Washington State
Health Care Authority

Infant-Early Childhood Mental Health Statewide Tour Report

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Acknowledgements

Washington is fortunate to have the support and investment of a broad array of partners committed to elevating the needs and potential solutions for improving the healthy development of children across the state. It is an honor and privilege to be able to share the voice of the participants from the IECMH Statewide Tour. We could not imagine how an idea to gather feedback from the field would grow into this collection of experiences, ideas, and possibilities. We are incredibly grateful for the outpouring of support from the individuals and agencies who gave their time, shared their wisdom, and offered resources to this project. In addition to this report, we are taking away many new relationships and wonderful memories from our visits across Washington.

We would be remiss not to acknowledge that this project would not have been possible without the dedication and support of our HCA colleagues. Special thanks to our leadership, especially Beth Tinker and Diana Cockrell, and supporting coworkers, especially Keah Hardy, Genevieve De La Cruz, and Jennifer Peterson. We could not have accomplished the tour and this report without your collaboration.

Finally, we would like to thank our regional partners and the listening session participants. Your passion and investment in your communities was evident through the experiences you shared and your intentionality in collaborating on this project. We hope we accurately captured your voices and perspectives. We feel especially grateful for your willingness to not only elevate the challenges that exist, but to highlight your ideas for the future and to share your innovations with others in the field.

In gratitude,

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Executive Summary

Infant-Early Childhood Mental Health (IECMH) is the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture (Cohen & Andujar, 2022).

In alignment with its mission, HCA has increased its efforts to provide evidence-based, effective, and integrated care to infants, young children, and their caregivers through the development of new policies and resources to support **infant-early childhood mental health (IECMH)** implementation across Washington state. In response to requests for support and guidance from providers and agencies, HCA's IECMH team conducted a statewide tour to understand barriers and potential solutions to improving access to quality IECMH services.

IECMH principles, values, and practices grounded the approach to the design, planning, and implementation of this project, which resulted in:

- **10 listening sessions**
- **Across all regions**
- **With 96 providers**
- **From 53 organizations**

Participants shared they were hopeful that the feedback they shared through the event would have **positive impacts on policy and practice**. Providers also shared that the event:

- **Strengthened their connections with other providers.**
- **Helped them learn more about IECMH.**
- **Encouraged them to build their organization's ability to serve young children.**

Key findings

Through the listening sessions, providers elevated seven core themes. Within these core themes, providers shared both best practices and challenges, many of which are supported by the broader literature and evidence base. These were used to inform the development of HCA's IECMH priorities and next steps HCA is committed to taking. The most frequently shared are included on the following pages.

Health equity is a core value of HCA. Across themes, providers noted opportunities to center equity in IECMH work.

IECMH Statewide Tour Key Themes

IECMH Workforce	Best practices	Challenges
	• IECMH specialty training. • Additional IECMH professional development supports. *"[Our] IECMH team…has the lowest turnover in the agency & highest team satisfaction."*	• Recruiting qualified IECMH providers. • Need for more IECMH training. • Need for more professional development supports. *"I think that we as clinicians should be offered more training in this age group because I know for me, I would love to work more with the B-5 age group."*

Mental Health Assessment for Young Children

Best practices

- Multi-session assessments DC:0-5.
- Developmentally appropriate screening and assessment tools.
- Observation in the assessment process.

"We really appreciate the five sessions, because now we're able to meet with the birth and the foster parent, and visit the childcare center, seeing every caregiving relationship."

Challenges

- Barriers to accessing screening & assessment tools.
- Adapting assessment procedures.
- Adapting electronic health records.

"We do not have a specific DC-0-5 assessment; we use a standard biopsychosocial that is used agency-wide. Many questions do not apply, and many developmental questions are missing."

Mental Health Treatment for Young Children

Best practices

- Developmentally appropriate evidence-based practices.
- Dyadic approaches to treatment.

"We did lots of training … We shifted to providing dyadic therapy, centering the relationship, and doing intensive assessment with caregivers, diving into their childhood. We're seeing fruits of it and why it makes a difference."

Challenges

- Need for training on IECMH treatment models.
- Barriers to developmentally appropriate spaces.

"I get really nervous doing treatment for kids that are young, especially if they can't talk to me and tell me their feelings. I need to know how to have conversations with parents in a better way."

Services in Home and Community Settings

Best practices

- Offering services in-home and community settings.

"In the natural environment, you catch natural moments as they are occurring. You are doing life alongside and making it therapeutic. It feels less like another task or a burden."

Challenges

- Time and costs when offering services in-home and community.
- Challenges with MHAYC reimbursement process.

"It is evidence-based that home visiting has a huge benefit. Yet going to homes is time consuming, expensive, and it is higher risk work for providers; thus, requiring additional training for staff, safety protocols, and screening. It's all at odds."

Caregiver Engagement

Best practices

- Relationship-based and family-centered approaches.

"There is no conversation where the caregiver is excluded. They are treated as a primary part of the relationship. When parents feel that way, when they feel seen and heard, they want to engage."

Challenges

- Caregiver awareness of and buy-in to services.
- Addressing family stressors and logistical barriers that prevent engagement in services.

"It can be a struggle for parents to have time and resources to participate, to not be struggling so much themselves so that they can be available."

Allied Professional Collaboration

Best practices

- Co-located services and shared referrals.

"In our program, mental health services has a team approach - we work in direct collaboration with the child's other providers...it leads to cross learning, thought partnership, and a shared commitment to whole child well-being...and this program has the lowest turnover."

Challenges

- Need for shared knowledge, awareness, and language regarding IECMH.
- Earlier identification of IECMH concerns by allied providers.

"We can serve 0-5, but other systems like child welfare and the schools don't see infants or young children as having behavioral health needs."

IECMH Finance

Best practices

- Support from billing and administrative staff.
- IECMH-specific payment models.

"Our IECMH team has different productivity standards due to the complexities of the services, like setting up room/toys, and increased drive time compared to the rest of the agency."

Challenges

- Difficulty understanding Apple Health billing.
- Working with managed care organizations (MCOs).
- Added costs for developmentally appropriate care.

"I believe if it was more financially sustainable, there'd be more urgency to offer these B-5 services.".

Taking action

Everyone has a role to play in building a stronger IECMH system for Washington state. The report outlines concrete steps that mental health providers, allied providers, agency administrators, and state policy & system partners can take to support best practices and address challenges, as well as HCA's priorities and next steps for continued IECMH work.

To learn about HCA's progress on our priorities and next steps since the publication of this report, read the IECMH at HCA brief.
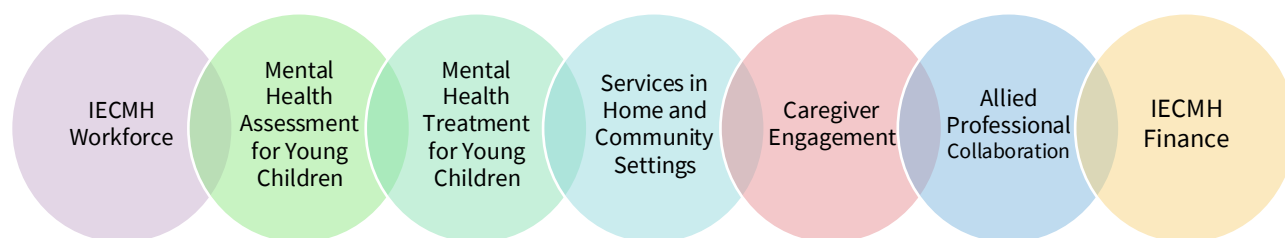
How to use and navigate this report

This report is for all community and system partners in Washington state who work to support the infant and early childhood mental health (IECMH) system. This section provides an orientation to the structure and topics captured throughout the report.

Introduction and conclusion

The report begins with background information on infant-early childhood mental health (IECMH) at the Health Care Authority (HCA) and our approach to this project, then transitions into the desires to strengthen services and support for young children and families in their communities shared by providers (Motivations and Influence). It closes with HCA's IECMH Priorities, including next steps from HCA in acting on the themes shared throughout the report.

Main sections: Key themes

The main body of the report focuses on best practices and challenges in providing IECMH services, as identified by providers. These best practices and challenges are organized into **seven key themes**:

IECMH Workforce · Mental Health Assessment for Young Children · Mental Health Treatment for Young Children · Services in Home and Community Settings · Caregiver Engagement · Allied Professional Collaboration · IECMH Finance

These key themes are marked in the top left corner of each page in its corresponding section.

Subtopics by theme

Each theme is its own section of the report, in which you will find:

- An introduction to the theme with foundational information on the topic and subtopics.
- Best practices elevating innovations and possibilities providers have adopted.
- Challenges identified by providers as barriers to IECMH.
- Ideas for taking action to address the challenges and adopt best practices.
- A resource spotlight to support readers in next steps.

Symbol guide

(N =)

For each best practice or challenge, a frequency value **(n=XX)** will indicate how frequently that best practice or challenge was expressed by providers[1]. The frequency of best practices ranged from 2 to 75 per best practice, with an average of 23; the frequency of challenges ranged from 3 to 132 per challenge, with an average of 33.

Direct quotes

Content with yellow highlighting behind the text indicates direct quotes from providers. Some direct quotes are also included within callout boxes.

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[1] The frequencies reported throughout the report represent the number of times a certain theme was expressed by any provider; frequencies do not represent the number of distinct providers who expressed a theme. For more information, please refer to Methods and Materials.

Top Desire

At the end of each Listening Session, providers were also asked which of all the challenges discussed would be the number one item they would like to be addressed (see Appendix D for all Listening Session questions). These items are noted using the orange starburst symbol.

Additional costs

The green coin symbol indicates when providers noted challenges around the costs associated with IECMH services or practices; the combined impact of these costs is described more fully in the Financial Sustainability of IECMH Services section.

Call-out boxes

Call-out boxes throughout the report highlight additional information, data, connections, reflections, and opportunities to center equity.

General Shares background information regarding broader behavioral health and early childhood systems.	
Making the case Highlights relevant data from other national and Washington state sources.	
Centering equity Identify opportunities to strengthen health equity in IECMH.	
Continuing reflection Notes questions for further inquiry and consideration.	
Connecting the dots Calls out a connection between different themes of the report	
Resource Spotlight Highlight materials to support next steps on taking action[2].	

Taking Action

Taking Action is organized by audience, providing strategies based on the best practices and challenges identified by providers, as well as approaches identified in literature. The section below describes the intended audiences, though individuals may fit more than one audience. While Taking Action for each theme is at the end of the section, each audience can find a summary of all strategies for taking action in Appendix J.

Mental Health Providers

Individuals who are or are interested in providing mental health services to young children and their families, such as:

- Marriage and family therapist
- Mental health counselor
- Clinical social worker

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[2] All resources referenced in the report can be found at the end of the document.

- Psychologist

Strategies in this section highlight actionable steps an individual can take to build their skills and practice as well as support strengthening the workforce and system.

Allied Providers

Individuals who are allied providers supporting IECMH in physical health care, social services, early learning, and adult behavioral health, such as:

- Pediatrician
- Family doctor
- Public health nurse
- Child welfare social worker
- Family/care navigator
- Childcare/early learning provider
- Early intervention provider
- Mental health professional

Given the report is based on mental health provider feedback, strategies are primarily identified in the Caregiver Engagement and Allied Professional Collaboration sections, though individuals may be interested in strategies identified for other audiences throughout the report.

Agency Administrators

Agency administrators at organizations who are or are interested in providing mental health services to young children and their families, such as:

- Supervisor
- Manager
- Director
- C-suite executives

Strategies in this section highlight actionable steps organizations can implement to incorporate IECMH services and best practices into their agency policies, practices, and service delivery.

State Policy & System Partners

State cross-system partners invested in fostering the mental health and well-being of young children in Washington state, including:

- Tribes
- Local and state government agencies
- Community-based organizations and IECMH providers
- Policymakers and advocates
- Payors
- Researchers
- Higher education institutions
- Community members

Background

Functioning as both the state's largest health care purchaser and its behavioral health authority, the Washington State Health Care Authority (HCA) is a leader in ensuring Washington residents have the opportunity to be as healthy as possible[3].

HCA's three pillars of work, Apple Health (Medicaid); the Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) programs; and behavioral health and recovery, are the foundation of our mission to provide equitable, high-quality health care through innovative health policies and strategies for a healthier Washington.

Infant-Early Childhood Mental Health at HCA

Early life is critically important in shaping lifelong health and well-being. In alignment with its mission, HCA has increased its efforts to provide evidence-based, effective, and integrated care to infants, young children, and their caregivers through the development of new policies and resources to support **infant-early childhood mental health (IECMH)** implementation across Washington state while centering HCA's values.

HCA Values

People first
We put the best interest of the people we serve and our employees first.

Diversity & inclusion
We value work and life experiences while practicing cultural humility with the people we serve and each other.

Health equity
We help ensure everyone has the opportunity to obtain whole-person health.

Innovation
We develop creative solutions and put them into action to improve our processes, systems, and services.

Stewardship
We are accountable for the use of resources entrusted to us as public servants.

HCA's IECMH team holds knowledge and experience in the program development, research and evaluation, and clinical practice elements of the IECMH field which they bring into their work addressing the known complexities of Washington's publicly funded behavioral health system, especially with regards to Apple Health (Medicaid) policy. These positions have facilitated an IECMH-informed approach to the development and implementation of policies and programs grounded in IECMH principles throughout all aspects of policy implementation. HCA's IECMH Statewide Tour highlights practical strategies for infusing systems work with IECMH values principles.

What is IECMH?

Infant-Early Childhood Mental Health (IECMH) is the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture (**Cohen & Andujar, 2022**).

ⓘ IECMH and Birth to Five

Because many definitions of IEMCH often refers to infancy and early childhood as birth through five years of age, some people may use the phrases 'Birth – Five', 'B-5', or 'B5' to reference this age span and/or services provided to children in this age group. Throughout the report, quotes from providers may use this language as a synonym for IECMH or IECMH services.

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[3] Health Care Authority Strategic Plan 2022-25

The field of infant-early childhood mental health is relatively new, and the capacity to screen, refer, assess, and treat mental health disorders in young children may be limited (National Scientific Council on the Developing Child, 2008). A series of briefs from the Perigee Fund, informed by community, provider, and parent/caregiver input, reported that "*Washington, like many other states in the country, simply does not have enough qualified IECMH providers*" (Perigee Fund, 2021b). For those IECMH providers that do exist, a 2020 survey found that many experience challenges in billing for their services (Oxford & Lecheile, 2022). With these barriers to access, it may be no surprise that both national and Washington-specific data suggest that young children are less likely than older children and youth to receive needed mental health care (Ghandour et al., 2019; Health Care Authority, 2022).

Young children's mental health exists on a spectrum.

About 1 in 5 young children has a mental, behavioral, or developmental disorder (Vasileva et al., 2021).

When properly identified, mental health disorders in young children can be treated and children can return to healthy development.

IECMH treatment services offer a strong return on investment; $8.00-$15.00 in savings per child per dollar spent (Oppenheim & Bartlett, 2022).

In response to these challenges, there has been tremendous recent investment in the field of IECMH in Washington state, particularly regarding IECMH treatment services for children enrolled in Apple Health (Medicaid). Understanding the best practices and barriers to adopting IECMH services is key to bolstering supports for Washington's youngest citizens and their families.

Project purpose

Washington's Apple Health (Medicaid)[4] and behavioral health system is layered and difficult to navigate, for clients and providers alike. These complexities are often compounded as providers, agencies, and state entities implement policies and programs for newer concepts of care, such as Infant-Early Childhood Mental Health (IECMH). Current HCA-led IECMH initiatives have resulted in feedback from providers and agencies requesting additional communication, support, and resources from HCA on how to adopt IECMH services.

In alignment with HCA's values and strategic priority of building a person- and community-centered system, HCA's IECMH team conducted a statewide tour to partner with behavioral health providers and agencies to understand barriers and potential solutions to improving access to quality IECMH services. Feedback gathered will inform HCA strategies to address gaps, build workforce capacity, develop policies, and create resources to promote evidence informed IECMH services.

Our approach

IECMH principles, values, and practices grounded the approach to the design, planning, marketing, and implementation of this project. The following highlights key elements to our approach that aligned with or informed by a relationship-centered and developmentally informed process for engaging with providers.

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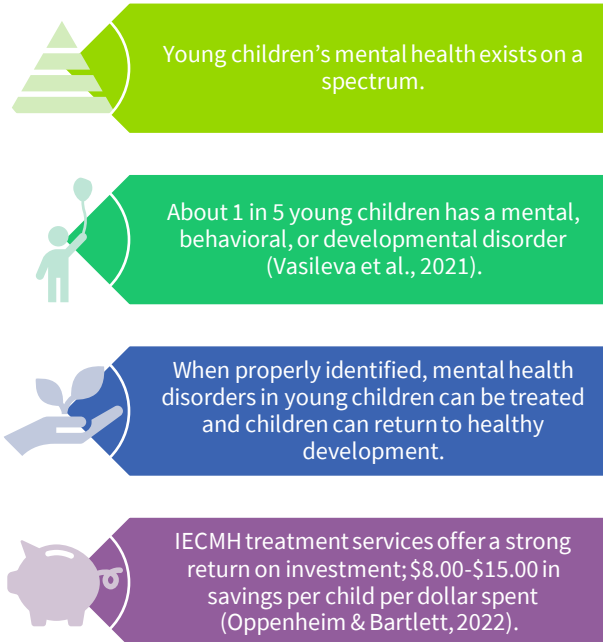
[4] Washington State Medicaid is called Apple Health. Medicaid is a federally and state funded program to provide health care coverage for the nation's most economically disadvantaged populations, including low-income children and their families, low-income seniors, and low-income people with disabilities.

Centering Relationships	Statewide Paternships	Provider Engagement
Strengths-based	Developmental Progress	Coordinated Systems

With these key elements in mind, the HCA held events in all 9 Accountable Communities for Health (ACH) regions and hosted 1 virtual session. Each event included a Listening Session with Apple Health mental health providers, structured around a series of guiding questions. To learn more about the elements used to develop the IECMH Statewide Tour and the guiding question, please refer to Appendix A: HCA's IECMH Statewide Tour Approach.

Participant experiences

Participants appreciated the relational and strengths-based approach of the event, and they shared that it helped them to learn more about IECMH, and to realize the importance of and strengthen connections with other IECMH providers. As one provider shared,

- *We need improved connection with other partners agencies who work with prenatal to five [age]. We need more days like today.*

The event also encouraged them to build their organization's capacity to serve young children, and they were hopeful that feedback shared through the event would have positive impacts on policy and practice. To learn more about participant experience, see Appendix E: Participant Experience.

Participant demographics

A total of 95 individuals from 53 different organizations participated in the Listening Sessions. Individuals who participated represented a range of roles, including peers and care coordinators, mental health clinicians, clinical program managers and supervisors, billing and administrative staff, and program directors and C-suite staff.

At the organizational level, each region of the state was represented by at least one organization. The majority of organizations served young children and were licensed behavioral health agencies, but there was some diversity in these organizational characteristics. A small number of organizations were Tribal clinics/Indian Health Care Providers. For more information about participant demographics, see Appendix C: Participant Demographics.

🕊 Centering Equity: Tribal clinics/Indian Health Care Providers

Washington state has a total of 29 federally recognized tribes and two Urban Indian Health Programs. Indian Health Care Providers play a critical role in providing culturally informed, community-driven American Indian/Alaska Native health care. To learn more about Indian Health Care in Washington state, review this presentation from the American Indian Health Commission (AIHC) of Washington State.

Methods and materials

Qualitative data (i.e., quotes) from the Listening Sessions were analyzed using a grounded theory approach (Strauss & Corbin, 1994). Because transcripts and written feedback were collected anonymously (i.e., speakers' identities were not associated with their quotes), the frequencies reported throughout the report represent **the number of times a certain theme was expressed by any participant**; frequencies do *not* represent the number of distinct participants who expressed a theme. For more information, see Appendix D: Methods and Materials.

Motivations & Influences

One of the foundational questions asked of providers was what motivated them, influenced, or inspired their interest in IECMH services. Understanding communities' desires, even when complex or shaped by barriers, provides critical context for policy work that is informed by lived experience and centered on hope (Tuck, 2009).

Need for IECMH services (n=49)

The primary motivation noted by providers was a recognition of the identified need for IECMH services.

⌖ Making the case: the need for IECMH services

While comprehensive data on the need for IECMH is limited, several other national and Washington state-specific reports have pointed to unmet need in this area.

- Nationally, it's estimated that 1 in 5 young children has a diagnosed mental, behavioral, or developmental disorder (Vasileva et al., 2021).

- In Washington state, only half of young children enrolled in Apple Health who had mental health need identified by a health care provider actually received any services (Washington State Health Care Authority, 2022).

- A 2022 survey of behavioral health agencies in Washington state found that only a third of behavioral health agencies serve children younger than 6, and an even smaller percentage (8%) serve children younger than 3 (Fabian et al., 2023).

- Findings from focus groups conducted in 2019-2022 with parents, providers, and state leaders noted that there are not enough IECMH services available to meet the need, particularly for infants and toddlers (Perigee Fund, 2021b); focus groups conducted in 2023 similarly found concerns about the lack of developmentally appropriate services for young children (CYBHWG, 2024).

- *We are seeing an influx of this age range coming in for behavioral health services. Parents are looking for support for certain behaviors and parenting skills. We see it on a daily basis.*

- *Our IECMH services have grown like crazy, there is so much demand…This has been building for a long time.*

For many, this need was unfortunately paired with a gap in communities' ability to provide those services.

- *We get referrals from home-based programs, but it's hard to find birth to five providers, so then we send them back to the physician. Kids are falling through the cracks.*

Some providers, in seeing this need, wanted to provide services 'in-house,' as a way to address gaps in service and provide a continuum of care to their community.

- *We were getting referrals for B-5, and we couldn't find a place to refer them. We would hear, 'Oh, we don't serve that population.' So that moved us to thinking about how we could provide those services in-house.*

Top Desire — While many providers noted that they were able to note the need for services through their own personal experience or through anecdotal evidence, a few shared that access to **quantitative data on the need for IECMH services**, particularly at the county level, would help them to '*make the case*' to organizational leadership that services were needed.

- *As a supervisor, I know from reviewing assessments that this is having an impact; but it doesn't stand out as obviously. What is needed is clear data, specific to our county, to demonstrate the need.*

> ⁎ **Motivations and Influences & Allied Professional Collaboration**
>
> Allied professionals play a key role in identifying the need for IECMH services, both for individual families, and the system as a whole. Providers spoke to their experiences in allied professional fields, such as early childhood education or child welfare, as helping them understand the need for IECMH services.
>
> - *I saw the barriers at kindergarten, all the behavioral health components that compete with child development and can continue to have an impact into adulthood.*
>
> - *It all started in child welfare and family preservation. It kind of grew organically because we wanted parents to raise their children and wanted children to be raised in their Tribal home.*

Upstream intervention (n=29)

Research shows that by intervening when children are young, IECMH treatment services offer a strong return on investment; $8.00-$15.00 in savings per child per dollar spent (Oppenheim & Bartlett, 2022). Providers with experience in the behavioral health system shared how they are motivated by a desire to intervene earlier through "upstream" services and supports.

- *The prevention aspect is huge. The kids we see at older ages, you can already spot problems started when they were 2, 3 ,4, and 5 years old. We can either address it before everyone's burned out or see them later when the problems are entrenched.*

- *It's easy for things to fall off, stepping into the 0-5 age range. But there is a storm coming; we can save a lot of money, trauma, and heartache by jumping in early. If we don't address it earlier, we'll just have a higher list for WISe[5].*

Agency leadership support (n=19)

Organizational leadership is a key component of successful implementation of new policies and practices in the behavioral health field (Aarons et al., 2015). A key influence for many providers was the support they received from agency leadership.

- *I'm lucky we have this perspective that IECMH is really important to us, and that really was never a question for our leadership.*

- *Having buy in from your clinical services manager or your supervisor is so important.*

- *Leadership came to me and said, 'Here! The state [HCA} is saying you should do this. And the majority of our clients are state insurance [Apple Health].*

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[5] Wraparound with Intensive Services (WISe)

IECMH Workforce

Young children's physical, emotional, social, and cognitive health are growing together. As children are building skills across these developmental areas, their physical health, emotional well-being, social skills, and cognitive abilities are all impacting each other and growing together (National Scientific Council on the Developing Child, 2007). These developmental domains are built through experiences and interactions with others; therefore, anyone who is in relationship with a young child plays a part in their mental health and well-being.

Because of the many different aspects that support young children's development, defining who all is included in the IECMH workforce can be challenging. The multidisciplinary nature of the field can be complicated when attempting to assess workforce capacity and needs given the diversity of disciplines, education and training, and services across the IECMH continuum of care.

Treatment

Assessment

Prevention

Promotion

Workforce

For the purposes of the IECMH statewide tour, HCA focused on professionals providing mental health services to children enrolled in Apple Health (Medicaid). The visual below illustrates the two primary avenues available to provide mental health services for young children enrolled in Apple Health[6].

Option 1 Licensed Mental Health Professional (LMHP)

Option 2 Licensed Behavioral Health Agency (BHA)
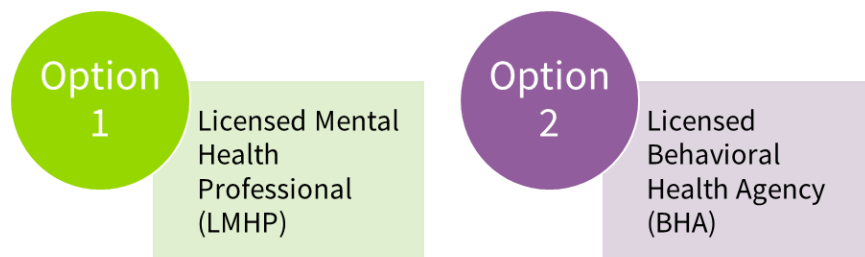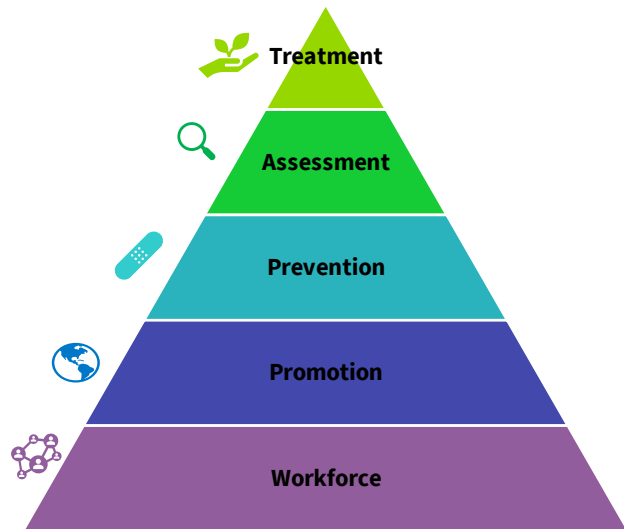
Quality IECMH services begin with a skilled and competent mental health workforce. Though mental health professionals receive graduate education, most programs have little to no curriculum focused on foundational child development and IECMH-specific content. Often professionals receive specialized IECMH training through professional development opportunities after they have completed their graduate programs. Notably, these opportunities are often prohibitive due to the time and cost necessary to participate (Weston, 2005).

In addition to opportunities to gain content knowledge, professionals need supports that allow for the development of skills over time, experience-based learning, and ongoing reflective supervision (Shea et. al., 2016). With limited introduction to IECMH early in one's career, mental health professionals entering the workforce may not have awareness of the opportunities to work with young children, nor feel they have the skills and knowledge to offer them quality services.

The themes elevated related to workforce from providers touched on both specific IECMH challenges, while also noting the broader context of the behavioral health workforce shortage in Washington and nationally.

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[6] Apple Health Infant-Early Childhood Mental Health Service Models Toolkit

IECMH Workforce - Best practices

Summary: Providers reported that specialty training in IECMH was key to building a strong IECMH workforce. In addition, other professional development supports such as dedicated IECMH teams, support from supervisors trained in IECMH, and reflective supervision/consultation, helped to build provider skills and increase retention.

IECMH specialty training (n=35)

IECMH specialty training was a key strategy for building a strong workforce. Additional training, especially in IECMH evidence-based practices (EBP), helped build provider knowledge and skills, and ultimately had a positive impact on practice.
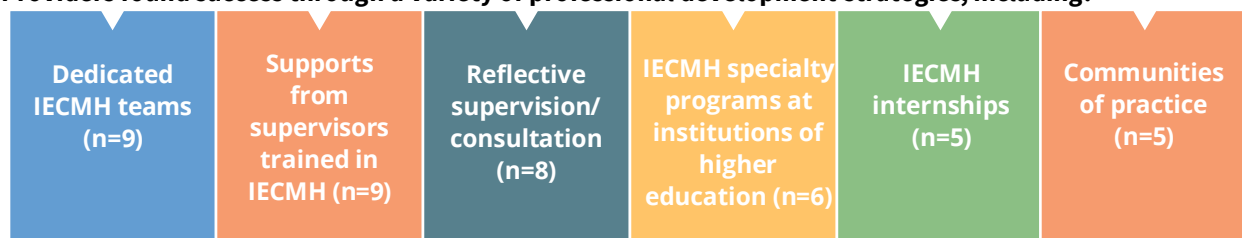
- *We did lots of training because lots of staff didn't come with knowledge. We got training from Barnard Center[7] and did CPP[8] [Child Parent Psychotherapy] training for all therapists. We shifted from addressing behavioral health to providing dyadic therapy, centering the relationship, and doing intensive assessment with caregivers, diving into their childhood. Everyone loves it. We're seeing fruits of it and why it makes a difference.*

Other professional development supports (n=35)

Providers also noted that while training was key to building the IECMH workforce, other professional development supports are also critical to supporting best practices and putting what is learned in training, into practices. Providers shared about the impact of these professional development supports on building provider confidence, preventing burnout, and increasing retention.

- *Having someone trained in IECMH who can supervise, it becomes a little less scary.*

- *We have a regional IECMH consultation group, and it really helps to feel connected.*

- *Having a standalone IECMH team helps because people come to do that specific work. It has the lowest turnover in the agency & highest team satisfaction.*

Providers found success through a variety of professional development strategies, including:

Dedicated IECMH teams (n=9)	Supports from supervisors trained in IECMH (n=9)	Reflective supervision/ consultation (n=8)	IECMH specialty programs at institutions of higher education (n=6)	IECMH internships (n=5)	Communities of practice (n=5)

ⓘ IECMH Professional Development Supports

Reflective supervision (RS) is a collaborative relationship for professional growth that improves program quality and strengthens practice. RS builds the capacity of individuals, relationships, and organizations by cherishing strengths and partnering around vulnerabilities (Shahmoon-Shanok, 2009).

A community of practice is group of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly. Through the process of sharing information and experiences with the group, members learn from each other, and have an opportunity to develop personally and professionally (Wenger-Trayner, 2013).

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[7] Barnard Center for Infant & Early Childhood Mental Health
[8] Child Parent Psychotherapy (CPP)

🕊 Centering Equity: Professional Development on Diversity, Equity, and Inclusion (DEI)

Providers noted the importance of ongoing professional development in building their team's knowledge and skills around DEI related topics (n=25). Providers shared that DEI-specific training and communities of learning, as well as reflective supervision/consultation, were key to building their providers' knowledge and skill in this area.

- *We are implementing more conversations and training with our staff around how cultural competency is essential, as well as how systemic oppression impacts access to services.*

- *We are working on implementing a pilot project to integrate reflective consultation for front line specialist staff to create space for folks to feel supported, examine biases, and learn new information.*

IECMH Workforce - Challenges

Summary: Providers noted that recruiting and retaining IECMH providers was a major challenge, often due to providers' lack of expertise, confidence, or interest in providing IECMH services. An additional layer of complexity was finding providers who could provide culturally and linguistically appropriate services to families of young children. Providers voiced that there is a strong need for more IECMH training and professional development supports to build out the workforce, but even when these opportunities are available, the costs associated with them can be a barrier.

Top Desire

IECMH recruitment and retention (n=73)

As highlighted in the Motivations & Influence section, the need for IECMH services is pressing, and in many regions, is exacerbated by a lack of available services. Providers shared that they experienced particular challenges around recruitment and retention of IECMH providers, often due to providers' lack of expertise in the subject.

- *We are having a hard time finding qualified candidates for this population.*

- *There's such a desert of providers in this specialty area that often gets overlooked.*

ⓘ Putting it in context: Behavioral health workforce shortages

Behavioral health workforce shortages are a challenge nationally (Counts, 2023), and in Washington state, the behavioral health workforce shortage has been described as in a crisis state (Boyd et al., 2022; CYBHWG, 2024). Providers noted that their experiences of workforce shortages were not isolated to IECMH services (n=66).

Retention of providers (i.e., turnover) was shared as particularly challenging (n=44), especially for behavioral health agencies, who noted a reoccurring pattern of staff leaving to work in private practice (n=12). Providers did not experience retention challenges as specific to IECMH; in some cases, their IECMH teams actually had lower turnover rates. However, the broader challenge of behavioral health workforce retention may be particularly impactful to IECMH services, given the importance of attachment relationships in this work.

- *There is a lot of turn-over, which is really tough for this age group when attachment is so important.*

- *Largely due to high staff turnover, we haven't developed a shared common language around parent-child relationships and early childhood development across the program.*

Provider interest and confidence in providing IECMH services (n=23)

Providers' lack of interest and confidence in this area also contributed to challenges in recruitment and retention. Strategies to build the IECMH workforce will need to find ways to attract providers to the work, and also build their confidence so they feel ready and willing to serve this population.

- *Most clinicians are terrified of working with 0-5. They say, 'Oh my gosh, I don't know what to do.'*

- *Recruiting interns who are interested in this age group is challenging. Most of them want to serve couples or older kids.*

> **☁ Continuing Reflection: Building a Strong IECMH Workforce**
>
> - *I'm a parent too, so I know there is a really strong need for these services. So, what would it take to get more people interested in the field?*

IECMH in higher education (n=8)

Providers shared how a key driver in IECMH recruitment and retention challenges was the fact that foundational and specialized IECMH content is often not a component of mental health graduate curriculum in higher education programs.

- *Child development is missing from college programs. How do we get the message to directors at these programs? It feels like it has to be part of the law, because programs will teach to what is required.*

- *I'm pursuing a master's degree in children's mental health, and I didn't know that the DC:0-5 existed.*

> **🕊 Centering Equity: Culturally and Linguistically Appropriate Care**
>
> In keeping with federal Culturally and Linguistically Appropriate Services (CLAS) standards, many providers noted their desire to hire providers who understand the experiences and speak the languages of the families they serve (n=35), as well as their use of interpreter and translation services when there were language differences between providers and families (n=14).
>
> - *We try to hire bilingual therapists, and we pay more for people who are bilingual and bicultural.*
>
> - *All my materials are offered in Spanish, and I have translation earbuds that I can use if no bilingual therapist is available.*
>
> However, providers noted that they experienced challenges hiring bilingual and/or bicultural staff (n=14), as well as in accessing interpreters on an ongoing basis (n=11).
>
> - *Finding clinicians who speak other languages and who want to do B-5 is a challenge.*
>
> - *You need really good interpreters to provide this level of B-5 service, and we don't have enough. We have two interpreters in [our region] that we know and trust, and they're always booked.*

Low wages (n=7)

While the impact of low wages on recruitment and retention is not unique to the IECMH field, providers shared how low wages made it particularly challenging to recruit and retain staff with specialized IECMH skills. Providers noted that increased wages for IECMH specialty providers could be a helpful strategy, but without increased rates for IECMH services, they struggled with how to operationalize this approach.

- *If I ever did find someone who wanted to do B-5, I would want to pay them twice as much. If we could pay them extra, that might keep them. Otherwise, they'll say, 'Oh, I got my license; I'm outta here.' They have to invest a tremendous amount of time in IECMH training; it's a lot of work.*

- *Once we train folks, then what? Moving on is about getting more dollars and fewer clients. How can we provide those two pieces in our setting, to folks who have advanced training? When the rate of reimbursement is the same, we don't have a lot of choices.*

Top Desire

Need for IECMH specialty training (n=138)

Given the challenges expressed by providers in recruiting and retaining a qualified IECMH workforce, it is not surprising that one of the most common needs expressed by providers was for more IEMCH specialty training opportunities.

- *I think there is a lot of room for growth in this age group. I think that we as clinicians should be offered more training in this age group because I know for me, I would love to work more with the B-5 age group.*

- *Many clinicians struggle with seeing young children as they aren't quite sure the best course of treatment, due to lack of training.*

Making the case: IECMH specialty training

While comprehensive data on the need for IECMH specialty training is limited, several other Washington state-specific sources point to unmet need in this area.

- A 2019 survey of 875 mental health clinicians in Washington state found that only 58% of those serving young children had received any specialized training in foundational IECMH skills (Perigee Fund, 2021d).

- Surveys and focus groups conducted with providers who have attended DC:0-5 training through the Infant-Early Childhood Mental Health Workforce Collaborative (IECMH-WC) found that providers expressed the need for additional training around mental health assessment for young children, as well as foundational concepts in IECMH (IECMH-WC, 2023).

Training in treatment models and in screening, assessment, and observation tools were the most desired topics for training noted by providers (see Figure 1). This may reflect the recent investments in training in the DC:0-5[9], which often prompts providers to recognize their need for additional training in other topics.

- *The DC:0-5 training is great, but now what? We need to know how to do treatment.*

Figure 1. Number of times of specific training topics were identified as a need by providers

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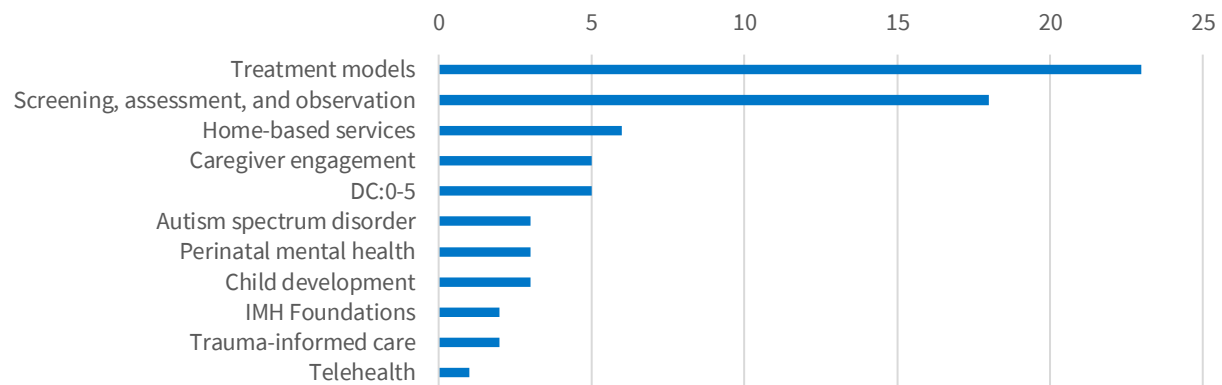
[9] The DC:0-5 is the internationally accepted system for developmentally appropriate assessment of young children's mental health. In 2022, ongoing DC:0-5 training became available to Apple Health providers at no-cost through the Infant-Early Childhood Mental Health Workforce Collaborative (IECMH-WC). Learn more about how providers are using the DC:0-5 in the Mental Health Assessment for Young Children section of the report.

☁ Continuing Reflection: Foundational IECMH Professional Development

- *One question we're left with is, as we develop our B-5 capacity, what core competencies would we want to see for staff working on B-5 teams? Which trainings would we want to prioritize for our B-5 staff? There are many, so which would be most beneficial to build a solid foundation?*

In discussing the need for training, providers also shared some key considerations for creating training programs that would best meet their needs, such as the length, frequency, location of training, as well as their eligibility criteria and incentives. More information about these key considerations is included in **Appendix F: Training Considerations**.

ℹ Putting it in context: Training & retention

As noted previously, retention is currently a key challenge in the behavioral health field. Providers noted bidirectional impacts between training and retention: they noted a pattern of providers leaving their organizations after receiving training, due to being more 'marketable' with their new skills (n=10). This turnover, then, increased the burden and costs of training for their organizations. While not specific to IECMH providers, the additional level of IECMH training that is often needed to support providers in this specialty may exacerbate this issue for the field.

- *Once you train people in everything needed for IECMH, they are licensed and leave for private practice.*
- *The churn means that we have to keep training all the time.*

⬢ Need for other professional development supports (n=57)

Top Desire

Many providers noted that they also needed other professional development supports, and they shared the value of these supports for feeling connected, learning from others, and making efficient use of resources.

- *Connecting to agencies who are at different levels of implementation is really helpful.*
- *We want to make sure supervisors are trained. We don't want to launch a new program if we don't have the leadership to support.*
- *What would be supportive if we could have a consultant to sit in at our agency for 6 months and help us fine tune everything, because they've done it.*
- *We need a way to do resource sharing among IECMH resources. Could we have a Basecamp for sharing things like assessment templates?*

Providers expressed a desire for a number of different professional development supports, including:

Communities of learning (n=26)	Support from supervisors trained in IECMH (n=10)	Mentorship for providers/ agencies who specialize in IECMH (n=8)	Reflective supervision/consultation (n=6)	Resource sharing hub (n=4)

🔍 Making the case: IECMH professional development supports

Surveys and focus groups conducted with providers who have attended DC:0-5 training through the IECMH-WC found that providers voiced a need for supervision by IECMH-trained clinicians, as well as consultation and collaboration with others in the field. Despite this expression of need, attendance at the DC:0-5 Communities of Practice offered to meet this need has been limited (IECMH-WC, 2023), potentially pointing to the fact that there may be additional barriers to participation in these sorts of opportunities. A study of providers working in Los Angeles County's community behavioral health system found that providers similarly desired more ongoing support and consultation for use of the DC:0-5 (Williams et al., 2023).

Costs for training and professional development support (n=30)

A key barrier to training and professional development supports was the cost associated, both the fees associated with training and professional development (n=25), as well as the impact on service time (n=9).

- *I tried looking at the models out there that are less of a lift; even then, there are big costs.*

- *It's not the cost of the training; it's the time spent when we pull clinicians offline for training.*

🔍 Making the case: considering the hidden costs of professional development

In a 2019 survey of 875 mental health clinicians serving young children in Washington state, 33% of participants shared that the cost and location/travel expenses associated with training were barriers to accessing professional development opportunities; 7% noted that 'release time' was also a barrier (Perigee Fund, 2021d).

IECMH Workforce - Taking Action

Strengthening and supporting a diverse IECMH workforce requires increased awareness and ongoing support to build capacity of providers and agencies. The following strategies identify ways to optimize existing resources, while also highlighting areas for further inquiry to sustain the IECMH workforce over time. These strategies are based on the best practices and challenges identified by providers, as well as approaches identified in literature. For literature references, please see Appendix J. Taking Action References.

The following actionable steps align with the strategies and approaches for HCA's IECMH Priority 1.

Mental Health Providers

- Increase awareness by sharing about IECMH with students and colleagues.
- If you are an IECMH professional, offer to supervise or mentor mental health professionals.
- Build your IECMH competencies and practice through self-study and attending IECMH trainings.

Agency Administrators

- Build IECMH workforce capacity through creating birth-5 specialty teams and providing IECMH internship opportunities.[28]
- Ensure staff have the necessary resources to meaningfully engage in IECMH professional development, including agency investment in training, provider release time, and supervision support.[16]

- Strengthen IECMH-specific supervisor capacity through supporting access to reflective supervision training and ongoing professional development, including supervisor-to-supervisor learning opportunities.
- Prioritize diverse workforce in hiring and offer career development opportunities support.[28, 31, 32]
- Provide IECMH staff with job-embedded professional development on cultural competence and working with diverse families.[17, 31]

State Policy & System Partners

- Conduct an environmental scan and/or workforce analysis to understand the current IECMH workforce landscape, identify facilitators to expanding IECMH capacity, and support the creation of an IECMH workforce development plan.[2, 4, 7, 4, 10, 15, 26]
- Leverage investments and identify policies to increase accessible, ongoing, and tailored IECMH-specific training and ongoing professional development supports, including cohort models for provider-to-provider support.[2, 4, 7, 17, 26, 29, 30]
- Partner with higher education institutions to incorporate IECMH curriculum and assure foundational IECMH knowledge is included in mental health graduate programs.[28]
- Identify and implement strategies to recruit and support providers from underserved communities and increase capacity for cultural match to populations being served.[1, 7, 17, 31, 32]

Resource Spotlight:

Alliance for the Advancement of Infant Mental Health

The Alliance for the Advancement of Infant Mental Health (Alliance) is a global organization that partners with associations of infant mental health so that associations can support, grow, diversify, and advocate for their local infant & early childhood mental health-informed workforce. Below highlights some of the Alliance's goals aimed at strengthening the IECMH workforce:

- Support professionals who serve pregnant people, infants, young children, and families through workforce development.
- Identify funding to strengthen and support the IECMH field.
- Convene policy makers and advocates to serve as champions for policies and practices that foster the healthy development and well-being of young children and those who care for them, with an emphasis on policies that integrate IECMH practices into early childhood service delivery across systems.
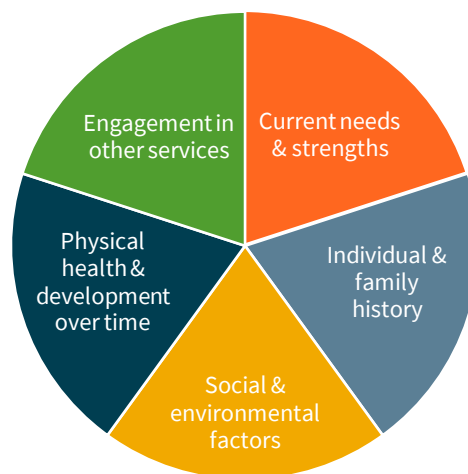
The Washington Association for Infant Mental Health represents Washington state as one of the 35 state associations that are members of the Alliance.

Mental Health Assessment for Young Children

Mental health assessment (i.e. intake evaluation; psychiatric diagnostic interview) is the process for gathering information to assess whether there is a need for mental health services and helps create a plan for care.

When providing these assessments for young children, mental health professionals must also consider the unique developmental stages for this age group. Unlike adults and older youth, young children often do not have the capacity to share their experiences and express themselves coherently through verbal language. Professionals need to create child-friendly spaces with age-appropriate toys and tools to support children's engagement in the session. For a full picture of the child in different contexts, professionals may need to gather information from multiple caregivers and other allied professionals who are a part of the child's life (e.g., early learning educator, pediatrician, developmental specialist). A critical component to young children's mental health is understanding the caregiver-child relationship; therefore, professionals benefit from the chance to observe the child with each of their caregivers as well as time to meet with caregivers individually to learn about their own needs and supports. (Srinath et. al., 2019)

Assessments include topics such as:

Pie chart sections: Current needs & strengths; Individual & family history; Social & environmental factors; Physical health & development over time; Engagement in other services

Young children's mental health needs often manifest and present differently than older children and adults; therefore, best practice recommends use of developmentally appropriate diagnostic tools that reflect the unique symptoms and classifications of mental health disorders for young children. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) is the internationally accepted system for developmentally appropriate assessment and diagnosis of young children's mental health. The multiaxial structure supports gathering the information needed to achieve a full picture of the child and their caregivers. Professionals often require multiple sessions to gather all the relevant information (typically 4 – 6 sessions).

Key Topic: Implementation of MHAYC

Following a recommendation of the Children & Youth Behavioral Health Workgroup – Prenatal to Five Relational Health Subcommittee, the Washington State Legislature passed legislation (2021 c 126 § 2) to align Apple Health policies with best clinical practices for mental health assessment for young children (MHAYC).

reimbursement for **multi-session assessments**

reimbursement for **provider travel** costs for sessions in home or community settings

Requiring providers to **use the DC:0-5**

The following topics highlight innovations to adopting multi-session assessments and use of the DC:0-5, as well as implementation challenges.

Implementation of MHAYC - Best Practices

Summary: Providers shared about their successes in implementing MHAYC policies, including the use of multi-session assessments and the DC:0-5; implementing these policies allowed them to gather the information needed to support developmentally appropriate assessment and diagnosis. Providers also noted specific strategies that were useful in organizational implementation of these practices, such as attending DC:0-5 training, adjusting assessment workflows and staffing, and updating EHRs.

Multi-session assessments (n=33)

Multiple providers noted that they were now providing multi-session assessments and the positive impact it had on their practice.

- *We really appreciate the five sessions, because now we're able to meet with the birth and the foster parent, and visit the childcare center, seeing every caregiving relationship.*

- *Allowing for up to 5 sessions for the intake assessment allows us to obtain the info that is needed. We certainly know it can take that long for a young child. Knowing that it can be billed up to five times is great, when it used to be only once per year.*

Providers noted that the transition from single session assessments to multi-session assessments did require organizational culture shifts, as well as operational shifts in workflows, scheduling, and explaining the assessment process to caregivers.

- *There were some bumps when we started doing multiple sessions, but now it's mostly working. We have a workflow created, but it's still a culture shift. For so long, we had to do intakes[10] that were two hours, and that was it. So, we need time to create that culture shift.*

- *When the team schedules an intake, they now just schedule the five sessions. Because people just want to check it off the list, they don't want to do five, so it's good to have it on the calendar.*

- *Families were used to a one-session assessment. We saw a 50% drop off rate after we started doing multi-session assessments. So, we changed the script to explain why, and now we book two sessions to start with.*

ⓘ A year's progress

Preliminary analysis of Apple Health claims data suggests that in the first year of MHAYC implementation, the percentage of assessments for young children that were completed over multiple sessions increased from 6% in 2021 to 10% in 2022 (*see Appendix G*).

Use of the DC:0-5 (n=25)

Many providers also noted they had transitioned to using the DC:0-5, and that the use of this diagnostic manual helped to guide improved assessment practices for young children and families.

- *Before [using] the DC:0-5, we didn't know what to look for. There was thinking that if a 3-year-old comes in, they don't meet access to care, because it's not in the DSM [Diagnostic & Statistical Manual].*

---

[10] Colloquially and in some billing guidance, the phrase "intake" is sometimes used to refer to the process of a mental health assessment.

- *We base our own psychosocial assessment on the DC:0-5, as it is the best practice, multidimensional, and allows us to note, family, strength, and innovations.*

🔍 **Making the case: Using the DC:0-5**

While the DC:0-5 may be a new practice to some providers, a 2022 survey completed by some behavioral health agencies who serve young children in Washington state found that 75% of these agencies require or recommend the use of the DC:0-5 (Fabian et al., 2023). Surveys and focus groups conducted with providers who have attended DC:0-5 training through the IECMH-WC found that providers shared the value of the DC:0-5 multiaxial approach to assessment and diagnosis and how it has increased their confidence in providing assessment and diagnostic services to very young children, their engagement with families, and their intentionality around gathering comprehensive information related to assessment (IECMH-WC, 2023).

Updating EHRs (n=9)

A few different providers also shared about how they had updated their electronic health record (EHR[11]) system to align with MHAYC practices, to align with multi-session assessments, the multi-axial system of the DC:0-5, and/or DC:0-5 diagnoses.

- *It used to be in our EHR that there was a set assessment template that took one session. It was a lot of work to document a multi-session assessment, with lots of copy and paste. We wanted to eliminate those technical struggles, because we want people to want to be part of the IECMH team. Now with the update, we can submit a different note for each session and keep the intake open for five sessions until it's complete. It makes more sense.*

- *We just added an additional category to our mental health assessment. Our person who does Credible (EHR) sat down and added in each different [DC:0-5] axis and put in some of the DC:0-5 forms. Getting it in there is the hard part, but it's going to make it much faster. It was actually our Compliance Officer who motivated [the update]; they said, 'This is what's in WAC[12]: it has to be developmentally appropriate, and DC:0-5 is developmentally appropriate.'*

IECMH-specific assessment staffing (n=5)

In many large community behavioral health agencies, a separate assessment team or assessment provider conducts the assessment, before transitioning the client to the service provider. While this can improve workflows for the majority of clients, it can create complications for MHAYC practices, particularly in ensuring assessors have the capacity to schedule multi-session assessments and have DC:0-5 training. One way that agencies addressed this challenge was by having the treatment provider conduct the assessment for young child clients.

- *For our 0-5 kids, we take them away from our assessors, and [the treating clinician] keeps client from assessment to services.*

---

[11] An electronic health record (EHR) is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider's office and can be inclusive of a broader view of a patient's care.

[12] Washington Administrative Code (WAC) governing the licensure of behavioral health agencies states that behavioral health assessments must be 'age-appropriate' and utilize either the DC:0-5 or the DSM-5 (WAC 246-341-0640)

Implementation of MHAYC - Challenges

Summary: Providers noted a few challenges to implementation of MHAYC policies, primarily the need to restructure billing practices and workflows. The most prevalent challenge was lack of alignment between organization's EHRs and the use of multi-session assessments and the DC:0-5, especially given the high costs and complexity to update EHR systems.

Multi-session assessments (n=15)

Some providers noted that they experienced challenges in implementing multi-session assessments specifically. Those that did noted that changes were needed to billing patterns, organizational culture, and workflows/scheduling, and electronic health records.

- *We don't schedule intakes; we do walk in intakes. So, scheduling multiple sessions would be a change.*

- *Our agency is still doing the assessment in 1 session. We're aware of the five-session allowance, but we're still in need of a culture shift.*

Use of the DC:05 (n=16)

Some providers noted challenges with implementing use of the DC:0-5, such as the need to send additional staff to DC:0-5 training or a lack of alignment between the DC:0-5's multi-axial structure and their electronic health records or standard assessment processes.

🕊 Centering Equity: Culture and Diversity in the DC:0-5 Training

While overall feedback about the DC:0-5 was been positive, it was noted that there was room for improvement in how the DC:0-5 training approached issues of culture (n=3).

- *DC:0-5 training didn't always translate well into practice, particularly for highly stressed, low-income families. The cultural component particularly is challenging to translate.*

Surveys and focus groups conducted with providers who have attended DC:0-5 training through the IECMH-WC also found that there is more work to be done to ensure that DC:0-5 training is grounded in principles of diversity, equity, inclusion, and belonging (IECMH-WC, 2023), and a study of providers working in Los Angeles County's community behavioral health system found similar challenges (Williams et al., 2023).

Assessment staffing (n=11)

As noted above, agency workflows for which staff complete the assessment are a key consideration in successful implementation of MHAYC practices. Some providers noted that this was still a challenge they were experiencing.

- *The way our agency does intake assessment, you see whoever is available, whether they serve adults or kids. It's hard enough to get adult clinicians to do child intakes; it would be really hard to get them to DC:0-5 training.*

- *The person who does the intake is not always the clinician [who sees the family]. If we could integrate some of the assessments [with the treatment provider], then that would streamline things.*

Top Desire

Electronic Health Records (n=39)

The most common challenge providers noted in implementing MHAYC practices was lack of alignment with electronic health records (EHR). Because EHRs are usually designed with either medical practitioners or adult behavioral health providers as the primary audience, most EHRs do not come programmed specifically for serving the early childhood population. This lack of alignment creates additional administrative burden for providers.

> - *IECMH is not part of a "normal EHR build," unless the organization has this population as their priority. EHRs need to be updated to be more intuitive and user-friendly for IECMH providers. The more efficient our tools are, the more time we can spend with families.*

Specifically, EHRs may need to be updated to allow documentation of multi-session assessments and use of the DC:0-5, including DC:0-5 diagnoses and the multi-axial structure.

> - *Our EHR is not set up to allow for multiple intake appts. I would have to create a new document each time I meet with someone.*
>
> - *These [EHRs] come with certain assessments built in, but the [EHR] companies don't have an understanding of infant early childhood mental health, so it isn't phrased in ways that are compatible.*

While not exclusive to making updates to align with IECMH services, providers did note some of the barriers that organizations may experience when trying to update or customize their EHR, such as introducing new changes to an already complex system and the costs associated with updates, which must be paid for and made by each individual agency.

> - *If I want assessments for young children, I have to add them myself, and then it only helps [my organization].*
>
> - *This is a small population, so making expensive changes to our EHR for just this group is not cost effective.*

> **Making the case: organizational considerations for using the DC:0-5**
>
> Surveys and focus groups conducted with providers who attended DC:0-5 training through the IECMH-WC also found providers had concerns about their ability to integrate the use of DC:0-5 into their work when they face practical challenges in organizational-level policies and procedures, including time for multiple assessments and documentation processes (IECMH-WC, 2023). A study of providers working in Los Angeles County's community behavioral health system found that providers faced similar challenges (Williams et al., 2023).

Key Topic: Approaches to Gathering Necessary Information

MHAYC policies require providers to use the DC:0-5 for assessment and diagnosis. While the policy does not require specific documentation around what information needs to be collected as part of the assessment, the multiaxial structure of the DC:0-5 provides broad categories of information that are necessary to inform diagnosis. Mental health professionals may use a variety of approaches to gather the necessary information across these categories, including interviews with caregivers, consult with other providers, observation, and use of standardized instruments.

Many agencies have a standard assessment process for information gathering and templates for documenting the necessary components used for all clients. These processes are often developed to align with agency policies, state and local regulations, and standard insurance requirements for establishing medical necessity.

Approaches to gathering necessary information - Best Practices

Summary: Providers noted that they took different approaches to the process of gathering necessary information for mental health assessment. Some providers utilized a standard assessment process designed for all ages but adapted their responses or utilization to better fit the needs of young children and families. Other providers developed assessment processes specifically for young children and their families, which often included interviews with caregivers, consultation with other providers, observation, and use of standardized screening and assessment tools.

Creating IECMH-specific assessment processes (n=19)

Other providers noted specific assessments processes and procedures for mental health assessment of young children. These processes often took advantage of the allowance of multi-session assessments, and they used a variety of approaches to gather the necessary information for their assessment, including interviews with caregivers, consultation with other providers, observation, and use of standardized screening and assessment tools.

- *Our IECMH assessment takes 5 sessions, and most are home visits. We do observation in multiple settings, including in the school, at childcare, and with extended family, as applicable. We conduct two screeners at intake and collect the ASQ-SE[13] from preschool if available.*

- *Our assessment takes 3-5 sessions and uses the DC:0-5. We do a developmental evaluation, clinical interview, and assessment of parent and child. We do home-based observation and daycare observation, and also observe multiple relationships.*

To see additional examples of reported IECMH-specific assessment processes, please see Appendix H: IECMH-specific assessment processes.

Adapting standardized assessment processes for IECMH needs (n=14)

Some providers utilized a standard assessment process designed for clients of all ages, but they were able to adapt their responses or utilization to better fit the needs of young children and families. This was easiest for organizations who already included questions that are especially relevant for early childhood population as part of their standard assessment process.

- *We typically embed asking about prenatal care, birth history, and early development, in intakes for children in general. As kids get older, it's less and less present, but for a 5-year-old, it's right there in front of mind for the parent.*

- *We use the standard assessment, but we have additional axis info to pull in. Early childhood specific screening tools are used to support diagnosis, and a more comprehensive case summary is included.*

Screening & assessment (n=75)

Standardized instruments provide useful information for identifying needs and strengths to inform a comprehensive assessment, though they are not sufficient at determining a diagnosis. Many providers reported the use of standardized screening and assessment tools as part of the mental health assessment process for young children. Providers used tools to assess behavioral/social-emotional needs, development, caregiver-child relationships, adverse/traumatic experiences, social determinants of health, caregiver behavioral health, and level of care (see Figure 2).

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[13] Ages & Stages Questionnaires: Social-Emotional, Second Edition (ASQ®:SE-2)

Figure 2. Number of times of specific training topics were identified as a need by providers
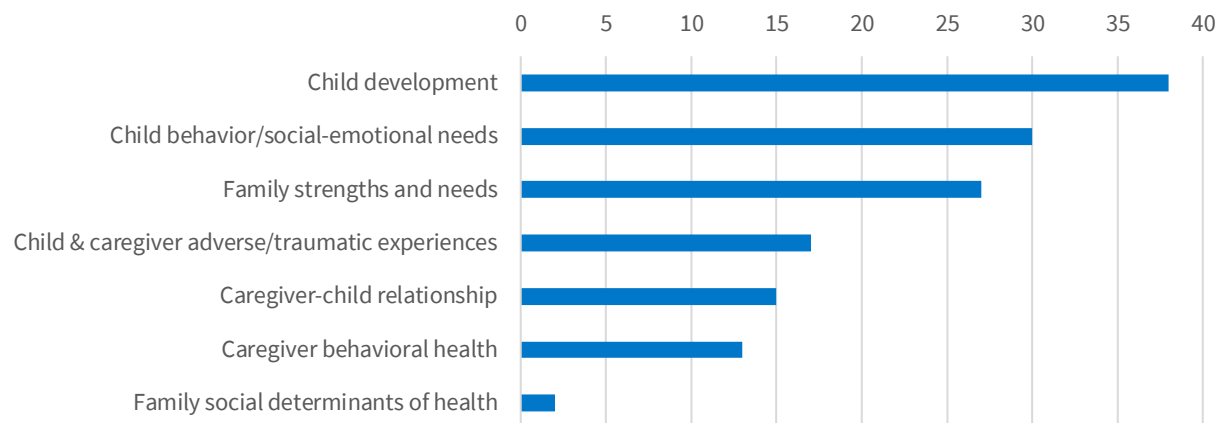
For a list of the specific tools referenced by providers, please see Appendix I: Screening and assessment tools.

Gathering collateral information from allied providers (n=28)

A thorough mental health assessment includes gathering information about child functioning across settings and caregivers over time. This often necessitates partnership with other professionals and disciplines. Providers reported working with primary care, early childhood education, and child welfare.

- *I've also found that there's a greater need for collateral information from other providers serving the same child; this is obviously important for all ages, but the developmental considerations and unique caregiving relationships (for example, child care providers) make it critical during the B-5 period.*

Observation (n=26)

Observations provide critical insights on the caregiver-child relationship and the child's developmental functioning. Providers commented about the importance of observing children and caregivers in their natural environments (i.e., in home and community settings) and of observing across different child-caregiver dyads.

- *We do observation in the home of each caregiver, as naturally as possible.*

- *For observation, we may use the Crowell [procedure] or What to Look for in Relationships, and the Dyadic Parent-Child Interaction Coding System (DPICS) is used for PCIT [Parent-Child Interaction Therapy][14].*

Providers noted the use of several standardized observation procedures, including[15]:

Dyadic Parent-Child Interaction Coding System (DPICS) (n=2)	Parenting Interactions with Children: Checklist of Observations (PICCOLO) (n=3)	What to Look for in Relationships (WLF) (n=1)	The Crowell Procedure (n=1)	Parent Child Interaction (PCI) Feeding & Teaching Scales (n=1)

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[14] Parent-Child Interaction Therapy (PCIT)

[15] Observation procedures referenced by providers are included in Appendix L: Additional Resources.

Conducting caregiver-only assessment sessions (n=8)

An essential component to mental health assessment for young children is the participation of parents/caregivers. Caregivers provide critical information regarding the child's needs and strengths, family and environmental factors, and their own health and well-being.

- *It's important to have the time to meet with the parent only, for going over the trauma history of child without the child present, and also to get the parent's trauma history, which is activating, so it's not a great practice to do in front of child.*

Approaches to gathering necessary information - Challenges

Summary: Providers experienced challenges in gathering necessary information to inform assessment and diagnosis for young children. Many providers shared that the standardized assessment process used at their organization did not feel aligned with IECMH best practices, and multiple providers voiced the desire for examples of standardized assessment processes specifically designed for the infant-early childhood population. Providers also shared challenges around the use of screening and assessment tools and with gathering relevant collateral information from other allied providers.

Top Desire

IECMH-specific assessment processes (n=49)

Many providers shared that the standardized assessment process used at their organization did not feel aligned with IECMH best practices, and multiple providers voiced the desire for example standardized assessment processes specifically designed for the infant-early childhood population.

- *We do not have a specific DC-0-5 assessment; we have a standard biopsychosocial [assessment] that is used agency wide. Many questions do not apply, and many developmental questions are missing. We are attempting to create a structure which includes the parent-child relationship and observation.*

- *It would helpful if we could have a sample infant mental health assessment write up or guidance as to what information to include and what information that might not be included with 6+ years that should be included with 0-5.*

- *We would like examples of templates that have already been applied, so we don't have to start from scratch.*

Providers shared that an ideal IECMH assessment process form would be '*well-defined, yet flexible,*' and would be aligned with both the DC:0-5 and behavioral health licensing and accreditation requirements.

- *We'd like a Washington specific, DC 0-5 specific intake example, that is also WAC [Washington Administrative Code] compliant.*

Providers also noted that there may be barriers to adapting assessment processes for IECMH in organizations that primarily serve adults and older children.

- *There's a balance having a new special thing for young kids and having to learn three different assessment [processes], because most therapists work with all ages of kids. But, on the other hand, it's nearly impossible to have a one-size-fits-all assessment.*

- *We actually used to have an adult [assessment] form and a kid [assessment] form, but we merged them. But we don't have a huge B-5 population; if we did, we would need to make adjustments.*

Top Desire

Screening, assessment, and observation (n=56)

Many providers shared that they experienced challenges in the use of developmentally appropriate screening and assessment tools with young children and their families. The primary challenge that providers shared was a lack of awareness of appropriate tools for the early childhood population (n=30).

- *There's no recommended set of screening tools. We feel left on our own to figure it out. I appreciate the flexibility, but it is challenging.*

- *We have tools for older children, but we don't have a standard list for young children. As a supervisor, I have to find time in my day to research another tool, which would be great if I didn't have to supervise. I have to figure out which ones are validated, and inexpensive. I want to get familiar with tools before implementing. It would be great if someone could give us a little packet. What are people using and can we have copies?*

🕊 Centering Equity: Culturally appropriate screening tools

Culturally and linguistically relevant tools are necessary to improve family-centered screening and assessment practices (Perigee Fund, 2021b), and providers noted a desire to know which early childhood screening and assessment tools are culturally appropriate (n=2).

- *Which screenings are culturally competent? There was a mandate[a] for the state to have a list of culturally competent screening tools; that just resulted in the same old list, because nothing is culturally competent.*

Providers also noted a need for training in using standardized screening, assessment, and observation tools (n=19).

- *Back in the day, we used to get training on how to use them all the core screening measures. But they were only ever for older children.*

- *What are the best ways to use the screening/assessment tools? It would be really nice for all the agencies if there was training available.*

The last major challenge that providers expressed was around the costs associated with purchasing these tools, as well as the materials and software that some tools required (n=10).

- *The ADOS[16] is very strict about not using damaged toys, but that can be expensive. It feels like gatekeeping, like it's a privilege to get services.*

Top Desire Gathering collateral information (n=12)

While providers often recognized the need for collateral information to inform a comprehensive assessment for young children, they did experience barriers in gathering this information. A key barrier was challenges in connecting with and receiving relevant information from other allied providers, such as primary care providers and child welfare providers.

- *We [mental health providers] need access to the UDS [universal developmental screening] system[17]. It's difficult to access developmental screening records from the primary care providers. It takes a long time to get a response from them.*

- *I'm not sure how much good info we get back from PCPs [primary care providers]; they are busy. Then sometimes they send us all their medical records, like that the client got a sinus infection 6 months ago, which is not really relevant.*

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[16] Autism Diagnostic Observation Schedule (ADOS)
[17] Universal Developmental Screening — A Strong Start for Children
[a] Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Documenting caregiver information (n=9)

When completing a mental health assessment for young children, mental health providers learn information about family circumstances, including caregiver medical and mental health history. This information is important to understanding factors that may be impacting the young child's health and well-being, though it can also raise concerns about how to ensure documentation follows privacy regulations and is sensitive to the other caregivers who may have access to the child's medical records.

- *The challenge with the medical model is that the record is for the identified patient, rather than being about the dyad or the relationship. It's difficult to include caregiver content in the chart.*

- *We give the information back to the parents, and then they can decide what they do with that – we don't keep it in the file. CPP [Child Parent Psychotherapy] has us collect the parents' trauma history, but we work with divorced parents and those with domestic violence issues, so it's not safe to keep it in our records. We just document that we had the conversation.*

Mental Health Assessment for Young Children - Taking Action

The recent investment and implementation of the Mental Health Assessment for Young Children (MHAYC; SHB1325) is a notable accomplishment in Washington's efforts to align with IECMH best practices. It marks the achievement of the Children and Youth Behavioral Health Workgroup's 2016 – 2020 recommendation to "identify mental health assessment, outcome, and diagnostic tools for children ages 0 – 5. These efforts are built on years of advocacy to align with other state and national recommendations and strategies to promote developmental appropriate assessment and diagnosis, such as:

- Recommend and/or require the use of DC:0-5.[7, 14, 20, 25, 30]
- Create a state-specific DC:0-5 crosswalk.[20, 30]
- Train providers in using the DC:0-5.[13]
- Allow use of ICD-10 Z codes for primary diagnosis.[20]
- Reimburse for three or more mental health assessment sessions.[30]

Providers and agencies may utilize MHAYC resources to update policies and align practices, though equitable statewide implementation may require additional investments. Further, providers elevated the desire for shared guidance and resources on developmentally appropriate tools. These strategies are based on the best practices and challenges identified by providers, as well as approaches identified in literature. For literature references, please see Appendix J. Taking Action References.

The following actionable steps align with the strategies and approaches for HCA's IECMH Priority 2.

Mental Health Providers

- Attend a DC:0-5 Clinical Training and incorporate into your mental health assessments with young children.
- Review and share with agency leadership HCA's MHAYC and IECMH resources to support incorporating IECMH best practices.
- Participate in IECMH-WC professional development opportunities focused on building skills in assessment and observation.

Agency Administrators

- Choose a best practice to support implementing multi-session assessment and use of the DC:0-5, such as dedicated efforts to shifting agency culture about the assessment process, aligning intake staffing and workflows, or updating electronic health record systems.

- Encourage staff, especially assessment staff, to attend HCA webinars and DC:0-5 Clinical and Overview Trainings.
- Develop IECMH-specific intake processes or adapt current templates to align with IECMH best practices (Appendix H) and use of IECMH-specific tools.
- Explore funding mechanisms to support collateral information gathering.
- Provide **DC:0-5 Casebook** (see below) as a resource to support staff in building competencies in assessment and diagnosis for young children. Update agency workflow/s to support information gathering best practices and use of IECMH-specific tools.

State Policy & System Partners

- Identify and address barriers to increase use of culturally and linguistically relevant screening and assessment tools, including new policies, investments, or adopting a list of standard IECMH-specific tools.[1, 17, 26]
- Establish cross-system leadership from providers, professional associations, and state agencies to collaborate on developing a standard IECMH intake form that addresses IECMH best practices, clinical and ethical standards, and state regulations.
- Provide investment to support providers and agencies in updating EHR systems to align with MHAYC the policy.[13]

Resource Spotlight:

The Casebook for the DC:0–5 (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood)
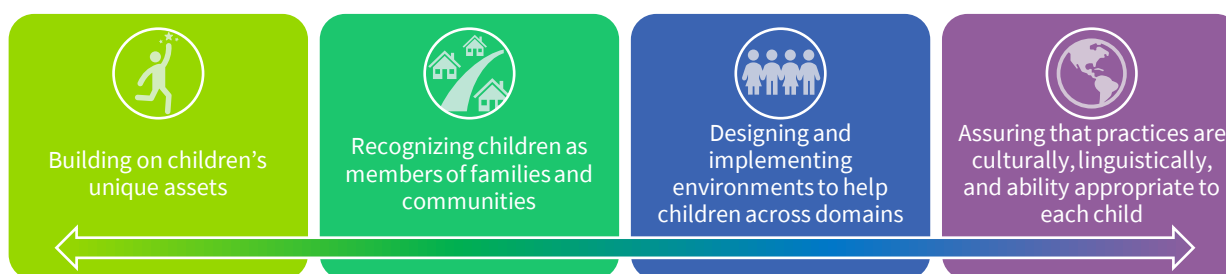
The DC:0-5 Casebook is a compilation of case studies as a companion volume to DC:0–5. It is designed to strengthen understanding of clinical disorders in infancy and early childhood, and to help clinicians better understand the application of the multiaxial framework and culturally sensitive/relational approach to diagnosis that is fundamental to DC:0–5 Featuring over 15 clinical cases written by leading IECMH professionals from across the globe, each case study provides:

- Historical background, cultural context and key clinical observations made.
- Detailed diagnostic summaries and practical guidance for moving cases from assessment to formulation.
- Tools, worksheets, and other resources that support the diagnostic formulation process.

Mental Health Treatment for Young Children

Mental health treatment for young children is designed to alleviate the distress and suffering of the young child's mental health problems, and support the return to healthy development and behavior by enhancing the quality of the caregiver-child relationships. A best practice when providing mental health treatment to young children is using dyadic approaches. Therapeutic dyadic approaches are a form of family therapy involving both the young child and their caregiver/parents with the mental health professional providing interventions that encourage positive interactions, enhance caregiving capacities, and promote health social-emotional development.

Similar to the need for developmentally appropriate diagnostic tools, mental health professionals require different resources when working with young children to ensure services are developmentally appropriate. Though developed for early learning, the National Association for the Education of Young Children's (NAEYC) position statement on developmentally appropriate practice provides a useful lens for applying to the IECMH space. It states that "methods that promote each child's optimal development and learning through a strengths-based, play-based approach to joyful, engaged learning," and it further highlights the importance of:

Building on children's unique assets	Recognizing children as members of families and communities	Designing and implementing environments to help children across domains	Assuring that practices are culturally, linguistically, and ability appropriate to each child

Adapted from NAEYC, 2020

Mental Health Treatment for Young Children - Best Practices

Summary: Providers noted several best practices for serving young children and families, including the use of dyadic approaches that center the importance of caregiver-child relationships, evidence-based practices specifically designed for young children and families, providing on-site child care, and using developmentally appropriate spaces and materials.

Dyadic approach (n=46)

Many providers noted their dyadic approach to IECMH treatment, which centers on the importance of caregiver-child relationships. Though dyadic approaches primarily include joint child-caregiver sessions, providers may also provide caregiver-only sessions to support the caregivers' ability to meaningfully participate in sessions with their child.

- *How do you treat a child 0-3? You're not; you're treating the parent and the relationship. So, you're not just holding the child, you're holding the caregiver too.*

- *In our B-5 work, more time is spent with caregivers. We are relationship focused rather than focused on the individual.*

Use of EBPs (n=43)

"Evidence-based practices (EBP) are interventions for which there is scientific evidence consistently showing that they improve client outcomes" (Drake et. al., 2001). In the mental health field, EBPs are highlighted as models to care with evidence demonstrating their effectiveness at reducing symptoms or addressing mental health challenges. EBPs are important when considering specialty populations, such as young children, to ensure models are addressing age-related needs and the relational-context between the young child, their caregivers, and the environment (Hoagwood, 2001).

Providers noted the use of EBPs designed for young children (see Figure 3 below). Some providers also shared successes in documenting the use of EBPs[18] and in receiving enhanced rates for providing EBPs to fidelity.

- *Because we are doing PCIT to fidelity, we are able to bill the session as an evidence-based practice, and we get a higher rate from the MCOs. Once a therapist is trained in PCIT, their profile is updated to reflect they are able to bill for that enhanced EBP rate.*

Figure 3. Number of times the use of specific EBPs were expressed by providers [19]
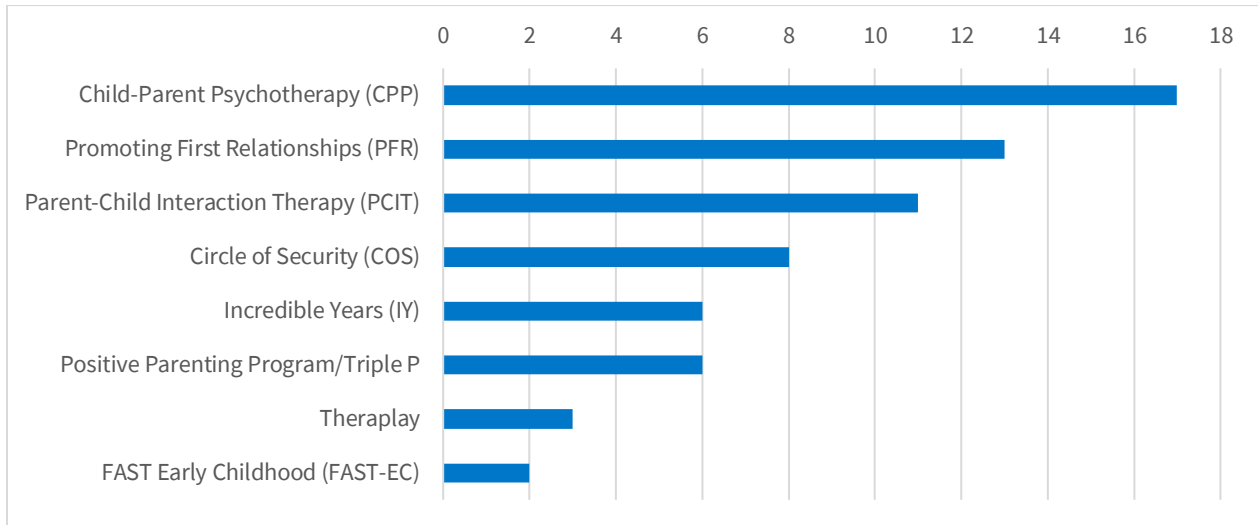
> ### 🕊 Centering equity: culturally based practices for healing
>
> Providers, particularly Tribal providers, noted the importance of culturally based practices and interventions as a best practice for supporting families in their healing process (n=4).
>
> - *It's so great having the Canoe Journey[a] back. We also used to have elders in the early learning center reading and telling stories, and the Fatherhood is Sacred[b] men's group. We're hoping to reinstate these.*
>
> Providers noted that the use of some evidence-based practices that are not aligned with cultural values and experiences can harm communities (n=3).
>
> - *CBT [Cognitive Behavioral Therapy] doesn't always work with the BIPOC [Black, Indigenous, and People of Color] community; it comes from a very privileged perspective.*
>
> - *Our community is disconnected from predominantly white clinical landscape; mental health looks different from a cultural perspective, and their needs are not being met.*

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[18] Apple Health providers providing mental health services to children are encouraged to document the use of EBPs using the Evidence Based Practices Reporting Guide, provided by the Evidence Based Practice Institute (EBPI). EBPI provides resources to promote the use of evidence-based practices in Washington State.

[19] Links to learn more about the EBPs included in the chart below are included in Appendix L: Additional Resources.

[a] Tribal Canoe Journey/Paddle to Seattle

[b] Fatherhood is Sacred

On-site child care (n=8)

Providers noted the benefit of providing onsite child care as a way to assure families ability to participate in sessions. Families may have other children who are not involved in the treatment sessions or providers may need to meet with the caregiver alone to support their engagement in joint child-caregiver sessions. Offering child care in the same place as services reduces barriers for families while also ensuring providers are able to adjust to the needs that are present during the session.

> - *We have a community organization that approached us to offer this service. Historically, they provided child care services for child welfare, and they just had more volunteers than needed. We're using it for the intake for children under age 10, because it allows us to offer a parent-only session. We let them know in advance how many children to expect, so they know how many volunteers to send. They provide all the equipment, and they recruit and train all the volunteers.*

Developmentally appropriate space and materials (n=6)

Professionals need spaces designed for children when services are provided in agencies to support engagement. Further, recognizing that play as an essential ingredient to care and the unique aspects to each children's development, a variety of toys are needed to meet the developmental stages of children across the birth to five age lifespan. Often mental health agencies have designed their spaces, purchased their materials, and developed policies with older youth and adults in mind. In order to provide developmentally appropriate care for young children, agencies may need to make structural changes, invest in new furniture and toys, and revise policies.

Mental Health Treatment for Young Children - Challenges

Summary: Providers noted that more training and professional development supports are needed to increase their knowledge and skill around developmentally appropriate treatment services. Additionally, the costs associated with certain aspects of developmentally appropriate care, such as on-site child care and toys were also noted as barriers.

Top Desire

Training and professional development supports for developmentally appropriate and dyadic treatment models (n=30)

Providers shared that they needed to build their knowledge and skills around developmentally appropriate and dyadic treatment services for young children and families; the need for training and other professional development supports, like supervisor coaching, was noted as key addressing this challenge.

> - *I get really nervous doing treatment for kids that are young, especially if they can't talk to me and tell me their feelings. I need to know how to have conversations with parents in a better way.*
>
> - *Our main challenge is lack of training; we would love to have certified training for staff in PCIT [Parent Child Interaction Therapy], Circle of Security[20], or other models.*
>
> - *We need to start a program like CBT+ [Cognitive Behavioral Health Therapy][21] with follow-up support, but for IECMH. People feel like they get something out of it; they can say, 'I'm EBP trained.'*

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[20] Circle of Security
[21] CBT+ Learning Collaborative

> ## 🔍 Making the case: IECMH EBP training
>
> While comprehensive data on the need for IECMH is limited, several other Washington state-specific reports have pointed to unmet need in this area.
>
> - A 2019 survey of 875 mental health clinicians serving young children in Washington state found that fewer than 10% of providers had formal training in any of the IECMH EBPs) (Perigee Fund, 2021d).
> - A 2022 survey of behavioral health agencies (BHAs) in Washington state found that less than half of all BHAs who serve children younger than 6 provide dyadic treatment (Fabian et al., 2023).
> - Based on EBPI reports, only six instances of therapy sessions using Child Parent Psychotherapy have been reported since 2021.

A provider also noted they experienced challenges in reporting the use of EBPs through their billing/EHR system.

- *We try to follow the EBP reporting guidelines for CPP, but it's not working… Even though our clinicians have completed the CPP training, and we try to submit, it still ends in nothing [being reported].*

Developmentally appropriate space and materials (n=6)

Providers noted some challenges to offering developmentally appropriate spaces and materials, primarily related to uncertainty about what is needed to make space developmentally appropriate, the costs to build spaces and buy toys, and agencies policies that may not align with these best practices.

- *We are an FQHC (Federally Qualified Health Center)[22], so there are additional rules. We can't use stuffies because they carry germs, but those are the toys you need to conduct a developmental screening.*
- *For IECMH toys, historically, clinicians had to pay out of their own pockets. Now, we have a very small agency budget for this, which is the result of Best Starts for Kids funding[23]. This is wonderful for King County, but it's a huge disparity for other parts of the state.*

Providing onsite child care (n=2)

Though onsite child care is beneficial to support engagement, it is an additional cost to care that is not often needed or considered when working with older populations. Agencies may need to hire staff, modify space, and purchase additional materials. Additionally, agencies need to ensure they are following any state and local childcare regulations.

- *We have childcare, but since it's not a billable service, it's definitely a cost.*

Mental Health Treatment for Young Children - Taking Action

Washington Apple Health is one of 38 states that already allows for Medicaid reimbursement for dyadic family therapy (Burak, 2023). Achieving equitable access to quality, developmentally appropriate IECMH services relies on strategies and solutions to build workforce capacity and ensuring comprehensive reimbursement for all aspects of care. Providers and agencies can build the case for system solutions through documentation and billing practices that capture the need for services and current utilization of EBPs. Additional analysis may be needed to assess the full costs of care to inform future state and system investments. These strategies are based on the best

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[22] Federally Qualified Health Centers in Washington state
[23] Best Starts for Kids Prenatal to Five Strategies

practices and challenges identified by providers, as well as approaches identified in literature. For literature references, please see Appendix J. Taking Action References.

The following actionable steps align with the strategies and approaches for HCA's IECMH Priority 2.

Mental Health Providers

- Provide dyadic services when working with young children and involve all caregivers when possible.
- Document your use of IECMH evidence-based practices using the EBP reporting guide.[20]
- Build partnerships with Tribes and BIPOC by-and-for organizations in your region to identify opportunities to strengthen your culturally based practices and opportunities to expand access to young children in these communities.[32]

Agency Administrators

- Update your policies to support and promote developmentally appropriate dyadic care.
- Explore local partnerships and alternative financing to provide onsite childcare for caregiver only sessions.
- Ensure your teams are documenting use of IECMH evidence-based practices using the EBP reporting guide.[10, 20]
- Commit to making resources available to providers in adopting evidence-based models, such as release time for training, reduced caseload, and dedicated supervision.[16]

State Policy & System Partners

- Identify and implement strategies to build infrastructure and sustain access to evidence-based, dyadic IECMH services, including updating or creating new policies.[10, 20, 27, 31]
- Provide investment to support the operating costs for developmentally appropriate care, including onsite childcare, child-friendly spaces, and age-appropriate toys.
- Invest in research, pilot programs, and implementation evaluation of evidence-based models and culturally driven interventions to strengthen the evidence base, identify gaps, and inform scalable solutions in community-based mental health.[1, 10, 16, 17, 31, 32]

Resource Spotlight:

SAMHSA's Infant Early Childhood Mental Health (IECMH) Grant Program

As a part of its mission to reduce the impact of substance use and mental illness on communities, the Substance Abuse and Mental Health Services Administration (SAMHSA) funds programs to that promote and support early childhood mental health, including the IECMH Grant Program. The purpose of the IECMH Grant Program is to improve outcomes for children, from birth up to 12 years of age, by developing, maintaining, or enhancing infant and early childhood mental health promotion, intervention, and treatment services. As of 2022, the program had provided evidence-based mental health and related services to over 23,000 young children and caregivers.

Services in Home & Community Settings

The ability to provide services to children and families in natural settings (i.e. home and community settings) has been shown to be effective for young children and their families (Hoffman, 2016). It can provide the opportunity to gain greater understanding of the families' social and cultural experiences. This insight allows for tailored, individualized services for the child and their caregiver, though providers need to consider the advantages and disadvantages of these settings. Family preferences, safety, and confidentiality are key considerations that professionals should talk to caregivers about prior to offering sessions in home and community settings.

Services in Home & Community Settings - Best Practices

Summary: Providers shared their practices around providing services in home and community settings, including for the mental health assessment process for young children. They noted the positive impacts of seeing families in natural settings, such as better understanding of behavior in different contexts, as well as increased family engagement. Providers also shared specific strategies they used to cover the additional operating costs for and to ensure provider comfort and safety when serving families in their homes and communities.

Providing services in home and community settings (n=64)

Many providers noted that they provided services in home and community settings, and several noted it's unique value as a best practice, especially for families of young children.

- *In the natural environment, you catch natural moments as they are occurring. You are doing life alongside and making it therapeutic. It feels less like another task or a burden.*

- *Seeing families in their natural environment is more soothing. It helps put families at ease and promotes more engagement.*

Mental health assessments for young children in home and community settings (n=16)

A subset of providers also described their process for doing assessments, particularly for conducting observations, in home and community settings, and its value.

- *I observe in childcare and other places. Behaviors are different across different environments.*

- *The things you learn in the home are really valuable.*

Ensuring provider safety and comfort (n=23)

Providers noted that offering services in home and community settings introduces new dynamics to mental health services, that are often not present in office-based settings.

- *It's a whole different thing to sit on a pile of laundry or wonder, 'what is that smell?' and still do your therapy.*

They noted a number of different strategies to ensure their teams felt comfortable and confident going into clients' homes, many of which involved different mechanisms for ensuring provider safety.

- *When we do it in [home & community settings], we have a whole procedure, with screening questions about animals in the home, etc. Because doing an intake in the home is unique, we screen on a case by case.*

- *We have a check in check out policy at [our agency]. You send an email to admin that you are in the home. If you don't check out, the admin initiates checking on you, and if they don't hear from you, they will call your emergency contact. It has only happened once, and it is not to micromanage where you are; it's for safety.*

- *You have to have good policies and procedures in place for home visits.*

The top strategies mentioned by providers for ensuring provider safety included:
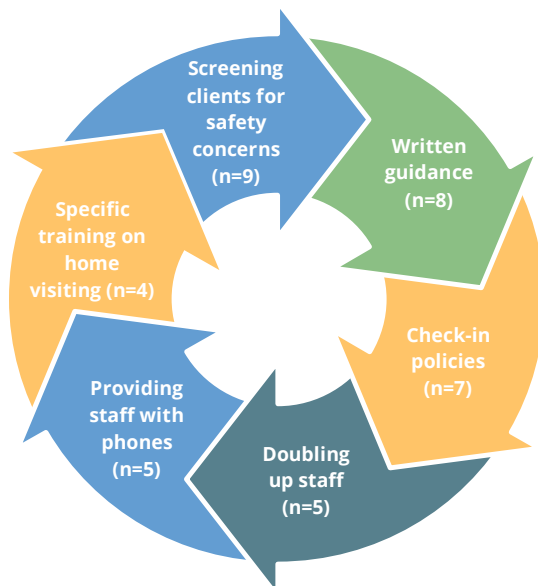
Organizations who provided home/community-based services through other specialty programs, such as Early Support for Infants and Toddlers (ESIT), early childhood home visiting, Wraparound with Intensive Services (WISe), or mobile crisis response, were often at an advantage, as they had background knowledge and resources about how to provide services in home and community settings.

> - *Our agency used to provide mobile crisis services, so we plan to simply adapt our safety guidance & protocols to apply to home visits for B-5 assessments. Our peers and case managers also regularly work with clients in the home & community setting, so those policies and procedures would apply similarly with open families getting 0-5 services.*

Addressing increased costs (n=12)

Providing services in home and community settings introduces new costs, such as mileage, vehicle maintenance, and the impact of service-related time due to time spent traveling to home and community settings. Organizations developed strategies to address these costs, such as developing different productivity or caseload standards or negotiating higher rates with managed care organizations (MCO) for providing services in home and community settings, providing agency cars, and reimbursing providers for gas mileage and liability insurance.

> - *Some of our programs are paid different rates based on whether the service is in the office or the community.*
>
> - *All our services are home and community based. So, to allow time for travel, we have lower caseloads.*
>
> - *We pay the difference in liability insurance; providers just need to show us their insurance bill before and after.*

Services in Home & Community Settings - Challenges

Summary: While providers often recognized that providing services in home and community settings was a best practice, they experienced many challenges, including the need for additional supports to ensure provider comfort and safety. Providers especially elevated the increased costs associated with these services, particularly the impact on the amount of time providers need to spend traveling to home and community locations. Even for the mental health assessment process, where policies were specifically designed to offset these additional costs, providers shared that the fact that reimbursement only covered milage, lack of awareness of the reimbursement process, and the administrative burden associated with the process were all barriers to implementation.

> - *It is evidence-based that home visiting has a huge benefit: providing care flexibly and in the child's main environment. Yet going to homes is time consuming, expensive, and it is higher risk work for providers; thus, requiring additional training for staff, safety protocols, and screening. It's all at odds.*

Increased costs (n=74)

The primary barrier to providing services in home and community settings was the additional costs associated with these services.

> - *Traveling to families [in rural areas] with limited schedules is a challenge. Also, paying for gas upfront and waiting to be reimbursed is hard.*

- *Travel is hard because there are so many costs – mileage, travel time, and the reduced capacity.*

Impact on service-related time (n=35)

The primary cost driver for services in home and community settings was the impact on service-related time, given the additional time it takes for providers to travel to home and community settings. This was noted as a key challenge, as many providers felt that impacts of service-related time were not reflected in the rates of service and that it limited their ability to see clients.

- *Reimbursements for time and travel for home-based visits is a challenge. Home visits address one barrier (access/transportation) but cause another barrier, which is the reduced number of families that can be served.*

While mileage costs (n=4) were also noted as a component of the total cost to provide home and community services, they were seen as a much smaller component of cost, compared to productivity and travel time.

Mental health assessments for young children (MHAYC) in home and community settings (n=26)

MHAYC policies attempted to address the barrier of these costs by providing mileage reimbursement for travel when mental health assessments for young children take place in home and community settings. However, given the fact that travel time is seen as a larger cost component than mileage, it may not be surprising that several providers shared the fact that MHAYC reimbursement only covered mileage (and not travel time) was a major barrier to implementation.

- *The biggest issue with travel is not getting paid for the therapist's time. If we're only paid for mileage, it's basically not worth it.*

- *Without reimbursement for travel time, we won't go into community for assessment.*

ⓘ A Year's Progress

Preliminary analysis of Apple Health claims data suggests that in the first year of MHAYC implementation, the percentage of assessments for young children that took place in home and community settings actually decreased from 19% in 2021 to 11% in 2022 (see Appendix G).

A further challenge was that even for the small number of assessments provided in home and community settings in 2022, no providers sought reimbursement for mileage costs through the MHAYC invoicing process. Providers shared that their primary reasons for not utilizing the invoicing process was lack of awareness (n=10) of or the administrative burden (n=11) associated with the MHAYC reimbursement process.

- *No one is doing the travel reimbursement because no one has told the billing people that it's okay.*

- *We probably will never bill for the travel because the administrative burden is more work than we would get back.*

- *It takes too much time to track what is or isn't allowable, and then filtering each case for each MCO takes a long time*

This administrative burden was especially heightened for organizations who did not serve many B-5 clients.

- *We do not currently submit payment request for travel, because we serve so few young kiddos, the administrative burden would not be worth the payment.*

✲ Home & Community Services & Mental Health Assessments for Young Children

Some providers noted an additional obstacle to implementation of the MHAYC reimbursment process; relying on a system provided financial support for assessments in home and community settings, but not for ongoing treatment, could negatively impact caregiver engagement in the long-term (n=3).

- *If you're not already a home-based program like ESIT or WISe, it is a barrier to [reimburse] for assessment travel but not treatment travel. It creates expectations from family that can't be met.*

Provider comfort and safety (n=23)

After costs, a secondary challenge to providing services in home & community settings was maintaining provider safety and comfort. Notably, the costs associated with addressing these concerns were also noted as a key factor in addressing this challenge.

- *Families live in neighborhoods with high crime and gangs. How do you provide services while maintaining staff safety?*

- *The safety of home-based assessments is a concern, but there is no funding to double-up staff.*

- *People don't always want to travel for what we pay, because of the safety issue and anxiety about doing that sort of work.*

- *I wonder if there could be some training or guidance online on how to engage in safe home visits for private practice providers who bill Medicaid?*

Services in Home & Community Settings - Taking Action

An initial step to supporting IECMH in home and community settings starts with developing and using foundational materials to support providers comfort and safety. Though MHAYC provided an initial investment, further analysis of the true cost for providing care in natural settings may be needed to achieve adoption. Further, allied providers and specialty programs may have lessons learned and best practices that could be collected and applied to the IECMH space. These strategies are based on the best practices and challenges identified by providers, as well as approaches identified in literature. For literature references, please see Appendix J. Taking Action References.

The following actionable steps align with the strategies and approaches for HCA's IECMH Priority 2 and Priority 4.

Mental Health Providers

- If you work in an agency, share your interest and/or openness to providing IECMH services in home and community settings.
- Incorporate safety assessment into your initial information gathering with families.
- Share about the MHAYC travel reimbursement policy with your administrative and billing staff.

Agency Administrators

- Develop safety policies and protocols for offering services in home and community settings.
- Invest in resources to support staff comfort and safety, such as agency cell phones.
- Ensure billing staff are aware of the MHAYC travel reimbursement policy and resources.

State Policy & System Partners

- Provide investment to support the access to IECMH services in home and community settings, including opportunities to leverage co-located and integrated IECMH services where families and children already receive care.[9, 29, 30]
- Gather best practices across allied services and specialty programs to inform standard tools and guidance for services in natural settings.
- Support initiatives aimed at ensuring IECMH providers have access to resources and supports for best practices in home- and community-based care.

Resource Spotlight:

Head Start's Early Childhood Learning & Knowledge Center - Ethical and Safety Considerations for Home Visiting

Head Start's Early Childhood Learning & Knowledge Center (ECLKC) Ethical Considerations for Home Visiting offers key considerations aligned with national Head Start standards that can be adopted when considering confidentiality, professional boundaries, and honoring various cultures when offering services in home and community settings. ECLKC also developed a webpage focused on Home Visitor Safety which includes strategies to support safe practices when offering care in home and community settings.

Caregiver Engagement

Responsive, nurturing, stable and safe caregiving relationships are essential to young children's mental health and wellbeing.

Work with young children requires intentional partnership and support of caregivers. This may take the form of ensuring caregivers have the information they need to understand when their child has a mental health concern, promoting adult wellbeing, reducing family stressors, and adopting family-centered practices. Adopting strategies in these areas and ensuring caregivers feel supported are critical components to promoting children's healthy development and assuring access care when needed.

It is well known that families and their children of all ages experience difficulties accessing and maintaining engagement in mental health supports. Though system factors such as eligibility, limited workforce, and unclear referral pathways are key contributors, agency-level policies may also impact families' ability to receive and meaningfully participate in care. Programs like Head Start have a long history of designing their programs specifically for families and young children. They have developed frameworks for family-centered practices which could be adopted by the mental health system as an approach to increasing access and engagement to ongoing mental health services.

> **ⓘ Building caregiver awareness and empowerment**
>
> Similar to children's growth and development physically, it is important for caregivers to be aware of normal social-emotional milestones and indicators that there may be a mental health concern. Though resources on this topic exist, caregivers often would need to know what to search for or already have concerns in order to access them.
>
> Additionally, caregivers may be hesitant to share their concerns or seek help due to fear and stigma. For caregivers that come from communities that have been discriminated against or have their own history of trauma, there may be a heightened distrust and lack of safety impacting their comfort in accessing care.

Collaborating with caregivers in addressing family stressors may support family engagement by both alleviating barriers and fostering a strong therapeutic alliance. A critical consideration when working with families is the availability and access to social and financial resources, as well as their experiences of adversity and economic hardship. Families may have limited knowledge, access or support to aid in coping with these circumstances and managing stressors. These factors not only impact families' ability to participate in mental health services; they are known to influence child outcomes that persist throughout their lives. Family-centered policies and approaches include practices aimed at reducing family stressors, addressing unmet needs, and increasing families access to resources as a means promote children's health and development. (Berger and Font, 2015)

Caregiver Engagement - Best Practices

Summary: Providers shared many different strategies for engaging with families, including family-centered practices that helped to address family stressors, relationship-based practices that emphasized the importance of family voice and choice, and the inclusion of all family members and caregiver relationships. Some providers also shared about the success of caregiver peer supports in engaging and empowering caregivers, and how education and outreach, especially to communities of color helped to build trust and awareness.

Family-centered practices (n=54)

Collaborating with parents/caregivers in addressing family stressors may support family engagement by both alleviating barriers and fostering a strong therapeutic alliance. Providers noted strategies they used to address family stressors and provide family-centered care, such as case management services, referrals to allied services, using flexible funds for concrete supports, and offering hours for working parents to accommodate working schedules.
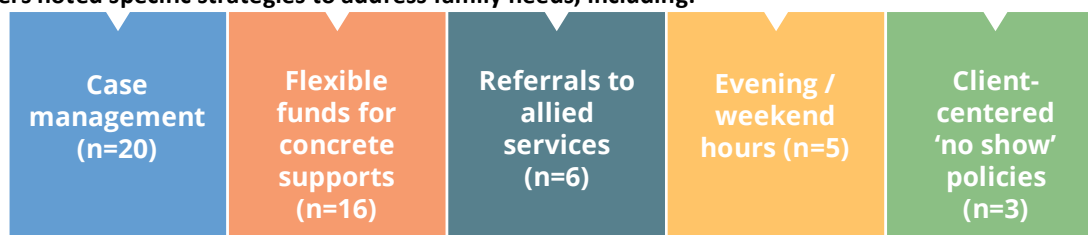
- *We use a case manager to have conversations about finding ways to engage in services, like working through their work schedule, child care options, etc.*

- *We provide transportation, meals, and child care…It's not about our agenda, it's about what the family needs.*

- *We screen for caregiver depression, and will refer out to a BHA that serves adults when it's identified.*

Providers noted specific strategies to address family needs, including:

Case management (n=20)	Flexible funds for concrete supports (n=16)	Referrals to allied services (n=6)	Evening / weekend hours (n=5)	Client-centered 'no show' policies (n=3)

Relationship-based practices (n=37)

Many providers noted an approach to caregiver engagement that centered their relationship with the caregiver. These approaches emphasized the importance of family voice and choice, as well as strengths-based approaches.

- *There is no conversation where the caregiver is excluded. They are treated as a primary part of the relationship. When parents feel that way, when they feel seen and heard, they want to engage.*

- *See them as experts regarding their own lives and their children's lives. Be prepared to explain everything in terminology they can understand. Answer all questions. Ask families what they think is the most important need. Treat them like a customer/consumer, rather than a patient.*

- *In my experience, most caregivers for kids under 5 I've worked with are very interested in engaging in dyadic work and appreciate being supported.*

✳ Caregiver Engagement and Mental Health Assessment for Young Children

For many caregivers, the assessment process may be their first interaction with the mental health system. Providers noted the use of relationship-based practices as part of collaborative assessment and treatment planning process as key both for generating caregiver buy-in, but also for developing a comprehensive picture of the child and family to inform diagnosis and care planning (n=8).

- *The conversation about diagnosis starts before the assessment. We talk about why we diagnose. We make it a collaborative process. We may look at the DC: 0-5 together. It is important to normalize this, that this impacts 1 in 5 kids, and why that may be. We're holding space for the many things that come up.*

- *Our providers set up the intake to emphasize that the caregiver is going to be absolutely crucial to treatment, and this sets it into motion for caregiver to know it will be important to engage.*

Including all caregiving relationships (n=28)

While IECMH best practices highlight the importance of caregiver-child relationship. recognizing the full ranges of caregiver-child relationships in which the child is embedded is critical (Frosh et al., 2019). Providers noted the importance of including all caregiver-child relationships in assessment and treatment, especially foster parents, kinship caregivers, and grandparents.

- *Everyone has a different story, bio parents, foster parents, and kinship parents. I want to include all of the parents, because everyone is getting a different version of the child.*

- *We don't just work with the person but with their entire family. We are looking at the impact of issues like boarding schools on the next generation and generations to come.*

🕊 Centering equity: including fathers

Research has shown that father involvement during the first years of life has positive impacts on children's social skills and emotional regulation (Yogman & Garfield, 2016). However, fatherhood-inclusive services often require collaboration, adaptation of current practices and policies, and prioritization of equity (Washington Fatherhood Council). Providers noted the importance of and their efforts to ensure the inclusion of fathers in IECMH services, in a world that often did not center their experiences and needs (n=5).

- *For a lot of these kinds of services, the mom has the possible time to engage, but dads need to be included, however that works. Dad groups are really important.*

- *Moms tend to seek services, and it takes purposeful effort to engage fathers when partners are a male-female dyad.*

Supports from other caregivers: parent/family-peers and parent/caregiver groups (n=23)

A newer approach shown to impact caregiver engagement and empowerment is the additional support of parent/family-peers, alongside IECMH services provided by a mental health clinician (Molnar et. al., 2018). Providers noted the importance of receiving support from those with shared lived experience as key to caregiver engagement. Support from other caregivers, either from parent/family-peers or through parent/caregiver groups, helped caregivers build stronger social connections and feel more empowered in the treatment process.

- *Peer support is really successful, and really helpful for parent engagement. They feel like someone has their back and can advocate for them, when their other providers are clinicians.*

- *Groups are really great because the caregivers support each other. I actually wish I had it when I had my kids!*

Community education & outreach (n=13)

Some providers shared that they conducted outreach and community education to raise awareness of and to engage families in services.

- *Services are so stigmatized, so I offer free webinars for parents.*

- *We do a lot of outreach to get families engaged.*

🕊 Centering equity: Culturally responsive community outreach

Culturally responsive community outreach can help reduce stigma, remove barriers, and provide a pathway toward wellness for marginalized and underserved communities. Providers noted the importance of outreach and community education that centers the culture and values of the families they served (n=4).

- *I go to churches, mosques, and temples. Many people in the BIPOC [Black, Indigenous, and People of Color] community are more likely to listen to their spiritual leader than a mental health professional.*

- *We need to provide mental health education in the culture of the community.*

Caregiver Engagement - Challenges

Summary: Providers noted several challenges to caregiver awareness, including limited caregiver awareness of available IECMH services and challenges with caregiver buy-in to services even when aware of them. Providers also shared about the financial and logistical barriers caregivers faced engaging in services, such as managing various stressors, finding time in their busy schedules, and figuring out transportation. Lastly, providers shared about broader systems barriers to caregiver engagement, such as difficulties in accessing allied services that might support caregivers in engaging in IECMH services, as well as the need for additional provider training on caregiver engagement best practices.

Top Desire

Awareness (n=18)

Providers shared that a key barrier to caregiver engagement was awareness of the available IECMH services, as well as how they could potentially support their child and family.

- *Most parents wouldn't even think their child has a mental health issue; they think, 'oh, it's just a tantrum.' How would parents know if there's a situation?*

- *We need training for parents to educate families on the services available.*

Buy-in (n=31)

Providers also noted that caregiver buy-in to participated in services was a primary challenge to caregiver engagement. Buy-in may be particularly challenging given the amount of caregiver involvement required for best practice IECMH services.

- *When we tell caregivers about our expectations for their involvement and engagement in services, sometimes they choose to not enroll in services. That's not how they view what their child needs.*

- *We had a contract to serve children in an early learning center, but we weren't as busy as we thought were going to be. There seems to be some hesitancy to get involved in mental health services. We hear from the schools, 'We have all this need,' but sometimes it doesn't trickle down.*

🕊 Centering equity: healing from distrust and discrimination

There is a justified and deep distrust of the mental health system that inhibits access to IECMH services in Washington state, particularly among communities of color (Perigee Fund, 2021c, CYBHWG, 2024). Providers noted how one component that may contribute to caregiver buy-in challenges is the stigma associated with mental health services, as well as worries about and/or past experience with providers and systems dismissing their concerns, treating them with judgement, or actively discriminating against them (n=26).

- *Historically, this system has been a bunch of white women who come into your home and tell you what to do.*

- *Parents have stories of professionals with letters after their name like doctors that said, just wait it out. Then the parents come when the child is 8 years old, feeling embarrassed and disenfranchised, like a bad parent.*

Financial and logistical barriers to participation (n=43)

Caregivers' access to social and financial resources can have major impacts on a families' ability to participate in mental health services; providers shared that barriers like working hours, concrete needs and stress, and lack of transportation all had the potential to negatively impact caregivers' ability to engage.

Hours (n=21)

Caregivers' work schedules were often a barrier to attending appointments during providers' operating hours. Providers noted that they recognized this was a challenge, but they often were unable to provide evening/weekend appointments due to their own availability.

- *We did a survey of parents, and the top barrier to care was provider hours.*

- *You have to find the hours that parents are available, if they're working, and then the staff that are willing to work those hours.*

- *Before COVID we had appointments in the evening one day a week, but a lot of clinicians are single moms, so they can't do that.*

Concrete needs and caregiver stress (n=18)

Providers also shared that many of the families they worked with were balancing multiple needs and challenges, and the stress of managing these needs could make engagement in mental health services challenging. However, providers struggled to help address these needs with the limited funds they had.

- *It can be a struggle for parents to have time and resources to participate, to not be struggling so much themselves so that they can be available. Other needs, like housing and transportation, are often prioritized.*

- *We want to make it as easy as possible to engage, because for the first couple of years, you don't sleep. Parents are functioning at a lower level.*

- *Families' healthcare could go a long way if something like nutritious food and basic hygiene products could be funded.*

Transportation (n=6)

Providers also noted that lack of transportation could be a barrier to engagement in services, especially when services took place in office settings.

- *Transportation is a huge barrier.*

- *There's just not enough public transit.*

Challenges accessing allied services (n=19)

The need for IECMH services was not the only one identified by providers. Long wait times and lack of service providers were noted for adult behavioral health, developmental services, primary care and dental care, mental health consultation, and housing.

- *We could provide services for the parents, but the need is so great, so we prioritize the kiddos. We would love to provide more for caregivers on their own.*

- *Getting folks into primary care is a challenge. The wait times for an appointment with a pediatrician or family physician are long.*

- *Just having mental health providers isn't enough, because that kid is going to child care. Child Care Action used to do interventions in the day care setting, like pull-outs, but we can't find the person who does that work anymore.*

🕊️ Centering equity: Serving rural communities

For rural communities, challenges in accessing health care and social services may be particularly acute (Perry et al., 2023; CYBHWG, 2024). Providers working in rural communities shared that families faced increased barriers in accessing services due to fewer service providers, farther distance between those providers, and more limited public transportation options; some providers also noted they faced barriers of their own in accessing limited opportunities for training and professional development (n=9).

- *The closest [developmental services provider] is about a half hour way, in another county. But that's how it always goes. And they only serve [children] younger than three.*

Provider training on caregiver engagement (n=6)

Providers shared a desire for additional training and professional development support on the topic of caregiver engagement.

- *We need to know more about what engagement looks like for families. We lose them or often don't fully connect because we may benefit from more capacity building for our teams on how to effectively figure out what the family needs.*

- *Caregiver buy-in and participation is a major challenge. We need more clinical tools to support engaging with caregivers when the child is present and disruptive.*

Caregiver Engagement - Taking Action

Caregiver engagement is essential to the delivery of developmentally appropriate care that supports children's return to health development. Providers, agencies, and system leaders can promote family well-being through adopting approaches and policies that center supporting the whole family, including addressing life stressors and caregiver behavioral health needs. These strategies are based on the best practices and challenges identified by providers, as well as approaches identified in literature. For literature references, please see Appendix J. Taking Action References.

The following actionable steps align with the strategies and approaches for HCA's IECMH Priority 3.

Mental Health Providers & Allied Providers

- Ask families about social determinants of health and life stressors to support connecting them to resources.[1, 27]
- Ensure your services and treatment goals use family-centered language and center the strengths and priorities of families.[17, 31]
- Foster trusted and respectful relationships with all caregivers recognizing the range of relationships and importance of collaboration to support young children's healthy development.[5, 6]

Agency Administrators

- Update policies and leverage flexible funding to support families access to concrete needs and allied services, including those to support caregiver mental and behavioral health.[1, 5, 31]
- Build local partnerships and collaborate with community partners and regional Accountable Community for Health (ACH) to support referrals for families.[6]
- Adopt family-centered practices and two-generation approaches that support the wellbeing of children and their caregivers.[1, 5, 21]
- Expand your service offerings to include IECMH-focused parenting groups and peer supports.[8]

- Review agency policies and identify opportunities for reducing logistical barriers to families accessing care.[31, 32]

State Policy & System Partners

- Align policies and initiatives with the Washington State Early Learning Coordination Plan that prioritize approaches and programs that promote family wellbeing and address sources of stress, including caregiver mental and behavioral health supports.[1, 5, 6, 31]
- Develop parent leadership networks and opportunities to inform policymaking and hold systems accountable.[1, 27, 31]
- Create cross-system IECMH communications and caregiver education for families with young children that fosters trust, normalizes mental health and well-being, and builds awareness for how to access services when needed.[17, 31]
- Explore cross-sector policy solutions to make the IECMH system easier to navigate for families.[23, 31, 32]
- Invest in research and analysis of parent/family-peer models and IECMH parenting groups to evaluate and strengthen the evidence base, identify gaps, inform scalable solutions, and identify funding strategies to increase access to these services.[1]

Resource Spotlight:

Children's Behavioral Health Statewide Family Network

The Children's Behavioral Health Statewide Family Network (CBHSFN) aims to ensure families across the state are educated, empowered, and can access what they need within their communities. The Statewide Family Network provides recommendations to state systems, develop resources, and collaborate across the children's behavioral health system to create a pathway for families to participate in planning and policy development.

Allied Professional Collaboration

Cross-system collaboration across allied services is an essential component to strengthening the social-emotional development and mental health of children and their families through aligned efforts to identify needs, coordinate referrals, and continue to connect throughout services (Administration for Children & Families, 2021, 2022). As noted previously, the IECMH workforce includes a diverse and broad array of professionals across disciplines and sectors. Though a central aspect across providers is their focus on supporting the healthy development of young children and family resilience, they provide care with different professional standards, funding streams and governing authorities. This can create unique and complex challenges in collaborating across sectors as professionals have differences in foundational training, language and terminology, and standards of care. Additionally, families are often burdened with the tasks of adjusting and adapting to the differences across services delivered in these different sectors.

Though there is agreement that connection with allied professionals is a best practice both during the initial assessment and ongoing treatment services, mental health providers note that regular contact can be challenging as providers across early childhood sectors face workforce shortages and capacity challenges (Department of Education, 2021; Administration for Children & Families, 2022). Strategies and practices that bring providers together across professions and allow for ongoing collaboration have the potential to support families' wellbeing and increase our system's capacity for whole-person care.

Allied Professional Collaboration - Best Practices

Summary: Providers noted many different ways they interreacted with allied professionals, including through co-located services, receiving referrals for IECMH services, and collaborating as part of ongoing treatment services. Providers also noted different concrete strategies for improved coordination that helped to build stronger relationships and to streamline collaboration efforts.

Providing co-located services (n=31)

Colocation of services can lead to greater access to and family satisfaction with care because services are provided in a setting familiar to families, and the interprofessional relationships resulting from colocation can help improve provider satisfaction and clinical practice (Ginsberg, 2008). Providers noted that co-located services helped create smoother referral pathways for families, or provided an environment that could serve as a 'one-stop shop' to meeting family's different needs, such as adult behavioral health, early learning, physical health care, developmental services (e.g., occupational therapy, physical therapy), and housing.

- *We moved early childhood mental health from our CYF [Children, Youth, & Families] Behavioral Health building to our early learning center. Colocation is long overdue, and this makes sense. And we want to add occupational, physical, and speech therapy as well.*

- *When we do assessment, the intake clinician may hear something and think, 'Oh, this parent would benefit from their own mental health services.' Sometimes they are able to have that conversation right away, and say, 'Let's walk you over [to adult mental health services] right now.*

- *We were losing a lot of families in referring them out to mental health services, so we decided to implement this integrated program, where it's all in one building. Now, our PCPs [primary care*

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providers] can immediately do a warm handoff to the behavioral health consultant, in the same exam room during that visit, so family can see there is coordination between doctor and the consultant.

Referrals from allied services (n=26)

Another way in which mental health providers interacted with allied services was through referrals to mental health services from allied services, including primary care, child welfare, early childhood education, and home visiting. Some of these referrals were the result of developmental and social-emotional screening conducted by these allied providers.

- *PCP [primary care provider] referral is key. Doctors in the clinic help to identify patterns in younger kids.*

- *We worked closely with child welfare, and the program grew with social workers referring to our program.*

- *Our referrals come from Early Head Start[24], through them doing the developmental screening, or teachers saying, 'We have issues,' where there's a threat of kiddo getting kicked out.*

✱ **Allied Professional Collaboration & Mental Health Assessment for Young Children**

As discussed previously, using standardized screening and assessment tools and gathering collateral information are key components of the mental health assessment process. Providers (n=3) shared that alignment between screening tools used by pediatricians, early learning providers, and behavioral health agencies could support coordination, especially as part of the mental health assessment process.

- *It would be helpful if there was coordination with PCPs around assessment tools. There are some tools in the DC: 0-5 manual but if there isn't standardization between providers even valid screening tools could complicate care coordination with allied providers such as pediatricians.*

Ongoing collaboration with allied providers (n=16)

As discussed previously, many providers collaborated with allied professionals to gather collateral information as part of the assessment process. Many providers also reported that they continued to collaborate with allied professionals as part of their ongoing treatment services, to ensure alignment across treatment plans to support the child and address the family's needs.

- *There isn't a kid on my caseload where I don't need to connect with the child care provider and occupational therapist.*

- *In our program, mental health services have a team approach - we work in direct collaboration with the child's other providers, like pediatricians, occupational therapists, and educators...it leads to cross learning, thought partnership, a shared commitment to whole child well-being...And, this program has the lowest turnover.*

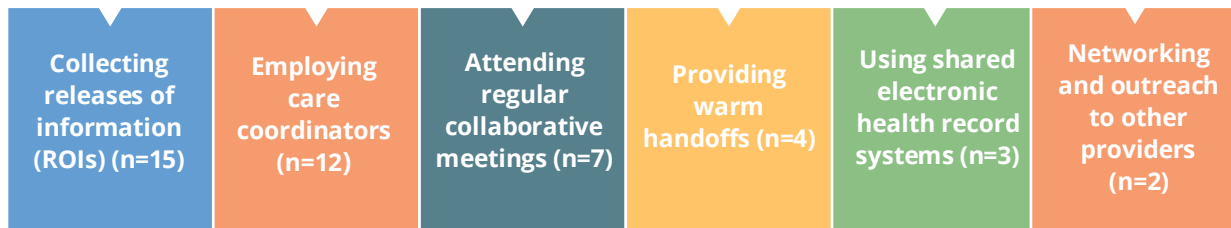## Other concrete strategies for coordination

Providers shared that they employed different concrete strategies for enhanced systems coordination and noted that these strategies helped to build stronger relationships and to streamline collaboration efforts.

- *ROIs [Releases of information] from all partners are collected at the start of services in order to coordinate. Additionally, we actively have ongoing contact with various partners like schools, child welfare, and medical providers, so our team is known to the local and larger community.*

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[24] Washington State Head Start and ECEAP

- *Our agency currently networks with local providers who frequently have clients in common with us through regular staff meetings by Zoom, or regular check ins from a case manager to a specific point of contact at the other agency to support care coordination.*

- *We get a couple hundred referrals a year from cultivating years of relationships. Folks who speak Spanish and are undocumented, they are never going to contact us off of a flyer. Please do a handoff to other providers to services to "soften the ground", because then we hear, "Oh yeah, I was waiting for your call".*

The specific strategies that providers mentioned included:

Collecting releases of information (ROIs) (n=15)	Employing care coordinators (n=12)	Attending regular collaborative meetings (n=7)	Providing warm handoffs (n=4)	Using shared electronic health record systems (n=3)	Networking and outreach to other providers (n=2)

✳ **Allied Professional Collaboration & IECMH Workforce**

In sharing about their motivations for providing IECMH services, some providers noted that they originally came from the early childhood education field (n=10). Providers with experience in both fields may be especially well positioned to support cross-sector coordination; supporting early childhood education providers with an interest in IECMH may also be a strategy for addressing the previously discussed need for a strengthened IECMH workforce.

- *I want to support child care providers, because I saw the need after spending years in early learning. There was a mental health consultant, and I said, 'I want her job.' So, I went back to school for my Master's.*

Allied Professional Collaboration - Challenges

Summary: Providers shared several challenges to collaboration with allied professionals, with a primary challenge being a lack of knowledge, awareness, and shared language regarding IECMH in allied sectors. Providers also noted that this gap could be preventing the earlier identification of IECMH concerns. Providers also experienced challenges in connecting with allied providers for collaboration on approaches to care and treatment, and some providers also shared about the need to increase knowledge of available resources to build effective referral pathways for coordination.

Cross-system understanding and approaches to IECMH (n=27)

A major challenge to cross-system coordination was lack of knowledge, awareness, and shared language regarding IECMH in allied sectors.

- *I've noticed a lack of IECMH knowledge for some providers. I've reviewed treatment plans from developmental service providers that reflect a lack of understanding of the impact of development and trauma and the appropriate intervention.*

- *People are already concerned about children entering school with a diagnosis, and it's going to be very different for a school seeing this at 36-months. Schools are just not used to kids coming in with a diagnosis at an early age.*

- *I'm not seeing connection between mental health consultation[25] and mental health services. Mental health providers are providing services to the families, and then Early Achievers coaches[26] are providing services to the early learning providers…If those could just be together, it could save money and stuff, and early learning providers wouldn't be confused.*

- *People focus on the parents and forget there is a kiddo there. Peers could focus not just on recovery for the parent but also on child development.*

☁️ **Continuing Reflection: Integrating IECMH across the continuum**

- *How do you integrate early childhood education and IECMH? For prevention and intervention, how do we make it work all together?*

Need for earlier identification of IECMH concerns (n=25)

In many cases, providers noted that earlier identification of mental health challenges by allied professionals could have supported upstream referrals and engagement in services for young children.

- *People are waiting for the wheels to come off before referring, especially for children of color, and then they need special ed[ucation] services when they come into school. Sometimes I start working with a child, I think to myself, 'Where have you been, my little person?'*

- *We can serve youth 0-5, but other systems like child welfare and the schools don't see infants or young children as having behavioral health needs.*

- *Sometimes providers think of child development with a more medical or physical health lens, but they don't see the mental health stuff. It takes an educated [provider] to make that sort of referral.*

✳️ **Allied Professional Collaboration & IECMH Workforce**

As noted previously, providers elevated IECMH training as a key need to strengthen the IECMH workforce. Providers noted the importance of training for allied professionals to build shared knowledge (n=6).

- *There should be training for OBGYNs [obstetricians and gynecologists], doulas, and birthing centers; we should get them to include IECMH info in their curriculums.*

- *We need for trainings for professionals like peers on how to recognize the need for infant early childhood mental health services.*

Top Desire

Up-to-date service and resource availability (n=9)

Across multiple sectors, knowledge of available resources was noted as a key need for building effective referral pathways and coordination. Providers noted that this knowledge was often relational and '*built over time*;' providers who did not have up-to-date resource directories struggled, especially when dealing with the high rates of turnover in the field.

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[25] IECMH consultation (IECMH-C) is a prevention-based approach that pairs a mental health consultant with adults who work with infants and young children in the different settings where they learn and grow, such as child care, preschool, home visiting, early intervention and their home (Cohen & Kaufmann, 2005). Learn more at the Center for Excellence in Infant Early Childhood Mental Health Consultation.
[26] Holding Hope: Infant-Early Childhood Mental Health Consultation program for Early Achievers participants

- *Referrals are a challenge - our numbers have been low. How do we continue to partner with others to let them know we exist and can support? There are always plenty of 6+ referrals but our specialty is infant-early childhood mental health.*

- *A community resource compilation for birth to 5 would be helpful, with places for occupational therapy, speech therapy, nutrition, and mental health assessments.*

Making the case for: aligned resource and referral networks for IECMH

Surveys and focus groups conducted with mental health professionals and allied professionals who have attended DC:0-5 training through the IECMH-WC found that there is a need for community resources and referral options to support providers in referring children for IECMH services (IECMH-WC, 2023). As one participant shared, "*I need access to infant early childhood mental health providers who do assessment. Patients do not have a cohesive guide to regional providers. (I am) constantly referring them to insurance lists, but those are outdated and immense.*"

Ongoing collaboration with allied providers (n=6)

As discussed previously, providers experienced challenges in connecting with allied providers when gathering collateral information for mental health assessments. Unfortunately, engaging with allied providers sometimes remained challenging going into treatment.

- *I have found that partners are willing to engage in initial conversations to inform assessment, but there is a lack of availability for ongoing care coordination in service of treatment and ongoing assessment.*

- *Everyone is so overworked and busy; it's hard to find time to build those relationships.*

Allied Professional Collaboration - Taking Action

A foundational step to strengthening allied professional collaboration identified by providers is through identifying commonalities, as well as the gaps in foundational understanding, awareness, and training on IECMH across sectors. While providers shared potential, key topics highlight the need for greater alignment and strategies at the policy- and systems-level to achieve a coordinated IECMH system in Washington. These strategies are based on the best practices and challenges identified by providers, as well as approaches identified in literature. For literature references, please see Appendix J. Taking Action References.

The following actionable steps align with the strategies and approaches for HCA's IECMH Priority 1 and Priority 5.

Mental Health Providers & Allied Providers

- Strengthen coordination across mental health and allied providers working with families of young children throughout treatment.
- Use the Mental Health Referral Service Line, MHAYC Multidisciplinary Referral Guide and Help Me Grow to identify and connect to mental health and allied services that meet young children's needs.
- Share and use the Emotional Health of Babies and Toddlers flyers detailing how we all can play a role in supporting families of young children.

Agency Administrators

- Establish ongoing collaborative relationships and strengthen your regions IECMH network by attending or creating collaborative meetings spaces.[9]
- Partner with other agencies supporting young children and families to offer co-located services.[21,22]
- Invest in offering reflective supervision to staff and invite allied providers to participate when possible.[22]
- Update agency policies and workflows to support coordination with allied providers throughout services.[31]

State Policy & System Partners

- Leverage higher education and professional development initiatives to ensure IECMH providers across sectors have a foundational awareness and understanding of IECMH as it relates to their work.[4, 18, 27]
- Explore policy strategies and technological solutions to align referral systems, promote ease of coordination, and streamline information sharing across IECMH professionals and settings.[1, 17, 31]
- Support initiatives that prioritize co-located services where families already access care and concrete needs.[2]
- Optimize existing cross-sector groups, such as the Children and Youth Behavioral Health Workgroup, to strengthen efforts for shared policy development and investments for the IECMH system.[17, 22, 31]
- Identify key cross-system IECMH champions to define elements of the continuum of care and establish roles to identify IECMH policy priorities, support integration across sectors, and address services gaps.[1, 4, 7, 17, 22, 27]

Resource Spotlight:

From building blocks to care pathways: Working together to support timely access to infant and early mental health care

In July 2023, HCA had the opportunity to meet IECMH colleagues from The Knowledge Institute on Child and Youth Mental Health and Addictions and Infant and Early Mental Health Promotion (IEMHP) to learn about their work partnering with communities to develop, "From building blocks to care pathways: Guide to working together to support timely access to infant and early mental health care." This guide provides an approach for cross sector partnership in developing shared care pathways for infant and early childhood mental health in communities.

IECMH Financing

Sustaining an array of IECMH services that meet the needs of all children requires coordinated policy and braiding or blending of multiple funding streams (McCance-Katz, & Lynch, 2019). Often different funding streams have unique eligibility and reporting requirements that create additional challenges when attempting to integrate into service delivery systems. Further, some funding sources are time-limited impacting the ability to assure financing over time. For the mental and behavioral health system, financing has evolved over time due to shifts in priority populations, types of settings and services, and funding options available. These changes have required behavioral health providers and agencies to develop business strategies to sustain their ability to offer care as they identify which services to offer, how to staff their services, and incorporating a variety of funding streams. (Everett et. al., 2012)

ⓘ **Federal Funding Streams (other than Medicaid) that support IECMH:**

- Community Mental Health Services Block Grant
- Substance Abuse Prevention and Treatment Block Grant
- Head Start and Early Head Start
- Part B of IDEA: Preschool Special Education Program
- Part C of IDEA: Early Intervention

- Child Care Development Block Grant
- Title V Maternal and Child Health Block Grant
- Title IV-B of the Social Security Act – Child Welfare Services
- Title IV-E Foster Care

Adapted from: Cohen & Andujar, 2022

Providers noted the impact that finance and funding stream structures have on service delivery, and they hoped that funding could be structured in 'a way that works:' a way that would support developmentally appropriate care and best practices. In particular, providers noted the desire to be able to provide developmentally appropriate care no matter what, if any, health insurance families had.

- *Whatever coverage the child has, whether Coordinated Care, integrated managed care, or private insurance – that determines what we can do.*

- *The way mental health is structured today, billing is led by insurance companies, and not structured to help families. The system is not meant for care; it is meant to make money.*

- *Not everyone has insurance, how can we still provide mental health services?*

Medicaid plays an important role in financing IECMH services with approximately 40% of children birth to five years of age nationally insured through the Medicaid program (Johnson and Bruner, 2018), and it's role as the largest payor for behavioral health (Guth et. al., 2023). Further, Medicaid's Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate assures coverage for comprehensive preventive health care and medically necessary services for children and youth under 21 years of age. For this reason, Medicaid is often cited as a powerful lever and catalyst for initiating change in what services are covered, how they are paid for, and driving delivery system change. At the same time, Medicaid rules and structure may feel limiting when offering client-centered and individualized care.

ⓘ **Putting it in context: Commercial insurance**

Over half of all children in Washington state are insured through commercial insurance plans (KFF, 2022). State and federal oversight of commercial insurance is more diffuse, and providers who serve these children on these plans must navigate many distinct rules and regulations.

Research shows that children enrolled in commercial insurance are more likely to experience inadequate coverage (such as unnecessary denials or unreasonable out-of-pocket payments; also known as being 'underinsured') (Daw et al., 2023; CYBHWG, 2024). While this phenomenon is not unique to IECMH, providers noted that they experienced challenges in providing IECMH through commercial insurance, and they shared that Apple Health billing and clinical policies often felt more aligned with best practices than those of commercial plans (n=6).

- *We can only bill for multi-session assessments for Medicaid families. Is there any way we can force the commercial insurance to allow multiple assessment session?!*

- *Some private insurance won't cover visits in home and community settings, or family treatment without the client present. Medicaid allows us to do more.*

Key Topic: Navigating the behavioral health care system

Medicaid and other health insurers hold standards for who can provide covered services for enrolled members. Providers must complete credentialing processes to ensure that they meet the necessary qualifications. Once credentialed, providers follow a standard process for reimbursement across insurance carriers, requiring providers to identify who they provided care to, what service was provided, and why it was medically necessary. Though the process may appear straightforward, providers may have to resubmit claims in order to be reimbursed for the services provided; Medicaid providers accrue a cost of $13 to $15 when resubmitting a single service claim. Given Medicaid's current rates, this cost may disincentivize providers' offering care to Medicaid members. (Dunn et. al., 2021; Holgash & Heberlein, 2019)
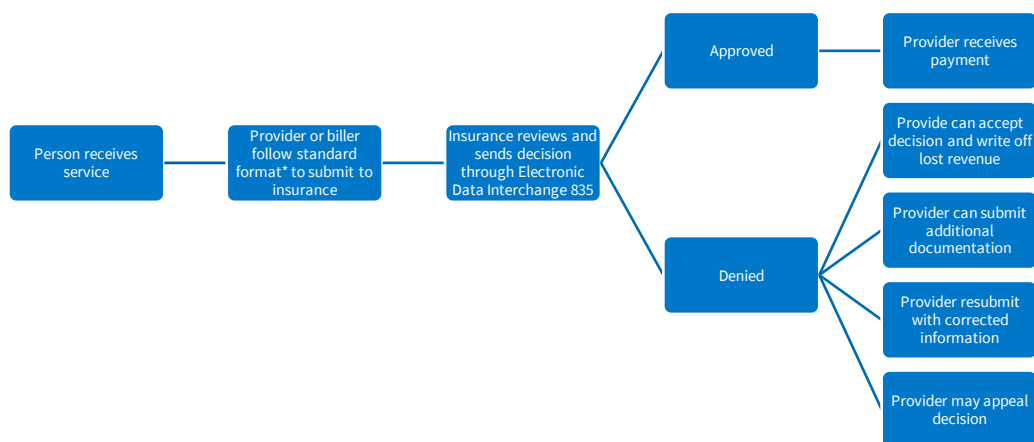
Adapted from: Dunn et. al., 2021

*CMS form 1500 requires client identifier and insurance plan information, treatment provided (CPT or HCPC code), condition treated (ICD code), justification for care provided, and amount to be paid.

Providers are often faced with burdensome processes ranging from lengthy forms, unclear guidance, and time intensive credentialling which can further deter providers from accepting insurance, particularly for Medicaid if disproportionate to other payors (Guth et. al., 2023). Beyond the financial impact of administrative burden, providers may also experience additional psychological and learning costs (Moynihan et. al., 2015):

Learning costs: Time and effort to research and learn about the Medicaid program (e.g. provider eligibility/ enrollment, covered services, billing guidance).

Psychological costs: Emotional burden and stress of navigating complex and nuanced bureaucratic processes.

Compliance costs: Filling out documentation and ensure regulations and requirements are met.
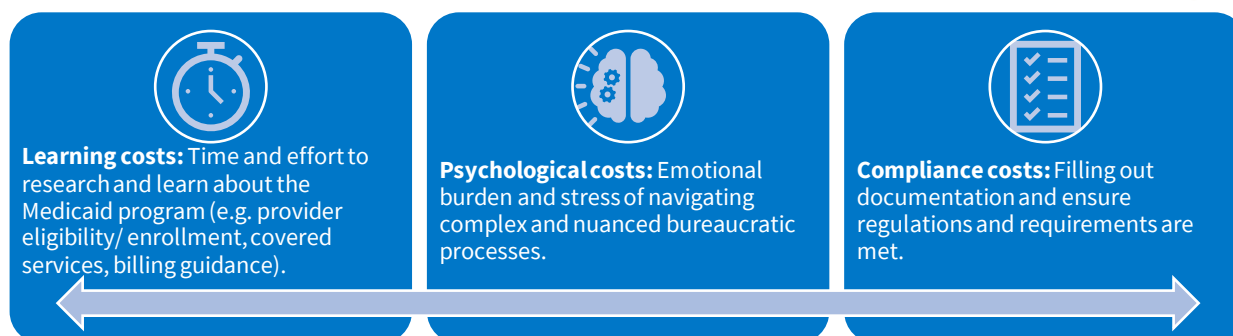
Medicaid managed care provides an additional layer of complexity and administrative tasks. Managed care organizations (MCO) are often private health plans the state has contracted with to manage Medicaid costs, utilization, and quality. In these arrangements, MCOs receive a per member per month (PMPM) payment to cover services for enrolled members. MCOs then contract directly with providers and agencies to provide services to members. This often requires providers to become credentialed and negotiate contracts with each MCO in their region. These providers then face the additional burden of identifying the unique requirements and processes for each MCO, due to a lack of standardization across plans (Guth et. al., 2023).

Though core mental health services are covered by Medicaid (Dormon et. al., 2016), there is often confusion around what is covered, who can provide it, and limitations on how care is delivered. Many providers and agencies may be familiar with the more adult-focused system, which can create additional gaps in awareness and understanding of coverage for developmentally appropriate services to young children (Johnson and Burak, 2023).

Navigating the behavioral health care system - Best Practices

Summary: Providers noted that dedicated billing, coding, and administrative staff were key to navigating the complexities of billing and coding, and some providers highlighted HCA resources on the topic as helpful.

Dedicated billing, coding, and administrative staff (n=20)

Providers noted the importance of dedicated billing, coding, and administrative staff, who could provide expertise and support in navigating the complexities of billing and coding.

- *Our clinical team has conversations about how to code, but I try to minimize that because I know it's stressful. We talk about making sure you're coding things appropriately, how you probably you could use multiple different codes for one thing. There's a lot of different things that need to go in the billing, and clinical people don't need to be burdened.*

- *We have a weekly meeting with our billing person, so she answers all our questions.*

- *Our behavioral health team is educated and informed on what codes to use; we use the same codes over and over again. Our billing department will tell us if we forgot a code, or if we didn't include the diagnosis code. They let us know if we are not billing correctly.*

HCA guidance and technical assistance on IECMH billing (n=4)

Some providers also noted that guidance and technical assistance on IECMH billing provided by the Health Care Authority also supported them in navigating the system successfully[27].

- *The IECMH Toolkit[28] is a valuable tool, and I look forward to its continued development.*

- *Contacting HCA is helpful.*

Navigating the behavioral health care system - Challenges

Summary: Providers experienced many challenges in navigating the behavioral health system to provide IECMH services. In particular, working with managed care organizations (MCOs), understanding billing guidance, and navigating the differences in billing across behavioral health delivery systems were barriers to providing IECMH services. While many of the challenges elevated were not confined to IECMH services, they may have an outsized impact on the field given its growth and development.

Provider enrollment (n=6)

Before providers can begin to offer Apple Health services, providers must enroll with Apple Health in order to ensure they are qualified to offer services and ensure the necessary information is on file to receive payment for care provided[29]. Some providers who had recently gone through provider enrollment noted how challenging and time-consuming the process can be. Although provider enrollment challenges are not specific to IECMH providers, they may be particularly impactful for the field, since efforts to grow IECMH workforce capacity and expand access to these specialty services may result in new providers starting the process to become an Apple Health provider.

- *I recently went through enrolling with Apple Health and found it to be quite hard, with lots of steps to go through. Some agencies may have people who do it but there may be barriers for small organizations. All the additional steps may cause some not to enroll.*

- *We have gone through the check list, and still haven't gotten to process for P1 [ProviderOne] yet. We're adding SUD [substance use disorder] services to our portfolio, and we didn't know that was a separate part of the process, so that's taking several emails with HCA and DOH [Department of Health] to get through the steps.*

- *It's been really hard to contract as an enrolled Apple Health provider. There are so many steps, and it is taking so long to get through the process. In the meantime, I'm forced to decide whether to provide services and hope I'll eventually be able to back-bill.*

Top Desire

Working with managed care (n=52)

Providers frequently noted challenges in working within the Apple Health managed care system. Although managed care challenges are not specific to IECMH services, providers noted challenges both with understanding the foundational aspects of working with managed care, as well as need for greater manager care organization (MCO) knowledge of IECMH best practices. The potentially higher proportion of providers and agencies who are new to health care billing or working with MCOs may exacerbate these challenges for the IECMH field.

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[27] Apple Health providers with questions related to billing, claims, and service limitations may contact Medical Assistance Customer Service Center (MACSC) using the secure form or calling 1-800-562-3022.
[28] Apple Health Infant-Early Childhood Mental Health Service Models Toolkit
[29] For questions or concerns about Apple Health Provider enrollment, Contact HCA Provider Enrollment by email or call 1-800-562-3022 ext. 16137 (Phones are open: Tuesdays and Thursdays from 7:30 a.m. to noon and 1:00 p.m. to 4:30 p.m.).

- *It's a challenge to understand the variability of MCO services and payments.*

- *Being audited by the various MCOs is a major challenge, and it causes so much stress. We get requests at least 2-3 times a week. They request 45 files and give us 10 days to respond. And then they say, you guys didn't do just one thing, so you're not meeting fidelity. We just finished our DOH [Department of Health] audit; can we catch a break?*

- *We're brand new in starting to bill Medicaid, and we don't get payment from the MCOs for 2 months. For smaller orgs, it's harder to float the costs when there's a delay for reimbursement.*

The top challenges related to working with MCOs included:

Differences across MCOs (n=13)	MCO contract negotiations (n=13)	MCO claim denials & appeals (n=13)	MCO auditing (n=8)	Administrative issues when clients switch MCOs (n=5)	MCO payment timelines (n=3)

Understanding Apple Health billing (n=81)

Top Desire

Providers noted a lack of understanding of billing guidance as a key barrier to providing services. Some noted that when they felt confused or unclear about billing, they were more likely to refrain from providing services at all, or for billing for those services. Although these challenges are not specific to IECMH services, confusion and anxiety over the translation of IECMH practice into appropriate billing, as well as a potentially higher proportion of providers who are new to health care billing, may exacerbate these challenges for the IECMH field.

- *When we're not sure how to bill, we just don't bill in those circumstances. Eating the costs seems better than potential risk of getting in trouble.*

- *We've been skittish about serving B-5 because we've been worried that we're not coding right.*

- *We're currently not billing for any services for this demographic. Our agency needs to know how to implement and bill effectively for services. We have the clientele, just lack of billing knowledge.*

Need for dedicated billing, coding, and administrative staff (n=12)

Given the complexities of understanding health care billing, providers noted that without dedicated staff with expertise in this area, they struggled to provide services. This was especially highlighted by smaller organizations and community-based early childhood organizations who were new to providing mental health services.

- *Our billing team doesn't have the capacity to bill for mental health. We need staffing to build this.*

- *I don't have a medical biller because I'm in private practice. Is there technical assistance that could be available? Could we all chip in on the costs of a medical biller? What if there was something like Imagine Institute[30], which is a business support for Family, Friend, & Neighbor child care providers, funded by DCYF?*

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[30] The Imagine Institute

✳ **Navigating the Behavioral Health System & Mental Health Assessments for Young Children**

Approximately a third of the challenges around understanding billing that providers noted were specific to mental health assessments for young children (n=22). The Health Care Authority has dedicated staff time and effort towards creating specific MHAYC billing guidance, materials and resources that are continuously updated to respond to provider questions. Additionally, HCA offers regular billing webinars and tailored technical assistance on this topic. The ongoing challenge, even with custom billing guidance, demonstrates the necessity for comprehensive communication strategies to ensure information reaches all relevant providers and highlights the time for new policies and guidance to be familiarized.

Billing differences across behavioral health delivery systems (n=39)

The current publicly funded behavioral health system consists of multiple different funding streams and authorities, and allowable services, billing guidance and reimbursement rates differ across the behavioral health delivery system, particularly when it comes to licensed behavioral health agencies and providers providing care independently under their license, though it also includes differences for entities like Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), and Indian Health Care Providers (IHCPs). Additional variability occurs when providers work with children and families not enrolled in managed care (i.e., Medicaid without a managed care plan, historically called fee-for-service).

Work to integrate behavioral health payment across the Medicaid system in Washington state has been ongoing since 2014 (Center for Health Care Strategies, 2020), but providers experienced challenges in navigating current differences, leading some to wonder '*what happened*' to integration. These challenges can exist for behavioral health providers regardless of the population served, though IECMH's history as a multi-disciplinary, integrated field, and likelihood that historically young children's mental health needs did not rise to the level of care provided in behavioral health agencies, may exacerbate these challenges for the IECMH field.

- *I could bill other services when I worked in community behavioral health. What happened to equitable access to billing codes with integration? It was all supposed to end up the same.*

- *When I worked at a primary care clinic, they would add other codes. What happened to integration?*

Care coordination/case management (n=22)

Providers noted that differences in billing for care coordination services between licensed behavioral health agencies and independently licensed mental health practitioners were a particular challenge. While not specific to IECMH services, this issue may be particularly challenging for IECMH providers because, as noted previously, care coordination with allied providers and family-centered practices to address family stressors are very beneficial for serving families of young children.

- *We are a Rural Health Clinic, that makes our billing different for care coordination or case management services; we cannot bill for those services. We do have a CHW [Community Health Worker] from the grant position from HCA[31], so we do have someone who can provide those services, but it's definitely different from a community mental health agency.*

- *In community behavioral health, I could bill for collaborative work. … now I struggle to engage allied professionals. Everyone has high productivity expectations, so if care coordination can't be billed, it*

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[31] Health Care Authority Pediatric Community Health Worker grant

can't be provided consistently. This is especially concerning in light of the lack of infant-early childhood mental health knowledge for some providers.

✳ **Navigating the Behavioral Health System & IECMH Workforce**

As noted previously, recruiting and retaining providers is a major challenge to the provision of IECMH services. Providers noted that the administrative burden associated with navigating all the requirements of the behavioral health care system is a barrier to maintaining a strong behavioral health workforce in general, as well as maintaining a strong behavioral health network for Apple Health (n=8).

- *Turnover is really high, and it's high because of administrative stress, not because of clients. I'm worried serving this age group will be even more administratively heavy.*

- *I had a conversation with a group of providers who said it would be better to disengage with Medicaid and not even try to work with the system to make it better. Even when people say things will be made simpler, it doesn't happen, and that's why providers leave.*

- *Private practice people don't want to deal with MCOs, so they are not taking Medicaid.*

Key Topic: Financial sustainability of IECMH services

When determining whether to offer IECMH services, providers and agencies must consider whether these services and the associated staffing are sustainable for their programs. As described throughout the report, developmentally appropriate IECMH services may require additional training, resources, and elements to care than mental health services provided to older populations.

Standard mental health reimbursement rates set broadly for all Medicaid recipients may not account for the unique costs of care when working with young children. Behavioral health rates assumptions utilize service-related time (including direct, indirect, travel time, training, and supervision), transportation expenses, and operating expenses (see Figure 4 below). Even with reimbursement being available for core mental health services, this may not provide financing for the initial start-up costs to build an IECMH team or program.

Figure 4. Components of independent rate modeling
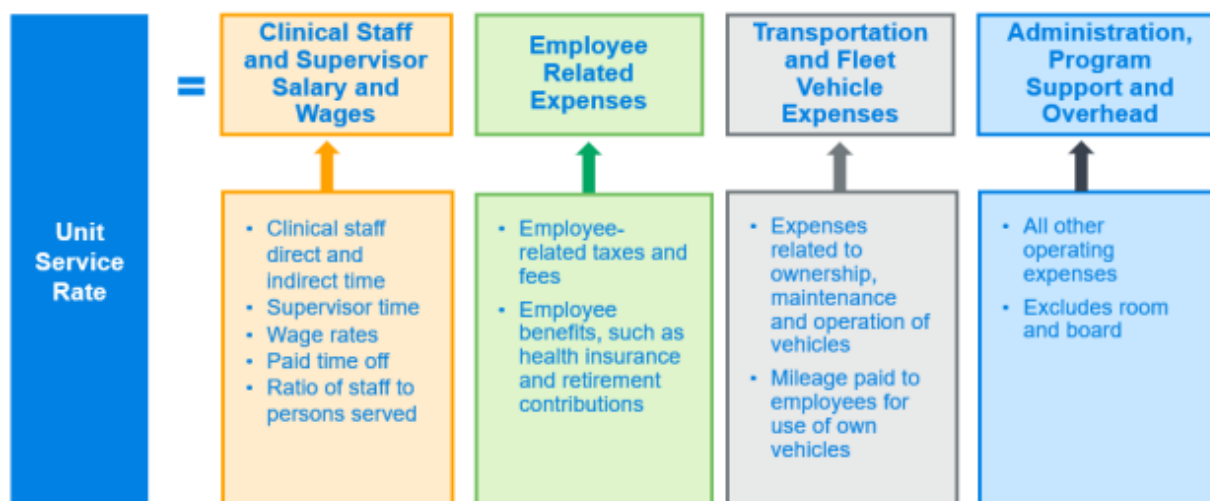
Source: Cunningham et al., 2023

Financial sustainability of IECMH services - Best Practices

Summary: Though best practices for addressing the financial sustainability of IECMH services were limited, some providers noted the use of special payment models that took into consideration the unique considerations of developmentally appropriate IECMH services.

IECMH specific payment models (n=7)

Some providers noted that they utilized IECMH-specific payment models to fund their services, in order to reflect the IECMH-specific impacts on service-related time and operational costs.

- *Our IECMH specific team has different productivity standards due to the complexities of the services, like setting up room/toys, and increased drive time compared to the rest of the agency.*

- *CYF [Children, Youth, & Family] centers have lower productivity expectations than adult teams, because you are working with parents, schools, and PCPs [primary care providers]; you may as well be doing wrap-around [WISe].*

- *King County [Integrated Care Network][32] stratifies all 0-5 cases as 'high level', which means higher rates for those services.*

Financial sustainability of IECMH services - Challenges

Summary: Ensuring that there are financially sustainable avenues for providing IECMH services to Apple Health enrolled families was a key priority of providers. Many remarked that funding drives their service provision, and without viable funding, they were less likely or unlikely to provide IECMH services. Providers shared that IECMH rates often did not reflect the service-related time or operational costs necessary for IECMH services, and as a result, many needed to rely on short-term funding streams like grants and private donations to sustain their programs. Providers noted that alternative payment models that take into consideration the unique developmental and relational needs of young children are needed to ensure sustainable IECMH finance, and ultimately, to ensure sustainable IECMH services that can address the unmet mental health needs of young children and families.

- *I believe if it was more financially sustainable, there'd be more urgency to offer these B-5 services.*

- *Our agency as a whole has not emphasized infant-early childhood services, I speculate due to financial reasons.*

- *We need better funding. We have a model that attracts & retains clinicians, and we would hire more staff if funding allowed it. We don't struggle to find clinicians, but we always take big risks when we bring on a new hire, because we are not aware of where the funds will come from.*
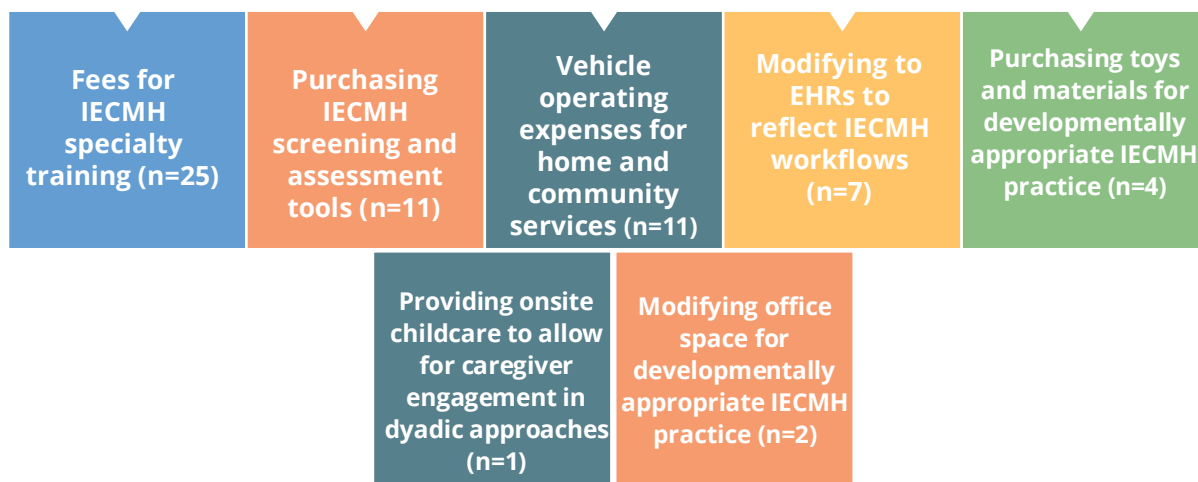
Program operating expenses (n=73)

As noted throughout the report, providing developmentally appropriate IECMH services can require additional operating costs and purchases that may go beyond what is typical for adult or youth driven behavioral health service models; as such, typical rates for behavioral health services may not reflect these increased costs. In addition, because providers may be new to providing IECMH services, these operating expenses may be needed at the onset of service provision while reimbursement for services won't be received for several months. Without up-front investment, providers and agencies must be able to operate at a loss or find alternative funding streams until consistent reimbursement for services is in place.

- *We need funding for starting up 0-5, to help to cover the costs of updating EHRs and forms and training staff, because billing takes time to kick in. We want and need these services.*

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[32] King County Integrated Care Network

The top operating expenses noted by providers included:

Fees for IECMH specialty training (n=25)	Purchasing IECMH screening and assessment tools (n=11)	Vehicle operating expenses for home and community services (n=11)	Modifying to EHRs to reflect IECMH workflows (n=7)	Purchasing toys and materials for developmentally appropriate IECMH practice (n=4)

Providing onsite childcare to allow for caregiver engagement in dyadic approaches (n=1)	Modifying office space for developmentally appropriate IECMH practice (n=2)

Service-related time assumptions (n=57)

As previously noted, the unique considerations of providing IECMH may result in increased service-related time, especially for participation in IECMH specialty training and providing services in home and community settings. Providers also noted the need for flexibility in scheduling and productivity requirements to ensure providers are able to connect with caregivers and allied providers outside of session and to respond to behaviors that are more likely to occur when working with young children.

- *There is a huge push for productivity, but you can't rush a tantrum. The pay is just not sustainable for serving a 3-year-old.*

- *It seems like, when you're working with young children, instead of seeing one client, you're really seeing three or four, because you're also working with the caregivers.*

Reliance on short-term funding streams (n=22)

Given the challenges and barriers associated with Apple Health reimbursement, many organizations use short-term funding streams, such as grants and donations, to cover costs for components of IECMH care not adequately covered, such as purchasing toys and screening tools, paying for training, providing services in home- & community-based services, offering parent groups, care coordination, and peer services, and serving families who are uninsured or underinsured.

- *We are lucky to have a lot of grants, otherwise we wouldn't have the funding to start up new services, like IEMCH.*

- *We utilize grants and donations to be able to provide far more flexible services than would be available with Health Care Authority funding.*

However, while short-term funding streams like grants allowed organizations to cover costs for developmentally appropriate services they might otherwise struggle to provide, the administrative burden and lack of sustainability of these funding streams posed a challenge.

- *We have a patchwork of grant funding often in 1- to 2-year cycles, which makes it hard to maintain positions and sustain programming.*

- *Without statewide programs, each agency has to apply for grant funding, which often falls on the shoulders of busy providers.*

Top Desire

Need for IECMH alternative payment models (n=10)

In recent years, Centers for Medicare and Medicaid Services (CMS) has prioritized innovative alternative payment models (APM) to promote quality care. Oftentimes, APMs provide structures and incentives aimed at transforming the health care delivery system to improve outcomes. APMs may focus on a specific health condition, episode of care, provider type, or population. APMs are not intended to create new programs; rather, they change the way providers are paid for their services. Some providers noted the opportunity to think about new payment approaches in Washington given the additional elements to providing IECMH services.

- *B-5 is a specialty within a specialty, so I want to have it pulled out of the [managed care] capitation rate [for behavioral health][33]. You have driving time and costs for home visiting, time spent not facing the client, like taking videos and reviewing videos, and providers are spending lots of time with families. This is not regular outpatient services; it seems as intensive as WISe.*

- *The dream is that I think this needs to be done with families too, who are engaging in the mental health system. Once you hear from providers and families, instead of taking their ideas and trying to shove them into existing billing, go to the legislature and see if we could get funds to fill in the spaces and the gaps.*

🕊 Centering equity in financing models

Alternative payment methods have the potential to impact disparities in access to and quality of care, but equity considerations must be intentionally considered and centered in the development of APMs to ensure they address existing disparities, rather than maintaining them (Kannarkart, 2023).

- *The marginalized are staying marginalized – how can our funding systems change that?*

IECMH Financing - Taking Action

The financing of behavioral health and early childhood care has evolved over time. Though various funding streams exists, providers and agencies must balance responding to community needs with navigating the rules and restrictions of the different funding sources. With the perspective that funding and the associated requirements to access the funding drive what services are offered, solutions must prioritize intentional approaches that optimize existing funding, identifying gaps, and offer strategies to support providers and agencies. These strategies are based on the best practices and challenges identified by providers, as well as approaches identified in literature. For literature references, please see Appendix J. Taking Action References.

The following actionable steps align with the strategies and approaches for HCA's IECMH Priority 4.

Mental Health Providers

- Utilize HCA's billing resources and participate in HCA's IECMH Office Hours for questions and provider-to-provider support.
- Engage in groups like the Children and Youth Behavioral Health Workgroup's Workforce and Rates Subgroup to share your perspective and inform policy recommendations.
- Sign up for HCA's GovDelivery listservs to stay current on policy and billing updates.
- Strengthen partnerships with billing staff/teams to increase awareness and understanding of your services.

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[33] Medicaid Managed Care Capitation Rate Setting

Agency Administrators

- Share HCA's billing resources and encourage staff to attend HCA's IECMH Office Hours and share HCA's IECMH resources and billing guidance.
- Build relationships with provider relations representatives at MCOs to strengthen communication and partnership around administrative challenges.
- Encourage and support clinical and billing staff relationships to ensure alignment between services and billing practices.

State Policy & System Partners

- Leverage existing funding streams to support developmentally appropriate care through aligned regulations, braided/blended funding strategies, and identification of overlaps in services.[1, 11, 17, 21, 22]
- Utilize policy and investments to expand funding options increasing access to and the delivery of high-quality IECMH services.[1, 17, 22, 31]
- Assess rate adequacy and sustainability to inform implementation of policies that ensure reimbursement covers the full cost of care for developmentally appropriate, evidence-based dyadic services.[1, 17, 18, 31]
- Build capacity for a comprehensive IECMH network of providers by providing tailored resources, training and technical assistance to increase clarity and confidence navigating the complex health system.[17]
- Identify and implement systems-level strategies to reduce duplication of administrative functions and streamline reimbursement processes.[17, 21]

Resource Spotlight:

Fiscal Mapping for Early Childhood Services & Early Childhood Finance Toolkit

In August 2019, The Center for Health Care Strategies, Inc. developed a technical assistance tool as "A How-To Guide" recognizing the siloed nature of early childhood services. The Fiscal Mapping for Early Childhood Services guide provides step-by-step guidance to inventory early childhood funding streams.

In January 2021, the Administration for Children and Families (ACF) published the Early Childhood Finance Toolkit: A Curated Resource to Support State Leaders in a Mixed Delivery System. The toolkit offers tools, guidance, and links to additional resources to support state early childhood leaders exploring strategies to sustainable funding in early childhood systems.

HCA's IECMH Priorities

HCA's IECMH statewide tour report reflects the wisdom and innovations of Washington's mental health workforce. Providers elevated the challenges to offering IECMH services as well as potential solutions. The key topics, best practices, and challenges informed the following HCA IECMH priorities and strategies that build on goals identified in HCA's Strategic Plan (2022-2025). The table in Appendix K highlights alignment between other Washington state IECMH plans to prioritize IECMH in the state.

The following section offers a deeper look at each of the identified priorities with potential approaches to addressing each priority consider for state policy and system partners. This section closes with the next steps HCA is committed to taking in order to move forward in addressing the needs and challenges identified throughout the report.

Priority 1: Strengthen and support a diverse infant-early childhood mental health workforce.

1.1 Build mental health capacity to address IECMH needs of young children and their families, and improve high quality, equity informed IECMH services.

1.2 Use payment and contracting levers to support a diverse IECMH workforce that understands the needs of and has connections with the communities they are serving.

1.3 Explore pathways to expand IECMH services through optimizing a variety of service providers.

1.4 Develop partnerships for sustainable funding for IECMH workforce development.

Priority 2: Ensure equitable access to developmentally appropriate IECMH services for young children.

2.1 Ensure providers and organizations have the resources needed to implement high quality, developmentally appropriate IECMH services for young children.

2.2 Improve HCA program policies and processes to support IECMH best practices.

2.3 Enhance upstream approaches and strategies to strengthen IECMH promotion and prevention in Apple Health.

2.4 Actively seek to understand and remove systemic barriers to developmentally appropriate, evidence-informed care.

Priority 3: Build person- and community centered IECMH services and systems.

3.1 Engage with families of young children to help ensure HCA IECMH policies and programs reflect their needs and priorities.

3.2 Collaborate with Tribal and local governments, community-based organizations, health and social service providers, and stakeholders to reflect their priorities in our IECMH policies and programs.

3.3 Build feedback systems to enable HCA to analyze gaps, issues, and opportunities to understand how HCA and non-HCA systems create barriers.

Priority 4: Achieve value-based, sustainable IECMH care through aligned payments and systems.

4.1 Support development of tools and care delivery approaches that help providers succeed in delivering person-centered IECMH care.

4.2 Use data, evidence, and culturally appropriate standards in policies impacting young children.

4.3 Simplify and standardize payment and delivery reform implementation to reduce administrative burden for providers and families.

4.4 Explore and incorporate innovative payment approaches to finance comprehensive IECMH services that support prevention and early intervention activities.

4.5 Use purchasing power to drive improved outcomes for young children.

Priority 5: Strengthen cross-system alignment to achieve integrated whole person care for young children and their families.

5.1 Lead and/or support innovative community-wide solutions and technology to improve access to care and allow care coordination.

5.2 Work with state partners and Tribes to secure solutions that enhance young children and families' experience, build efficiencies across public programs, and provide better service delivery.

5.3 Align policies and programs to foster integrated, whole-person care that addresses physical health, behavioral health, and health-related social needs.

Priority 1: Strengthen and support a diverse infant-early childhood mental health workforce.

Strategy 1.1: Build workforce capacity to address IECMH needs of young children and their families, and improve high quality, equity informed IECMH services.

Strategy 1.2 Use our payment and contracting levers to support a diverse IECMH workforce that understands the needs of and has connections with the communities they are serving.

Strategy 1.3: Explore pathways to expand IECMH services through optimizing a variety of service providers.

Strategy 1.4: Develop partnerships for sustainable funding for IECMH workforce development.

A critical component to ensuring equitable access to high quality services for young children is a skilled and competent IECMH workforce. Given HCA's commitment to health equity, we are committed to strengthening and supporting a diverse workforce that is reflective of the communities served. Beyond our payment and contracting levers (**Priority 4**), HCA will collaborate with partners to identify solutions for building workforce capacity and coordinating across public programs to support quality services.

In addition to the next steps identified in IECMH Workforce Taking Action, the following provides additional approaches for where Washington state policy and system partners could go next to move forward in strengthening and support the IECMH workforce.

Potential approaches:

- Continue to fund and support workforce development through initiatives like the Infant-Early Childhood Mental Health Workforce Collaborative (IECMH WC) to address IECMH-specialty training needs and incorporate the professional development considerations identified during the IECMH Statewide Tour.[2, 7, 30, 31]

- Explore partnership opportunities to leverage Federal match authority to promote IECMH-specific training and ongoing professional development supports for Apple Health (Medicaid) providers.

- Align HCA workforce efforts with Washington accepted IECMH competencies and current workforce development initiatives.[7, 24, 30]

- Collaborate with state and community partners to assess IECMH workforce capacity to support the development of a IECMH workforce development plan.[7, 10, 26]

- Identify funding and partnership opportunities to support provider-to-provider learning opportunities, such as cohort and mentorship models for providers and agencies serving children birth – 5 years old.[26]

- Collect other state financing approaches and models for IECMH workforce development.[24]

Recent Achievement:

Infant-Early Childhood Mental Health Workforce Collaborative

The Infant-Early Childhood Mental Health Workforce Collaborative (IECMH-WC) is a statewide professional development initiative to support mental health assessment and diagnosis best practices for young children enrolled in Apple Health (Medicaid). Since its inception in the spring of 2022, the IECMH-WC has

- Provided DC:0-5 Clinical Training to 535 mental health professionals,
- Provided DC:0-5 Overview Training to 435 allied professionals, and
- Supported 11 individuals in becoming DC:0-5 trainers, growing the statewide pool of DC:0-5 trainers from 2 to 13.

To learn more about the work of the IECMH-WC, read their 2023 Annual Report.

Priority 2: Ensure equitable access to developmentally appropriate IECMH services for young children

Strategy 2.1: Ensure providers and agencies have the resources needed to implement high quality, developmentally appropriate IECMH services for young children.

Strategy 2.2: Improve HCA program policies and processes to support IECMH best practices.

Strategy 2.3: Enhance upstream approaches and strategies to strengthen IECMH promotion and prevention in Apple Health.

Strategy 2.4: Actively seek to understand and remove systemic barriers to developmentally appropriate, evidence-informed care.

In alignment with HCA's strategic goals, HCA will identify and address barriers to equitable access to high quality IECMH services for young children. An essential element to services being available is providers and agencies being aware and having access to existing reimbursement pathways. HCA will continue to update communication tools and develop tailored resources to ensure providers and agencies have foundational information on Apple Health billing, HCA resources, and how to access support. Further, HCA will work with providers and partners to identify solutions to enhance provider experiences and remove barriers to service delivery.

In addition to the next steps identified in Mental Health Assessment and Treatment for Young Children Taking Action, the following provides additional approaches for where Washington state policy and system partners could go next to move forward in ensuring equitable access to developmentally- appropriate IECMH services.

Potential approaches:

- Enhance efforts to identify young children's and caregivers' needs through use of developmentally appropriate and culturally appropriate screening tools.[13, 14, 15, 20, 26, 29]

- Assess current need for IECMH services compared to workforce and system capacity, including timely access to care.

- Identify and implement policies and strategies to support dyadic approaches to care, such as leveraging reimbursement rates to promote best practices IECMH services.[2, 14, 20, 31]

- Explore strategies to sustainably support operating costs for offering developmentally appropriate care, such as updating processes to reduce administrative burden in accessing reimbursement.[29, 30]

- Partner with existing state referral and access programs to build IECMH referral options that strengthen families of young children's awareness of their services and increase access.[15]

- Collect other state policies aimed at promoting IECMH services embedded within existing early childhood serving systems, such as Early Supports for Infants and Toddlers (ESIT).[24]

Recent Achievement:

Apple Health Infant-Early Childhood Mental Health Service Models Toolkit

In response to requests from providers and agencies, HCA developed an IECMH-specific reference tool to support adoption of IECMH services. In recognition that working within the Apple Health (Medicaid) system can be complex, the toolkit providers guidance on the following topics:

- Core service elements of IECMH treatment
- Avenues to provide mental health services and billing Apple Health for these services
- Requirements to become a licensed mental health provider or behavioral health agency (BHA) with the Department of Health (DOH) in order to provide and bill Apple Health for certain mental and behavioral health services
- Additional resources and supports

In January 2024, HCA published a new version of the toolkit highlighting IECMH best practices to support providers in adopting IECMH at their agencies while strengthening clarity around IECMH service elements and billing guidance.

Priority 3: Build person- and community-centered IECMH services and systems.

Strategy 3.1: Engage with families of young children to help ensure HCA IECMH policies and programs reflect their needs and priorities.

Strategy 3.2: Collaborate with Tribal and local governments, community-based organizations, health and social service providers, and stakeholders to reflect their priorities in our IECMH policies and programs.

Strategy 3.3: Build feedback systems to enable HCA to analyze gaps, issues, and opportunities so we understand how HCA and non-HCA systems create barriers.

Building out HCA's goal to build person- and community centered systems, we will intentionally seek and center the voices of young children, their families, and their providers to inform our IECMH policies and programs. HCA will continue to develop tailored IECMH-specific communications and resources, maintain and improve opportunities for feedback systems with providers, and identify strategies to support family partnership. Recognizing Washington State's long history of embedding peers into our behavioral health workforce, utilization of parent- and family-peers for young children and their families is an important component to enhancing caregiver engagement and quality services for this population.

In addition to the next steps identified in Caregiver Engagement and Home and Community Settings Taking Action, the following provides additional approaches for where Washington state policy and system partners could go next to move forward in building person- and community-centered IECMH systems.

Potential approaches:

- Align family engagement statewide efforts to strengthen our understanding of the needs and opportunities to improve IECMH policies in alignment with family priorities.[3, 31]

- Strengthen shared IECMH communications plan through co-created messages and resources prioritizing caregiver-focused materials to ensure families know what IECMH services are available and how to access them.[15, 30, 31]

- Integrate existing convenings of child- and family-serving organizations to drive state-level solutions based on provider and community experiences and best practices.[3]

- Continue to develop and foster partnership with behavioral health providers and agency administrators to identify needs and strategies for integration of IECMH into existing system of care.[24]

- Identify policy approaches to strengthen and support caregiver well-being and resilience through identification, timely access, and responsive services prioritizing mental and behavioral health needs.[31]

Recent Achievement:
Prenatal to Five: Grow and Thrive Newsletter

Comprehensive communication from state agencies about policies and programs can help to deepen understanding and build trust among partners, providers, and families. While HCA's IECMH communications approach has been built over time, it has always valued the importance of keeping the IECMH community informed about changes to guidance, new resources, and upcoming opportunities to learn. In May 2023, the HCA team began sending a monthly newsletter called **Prenatal – Five: Grow and Thrive**, which highlights announcements, events, and program spotlights about HCA's behavioral health work in the early years, reaching about 4,000 mailboxes each month.

To get the Prenatal – Five: Grow and Thrive newsletter in your mailbox each month, subscribe here.

Priority 4: Achieve value-based, quality, and sustainable IECMH care through aligned payments and systems.

Strategy 4.1: Support development of tools and care delivery approaches to help providers succeed in delivering person-centered IECMH care.

Strategy 4.2: Use data, evidence, and culturally appropriate standards in policies impacting young children.

Strategy 4.3: Simplify and standardize payment and delivery reform implementation to reduce administrative burden for providers and families.

Strategy 4.4: Explore and incorporate innovative payment approaches to finance comprehensive IECMH services that support prevention and early intervention activities.

Strategy 4.5: Use purchasing power to drive improved outcomes for young children.

As a strategy to achieve HCA's goal to transition 90% of state-financed health care to value-based care by 2021, we will explore payment innovations and levers to reward delivery systems and providers in offering high-quality, whole-person IECMH care. We will prioritize strategies that incentivize a focus on addressing and reducing the impacts of adverse experiences, trauma, and health inequities. Efforts will focus on data-driven, evidence-informed approaches and the development of tailored resources aligned with IECMH best practices across the continuum of care. In these efforts, it is essential to incorporate feedback received by participants of the IECMH statewide tour, especially those related to the difficulties in receiving reimbursement and operating costs associated with providing IECMH services to young children and families.

In addition to the next steps identified in IECMH Financing Taking Action, the following provides additional approaches for where Washington state policy and system partners could go next to move forward in achieving value-based, quality, and sustainable IECMH care through aligned payment and systems.

Potential approaches:

- Continue to develop and update IECMH finance and billing resources that help providers and agencies success in delivering high-quality, whole-person IECMH services, including clarifying what Medicaid does and does not pay for.[12, 24, 30, 31]

- Partner with managed care plans and commercial insurance to identify strategies to promote social-emotional health and ensure covered IECMH services are reimbursed.[21, 24]

- Leverage purchasing power to maximize allowable reimbursement through alternative payment approaches that improve social-emotional health outcomes for young children, incentivize quality IECMH services, and align payment with IECMH practice.[17, 19, 24, 31]

- Emphasize IECMH through Washington's Medicaid managed care procurement by requiring plans describe strategies for improvement social and emotional health of young children, including efforts to address workforce capacity.[19]

- Explore evaluation approaches to assess IECMH service utilization, outcomes, and disparities to inform continuous quality improvement and equity-driven policy development.[3, 15, 30]

Recent Achievement:

Embedding IECMH into Apple Health Managed Care Contracts

State Medicaid managed care contracts are an important vehicle for shaping managed care practices and policies (Silow-Carroll et al., 2016). A 2022 survey of Apple Health mental health providers highlighted that standardization of managed care organization (MCO) communication about mental health assessments for young children (MHAYC) could help support implementation (Fabian & Cole, 2023).

To address this, HCA updated the state's Apple Health (Medicaid) Integrated Managed Care (IMC) and Integrated Foster Care (IFC) contracts in July 2023 to require that *each MCO keep participating providers informed about and offer technical assistance on HCA and MCO policies, programs, and practice guidelines related to Infant Early Childhood Mental Health (IECMH)* (section 9.1.14.1.16, p. 203).

To learn more about Apple Health managed care contracts, visit HCA's Model managed care contracts webpage; to learn more about managed care contracts across states, visit the Commonwealth Fund's Medicaid Managed Care Database.

Priority 5: Strengthen cross-system alignment to achieve integrated whole person care for young children and their families.

Strategy 5.1: Lead and/or support innovative community-wide solutions and technology to improve access to care and allow care coordination.

Strategy 5.2: Work with state partners and Tribes to secure solutions that enhance young children and families experience, build efficiencies across public programs, and provide better service delivery.

Strategy 5.3: Align policies and programs to foster integrated, whole-person care that addresses physical health, behavioral health, and health-related social needs.

State and system partners have the opportunity to collaborate to decrease fragmentation and silos within the IECMH system. Through HCA's role in administering Apple Health and as the single state authority for behavioral health, we are committed to partnering across systems to build a comprehensive and coordinated multi-disciplinary network supporting young children and their families. We will work with providers, agencies, state partners, and Tribes to identify opportunities to align our efforts and reduce barriers to ensure young children have access to whole-person care.

In addition to the next steps identified in Allied Professional Collaboration Taking Action, the following provides additional approaches for where Washington state policy and system partners could go next to move forward in strengthening cross-system alignment to achieve whole person care for young children and their families.

Potential approaches:

- Elevate IECMH Statewide Tour feedback as an opportunity to strengthen partnerships across state agencies and programs to create shared goals, identify opportunities to align policies, improve access, and reduce duplication of services for young children across Washington.[2, 3, 7, 12, 15, 24, 25, 30]

- Explore HCA policy and reimbursement strategies to strengthen provider and agency capacity to offer whole-person, coordinated care IECMH services and share findings with partners.[3, 12, 15, 24, 31]

- Develop shared definitions of IECMH and related materials with state partners to establish common language across systems and support building community awareness of the IECMH continuum of services.[2, 7, 15, 30]

- Clarify and develop materials describing state agencies' roles in supporting a full range of services and providers across the IECMH workforce to promote young children's healthy development.[1]

- In partnership with other state policy and system partners, establish core data elements and data sharing processes to increase alignment across systems.[1, 32]

- Continue to support ongoing efforts of the Children and Youth Behavioral Health Workgroup's Prenatal to 5 Relational Health Subcommittee.[24]

Recent Achievement:

Pregnancy, Infancy, & Early Childhood (PIE) Cross-Agency Meetings

Supporting families in the early years of life involves the efforts of many different systems and state agencies. Since October 2022, HCA has been convening bi-monthly meetings of Washington state agency staff who focus on pregnancy, infancy, and early childhood (PIE) programs and policies. The PIE meetings are an opportunity for state agency staff to connect, share program updates, and engage in thought partnership on shared work.

PIE meetings over the past year have covered many different topics that cross the spectrum of whole-person care and support an integrated approach to IECMH, such as reproductive health care and pregnancy services, referral pathways and care coordination, pediatric health care, developmental services, employment supports, perinatal behavioral health, and child welfare.

Currently, over 60 individuals are on the PIE meeting list, representing the following state agencies:

- Health Care Authority (HCA),
- Department of Children, Youth, and Families (DCYF),
- Department of Health (DOH),
- Department of Social and Health Services (DSHS),
- Department of Revenue (DOR),
- Employment Security Department (ESD), and
- Office of Superintendent of Public Instruction (OSPI)

Taking Action at HCA

While HCA has identified potential approaches to support these priorities, we acknowledge the importance of aligning and collaborating across the IECMH system to ensure meaningful outcomes. Additionally, HCA recognizes many of these strategies identified may yield new learnings that may warrant revisions and additions to these five priorities. HCA is committed to taking the following next steps in response to the needs and challenges identified throughout the report.

1. Leverage cross-agency Pregnancy, Infancy, and Early Childhood (PIE) bi-monthly meetings to increase state agency coordination and clarify respective roles in supporting young children and their families. Using this collaborative space, identify opportunities to incorporate policies and programs that strengthen early childhood systems coordination. (**Priority 5**)

2. Utilize internal processes to propose increased family therapy reimbursement for young children to promote IECMH best practices for developmentally appropriate dyadic care. If approved, $450,000 ($225,000 general fund—state appropriation and $225,000 general fund–Medicaid appropriation) will be needed to implement. (**Priority 2**)

3. Following the state agency decision package process, HCA will draft a proposal to fund the design and piloting of an alternative payment model for IECMH treatment services. If approved, $150,000 state funding will be needed to contract with alternative payment experts and $500,000 to implement a pilot. (**Priority 4**)

4. Gather lessons learned from Oregon's implementation of a system-level social-emotional health metric to assess feasibility for Apple Health adoption. HCA IECMH team will share findings through the Prenatal to 5

Relational Health Subgroup of the Children and Youth Behavioral Health Workgroup, including resources needed to support future implementation of similar approaches in Washington. (**Priority 4**)

5. Partner with University of Washington's Barnard Center for Infant and Early Childhood Mental Health (Barnard) to launch a Child Parent Psychotherapy Learning Collaborative (CPP) by July 2024, including an implementation evaluation to support future approaches to sustainable IECMH specialty training. In addition to the training, the Evidence Based Practices Institute (EBPI)will offer EBP reporting support to address provider barriers and identify opportunities to strengthen EBP reporting (**Priority 1 & Priority 2**)

6. Partner with HCA's Office of Tribal Affairs (OTA) to strengthen partnership with through intentional and tailored communication and outreach to Tribal clinics and Indian Health Care Providers. (**Priority 3**)

7. Develop and launch a plan for family-driven IECMH priorities by engaging with caregivers and families about their experiences accessing and receiving IECMH services, including partnering with HCA's communications team to develop a family-focused communications strategy and assessing the need for additional resources to support this work. (**Priority 3**)

8. Explore different payment approaches informed by provider feedback to address barriers identified when providing mental health assessments for young children in home and community settings. (**Priority 2 & Priority 4**)

9. Incorporate training needs and considerations into IECMH-WC activities for FY25 training and professional development supports. (**Priority 1**)

10. By July 2024, partner with providers and agencies from the IECMH Statewide Tour to host IECMH Provider Spotlight series during quarterly IECMH Office Hours reflecting topics identified during IECMH Statewide Tour, such as IECMH-specific intakes and updates to electronic health records (EHRs). (**Priority 3**)

11. Continue to partner with Department of Social and Health Services Research and Data Analysis (DSHS RDA) team on MHAYC evaluation and publish a report by July 2025 on the outcomes of evaluating existing administrative data to assess utilization of MHAYC components, such as multi-session assessment and sessions conducted in home and community settings, to inform updates to MHAYC policies. (**Priority 4**)

12. Share feedback from IECMH Statewide Tour with managed care organizations (MCOs) and collaborate on potential solutions for increasing awareness of IECMH services and application of best practices. (**Priority 4**)

13. Partner with Washington's Mental Health Referral Service (MHRS) and Help Me Grow to identify strategies to build IECMH referral options and strengthen families of young children's awareness of their services. (**Priority 2**)

14. Analyze supplementary qualitative data provided through the Statewide Tour[34], and share findings with external partners to collaboratively develop strategies to address challenges. (**Priority 5**)

15. Continue to participate in early childhood convenings, such as the Early Childhood Courts State Advisory Council, Early Learning Coordination Plan Impact Network, and Washington State Communities for Children. In participating, explore opportunities for leveraging partnerships to collect, align, and share data about IECMH needs, services, and outcomes across systems to inform policy and practice. (**Priority 5**)

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[34] Though outside the original study design of the Listening Sessions, participants provided supplementary qualitative information on topics such as Child Welfare, Early Supports for Infants and Toddlers, Pregnant and Parenting Women programs, and other areas. Though this data was not included within this report, HCA is grateful to providers for elevating opportunities for cross-system alignment and identifying areas for continued partnership.

Conclusion

HCA's IECMH Statewide Tour represents a unique partnership between state leaders, community partners, and providers, and it resulted in rich and detailed information about the current state of IECMH services in Washington state. The report contributes to a growing literature basis about IECMH as a field, while also demonstrating the power of community voice and partnership in developing effective health care policy.

Providers voiced the critical importance for upstream approaches that meet the needs of young children, acknowledging the long-term benefit for the broader behavioral health system and for communities. As noted previously, this has been a key motivator for providers and agencies to offer IECMH services, and it highlights a window of opportunity in Washington, given the recent achievements for IECMH in Apple Health. Though this project was initiated and financed through Apple Health's Mental Health Assessment for Young Children policy, many of the themes, best practices, and challenges impact the broader behavioral health, early childhood, and physical health care systems. Achieving equitable, statewide change for Washington's youngest children and families will require intentional collaboration and action across sectors and payors to move IECMH policy and practice forward.

While the challenges shared in this report demonstrate there is additional work to be done, providers offered insights to guide meaningful change. We hope this report is a resource in inspiring hope and possibility for the future of young children and families, through offering concrete steps for forward action by providers, agency administrators, and state policy and system leaders[35].

HCA recognizes that this work will continue to depend on partnerships across communities and systems, to implement the action steps identified in this report. We are grateful for the trust of the IECMH community in sharing their experiences, as it has created a foundation for HCA's IECMH priorities, grounded in providers' needs and top desires. We look forward to future opportunities to come together, and we hope providers will continue to join IECMH events as we build on the work started through this report.

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[35] Access the summary of all taking action strategies in Appendix J.

Appendix A: HCA's IECMH Statewide Tour Approach

IECMH principles, values, and practices grounded the approach to the design, planning, marketing, and implementation of this project. The following highlights key elements to our approach that aligned with or informed by a relationship-centered and developmentally informed process for engaging with providers.

| Centering Relationships | Statewide Paternships | Provider Engagement |
| Strengths-based | Developmental Progress | Coordinated Systems |

Centering Relationships

Centering relationships is at the core of IECMH as a means to both understand current contexts as well as to influence meaningful change. A central aim of the IECMH statewide tour was to build supportive relationships both between HCA and providers as well as providers with one another.

Sessions were structured to prompt conversation while allowing for participants to guide the direction of the discussion. This allowed participants to direct what feedback felt meaningful and allowed for collaborative interactions amongst participants as they shared ideas and resources with one another.

Statewide Community Partnerships

In an effort to 'hear and represent all voices' (Weston, 2005), the HCA held events in all 9 Accountable Communities for Health (ACH) regions and hosted 1 virtual session. HCA partnered with ACHs and regional organizations to collaborate in preparation for each event to identify accessible and comfortable spaces, outreach local providers, and design community networking to ensure the events were tailored to the unique needs and cultures of each region.

Location	Partners
Port Gamble S'Klallam Tribe Longhouse Kingston, WA (Salish)	Peninsula Early Childhood Coalition Port Gamble S'Klallam Tribe
Grays County Public Health Aberdeen, WA (Great Rivers & Thurston – Mason)	Columbia Wellness Grays County Public Health
Skagit Station Mt. Vernon, WA (North Sound)	Skagit County Public Health
Tukwila Community Center Tukwila, WA (King)	King County Best Starts for Kids King County Behavioral Health and Recovery Division
Boys & Girls Club Henry T. Schatz Branch Tacoma, WA (Pierce)	Elevate Health HopeSparks

Location	Partners
	Kids Mental Health Pierce County
	Pierce County Early Childhood Network
	Pierce County Human Services
Bridgeview Vancouver, WA (Southwest)	Clark County Public Health Southwest Washington Accountable Community of Health (SWACH)
Benton-Franklin Health District Kennewick, WA (Greater Columbia)	Benton-Franklin Health District
Catholic Charities of Central Washington Wenatchee, WA (North Central)	Catholic Charities of Central Washington
Childrens Home Society of Washington Spokane, WA (Spokane)	Children's Home Society of Washington Spokane Regional Health District

Provider Engagement

A critical element to the success of this project was providers attending to share their experiences, issues, and feedback. Recognizing the scheduling and capacity constraints of providers required the structure of the event to allow flexibility for provider participation. This included offering numerous breaks throughout the day, encouraging providers to step away for staff and client calls, and flexibility around participation in the entirety of the event.

In recognition of the different ways individuals may prefer to engage, sessions included different methods for sharing input, including individual and group formats, activity-based, and both verbal and written options.

Note: In planning for the sessions, community partners also elevated the importance of scheduling that allowed **travel time** from other areas of the region, especially for providers who may have family priorities (e.g. child drop off) before and after the event. Additionally, community partners share the value in being able to provide **food and refreshments** throughout the session.

Strengths-based Developmental Progress

As a strengths-based discipline, IECMH works to "identify strengths from which to build competence and address problems" (Zeanah, 2019). Listening Session questions not only explored challenges and barriers faced by providers and agencies to adopt IECMH services, but also invited community-led solutions and explored strategies utilized to support IECMH in practice.

Further, strengths-based approaches acknowledge that development continuously builds over time, and individuals' active participation is essential to their own unique unfolding competencies (Emde, 2001). With this in mind, mental health professionals were invited to attend the Listening Sessions, regardless of where they or their agency were in their own understanding of IECMH or in offering services to children birth to age five. This was in an effort to acknowledge that providers and agencies may be at different developmental stages in this work, which may result in unique needs and solutions.

Though the primary purpose of the listening sessions was to gather feedback from providers, HCA also approached these events as an opportunity to provide education, technical assistance, and build workforce capacity. HCA presented foundational HCA IECMH materials, policies, and available resources, as well as additional educational resources as a means to support providers practice through building their knowledge of IECMH.

Coordinated Systems

Services for young children necessitate integrated, whole-person care given the intersection of children's development across domains (e.g., physical growth, social skills, emotional regulation, cognitive learning, gross motor, sensory processing). Though the sessions were focused on mental health services and providers, a Community Networking event was hosted at the end of listening sessions, open to providers from across disciplines, to build relationships and learn about each other's services. Regional connections across disciplines are essential to promoting whole-person care.

Marketing and outreach

The goal of the Statewide Tour was to ensure broad and wide participation of behavioral health providers, both those with deep experience providing IECMH services, as well as those new to the field. Marketing and outreach approaches centered these values, while also utilizing innovative communication strategies.

Marketing and outreach efforts involved the development of specific assets like social media graphics and region-specific flyers. Efforts were conducted through several channels, including:

- An IECMH Statewide Tour webpage, which served as the hub of updated information.
- Email bulletins sent through GovDelivery (HCA's email subscription system), specifically to those who subscribed to receive updates about prenatal – age 25 behavioral health.
- Inclusion in HCA's monthly Prenatal – Five: Grow & Thrive newsletter, which reaches approximately 4,000 mailboxes.
- Social media posts on HCA's LinkedIn, Facebook, and Instagram accounts.
- Presentations at various events, such as IECMH-WC trainings, meetings with managed care organizations, and the Division of Behavioral Health & Recovery's (DBHR's) monthly provider call.
- Individualized messages from HCA staff sent to mental health professionals through Psychology Today.
- Individualized emails from HCA staff sent to approximately 200 mental health providers who have participated in previous HCA IECMH webinars or workgroups[36].
- Outreach and marketing from statewide organizations, such as the Washington Association for Infant Mental Health, Perigee Fund, and the Washington Council for Behavioral Health, as well as the regional organizations partnering with HCA on the Statewide Tour.

Special efforts were made to ensure Tribal providers were aware of the event and felt invited to participate.

- Tailored emailed bulletins for Tribal providers sent through GovDelivery (HCA's email subscription system), specifically to those who subscribed to receive updates about Tribal behavioral health.
- Phone calls to individual Tribal providers.

Marketing and Outreach impact

The majority of participants (68%) heard about the event through personalized emails or phone calls from HCA staff, and 14% of participants heard about the event from statewide or regional partners, demonstrating the importance of relational approaches to communication. Some participants (14%) heard about the event from HCA email bulletins, which historically has been the primary channel for routine IECMH communication from HCA. A small percentage of participants (4%) heard about the event through more innovative marketing channels, like Psychology Today messages and social media posts (Table 1).

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[36] Over the years, HCA has hosted many IECMH webinars and workgroups. As part of registration or participation in these events, HCA asks participants whether they consent to have HCA contact them via email about IECMH related topics. Through this process, HCA has developed a contact list of over 600 providers across the state.

Table 1. How did you hear about this event?

How did hear about this event?	%
Personalized email or phone call from HCA staff	68%
HCA email bulletin	14%
Outreach from a statewide organization	8%
Outreach from a regional community partner	6%
Psychology Today message	2%
Social media post	2%

Appendix B. Participating Providers

Thank you to the 95 providers from 53 different organizations who participated in the Listening Sessions, including, but not limited to:

- Atlantic Street Center
- Behavioral Health Resources
- Catholic Charities of Eastern Washington Community Behavioral Health Services
- Center for Human Services
- Akin (Children's Home Society of Washington) of Vancouver
- Akin (Children's Home Society of Washington) of Wenatchee
- ChildStrive
- Education Service District (ESD) 105
- Excelsior Wellness
- Greater Lakes Mental Healthcare
- HopeSparks
- Kitsap Mental Health Services
- Partners with Families & Children
- Vashon Youth and Family Services
- Wahkiakum County Health and Human Services

Without your wisdom, compassion, and willingness to share, this report would not exist. We look forward to continued partnership and growth!

Appendix C. Participant Demographics

A total of 95 individuals from 53 different organizations participated in the Listening Sessions. Individuals who participated represented a range of roles, including peers and care coordinators, mental health clinicians, clinical program managers and supervisors, billing and administrative staff, and program directors and C-suite staff.

Regions served

A key goal of the IECMH Statewide Tour was to gather feedback from and build relationships with providers from across the entire state. As described previously, Listening Sessions were held in 9 different cities across the state, in each of the Accountable Communities of Health (ACH) regions; one additional virtual Listening Session was also held. While a sizable portion of participating organizations served the North Sound or King County regions, each region was served by at least one participating organization.

Figure 1/Table 1. Map of Washington state Apple Health regions, percentage of participating organizations who serve that region, and locations of Statewide Tour visits

Visit/Region	%
1 - Spokane	11%
2 – Greater Columbia	8%
3 – North Sound	19%
4 – Pierce County	8%
5 – King County	21%
6 - Southwest	6%
7 – Great Rivers	13%
7 – Thurston Mason	8%
8 – Salish	11%
9 – North Central	2%
10 – Virtual	NA
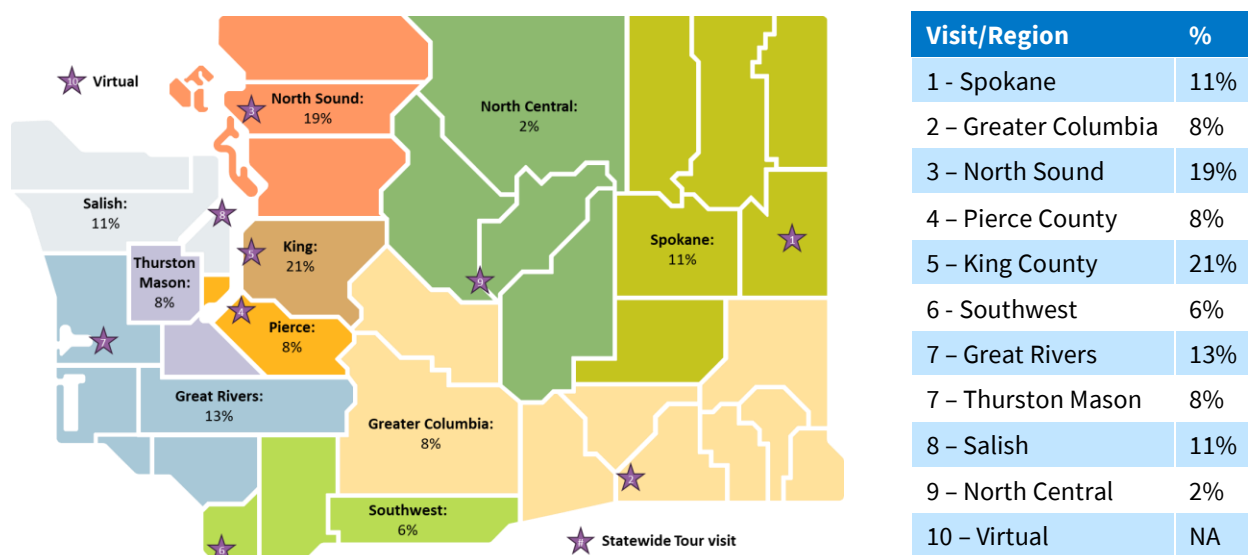
Ages of children served

To acknowledge that organizations may be at different developmental stages with regards to IECMH services, organizations were invited to attend the Listening Session regardless of where they were in their own understanding of IECMH and offering services children birth through age five. The majority of participating organizations (87%) did serve young children (under the age of six), but there was some variety in which specific ages of young children they served (e.g., only 0–2-year-olds, only children older than 3 years).

Figure 2. Ages served by participating organizations
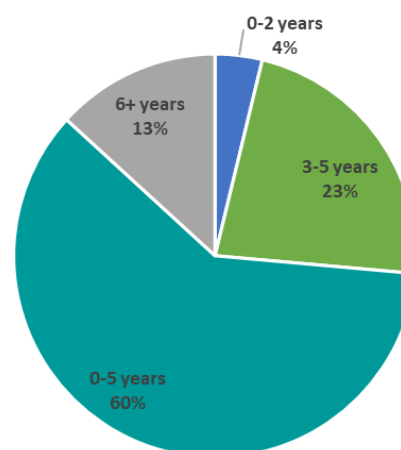
Mental health service pathway

There are two primary avenues available to provide mental health services through Apple Health[37] are as a licensed mental health professional or as a licensed behavioral health agency. The majority of organizations operated as licensed behavioral health agencies (85%), while a smaller proportion (15%) operated as licensed mental health professionals, practicing in integrated care settings or individual or group private mental health practices.

Figure 3 and 4. Service pathways for Apple Health mental health services and the percentage of participating organizations by mental health service pathway
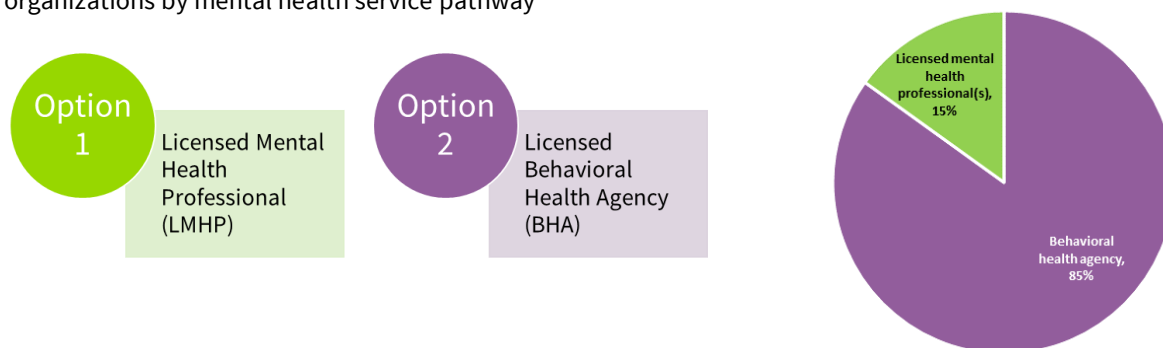
In addition to their mental health service pathway, organizations held could also function as other health care or other social service provider types.

Table 5. Other health care or social service provider types

Other health care provider types	%
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)[38]	11%
Pregnant and Parenting Women (PPW) substance use disorder (SUD) Residential Treatment Facility (RTF)[39]	6%
Tribal clinic/Indian Health Care Provider (IHCP)[40]	6%
Early Supports for Infants and Toddlers (ESIT) provider[41]	6%
Educational service district (ESD)[42]	4%
Neurodevelopmental Center (NDC)[43]	2%

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[37] Apple Health Infant-Early Childhood Mental Health Service Models Toolkit
[38] Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHCs)
[39] Pregnant and Parenting Women Substance Use Disorder Residential Treatment Facilities (PPW SUD RTF)
[40] Indian Health Care Providers (IHCPs)
[41] Early Supports for Infants and Toddlers (ESIT)
[42] Educational service districts (ESD)
[43] Neurodevelopmental Centers (NDCs)

Appendix D. Methods and Materials

Focus Group Questions

General IECMH/B-5 Services

1. What led to your organization to consider serving children birth - 5?
    a. What were/are the strategies to get leadership on board?
    b. What was/is needed to get your organization on board with providing IECMH/B-5 services?
2. What do services look like for children birth – 5 in your setting/organization? (i.e., types of services, specific processes and policies, how many staff support birth – 5)
    If you have not started, what are you considering?
3. How does your organization support the diverse and intersectional needs of families?
    a. Are there unique considerations when serving the birth to five population?
4. What have been/are the greatest challenges/barriers to providing services to this age group?

Billing and Contracting for IECMH/B-5 Services

1. Are there differences in how you bill/submit encounters when conducting these services with young children and their families?
    If you have not yet started, what are you anticipating may be different?
2. Have you experienced any differences in contracting for IECMH/B-5 services with HCA and/or Managed Care Organizations (MCOs)?
    If you have not yet started, what are you anticipating may be different?
3. What are the greatest challenges/barriers to billing and contracting for IECMH/B-5 services?

MHAYC Implementation

1. Share your organizations' policies or procedures, and best practices, and/or challenges experienced with regards to the following areas of the mental health assessment/diagnosis/intake process:
    - Coordination with other partners
    - Structure of intake sessions
    - Screening/assessment tools
    - Clinical documentation/Electronic Health Records (EHR)
    - Caregiver engagement
    - Travel to home and community settings

For the topics above, each table will dive deeper into one of the topics with the following questions:

2. What does this service/activity look like at your organization?
    If you have not yet started, what are you considering and/or what do you anticipate?
    - What led your organization to start incorporating this activity into your work with children birth - 5?
    - What was/is needed to get your organization on board?
    - Do you have specific policies/procedures for how this is offered at your organization?
3. Are there differences in how this is done for young children versus other ages at your organization?
4. What are the greatest challenges/barriers to providing this activity?

Closing reflections

1. What is one thing you are taking away from today?
2. If you could wave a magic wand and make one change, what would it be?

Agenda: Provider listening sessions

Agenda	
9:00 am – 9:30 am	Registration
9:30 am – 10:00 am	HCA welcome
10:00 am – 10:10 am	Break
10:15 am – 11:00 am	Table discussions: IECMH services
11:00 am – 11:10 am	Break
11:10 am – 11:40 am	Table discussions: Billing & contracting
11:40 am – 12:00 pm	Mental Health Assessment for Young Children (MHAYC) activity
12:00 pm – 12:45 pm	Lunch
12:45 pm – 1:45 pm	MHAYC topic discussions
1:45 pm – 2:00 pm	Break
2:00 – 2:30 pm	Closing

Analytic approach

Qualitative data was collected through transcripts of focus groups, as well as written feedback collected through notes, surveys, and group activities noted above. These materials collectively generated 1,720 unique quotes. Data was analyzed using a grounded theory approach (Strauss & Corbin, 1994), using Atlas.ti software. The final coding scheme resulted in 78 primary codes and 125 secondary codes.

Frequency values for each code ranged from 2 to 138 for primary codes, with an average frequency of 33, and ranged from 1 to 44 for secondary codes, with an average of 7. Because data was collected anonymously and not ids were assigned to quotes, the frequencies reported throughout the report represent the number of times a certain theme was expressed by any participant; frequencies do *not* represent the number of distinct participants who expressed a theme.

Appendix E: Participant Experiences

At the end of the Listening Session, participants had the opportunity to share their feedback about the event, through a form that asked the following questions:

1. What worked well?
2. What could have been better?
3. What's something you learned?
4. What emotions came up for you?
5. What's something you will take away and use?

Participants appreciated the relational and strengths-based approach of the event, and they shared that it helped them to strengthen connections with other providers and learn more about IECMH. The event encouraged them to build their organization's capacity to serve young children, and they were hopeful that feedback shared through the event would have positive impacts on policy and practice.

Strengthening relationships

Across all types of feedback, participants highlighted the centrality of relationships. Participants appreciated that the event structure allowed them to network and connect with one another (n=32), especially through the group discussions (n=41).

- *[What worked well was] the collaborative nature of the group discussions. There was so much knowledge in one room. It was all so great.*

- *[What worked well was] the group discussions - coming together, hearing stories, and seeing similarities.*

- *To be in a room of professionals who are able to share this sort of info – it's rare.*

Connections & Mutual Support

Many participants appreciated that the event helped them to feel validated that other agencies experience similar challenges in providing IECMH services through Apple Health (n=24), and they expressed gratitude and admiration for the other providers at the event (n=21). The event helped them to feel more connected to a broader network of IEMCH providers, and this sense of community was encouraging and supportive (n=22).

- *It's validating for me to know that we're not alone in what our site experiences. We're all trying to do better.*

- *Being with people who think the same way brings me hope.*

Participants also noted that after the event, they planned to connect and collaborate with other IECMH providers, including those they met through the event (n=17).

- *I'm going to continue to build a strong community of IECMH providers.*

Shared Learning

Many participants reported that they learned about organizations' approaches to IECMH service delivery, including strategies for recruiting and retaining staff, engaging with caregivers, and conducting mental health assessments (n=67); they also learned from each other about the available resources in their community, especially those for young children and families (n=19).

- *[I learned] about the different approaches to providing mental health care to children from others.*

- *[I learned] more about local partners that provide 0-5 services.*

What worked well? What could have been better?

Participants appreciated the welcoming and supportive space that was created through HCA staff's facilitation style (n=19) and the pacing of the event (n=8).

- *[What worked well was] the way information was presented and how comfortable the presenters made me feel.*

- *[What worked well was the] positive and safe learning space.*

Participants also noted that they appreciated the in-person, community setting (n=17), as well as the fact that food (n=11) and other resources (n=7) were provided.

- *[What worked well was] the community setting. In-person sessions are better, and I love that we were in the Longhouse!*

Participants' primary negative feedback was that they wished there was more representation of other providers and organizations at the events (n=10).

- *We didn't have enough representation and engagement.*

- *I would have liked more agencies to have participated. We need to hear from BIPOC providers.*

What emotions came up for you?

For many participants, the event helped them feel excited and empowered to provide IECMH services (n=59). For some, while IECMH was already an area of interest, the event was the 'fuel' that helped them to feel 'reinvigorated' about the possibilities for expansion and growth.

- *This feels fairly accessible! There are a lot of small places that we can begin.*

- *[I'm feeling] passion and excitement for continuing to explore possibilities of ways to support this age group.*
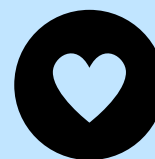
Some participants also expressed feeling frustrated and/or overwhelmed by the challenges that still existed (n=23). However, even for those who felt frustrated or overwhelmed, many also expressed hope and excitement about the possibility for change (n=10).

- *[I'm feeling] frustrated that systems issues are so difficult to disentangle, but also hope that conversations like these can move us forward. [I'm feeling] overwhelmed because it will be a lot of work. But I'm also feeling empowered and excited to get started, to enter into a new venture.*

What did you learn?

Participants reported that they learned more about Apple Health billing and clinical policy, including resources available from HCA on these topics (n=46).

- *I learned lots! I learned more about the administrative and billing stuff that I don't have to necessarily think about on a daily basis.*

- *[I learned] there is support for us statewide from HCA.*

A few participants also noted that the experience helped them to learn more about IECMH in general, as it was a topic that was new or unfamiliar to some (n=11).

- *[I learned] so much! I loved hearing about the world of IECMH - it's all new to me!*

- *[I learned] a lot. I had no idea there was so much going on with respect to infant early childhood mental health. I feel like I have a better foundation and understanding now.*

What's something you will take away & use?

Many participants noted that after the event, they planned to work on expanding their organization's capacity to provide IECMH services, such as by updating their assessment process for young children or by attending IECMH professional development offerings (n=36).

- *I'm going to work on creating a clear protocol for our agency to have standardized methods and training tools for therapists working with 0-5.*

- *I want to think through the process for five session intakes, and how to support a culture shift around this.*

Closing

Many participants shared that they appreciated the efforts of HCA to connect with providers, to listen to their perspectives, and to support them in their work (n=19). They expressed hope that efforts like the Statewide Tour would result in positive changes to policy and practice.

- *HCA is open to feedback and seeking it out; typically, we don't hear anything other than decrees that are sent out and expected to be followed. It's nice to meet humans who are working for the state; you guys are actively trying to check in on how things are going and finding out what else we need.*

- *I appreciate that HCA is validating that this is a big deal and there's lots of pieces. It gives me that hope, that it's not lost on HCA that there could be better ways to do things.*

- *I felt appreciative that HCA actually has some interest in making things better and more appropriate and willing to work with the community on the ground level.*

- *I appreciate curiosity from HCA in what we know and what we provide; hopefully it impacts outcomes.*

Appendix F: Training Considerations

The following components and aspects were elevated by providers as influencing their ability to participate in and/or the effectiveness of training opportunities.

Length of trainings (n=4)

- *I need capacity to learn more. I've been eying the ACT program, but it's so long. Supervisors have so little time, so could there be a shorter program?*

- *We need affordable EBP training that we can sign out people up for, especially the ones that are little nuggets. Even if they don't get certified, they get skills, and it becomes less scary.*

Reoccurring trainings (n=4)

- *Because of the churn, we have to keep training all the time.*

- *I would love to have more frequent virtual training. We have high turnover, so it's nice to have frequent trainings offered that fit busy schedules. If we know we miss one, there will be another one soon.*

- *The more specialized the training, the less often they have them.*

Training in and for teams (n=4)

- *Sometimes they only allow you to attend if you have multiple people in the agency or region, but even having one person trained would be beneficial. Could our programs go together as a team?*

- *We are a tiny little agency with three therapists. For the ACT program, the cost is less, but the model is group based, so that's our entire staff. Could we partner with another agency? Could there be an affordable, accessible training that doesn't require us to go across the state or to commit our entire team?*

Providing incentives for training participation (n=3)

- *We need methods to incentivize professionals to get IECMH training and certification.*

- *If there were a way to provide incentive pay for therapists who go to DC:0-5 training, that would be great.*

Virtual trainings (n=3)

- *We need free training, especially on Zoom.*

- *Would love to have more frequent online and virtual trainings.*

Continuing education units (CEUs) (n=2)

- *Please consider certification or CEUs. The need is there, and people want to support and care for families in terms of mental health. But going back to school for 8 years is a lot, especially for our community.*

Readiness for training (n=1)

- *We need something a little more basic, a bedrock under our providers at least. We have a 'chicken and the egg' problem. The clients we're already working with, we're supposed to use them as our training model; but we can't just bring a kid in as a guinea pig.*

Appendix G. Mental Health Assessment for Young Children Calendar Years 2021-2022 ProviderOne Report

Source

ProviderOne

Population

All paid claims/accepted encounters for mental health assessment sessions, with service dates within CY2021 and CY2022, for clients younger than six enrolled in Apple Health.

Data definitions

- **Mental health assessment session**: claim/encounter for procedure code 90791, 90792, or H0031
- **Mental health assessment[44]**: receipt of at least one assessment session per client, billing provider, per calendar year.
- **Mental health assessment, single session**: receipt of no more than one assessment session per client, billing provider, per calendar year.
- **Mental health assessment, multi-session**: receipt of more than one assessment session per client, billing provider, per calendar year.
- **Health care office and/or facility**: 07 (Tribal 638 Free standing facility), 08 (Tribal 638 Provider based facility), 11 (Office), 19 (Off campus-outpatient hospital), 21 (Inpatient hospital), 22 (On campus-outpatient hospital), 49 (Independent clinic), 50 (FQHC), 53 (Community Mental health), 56 (Psychiatric residential treatment center), 61 (Inpatient rehabilitation facility), 72 (Rural health clinic)
- **Home and/or community[45]**: Place of service codes 03 (School), 04 (Homeless Shelter), 12 (Home), and/or 99 (Other place of service)
- **Telehealth[46]**: Place of service codes 02 (Telehealth Provided Other than in Patient's Home) and/or 10 (Telehealth provided in patient's home)

Mental health assessment episode – number of sessions

Table 1. Number and percentage of single and multi-session mental health assessment episodes in CY2021 and CY2022, for children younger than six enrolled in Apple Health

	CY2021		CY2022	
	n	%	n	%
Mental health assessment, single session	3162	94%	2959	90%
Mental health assessment, multi-session	205	6%	311	10%
All mental health assessments	3367	100%	3270	100%

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[44] Per Apple Health - Mental Health Assessment for Young Children **clinical policy**
[45] Per Apple Health - Mental Health Assessment for Young Children **clinical policy**
[46] Per Apple Health - Telehealth **clinical policy**

Mental health assessment sessions - place of service

Table 2. Number and percentage of mental health assessment sessions that took place in a health care office and/or facility, in the home and/or community, or via telehealth, in CY2021 and CY2022, for children younger than six enrolled in Apple Health.

	CY2021		CY2022	
	n	%	n	%
Health care office and/or facility	1670	46%	2208	59%
Home and/or community	679	19%	400	11%
Telehealth	1243	35%	1117	30%
Total number of sessions	3592	100%	3725	100%

Appendix H: Example IECMH-specific Assessment Processes

The following quotes were shared by providers to describe their organization's mental health assessment process for young children.

- *Our IECMH assessment takes 5 sessions, and most are home visits. We do observation in multiple settings, including in the school, at childcare, and with extended family, as applicable. We conduct two screeners at intake and collect the ASQ-SE from preschool if available.*

- *I use all 5 assessment sessions. I typically start with a dyadic session with both the caregiver and child. Then I meet with the one caregiver alone (in person or via telehealth), and simultaneously I am conducting observation of all other caregiver-child dyads across settings, as well as communicating with professional partners.*

- *Our assessment takes 3-5 sessions and uses the DC:0-5. We do a developmental evaluation, clinical interview, and assessment of parent and child. We do home-based observation and daycare observation, and also observe multiple relationships.*

- *For our IECMH assessment, there is more observation, including caregiver assessment, dyad assessment, and child assessment. We also contact others like DCYF.*

- *I meet with the family for signed consent and intake. Then I meet the child and observe them with family at home, in the classroom, and in my office. Lastly, I read back to the family and teacher what is written for their feedback.*

- *The assigned therapist does intake and keeps the client ongoing. Multiple caregivers and daycare/preschool are included. Home visits are done at times.*

- *We use the following structure for our IECMH assessments:*
  - *Session 1: parent-only interview*
  - *Session 2: functional emotional assessment observation*
  - *Session 3: working model of child interview (no formal training, modified version)*
  - *Session 4: developmental assessment/ASQ*

- *We use the following structure for our IECMH assessments:*
  - *Session 1: Patient rights, consent, and general information*
  - *Session 2: Child routines, including sleeping and eating*
  - *Session 3: ASQ and ASQ-SE*
  - *Session 4: Collateral information from well-child visits*
  - *Session 5: Collateral information from preschool*

Appendix I: Screening and Assessment Tools Table

Table 1. Screening and assessment tools reported by providers. All tools referenced by providers are also included in Appendix L: Additional Resources.

Domain	Tool	n
Child behavior/social-emotional needs	Ages & Stages Questionnaire: Social-Emotional (ASQ-SE)	12
	Pediatric Symptoms Checklist-17 (PSC-17)	8
	Devereux Early Childhood Assessment (DECA)	5
	Child Behavioral Checklist (CBCL)	2
	Early Childhood Screening Assessment (ECSA)	1
	Survey for the Wellbeing of Young Children (SWYC)	1
	Temperament and Atypical Behavior Scale (TABS)	1
Caregiver-child relationship	Working Model of the Child Interview (WMCI)	4
	Parent-Infant Relationship Global Assessment Scale (PIR GAS)	4
	Parent-Child Relationship Competencies (PCRC)	2
	Parent Stress Index (PSI)	2
	Caregiver-child relationship assessment, not specified	2
	Parent-Child Relationship Scale (PCRS)	1
Caregiver behavioral health	Caregiver depression screening (PHQ-9)	8
	Caregiver behavioral health screening, not specified	5
Child development	Ages & Stages Questionnaire (ASQ)	28
	Developmental screening, not specified	5
	Modified Checklist for Autism in Toddlers (MCHAT)	2
	Battelle Developmental Inventory for Young Children (Battell)	1
	Developmental Assessment of Young Children (DAYC)	1
	Survey for the Wellbeing of Young Children (SWYC)	1
Family needs and strengths	Child and Adolescent Strengths and Needs (CANS)	25
	Early Childhood Service Intensity (ECSI)	2
Family social determinants of health	Social determinants of health screening, not specified	1
	Survey for the Wellbeing of Young Children (SWYC)	1
Child and caregiver adverse/traumatic experiences	Traumatic Events Screening Inventory (TESI)	5
	Life Stressors Checklist (LSC)	4
	Adverse Childhood Experiences Screening (ACES)	3
	Child trauma screening, not specified	3
	Caregiver trauma screening, not specified	2

Appendix J. Taking Action Summary

The table below highlights alignment between themes and HCA's IECMH priorities. The section then summarizes the strategies by audience described throughout the report. These strategies are based on the best practices and challenges identified by providers, as well as approaches identified in literature. For literature references, please see the Taking Action References.

Theme	HCA IECMH Priority
IECMH Workforce	Priority 1
Mental Health Assessment for Young Children	Priority 2
Mental Health Assessment for Young Children	Priority 2
Services in Home and Community Settings	Priority 2 & Priority 4
Caregiver Engagement	Priority 3
Allied Professional Collaboration	Priority 1 & Priority 5
IECMH Financing	Priority 4

Mental Health Providers

Individuals who are or are interested in providing mental health services to young children and their families, such as: marriage and family therapist, mental health counselor, psychologist, or clinical social worker. Strategies in this section highlight actionable steps an individual can take to build their skills and practice as well as support strengthening the workforce and system.

IECMH Workforce

- Increase awareness by sharing about IECMH with students and colleagues.
- If you are an IECMH professional, offer to supervise or mentor mental health professionals.
- Build your IECMH competencies and practice through self-study and attending IECMH trainings.

Mental Health Assessment for Young Children

- Attend a DC:0-5 Clinical Training and incorporate into your mental health assessments with young children.
- Review and share with agency leadership HCA's MHAYC and IECMH resources to support incorporating IECMH best practices.
- Participate in IECMH-WC professional development opportunities focused on building skills in assessment and observation.

Mental Health Treatment for Young Children

- Provide dyadic services when working with young children and involve all caregivers when possible.
- Document your use of IECMH evidence-based practices using the EBP reporting guide. [20]
- Build partnerships with Tribes and BIPOC by-and-for organizations in your region to identify opportunities to strengthen your culturally based practices and opportunities to expand access to young children in these communities.[32]

Services in Homes and Community Settings

- If you work in an agency, share your interest and/or openness to providing IECMH services in home and community settings.
- Incorporate safety assessment into your initial information gathering with families.
- Share about the MHAYC travel reimbursement policy with your administrative and billing staff.

Caregiver Engagement

- Ask families about social determinants of health and life stressors to support connecting them to resources.[1, 27]
- Ensure your services and treatment goals use family-centered language and center the strengths and priorities of families.[17]
- Foster trusted and respectful relationships with all caregivers recognizing the range of relationships and importance of collaboration to support young children's healthy development.[5, 6]

Allied Professional Collaboration

- Strengthen coordination across mental health and allied providers working with families of young children throughout treatment.
- Use the Mental Health Referral Service Line, MHAYC Multidisciplinary Referral Guide and Help Me Grow to identify and connect to mental health and allied services that meet young children's needs.
- Share and use the Emotional Health of Babies and Toddlers flyers detailing how we all can play a role in supporting families of young children.

IECMH Financing

- Utilize HCA's billing resources and participate in HCA's IECMH Office Hours for questions and provider-to-provider support.
- Engage in groups like the Children and Youth Behavioral Health Workgroup's Workforce and Rates Subgroup to share your perspective and inform policy recommendations.
- Sign up for HCA's GovDelivery listservs to stay current on policy and billing updates.
- Strengthen partnerships with billing staff/ teams to increase awareness and understanding of your services.

Allied Providers

Individuals who are allied providers supporting IECMH in physical health care, social services, early learning, and adult behavioral health, such as pediatrician, family doctor, public health nurse, child welfare social worker, family/care navigator, child care/early learning provider, early intervention provider, or mental health professional. Given the report is based on mental health provider feedback, strategies are primarily identified in the Caregiver Engagement and Allied Professional Collaboration sections, though individuals may be interested in strategies identified for other audiences throughout the report.

Caregiver Engagement

- Ask families about social determinants of health and life stressors to support connecting them to resources.[1, 27]
- Ensure your services and treatment goals use family-centered language and center the strengths and priorities of families.[17]
- Foster trusted and respectful relationships with all caregivers recognizing the range of relationships and importance of collaboration to support young children's healthy development.[5, 6]

Allied Professional Collaboration

- Strengthen coordination with mental health and allied providers working with families of young children throughout treatment.
- Use the Mental Health Referral Service Line, MHAYC Multidisciplinary Referral Guide and Help Me Grow to identify and connect to mental health and allied services that meet young children's needs.
- Share and use the Emotional Health of Babies and Toddlers flyers detailing how we all can play a role in supporting families of young children.

Agency Administrators

Agency administrators at organizations who are or are interested in providing mental health services to young children and their families, such as: supervisor, manager, director, or C-suite executive. Strategies in this section highlight actionable steps organizations can implement to incorporate IECMH services and best practices into their agency policies, practices, and service delivery.

IECMH Workforce

- Build IECMH workforce capacity through creating birth-5 specialty teams and providing IECMH internship opportunities.[28]
- Ensure staff have the necessary resources to meaningfully engage in IECMH professional development, including agency investment in training, provider release time, and supervision support.[16]
- Strengthen IECMH-specific supervisor capacity through supporting access to reflective supervision training and ongoing professional development, including supervisor-to-supervisor learning opportunities.
- Prioritize diverse workforce in hiring and offer career development opportunities support.[28, 32]
- Provide IECMH staff with job-embedded professional development on cultural competence and working with diverse families.[17]

Mental Health Assessment for Young Children

- Choose a best practice to support implementing multi-session assessment and use of the DC:0-5, such as dedicated efforts to shifting agency culture about the assessment process, aligning intake staffing and workflows, or updating electronic health record systems.
- Encourage staff, especially assessment staff, to attend HCA webinars and DC:0-5 Clinical and Overview Trainings.
- Develop IECMH-specific intake processes or adapt current templates to align with IECMH best practices (Appendix H) and use of IECMH-specific tools.
- Explore funding mechanisms to support collateral information gathering.
- Provide the DC:0-5 Casebook as a resource to support staff in building competencies in assessment and diagnosis for young children. Update agency workflow/s to support information gathering best practices and use of IECMH-specific tools.

Mental Health Treatment for Young Children

- Update your policies to support and promote developmentally appropriate dyadic care.
- Explore local partnerships and alternative financing to provide onsite childcare for caregiver only sessions.
- Ensure your teams are documenting use of IECMH evidence-based practices using the EBP reporting guide.[10, 20]
- Commit to making resources available to providers in adopting evidence-based models, such as release time for training, reduced caseload, and dedicated supervision.[16]

Services in Homes and Community Settings

- Develop safety policies and protocols for offering services in home and community settings.
- Invest in resources to support staff comfort and safety, such as agency cell phones.
- Ensure billing staff are aware of the MHAYC travel reimbursement policy and resources.

Caregiver Engagement

- Update policies and leverage flexible funding to support families access to concrete needs and allied services, including those to support caregiver mental and behavioral health.[1, 5]
- Build local partnerships and collaborate with community partners and regional Accountable Community for Health (ACH) to support referrals for families.[6]
- Adopt family-centered practices and two-generation approaches that support the wellbeing of children and their caregivers.[1, 5, 21]
- Expand your service offerings to include IECMH-focused parenting groups.[8]

Allied Professional Collaboration

- Establish ongoing collaborative relationships and strengthen your regions IECMH network by attending or creating collaborative meetings spaces.[9]
- Partner with other agencies supporting young children and families to offer co-located services.[21,22]
- Invest in offering reflective supervision to staff and invite allied providers to participate when possible.[22]
- Update agency policies and workflows to support coordination with allied providers throughout services.

IECMH Financing

- Share HCA's billing resources and encourage staff to attend HCA's IECMH Office Hours and share HCA's IECMH resources and billing guidance.
- Build relationships with provider relations representatives at MCOs to strengthen communication and partnership around administrative challenges.
- Encourage and support clinical and billing staff relationships to ensure alignment between services and billing practices.

State Policy & System Partners

State cross-system partners invested in fostering the mental health and well-being of young children in Washington state, including Tribes, local and state government agencies, community-based organizations and IECMH providers, policymakers and advocates, payors, researchers, higher education institutions, or community members.

IECMH Workforce

- Conduct an environmental scan and/or workforce analysis to understand the current IECMH workforce landscape, identify facilitators to expanding IECMH capacity, and support the creation of an IECMH workforce development plan.[2, 4, 7, 4, 10, 15, 26]
- Support investment and identify policies to increase accessible, ongoing, and tailored IECMH-specific training and ongoing professional development supports, including cohort models for provider-to-provider support.[2, 4, 7, 17, 26, 29, 30]
- Partner with higher education institutions to incorporate IECMH curriculum and assure foundational IECMH knowledge is included in mental health graduate programs.[28]
- Identify and implement strategies to recruit and support providers from underserved communities and increase capacity for cultural match to populations being served.[1, 7, 17, 32]

Mental Health Assessment for Young Children

- Identify and address barriers to increase use of culturally and linguistically relevant screening and assessment tools, including new policies, investments, or adopting a list of standard IECMH-specific tools.[1, 17, 26]
- Establish cross-system leadership from providers, professional associations, and state agencies to collaborate on developing a standard IECMH intake form that addresses IECMH best practices, clinical and ethical standards, and state regulations.
- Provide investment to support providers and agencies in updating EHR systems to align with MHAYC the policy.[13]

Mental Health Treatment for Young Children

- Identify and implement strategies to build infrastructure and sustain access to evidence-based, dyadic IECMH services, including updating or creating new policies.[10, 20, 27]
- Provide investment to support the operating costs for developmentally appropriate care, including onsite childcare, child-friendly spaces, and age-appropriate toys.
- Invest in research, pilot programs, and implementation evaluation of evidence-based models and culturally driven interventions to strengthen the evidence base, identify gaps, and inform scalable solutions in community-based mental health.[1, 10, 16, 17, 32]

Services in Homes and Community Settings

- Provide investment to support the access to IECMH services in home and community settings, including opportunities to leverage co-located and integrated IECMH services where families and children already receive care.[9, 29, 30]
- Gather best practices across allied services and specialty programs to inform standard tools and guidance for services in natural settings.
- Support initiatives aimed at ensuring IECMH providers have access to resources and supports for best practices in home- and community-based care.

Caregiver Engagement

- Align policies and initiatives with the Washington State Early Learning Coordination Plan that prioritize approaches and programs that promote family wellbeing and address sources of stress, including caregiver mental and behavioral health supports.[1, 5, 6]
- Develop parent leadership networks and opportunities to inform policymaking and hold systems accountable.[1, 27]
- Create cross-system IECMH communications and caregiver education for families with young children that fosters trust, normalizes mental health and well-being, and builds awareness for how to access services when needed.[17]
- Explore cross-sector policy solutions to make the IECMH system easier to navigate for families.[23]
- Invest in research and analysis of parent/family-peer models and IECMH parenting groups to evaluate and strengthen the evidence base, identify gaps, inform scalable solutions, and identify funding strategies to increase access to these services.[1]

Allied Professional Collaboration

- Leverage higher education and professional development initiatives to ensure IECMH providers across sectors have a foundational awareness and understanding of IECMH as it relates to their work.[4, 18, 27]
- Explore policy strategies and technological solutions to align referral systems, promote ease of coordination, and streamline information sharing across IECMH professionals and settings.[1, 17]
- Support initiatives that prioritize co-located services where families already access care and concrete needs.[2]

- Optimize existing cross-sector groups, such as the Children and Youth Behavioral Health Workgroup, to strengthen efforts for shared policy development and investments for the IECMH system.[17, 22]
- Identify key cross-system IECMH champions to define elements of the continuum of care and establish roles to identify IECMH policy priorities, support integration across sectors, and address services gaps.[1, 4, 7, 17, 22, 27]

IECMH Financing

- Leverage existing funding streams to support developmentally appropriate care through aligned regulations, braided/blended funding strategies, and identification of overlaps in services.[1, 11, 17, 21, 22]
- Utilize policy and investments to expand funding options increasing access to and the delivery of high-quality IECMH services.[1, 17, 22]
- Assess rate adequacy and sustainability to inform implementation of policies that ensure reimbursement covers the full cost of care for developmentally appropriate, evidence-based dyadic services.[1, 17, 18]
- Build capacity for a comprehensive IECMH network of providers by providing tailored resources, training and technical assistance to increase clarity and confidence navigating the complex health system.[17]
- Identify and implement systems-level strategies to reduce duplication of administrative functions and streamline reimbursement processes.[17,]

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Appendix K: Washington IECMH Priorities Comparison Table

As described throughout the report, Washington's Infant-Early Childhood Mental Health (IECMH) system is complex and spans across different settings and sectors. Often IECMH programs and providers interact with several state and local government entities who also use different terms and approaches to their work. In recognition of this context, HCA has partnered with King County Best Starts for Kids, Department of Children, Youth and Families (DCYF), and Department of Health (DOH) to develop the following table showing alignment across our IECMH priorities. While each effort and plan may have held a unique population in mind, the priorities and outcomes have significant overlaps as reflected in the comparison table below.

	HCA's IECMH Priorities	King County IECMH Strategic Plan	Early Learning Coordination Plan	Early Childhood Comprehensive System Strategic Activities[47]
	Priority 1: Strengthen and support a diverse infant-early childhood mental health workforce	Priority 4: Support all direct service providers across the continuum of care	Outcome area 4: A Strong and supported early learning workforce	Health Care Provider Training and Technical Assistance
	Priority 2: Ensure equitable access to developmentally appropriate IECMH services for young children	Priority 2: Connect more families with services for IECMH, including promotion, prevention, and treatment	Outcome area 5: Healthy children and families	Health Care Practice Change
	Priority 3: Build person- and community centered IECMH systems.	Priority 1: Promote social and emotional well-being for all children and families.	Outcome area 2: Strong, stable, nurturing, safe, and supported families.	Equity and Engagement Coordinated Intake and Referral System: Help Me Grow
	Priority 4: Achieve value-based, sustainable IECMH care through aligned payments and systems.	Priority 3: Provide high-quality, culturally relevant services that meet the needs of families.	Outcome 3: Positive early learning experiences.[48]	Early Childhood Systems Policy and Financing Health Care Systems Policy
	Priority 5: Strengthen cross-system alignment to achieve integrated whole person care for young children and their families.	Priority 5: Build and strengthen a network of IECMH services countywide.	Outcomes area 1: Powerful communities and a responsive early learning system.	Early Childhood Systems Coordination and Infrastructure

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[47] Strategic activities form the Washington State ECCS Strategic Plan which identified opportunities for alignment with the ELCP.

[48] ELCP's goals for positive early learning experiences focus on the growth and sustainable support for Washington state's early learning system's "mixed delivery system." Though educationally focused, Outcome Area 3's goals and strategies aimed at achieving access to affordable, inclusive, quality care aligns with HCA's strategies for using payment and delivery systems to achieve quality, whole-person care.

Appendix L. Additional Resources

Resources referenced throughout report
The following list includes resources included throughout the text of the report.

HCA Resources
The following resources are from the Washington State Health Care Authority.

IECMH-specific HCA resources

- Infant-early childhood mental health services webpage
  - Apple Health Infant-Early Childhood Mental Health Service Models Toolkit
  - Emotional Health of Babies and Toddlers flyers
  - HCA's IECMH Office Hours
- Mental Health Assessment for Young Children webpage
  - MHAYC Advocacy Timeline
  - MHAYC Multidisciplinary Referral Guide
- Prenatal – Five: Grow and Thrive newsletter
- Infant-Early Childhood Mental Health Workforce Collaborative (IECMH-WC)

Other HCA resources

- Washington state Indian Health Care Providers
- Introduction to Indian Health Care in Washington state
- About Washington Apple Health
- Washington State Health Care Authority Strategic Plan 2022-25
- About Apple Health EPSDT
- Accountable Communities for Health (ACH)
- HCA's GovDelivery email subscriptions
- Children and Youth Behavioral Health Workgroup (CYBHWG)
- Evidence Based Practice Institute (EBPI)
- Evidence Based Practices Reporting Guide
- Wraparound with Intensive Services (WISe)
- Behavioral Health Mobile Crisis Response
- **Resource Spotlight:** Children's Behavioral Health Statewide Family Network (CBHSFN)
- Mental Health Referral Service Line (MHRS)
- About Apple Health managed care
- About Apple Health coverage without managed care
- Medical Assistance Customer Service Center (MACSC) secure form
- HCA Provider Enrollment email inbox
- About Health Care Authority Pediatric Community Health Worker grant
- Apple Health model managed care contracts
- Pregnant and Parenting Women (PPW) Substance Use Disorder (SUD) Residential Treatment Facilities (RTFs)

Washington state resources

The following resources are specific to Washington state, but are not developed by HCA.

IECMH-specific Washington state resources

- Barnard Center for Infant & Early Childhood Mental Health
- **Resource Spotlight:** Washington Association for Infant Mental Health
- 2021 c 126 § 2 (Children and Youth Behavioral Health—Various Provisions)
- Holding Hope: Infant-Early Childhood Mental Health Consultation program for Early Achievers
- Emotional Health of Babies and Toddlers flyers
- King County Best Starts for Kids Transforming Infant & Early Childhood Mental Health - A Landscape Analysis and Strategic Plan for King County

Other Washington state resources

- CBT+ Learning Collaborative
- WAC 246-341-0640 - Behavioral health agency licensing and certification requirements: Individual service record content
- Universal Developmental Screening — A Strong Start for Children
- Tribal Canoe Journey/Paddle to Seattle
- Washington State Head Start and ECEAP
- King County Best Starts for Kids (BSK)
- Early Support for Infants and Toddlers (ESIT)
- Early childhood home visiting
- Washington Fatherhood Council
- Washington State Early Learning Coordination Plan
- Help Me Grow
- The Imagine Institute
- Rural Health Clinics (RHCs)
- Federally qualified health care centers (FQHCs)
- Early Childhood Courts
- Washington State Communities for Children (WSCC)
- Neurodevelopmental Centers (NDCs)
- Educational service districts (ESDs)

National/international resources

The following resources are from national or international organizations, but they may be of use to individuals in Washington state. A full list of all standardized screening, assessment, and observation tools, as well as evidence-based practices, referenced within the report is included on the following page.

IECMH-specific national/international resources

- **Resource Spotlight:** Alliance for the Advancement of Infant Mental Health
- DC:0–5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood
  - **Resource Spotlight:** DC:0-5 Casebook
- **Resource Spotlight:** SAMHSA's IECMH Grant Program
- National Center for Excellence in Infant Early Childhood Mental Health Consultation
- Infant and Early Mental Health Promotion (IEMHP)
- **Resource Spotlight:** From building blocks to care pathways: Guide to working together to support timely access to infant and early mental health care
- About Oregon's system-level social-emotional health metric

Other national/international resources

- About Medicaid
- About Medicaid EPSDT
- Culturally and Linguistically Appropriate Services (CLAS) standards
- Fatherhood is Sacred
- <mark>Resource Spotlight:</mark> Head Start's Early Childhood Learning & Knowledge Center (ECLKC) Ethical Considerations for Home Visiting
- <mark>Resource Spotlight:</mark> Head Start's Early Childhood Learning & Knowledge Center (ECLKC) Home Visitor Safety
- Head Start's Parent, Family, and Community Engagement (PFCE) Framework
- The Knowledge Institute on Child and Youth Mental Health and Addictions
- About Medicaid managed care
- About alternative payment models
- About Medicaid Managed Care Capitation Rate Setting
- <mark>Resource Spotlight:</mark> Guide to Fiscal Mapping for Early Childhood Services
- <mark>Resource Spotlight:</mark> Early Childhood Finance Toolkit: A Curated Resource to Support State Leaders in a Mixed Delivery System
- Commonwealth Fund's Medicaid Managed Care Database

Tools and models referenced by participants

Resources in this section reflect standardized screening, assessment, and observation tools, as well as evidence-based practice models referenced by providers during Listening Sessions.

Standardized screening, assessment, and observation tools

The following resources are standardized screening, assessment, and observation tools referenced by providers during Listening Sessions. These resources do not reflect Apple Health clinical policy or guidance regarding the use of specific tools for the purpose of mental health assessment and diagnosis, as Apple Health does not currently have clinical policy or guidance on this topic.

Child behavior/social-emotional needs

- Ages & Stages Questionnaire: Social-Emotional (ASQ-SE)
- Pediatric Symptoms Checklist-17 (PSC-17)
- Devereux Early Childhood Assessment (DECA)
- Child Behavioral Checklist (CBCL)
- Early Childhood Screening Assessment (ECSA)
- Survey for the Wellbeing of Young Children (SWYC)
- Temperament and Atypical Behavior Scale (TABS)

Caregiver-child relationship

- Working Model of the Child Interview (WMCI)
- Parent-Infant Relationship Global Assessment Scale (PIR GAS)
- Parent-Child Relationship Competencies (PCRC)
- Parent Stress Index (PSI)
- Parent-Child Relationship Scale (PCRS)

Caregiver behavioral health

- Patient Health Questionnaire 9 (PHQ-9)

Child development

- Ages & Stages Questionnaire (ASQ)
- Modified Checklist for Autism in Toddlers (MCHAT)
- Battelle Developmental Inventory for Young Children (Battell)
- Developmental Assessment of Young Children (DAYC)
- Survey for the Wellbeing of Young Children (SWYC)

Family needs and strengths

- Child and Adolescent Strengths and Needs (CANS)
- Early Childhood Service Intensity Instrument (ECSII)

Social determinants of health

- Survey for the Wellbeing of Young Children (SWYC)

Child and caregiver adverse/traumatic experiences

- Traumatic Events Screening Inventory (TESI)
- Life Stressors Checklist (LSC)
- Adverse Childhood Experiences screening (ACEs)

Observation tools

- Dyadic Parent-Child Interaction Coding System (DPICS)
- Parenting Interactions with Children: Checklist of Observations (PICCOLO)
- What to Look for in Relationships
- The Crowell procedure
- Parent-Child Interaction (PCI) Feeding & Teaching Scales

Evidence-based practice models

The following resources are evidence-based practice models referenced by providers during Listening Sessions. These resources do not reflect Apple Health clinical policy or guidance regarding the use of specific evidence-based practices for IECMH. For more information about EBPs identified by the Evidence Based Practice Institute (EBPI), please refer to the Apple Health Reporting Guide for Research and Evidence-based Practices in Children's Mental Health.

- Child-Parent Psychotherapy
- Promoting First Relationships
- Parent-Child Interaction Therapy
- Circle of Security
- Incredible Years
- Triple P/Positive Parenting Program
- Theraplay
- FAST Early Childhood

Resources sent to Listening Session participants

The following lists resources sent to IECMH Statewide Tour participants following the event. Some resources are already reflected in the lists above, but these resources were included again in this section to show a full compilation of participant resources.

HCA IECMH resources

- **Apple Health Infant-Early Childhood Mental Health Service Models Toolkit.** This toolkit is intended to support those interested in receiving reimbursement for Apple Health infant-early childhood mental health services. It provides guidance and best practices on topics such as core service elements of IECMH treatment and avenues to provide mental health services and bill Apple Health for these services.

- **Mental Health Assessment for Young Children (MHAYC) webpage.** This webpage has links to MHAYC billing webinars, billing guides, travel reimbursement forms, the DC:0-5 Crosswalk and more.

- **B-5 at BHAs presentation.** This presentation from the 2023 Washington Behavioral Health Conference covers infant-early childhood mental health best practices and opportunities, especially for behavioral health agencies.

- **WISe B-5 for providers.** This webpage includes information for WISe providers about available resources to support them in serving children birth through age five through WISe.

Other HCA resources

- **Apple Health Non-emergency Transportation services** (NEMT). NEMT ensures necessary transportation for Apple Health clients to and from health care services and appointments. This webpage offers several resources about this program, including a contact list for NEMT Transportation brokers, which vary by region.

- **HCA Managed Care programs mailbox.** This mailbox can be used for any Apple Health providers who are experiencing challenges with or have questions about managed care.

- **Children & Youth Behavioral Health Workgroup** (CYBHWG). The CYBHWG provides recommendations to the Legislature to improve behavioral health services and strategies for children, youth, young adults, and their families. There are several subgroups, including one focused on Prenatal – Five Relational Health.

IECMH Professional Development resources

- **Infant-Early Childhood Mental Health Workforce Collaborative.** The IECMH-WC offers no-cost training and other professional development supports for Apple Health providers on the DC:0-5 and other topics related to assessment and diagnosis for young children.

- **The Barnard Center Advanced Clinical Training (ACT) program for IECMH.** The ACT Program is a 15-month, community learning structured, professional development program designed for licensed and license-eligible mental health professionals introduces and grounds clinicians in the principles, knowledge, skills, and perspectives of infant and early childhood mental health and child development from prenatal to 5 years of age.

- **Best Starts for Kids (BSK).** BSK offers many workshops and other professional development supports for providers whose work impacts children prenatal-to five years of age in King County during the prenatal – age five period, including around infant-early childhood mental health.

- **Infant Mental Health (IMH) Endorsement.** Endorsement provides recognition of specialized knowledge and expertise in professionals working with expecting families, babies, and young children birth through six, and their families. It is an internationally recognized credential offered by states and

countries who are part of the Alliance for the Advancement of Infant Mental Health. In Washington state, IMH Endorsement is provided through the Washington Association of Infant Mental Health.

- Reflective supervision/consultation. Reflective supervision/consultation (RS/C) is a form of ongoing, intentional, scheduled professional development that focuses on enhancing the reflective practice skills of practitioners for purposes of program quality, staff wellness and retention.
    - RS/C provider registry from the Washington Association for Infant Mental Health
    - RS/C provider registry from the National Alliance for the Advancement of Infant Mental Health
- **IECMH Books**

    a. The Emotional Life of the Toddler
    b. Handbook of Infant Mental Health
    c. DC:0-5 Casebook
    d. Reflective Supervision and Leadership
    e. Psychotherapy with Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment
    f. Treating Infants and Young Children Impacted by Trauma
    g. Case Studies in Infant Mental Health
    h. Additional titles included as part of the Alliance for the Advancement of Infant Mental Health's Resource List.

Other Resources

- Perinatal Supports Washington Warm Line. The Warm Line offers free telephone support for all parents and their family members. The line is staffed by parents who have experienced a perinatal mood and/or anxiety disorder and have recovered fully, or professionals with specialized training in perinatal mental health.

- Strong Start. Strong Start is Washington state's universal developmental screening data system, managed by the Department of Health (DOH).

- Holding Hope. Holding Hope offers infant-early childhood mental health consultation (IECMH-C) services to Early Achievers child care providers and the families they serve.

- Early Supports for Infants and Toddlers (ESIT). ESIT services are designed to enable children birth to 3 with developmental delays or disabilities to be active and successful during the early childhood years and in the future in a variety of settings—in their homes, in child care, in preschool or school programs, and in their communities.

Community Networking Event Presentations

- Spokane Regional Health District: overview of the importance of positive childhood experiences (PCEs) and how they can support infant-early childhood mental health.

- HopeSparks Child Development Services: introduction to infant-early childhood mental health, as well as resources available through HopeSparks Child Development Services program.

- Pierce County Early Childhood Network: overview of the work of the PCECN, including available resources such as diaper banks, baby lounges, community gatherings, and learning networks for health providers.

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