Prenatal through Five Relational Health Subgroup Agenda (7/14/20)

Our Meeting Agenda

1. <u>Welcome</u> - legislative co-chair and new members
2. <u>Recommendations Brief</u> - Quick review of the template that can help us make the case for our recommended policy changes and gather our talking points
3. <u>Break Outs</u> – Most of the meeting will be with us broken out into the three issue groups we identified noted below.
4. <u>Next Steps and Assignments</u>

Issue Groups - If you have not yet indicated an interested, please reply to let me know ahead of time so I can assign you in Zoom.

- **ISSUE GROUP #1 (Kristin) - Telehealth Capabilities** – *Fund improved high-speed Internet and tools for telehealth. Fund development of standards of practice for telehealth services.*
- **ISSUE GROUP #2 (Garrison) - IECMH Consultation** – *Mental health consultation and workforce support in early learning settings.*
- **ISSUE GROUP 3 (Jamie) - Developmentally Appropriate Screening & Assessment** - *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.*

Materials

- During the meeting we will briefly review and then use the attached 2021 recommendations brief template that can help us make the case for our recommended policy changes and gather our talking points. Each issue group will be working toward completion of this.
- Issue groups will start at this meeting and then set their schedule for any needed future meetings going forward. The content generated about each issue area is attached as some starting point content.

During the meeting, we will break out into groups and do our best to approximate the way that an in-person "around the world" exercise can spur our thinking and help us to build towards agreement. For that to work well, everyone needs to be able to offer their comments on "Google Docs. Like last month, we will encourage you to add comments inline (note that is where a cursor like the pink one below indicates you are typing). Or you can click the + next to the area where you want to comment and add a comment. You might wish to test this capacity before the meeting, so you can fully participate that day.

During the meeting, we worked in three small breakout groups to consider current priority, what we'd need to explore, current opportunities, who needs to be involved, and next steps/assignments.

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

Group Members:

1. Amritha Bhat
2. Dr. Christopher Chen
3. Jamie Elzea
4. Elizabeth Krause

5. Jodi Kunkel
6. Anne Stone
7. Beth Tinker
8. Rachel Burke (HCA staff)

9. Kimberly Harris (HCA staff)
10. Ashley Taylor (HCA staff)

A. Questions/Comments/Exploration Needs
1. This relates to equity and future costs savings:
   a. expanding to existing services (e.g., HV); and,
   b. expansion of telehealth services for families without access to:
      ▪ services; and,
      ▪ devices, phone service, Internet (digital divide)
2. Digital divide must be addressed in correlation with increased access to telehealth.
3. Parity
   a. Continued need to define this as a billable activity (during current shelter-in-place/isolation; in near-term as things open/close/open/close; and in longer-term as good option in general).
   b. Continue to provide MH services via phone (not just videoconference).
   c. Note in chat from Rep. Senn: Senator Rolfes has requested that OIC do a quick survey of the health plans we regulate to see which ones are planning to continue with telehealth parity, after the order is no longer extended. Issue of language translation. How do doctor, patient, and translator get connected?
1. Regarding PALS. If there is screening, what is the action / service? Screening without service is not effective.

B. Opportunities/Special Session Requests
1. Near-term issues:
   a. Audio-only parity. Included in current policy? (Executive order until 6/17 and policy effective January 1?).
   b. Audio-only and perhaps parity at large. Private and public billing.
   c. School districts who are providing telehealth? Any issues. Consider demand for continued access as schools open/close.
   d. IECMH-C: What can be done in telehealth? What cost-savings can be made? Re: IECMH-C: protect. Thinking about equity.
   e. What is status of translation for telehealth?
      ▪ Chris Blake is House staffer. HCA item. Rashi may know, too.
   f. What is needed for flexibility in funding (e.g. MIECHV) to use tablets or phones for families? Equity issue. If families have phone/tablet/service, telehealth can work well.
      ▪ Technology at large is siloed (e.g. Internet access for CW visits, K12 e-learning, ECEAP/Head Start). Internet access now discussed as social determinant of health.

C. Who Should Be Involved?
1. Re: school-based, Camille.
2. Re: school-based. Rep. Thai co-chairing school-based subcommittee. Rep. Callan involved?
3. Re: digital divide. From Anne Stone. DSHS poverty reduction work may be a partner around the digital divide.

ISSUE GROUP #2 (Garrison) - **IECMH Consultation** – *Mental health consultation and workforce support in early learning settings.*

Group Members:

1. Fathiya Abdi
2. Victor Cardenas
3. Haruko Choosakul
4. Jamie Elzea
5. Lauren Hipp
6. Kathryn McCormick
7. Rep. Tana Senn
8. Sharon Shadwell
9. Rachel Burke (HCA staff)
10. Kimberly Harris (HCA staff)
11. Ashley Taylor (HCA staff)

A. Questions/Comments/Exploration Needs
1. There is amplified need for this service due to CoOVID-19 (both for families and providers). There is a case to be made.
2. There is a lot we don't know about how it's been happening in the state--not a coordinated system--lots to learn about existing workforce and models and whether that is working.
3. There is a huge range of kinds of consultation supports being provided. Consultants need help/support for best practices (There is currently no coordination of training services).
4. Definition of IECMH consultation scope is needed.
5. RAINE Group competencies.
6. There is not funding for workforce development or infrastructure for IECMH Consultation--but this may not be the time.
7. Who could be involved in the profession?

B. Opportunities/Special Session Requests
1. Coordination with child care health consultation efforts.

C. Who Should Be Involved?
1. Janet Fraatz
2. Victor Cardenas

ISSUE GROUP 3 (Jamie) - **Developmentally Appropriate Screening & Assessment** - *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:

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

A. Questions/Comments/Exploration Needs
1. We need to track this carefully as they develop some analyses to make sure that we are supporting what is found.
2. How long will we be waiting to make further recommendations to receive results regarding the cost analysis? Could there be policy recommendations from this issue if the cost is high such as utilizing the DC 0-5 in practice?
3. Are there policy recommendations that we assume will come from it (e.g., >1 session, DC:-0-5 use, etc.) that we can champion now?
4. Is there a "free" policy decision like endorsing use of DC:0-5 that sets the stage for later expansion?
5. How to tie the WCC visit to increase men's health if they are bringing in the child?
6. Make sure that we support HCA focus on funding levels that are "realistic" enough to spur the system development we need.

B. Who Should Be Involved?
1. Traditional health care, alternative care

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 footnotes[1]*

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).

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