5. Be Kind & Brave** – *Remember relationships first and work to be explicit with your language about race, class, gender, immigration, etc.*
- 6. Practice Examining Racially Biased Systems and Processes** – *Individual actions are important, and systems are what are left after all the people in this room leave.*
- 7. Look for Learning** – *Show what you're learning, not what you already know. Avoid playing devil's advocate, the devil has enough advocates.*

Children and Youth Behavioral 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 accessing behavioral health services for children, youth and young adults and their families that are accessible, effective, timely, culturally and linguistically relevant, supported by evidence, and incorporate tailored innovations as needed; and to advise the Legislature on statewide behavioral health services and supports for this population.

Important Elements of Work Group Charge:

- Support unique needs of children and youth (prenatally through age 25), including promoting health, and social and emotional development in the context of children's family, community, and culture
- Develop and sustain system improvements to support the 15 behavioral health needs of children and youth

P5RHS Calendar

Date	Actions
July 14	P5RHS meeting <ul style="list-style-type: none">• Issue groups explore and refine prioritized recommendations
August 11	P5RHS meeting <ul style="list-style-type: none">• Issue groups refine prioritized recommendations• Report on outreach to other coalitions and refine approach
By Sept 1	<ul style="list-style-type: none">• Some targeted cuts made by DCYF and other agencies
September 8	P5RHS meeting <ul style="list-style-type: none">• P5RHS finalizes prioritized recommendations• Generate message content for recommendation FAQs and talking points• Report on outreach to other coalitions and refine approach
September 18	Draft P5RHS recommendations due to CYBHWG
October 13	P5RHS meeting – Finalize recommendations – Meeting may be rescheduled
October 13	Final P5RHS recommendations due to CYBHWG
October-November	Advocacy agendas finalized
November 1	CYBHWG report due to the Legislature
	Legislature starts



Prioritized Recommendations to Explore

This year we agreed to rate issues on 5 criteria:

1. **REALISTIC** – Size and scope are appropriate for Washington’s budget context
2. **CAPACITY** – Implementation could be described and executed well and quickly
3. **ADVANCES EQUITY** – Closes gaps in health access and outcomes
4. **STRENGTHENS/TRANSFORMS** – Helps to build, sustain, or transform foundational systems
5. **FIT** - Within the P5RHS and CYBHWG scope, and does not duplicate the work of other Subgroups or coalitions

Prioritized Issues, Challenges & Recommendations

The P5RHS staff have prioritized 3 topics to explore that meet our criteria

- 1. Develop Workforce that Reflects Communities Served** - Create pathways for more types of professionals (e.g., peers and community-embedded professionals) and organizations to provide and bill for culturally relevant IECMH services.
- 2. Perinatal & Infant Mental Health Training** - Fund comprehensive education of providers and staff about perinatal and infant mental health.
- 3. IECMH Consultation** - Fund expansion of mental health consultation and workforce support in early learning settings.
- 4. Doula Funding** - Advance the legislative ask for Medicaid reimbursement for doula care (credentialed/non-credentialed).
- 5. Prenatal Care Funding** - Increase funding and routine access to prenatal care.
- 6. Post-Partum Medicaid Reimbursement** - Extend period for post-partum Medicaid reimbursement to 12 months.
- 7. Post-Natal Parent PMAD Screening** - Increase reimbursement rate for routine postnatal mood disorder screening of parents (currently \$1.84). Explore policies, funding levers, and/or coordination mechanisms to facilitate referral and feedback loops.
- 8. Infant Mental Health Endorsement Funding** - Provide funding to assist Early Achievers participating providers in meeting training and supervision requirements for an Infant Mental Health Endorsement (IMH-E).
- 9. Enhanced Funding for Developmentally Appropriate Assessment & Care** - Implement HCA findings to increase billing rates to allow up to 3 sessions to complete DC:0-5 assessments and fund resilience-focused dyadic care at a higher rate.
- 10. Social/Emotional Development Inclusion in B-5 Screening** - Fund B-5 social emotional development screening (e.g., ASQ is used in many early childhood settings, but often not the ASQ-SE).
- 11. Intentionally Support Culturally Responsive Approaches** - Fund interpretation. Fund research. Fund training. Fund desired strategies of communities of color and tribal communities.
- 12. Customized Support for Identified Communities** - Fund development of customized supports for specific populations such as: adoptive parents, teen parents, parents with special needs, specific cultural communities, refugees, etc.
- 13. Customized Support for Fathers** - Fund development of customized supports for fathers, including workforce development that considers gender and life path. Advocate for a bias toward co-parenting.
- 14. Telehealth Capabilities** - Fund improved high-speed Internet and tools for telehealth. Fund development of standards of practice for telehealth services.
- 15. Build Support for Infant Early Childhood Mental Health** - Fund a campaign to educate and raise awareness about perinatal and IECMH across the state (prevalence, support, social norming, community support).
- 16. IECMH Capacity** - Require health care systems to provide IECMH services on par with adults and on par with the burgeoning need in response to Covid-19.
- 17. Data Collection** - Require establishment of data definitions, system alignment, and analysis expectations in service to perinatal and early childhood mental health.
- 18. Trauma Informed Care** - Fund pilot of the DCYF child care model with all components in 2 communities.
- 19. Family Peer Support** - Secure funds for expansion of peer connection and support (e.g., PEPS, MOPS, etc.)
- 20. Washington Listens and Other Requests for Federal Money to Address Emergent BH Needs**

Breakout – Issue Groups

Articulate Elements of the Recommendation

- A. *What is the issue?*
- B. *What is the problem and how does it affect children, families, and communities?*
- C. *What is the impact on the state budget and society?*
- D. *What options do we have to change this?*
- E. *Why is taking the recommended action a smart move?*
- F. *Anything to let legislators know between now and January?*



Breakout – Issue Groups

Prenatal through 5 Relational Health Subgroup Recommendation Brief

[Issue groups are asked to develop and revise the italicized content]

Policy Brief: Recommendation Statement

Request: Brief detailed description of the legislative or agency request. Include what is requested (*funds, statutory change, rule change, etc.*) for **WHOM** so that **WHAT** good thing happens. (Consider this the bottom line up front. Be clear, concise, and use non-wonky language. Include your best arguments on equity and ROI.)

Issue/Problem/Challenge: Add footnotes¹

A. What is the issue?

Briefly and evocatively describe the problem or issue and the current incidence/prevalence at the population level. Use data graphics, and images to describe the scope of the problem.

B. What is the problem and how does it affect children, families, and communities?

Briefly and evocatively describe the problem or issue and the current impact on different groups and current inequitable outcomes. Use data graphics, and images to describe the scope of the problem. Add footnotes

C. What is the impact on the state budget and society?

Briefly and evocatively describe the current cost or impact of not seizing the opportunity to change. Use data graphics, and images to describe the current cost (higher cost care later, reduced well-being/productivity, etc.). Add footnotes

D. What options do we have to change this?

Briefly and evocatively describe and foot note what evidence (research, experience of other states/countries, pilot results) we have that taking the recommended action would help. Use data graphics, and images to describe the potential solution (closed health outcome gap, cost savings, etc.). Add footnotes

E. Why is taking the recommended action a smart move?

Briefly and evocatively describe the recommended solution/risk, what existing capacity can be leveraged, and how this could sustain or transform Washington's ability to quickly and effectively make a difference? [Use affirmative talking points as well as opportunity costs. Given the budget climate we are in, also highlight any opportunity costs if cuts were made is also important. Particularly for CBH, is there anything we see manifested down the line which increases costs to the state, strains program bandwidth, and is tough on kids and families?] Add footnotes

- Example affirmative talking point focused on future costs savings** - The right evidence-based treatment provided early can save later costs. For example, Parent-Child Interaction Therapy (PCIT) has been found to effectively address trauma and return \$3.64 per dollar of cost.
- Example talking point about opportunity costs if cuts are made** - A \$300,000 cut in Reach Out and Read services puts at risk a significant private match of \$6.5M annually in volunteer services from doctor's offices - each \$1 the state invests leverages a \$20 value in donated services.
- Example talking point for return on investment (ROI)** - Near-term (X# of kids will continue getting services, we know demand exceeds this); opportunity costs (limiting the services at this point will create X, Y, Z problems in child care, K12 system, and strain the CBH response system immediately).



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1. Telehealth (Garrison)
 2. IECMH-C (Kristin)
 3. Developmentally Appropriate Assessment & Care
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- Review the notes from last time
- “Round Robin” to share initial thoughts if you like
- Using Google Docs (“+” to add a comment in margin)
- Add & discuss comments
- Make assignments



Issue Group 1 – Highlights & Needs – Telehealth (see detailed meeting notes)

- Payment parity for audio/video and audio medicine/treatment is primary
- Technology (reliable high-speed Internet, tablets/computers, charging) is a major access issue
- There is an urgent need for practitioner preparation (how to deliver services, how to bill, how to adjust services in response to family situation)
- There need to be more patient-centered solutions along with the provider-centered

Benefits

- Addresses the current life or death trauma that families are experiencing
- Provides greater access to health care (from work, without transportation, access to a primary care provider)
- Can increase the accessibility of preventive services, which can avert long-term costs
- It promotes low-carbon impact
- Resources can go farther as the same number of staff can serve more families/more intensely (travel time can be re-focused)
- Visits can bring in interpreters more readily

Issue Group 2 – Highlights & Needs – Infant & Early Childhood Mental Health Consultation (see detailed meeting notes)

- Consultants are part of the process of identification of child assessment needs
- The workforce needs to be reflective of the providers and families served. We are still having a difficult time bringing in more diverse folks
- There may be other parts of the service continuum that can/should connect (i.e., multiple/different/varied roles and qualifications in different situations)
- We could use a strategy to include informal caregivers in the process given that most babies and young children ages 0-3 are in informal care
- We need to attend to the need to disrupt the disparities in inappropriate labeling during the identification/assessment. (Avreayl notes that IECMH-C is a “*promising disruptor of bias and disparities*” that focuses on reflective practice for the provider to eliminate racialized biases.) Report is here → https://www.swhd.org/wp-content/uploads/2015/02/Indigo-AZ-Smart-Support_FNL_2015_2.pdf

Issue Group 1 – Highlights & Needs – Developmentally Appropriate Assessment & Care (see detailed meeting notes)

- The outcome of the HCA analysis based on the DC:0-5 3 visits will be important to champion
- Issue: Children need accurate assessments. In early childhood, that has to include assessment of the relationship, the home, and the environment, which cannot be done in one DSM-related visit
- Impact on Children: Because only one assessment visit is funded, it affects access, quality of care, and increases chances of bias. This disincentivizes the appropriate services from providers. It should be the beginning of our relationship to build toward an intervention (i.e., child abuse and neglect prevention)
- Impact on State and Society: Effective treatment reduces long-term mental health challenges and helps to build out a system that can deliver this
- Why a Smart Move: It builds supports for families into post-Covid structures. It can stabilize and create a quality service reimbursement system that can build the workforce and system of care
- What Legislators Need to Know: This is an important and high value place to invest for well-being and societal benefit
- Action Steps: Bundling of services? Can we bring forward the argument for parity and standard of care?

Wrap Up

 Articulate our next steps

-
1. Convene issue groups
 2. Develop drafts of recommendation briefs



Thank You!

- Stay **healthy**
- **Reach out** to others → “Distant socializing”, not “social distancing”
- **Support our heroes** in child care, emergency services, health care, food production, and retail
- **Keep moving** the prenatal to 5 relational health systems forward!



**Prenatal through 5 Relational Health Subgroup
07-14-20 Issue Group Notes**

ISSUE GROUP #1 (Garrison) - Telehealth Capabilities – Fund improved high-speed Internet and tools for telehealth. Fund development of standards of practice for telehealth services.

Group Members: (Yellow highlight indicates people present for 7/14/20 conversation.)

- | | | |
|-------------------------|---------------------|---------------------------------|
| 1. Amritha Bhat | 5. Elizabeth Krause | 10. Rachel Burke (HCA staff) |
| 1. Dr. Christopher Chen | 6. Jodi Kunkel | 11. Kimberly Harris (HCA staff) |
| 2. Jamie Elzea | 7. Garrison Kurtz | 12. Ashley Taylor (HCA staff) |
| 3. Araceli Escargaza | 8. Anne Stone | |
| 4. Dorothy Gorder | 9. Beth Tinker | |

A. What is the issue?

- Reimbursement parity (A need for continuance into 2021). There is a need for consistency across fields and state (e.g., in some places we can get a pedicure, but not an ESIT visit)
- Include audio-only parity (**Practice considerations**)
 - Even scheduling the appointment needs to be compensated
 - From an equity lens - Some people may prefer to be audio only (building better relational health with families/clients)
 - As a practical matter, sometimes we cannot have video throughput as well as audio
 - Missed visualization and cues (physical or behavioral) - particularly vulnerable populations
 - Equitable access as well. Gaps are increasing (racial and native language, rural v urban)
 - Is there an obstacle if the “covered” client is not present for audio service? Are we missing necessary information? Is it beneficial? Is it possible from a payment point of view?
 - Are some services more or less amenable to audio only? How often are services needed? Is this different than in-person?
 - Should there be a mix (things that require physical assessment)?
- Parent choice - New opportunities to engage more clients (transportation, ELL, work commitments)
 - Increased engagement
 - Increased participation
 - Improved outcomes
 - Increased ability to access a primary care provider
- Eligibility limitations -
 - (Particularly for Medicare) People need to be in a specific distance from a qualified health care center to be eligible under the permanent roles
 - Only certain CPT codes are covered
 - Medicaid - Though we had parity and are covering telemedicine - the policies were not very clear - we were rolling out policies about how to do it and how to bill (training issues)

- WAC at DOH (currently waived) that affects providers ability to do telemedicine - First visit had to be in-person (at a licensed facility)
- There are a lot of issues related to clarity of what is allowable (current and eventual policy)
- Homeless families – They may have portable tablets but limited ability to have the tablet charged
- Consistent/timely Internet
- Adequate access to a device/Internet throughput for larger families
- Families are struggling economically since they have lost their jobs. And many have family commitments. Their needs have increased - Being the consistent person has been great, but they needed something more than resources in the community - Practical immediate help (care packages increased interest in interacting with us - getting some immediate needs met, could help them to avoid challenge and distraction)
- Families each have their own way of accessing information to help them make COVID-related choices.
- Some families have disconnected completely. (Pandemic, economic, plus whatever was true before) Keeping the “touch” light as they have many things to consider already. We have been adjusting interactions with families based on what is happening for them (**practice**).
- Some programs are not able to continue - Help families to see that there are other opportunities to continue child/family development even if the program is not available
- Continued flexibility in the system (e.g., contractors to re-purpose funds for technology, transportation, etc.)
- Communications (what is allowable - varies within and across agencies)
- Broadband expansion - Avoid siloing and unnecessary duplication of what is in place
- It can be harder to reach families
- Technological literacy to make telehealth possible for all consumers/patients

B. *What is the problem and how does it affect children, families, and communities?*

- ELL
- Basic intervening
- Rural/ no Broadband Internet
- Racial equity
- Language access
- Cultural
- Privacy/confidentiality of space
- Homeless families
- New families / PMAD and increased social isolation

C. *What is the impact on the state budget and society?*

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D. *What options do we have to change this?*

- E. Other states
- F. FRCs
- G. Child welfare navigation

- H. Zoom licenses for providers
- I. Are there more patient-centered training?
- J. Zoom HIPAA

K. *Why is taking the recommended action a smart move?*

- Reduction on our carbon footprint
- Easier for people to access preventive health care
- Ability for service providers to re-focus travel time to service time
- Avoiding pandemic-related health costs
- Life and death situation for a lot of people - this reduces their exposure
- This allows greater ability to provide/increase services at a time when the demand and need is spiking (see the HCA forecast of behavioral health challenges, child abuse)
- Greater reach to remote/underserved area
- More family choice/responsiveness - Many equity issues
- Ability to spread certified interpreters farther

L. *Anything to let legislators know between now and January?*

- Parity to continue on the faster track (some elements)
- Impact of school will be a significant determinant of family situation and behavioral health
- Second or third wave
- Phone codes have continued

Issue Group Scheduling

- Avoid Fridays
- Monday and Thursday ideal
- AM preferred (9a)
- Monday 9a or 10a?

ISSUE GROUP #2 (Kristin) - IECMH Consultation – Infant and Early Childhood Mental Health Consultation. *Mental health consultation and workforce support in early learning settings.*

Group Members: (Yellow highlight indicates people present for 7/14/20 conversation.)

- | | | |
|---------------------|-------------------------|---------------------------------|
| 1. Fathiya Abdi | 9. Janet Fraatz | 17. Joel Ryan |
| 2. Jessica Box | 10. Rep. Debra Entenman | 18. Rep. Tana Senn |
| 3. Rep. Lisa Callan | 11. Lauren Hipp | 19. Sharon Shadwell |
| 4. Victor Cardenas | 12. Nucha Isarowong | 20. Paula Steinke |
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| 7. La'Quonia Cooper | 15. Laurie Lippold | 23. Kimberly Harris (HCA staff) |
| 8. Jamie Elzea | 16. Kathryn McCormick | 24. Ashley Taylor (HCA staff) |

NOTES:

- We reviewed the criteria for selecting priorities and acknowledged the difficult timeline (draft recommendations due to CYBHWG in September). Criteria:
This year we agreed to rate issues on 5 criteria:

1. **REALISTIC** – Size and scope are appropriate for Washington’s budget context

2. **CAPACITY** – Implementation could be described and executed well and quickly
 3. **ADVANCES EQUITY** – Closes gaps in health access and outcomes
 4. **STRENGTHENS/TRANSFORMS** – Helps to build, sustain, or transform foundational systems
 5. **FIT** - Within the P5RHS and CYBHWG scope, and does not duplicate the work of other Subgroups or coalitions
- Infant and Early Childhood Mental Health Consultation (IECMH-C) can mean something very specific (e.g. 6 consultants, one per Child Care Aware WA region, that work with licensed child care providers through the Early Achievers coach). Status: 5 of 6 consultants are hired; final position is in the process of being hired. Plus director at CCA WA.
 - Legislative background: \$773,000 / year in SGF funding began in SFY20 in budget bill (to support policy bill that created IECMH-C; [2SSB 5903](#), 2019). This was enough to hire 6 consultants but not leadership position (at CCA WA) and infrastructure to support staff.
 - Question: How was it determined that management position was needed? Private funder supports this role?
 - Question: What are position requirements for 6 consultants? 5 of 6 regions indicated a need for bilingual consultants.
 - Broadly, consultation happens in other settings such as ECEAP, Head Start, Early Head Start, and through other efforts like Best Starts for Kids.
 - Chat questions from Joel: How many staff/programs/children can each individual consultant support? What are the most common reasons child care providers contact a consultant for? How much support goes towards parents vs. the teaching staff?
 - Response from Sharon: Joel, those are good questions. My understanding is that it varies from provider to provider/program to program. DCYF will be sending out a survey intended for all mental health consultants in the state to increase our understanding of the level at which consultation is being provided (programmatic, classroom, and/or child and family) and the model of consultation that is guiding their work. We are also asking questions about reasons for referral to mental health consultation, among other things. I'd be happy to connect with you about that if you're interested in more information.

A. What is the issue (broadly)?

- There are behavioral health needs for infants, toddlers, and their families.
- Support parents at an early stage that assistance can be helpful and make a difference in the well-being and trajectory of those children.
- Paula: There is no clear definition of MH-C. Need for clarity in field. (As observed in WA AIMH landscape analysis).
- Issues:
 - Where are children? (Particularly infants and toddlers, not in licensed child care settings.)

- Kids and families have stresses and needs.
- There's no existing robust CC MH-C system in general. Could build upon to include mental health.
- There are BH/MH needs.
- What is the response? What is the access? Who is responding?
- SE skills is a key foundation for learning, employment (executive functioning, soft skills). Why MH-C and not other consultants to support the workforce?
- Inequitable suspensions. Particularly African American boys.
 - Data points: 2x as likely -- Black children's expulsion rate compared to Latino and White children. 47% -- Black preschoolers' percent of suspensions (with 19% of enrollment) compared to 6% of suspensions (but 41% of enrollment) for White children
- How do we address bias and racism inherent in our system? IECMH-C helps people who don't know they have a bias. It's a concrete response to systemic issues.
- Can we call this something besides IECMH-C? It sounds wonky and not descriptive of the real service.

B. *What is the problem and how does it affect children, families, and communities?*

WORKFORCE ISSUES -- DISCUSSION ON MASTER LEVEL REQUIREMENT

- Behavioral health workforce challenges. Overall it is not diverse. Small segment serves infants and toddlers.
- Reflective workforce is an issue. Focus on diversity of workforce.
- Nucha: Examining how to address these workforce challenges. How can we grow a pipeline for this workforce? Families have a different experience with services, government, etc. Where are the barriers? How can we address those barriers?
- To be a consultant, you need a master's degree. Highlights broad challenge by BIPOC individuals to enter this workforce.
- Chat comment from Avreayl: Another part of this issue--the requirement for a master's degree, is our publicly funded health care system which is becoming more medicalized.
- Not only behavioral health, but early learning, child care, child welfare, etc. frontline workers engage with infants and toddlers
- Chat from Joel: I support paraprofessionals or peer led folks such as parents. I know this was something proposed a couple of years ago.
- Joel: In HS, parents like peer support. Better chance of building relationships with peers. When peers help them, it can be a more candid conversation. If there's a power dynamic, then the parent will be unwilling to share about DV and substance abuse issues. Consider how parent peers play a role with mental health supports.
- Nucha: CC providers can struggle with parent engagement. If the consultant was working with an organization to shift focus and bring in parent perspective and voices, the consultant is working at a different level of engagement.
- COVID is adding stress. BH/MH needs are increased.
- Laurie: CW reform. How do we meet needs without surveillance?
- Joel: Can we call this something besides infant and early childhood mental health consultation?

C. What is the impact on the state budget and society?

-

D. What options do we have to change this?

-

E. Why is taking the recommended action a smart move?

- IECMH can change some racial disparities in early childhood system (referring to AZ research)
- Increased need for mental health supports due to COVID

ISSUE GROUP 3 (Jamie) - Developmentally Appropriate Assessment & Care- Enhanced Funding for Developmentally-Appropriate Assessment & Care – Implement HCA findings to increase billing rates to allow up to 3 sessions to complete DC:0-5 assessments and fund resilience-focused dyadic care at a higher rate.

Group Members: (Yellow highlight indicates people present for 7/14/20 conversation.)

- | | | |
|---------------------|-----------------------------|--------------------------------|
| 1. Libby Hein | 5. David Willis | 8. Kimberly Harris (HCA staff) |
| 2. Elizabeth Krause | 6. Mary Ann Woodruff | 9. Ashley Taylor (HCA staff) |
| 3. Lou Olson | 7. Rachel Burke (HCA staff) | |
| 4. Sharon Shadwell | | |

A. What is the issue?

- Children need accurate assessment, early on for appropriate care. There are unique factors for p-5 because mental health is in the context of the relationship. Child, parent, relationship.
- Need to be able to assess in communities and homes not just health care settings.

B. What is the problem and how does it affect children and families?

- Inadequate reimbursement is leading to access barriers and consistent quality of care issues, equity issues.
- Providers can't take the time to do assessment (which is time intensive) because they can't get reimbursed.
- Workforce is being asked to do not evidence practice, leading to risks of poor outcomes for children, leading to disincentives for the workforce to continue their work. Higher turnover, less skilled providers and supervisors.
- A comprehensive assessment is part of the beginning of effective treatment--will be more time effective over time than poor start to assessment.
- Therapeutic relationship can form over course of assessment--the relationship makes a difference (make sure we have data to show to go with this)
- IECMH can be a pathway for parental mental health services that might not otherwise happen (identification and access into support)--trauma informed lens connection (ACES tie)
- IECMH services "Child abuse prevention strategy" (powerful case to make). Can also reframe parental neglect.

C. What is the impact on the state budget and society?

- We know effective early childhood treatment can prevent need for lifelong mental health services

- Can we look at cost benefits from other states? (may be thin)

D. *What options do we have to change this?*

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E. *Why is taking the recommended action a smart move?*

- This is smart a move to invest in the rebuilding of policy structures to support families post-COVID. Rebuild it the right way this time
- Children's mental health epidemic coming, this will be bigger cost if not addressed now. Globally countries that were earlier in COVID are seeing some of these effects now
- Workforce development to prepare for future crises.
- Reimbursement issues are preventing practitioners to do evidence-based assessment (or intervention--perhaps like CPP--we could look into this)
- Accurate initial assessment can lead to public health approach

F. *Anything to let legislators know between now and January?*

- Zero to Three time of rapid brain development, early is essential

Action Steps:

- Reach out to ZTT advisors to model states (including Minnesota--might have healthcare cost data for infrastructure--David), pull what we are learning (Perigee, WA-AIMH): looking at workforce stabilization and growth and cost savings, call for training
- Lou Olson (MaryAnn will reach out)/Sharon Shadwell may have already pulled making the case data
- Start fleshing out examples like CPP, parent stories where they have benefited from quality early assessment or the reverse of stories where it didn't go well (MaryAnn has some case example/story that she could pull)
- Find out where the HCA costing work is at (Rachel will find out--wondered if a finance person on this team should/could attend this meeting)

Wonderings:

- Bundle payment options?
- Is there a mental health parity at the level of quality issue?
- How can we tie the common humanity?

Children & Youth Behavioral 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
- Assessment
- Intervention
- 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 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)

Prenatal through 5 Relational Health Subgroup Recommendation Brief

[Issue groups are asked to develop and revise the italicized content]

Policy Brief: *Recommendation Statement*

Request: *Brief detailed description of the legislative or agency request. Include what is requested (funds, statutory change, rule change, etc.) for WHOM so that WHAT good thing happens. [Consider this the bottom line up front. Be clear, concise, and use non-wonky language. Include your best arguments on equity and ROI.]*

Issue/Problem/Challenge: *Add footnotes¹*

A. What is the issue?

Briefly and evocatively describe the problem or issue and the current incidence/prevalence at the population level. Use data graphics, and images to describe the scope of the problem.

B. What is the problem and how does it affect children, families, and communities?

Briefly and evocatively describe the problem or issue and the current impact on different groups and current inequitable outcomes. Use data graphics, and images to describe the scope of the problem. Add footnotes

C. What is the impact on the state budget and society?

Briefly and evocatively describe the current cost or impact of not seizing the opportunity to change. Use data graphics, and images to describe the current cost (higher cost care later, reduced well-being/productivity, etc.). Add footnotes

D. What options do we have to change this?

Briefly and evocatively describe and foot note what evidence (research, experience of other states/countries, pilot results) we have that taking the recommended action would help. Use data graphics, and images to describe the potential solution (closed health outcome gap, cost savings, etc.). Add footnotes

E. Why is taking the recommended action a smart move?

Briefly and evocatively describe the recommended solution/risk, what existing capacity can be leveraged, and how this could sustain or transform Washington's ability to quickly and effectively make a difference? [Use affirmative talking points as well as opportunity costs. Given the budget climate we are in, also highlight any opportunity costs if cuts were made is also important. Particularly for CBH, is there anything we see manifested down the line which increases costs to the state, strains program bandwidth, and is tough on kids and families?] Add footnotes

- a. Example affirmative talking point focused on future costs savings** - The right evidence-based treatment provided early can save later costs. For example, Parent-Child Interaction Therapy (PCIT) has been found to effectively address trauma and return \$3.64 per dollar of cost.
- b. Example talking point about opportunity costs if cuts are made** - A \$300,000 cut in Reach Out and Read services puts at risk a significant private match of \$6.5M annually in volunteer services from doctor's offices – each \$1 the state invests leverages a \$20 value in donated services.
- c. Example talking point for return on investment (ROI)** - Near-term (X# of kids will continue getting services, we know demand exceeds this); opportunity costs (limiting the services at this point will created X, Y, Z problems in child care, K12 system, and strain the CBH response system immediately).