A Path Forward

Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia

dc's CHILDREN'S LAW CENTER

Children's National.

DISTRICT OF COLUMBIA BEHAVIORAL HEALTH ASSOCIATION

EARLY CHILDHOOD Innovation Network

HEALTH ALLIANCE NETWORK

MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry

PARENT WATCH

Total Family Care Coalition

ACKNOWLEDGMENTS

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List of Acronyms

A-CRA	Adolescent Community Reinforcement Approach
ACE	Adverse Childhood Experiences
ACRA	Adolescent Community Reinforcement Approach
ACT	Assertive Community Treatment
ADD/ADHD	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
ASD	Autism Spectrum Disorder
ASL	American Sign Language
ASTEP	Adolescent Substance Abuse Treatment
BHIS	Behavioral Health Information System
BHO	Behavioral Health Organizations
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CBI	Community Based Intervention
CBO	Community-Based Organizations
CCBHC	Certified Community Behavioral Health Clinics
CCPEP	Children's Comprehensive Psychiatric Emergency Program
CDC	The Centers for Disease Control and Prevention
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CFSA	Child and Family Services Agency
ChAMPS	Child and Adolescent Mobile Psychiatric Service
CHIP	Children's Health Insurance Program
CHW	Community Health Workers
CJCC	Criminal Justice Coordinating Council
CMS	Centers for Medicare and Medicaid Services
CoCM	Collaborative Care Management
CoP	Community of Practice
CoRIE	Community Resource Information Exchange
CPP	Child Parent Psychotherapy
CRISP	Chesapeake Regional Information System for our Patients
CSA	Core Service Agency
CSS	Court Social Services
CYSHCN	National Care Coordination Standards for Children and Youth with Special Health Care Needs
DBH	Department of Behavioral Health
DBHIDS	Philadelphia's Department of Behavioral Health and Intellectual Disabilities Services

DC	District of Columbia
DC Health	Department of Health
DC MAP	District of Columbia Mental Health Access in Pediatrics
DC SEED	District of Columbia Social, Emotional and Early Development
DC:0-5	The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood
DCHA	DC Hospital Association
DCMR	District of Columbia Municipal Regulations
DCPCA	DC Primary Care Association
DCPS	DC Public Schools
DHCF	Department of Health Care Finance
DHS	Department of Human Services
DYRS	Department of Youth and Rehabilitation Services
EBP	Evidence-based Practice
ECMHC	Early Childhood Mental Health Consultation
ED	Emergency Department
EHR	Electronic Health Record
ENS	Encounter Notification Service
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FFS	Fee for Service
FFT	Functional Family Therapy
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Centers
FSMHC	Free-Standing Mental Health Clinics
FY	Fiscal Year
HCBS	Home and Community Based Services
HFW	High Fidelity Wraparound
HIE	Health Information Exchange
HIS	Health Information System
HIT	Health Information Technology
HPSA	Health Professional Shortage Area
HRLA	Health Regulation & Licensing Administration
HRSA	US Health Resources and Services Administration
iCAMS	Integrated Care Application Management System
ICH	Interagency Council on Homelessness
IDEA	Individuals with Disabilities Education Act
IECMH	Infant and Early Childhood Mental Health
IEP	Individualized Education Program

LANE	Low Acuity Nonemergent
LEP/NEP	Limited or Non-English-Proficient
LGBTQIA+	Lesbian, Gay, Bisexual, Trans/Transgender, Queer or Questioning, Asexual
MCAC	DC Medical Care Advisory Committee
MCO	Managed Care Organization
MCPAP	The Massachusetts Child Psychiatry Access Project
MD	Medical Doctor
mHealth	Mobile Health
MHGPS	My Health GPS
MHPAEA	Mental Health Parity and Addiction Equity Act
MHRS	Mental Health Rehabilitation Services
MPD	Metropolitan Police Department
MST	Multi-Systemic Therapy
NCQA	National Committee for Quality Assurance
NLHEC	National LGBTQIA+ Health Education Center
OHR	Office of Human Rights
OSSE	Office of the State Superintendent of Education
OWB	Office of Well Being
P4P	Pay-for-Performance
PASS	Parent and Adolescent Support
PCCM	Psychiatric Collaborative Care Management
PCIT	Parent Child Interaction Therapy
PCP	Primary Care Provider
PIECE	Parent Infant Early Childhood Enhancement
PMAD	Perinatal Mood and Anxiety Disorder
PRTF	Psychiatric Residential Treatment Facility
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SOC	System of Care
SUD	Substance Use Disorder
TAY	Transition Age Youth
USCDI	United States Core Data for Interoperability
VBP	Value-Based Purchasing
WHO	World Health Organization
WPATH	World Professional Association for Transgender Health
YRBS	Youth Risk Behavior Survey

The public behavioral health system for children and families in the District of Columbia (DC) needs to take a new path forward. The system fails to provide timely, accessible, high quality, culturally appropriate, or affordable care to thousands of children who need it - with devastating consequences.

This report, *A Path Forward-Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*, is a blueprint for creating a successful public behavioral health system, one that supports children and families and, in doing so, strengthens our entire community.

The recommendations in this report build on the commitment shown by the District's leaders – investments and improvements led by the Mayor, government agency leaders, and the DC Council.   It is informed by the expertise and experiences of youth, parents, experts, and best practices from across the country.

A Path Forward is the result of work begun in 2017, when several organizations came together with a shared purpose: to develop a plan of action to ensure DC children and families had the behavioral health supports and services they need to thrive. This informal coalition includes leaders from Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Early Childhood Innovation Network, Health Alliance Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition.

Many important executive, legislative, and public-private efforts have been launched since the coalition began its work. The dramatic increase in school-based behavioral health programs demonstrates a city-wide understanding of the importance of meeting children where they are. The integration of behavioral health into managed care contracts and the District's successful application for a Medicaid waiver to cover additional services shows a commitment to tackling key structural and funding barriers. These are just a few improvements made in the past few years.

However, our community has also suffered the devastating effect of a worldwide pandemic. Even before the pandemic, approximately 1 in 5 DC children – more than 20,000, were reported to have a mental, emotional, developmental, or behavioral problem.[i] Additionally, 47% of DC's children have had adverse childhood experiences (ACEs), including being exposed to violence and living with family members with severe mental health or substance use disorders.[ii] The pandemic has only exacerbated many of those experiences and created new traumas. Due to COVID-19, children have faced unprecedented levels of disruption, isolation, and toxic stress. Family engagement focus groups conducted to inform this report support these findings, with many youth speaking about the impact of the COVID-19 pandemic on their behavioral health.

Our current system does not meet the needs of children and families. A teenager who participated in a focus group conducted for this report stated, "I feel like one of the main challenges, the main mental health challenges that is currently being faced by the DC youth, I feel like, is the lack of resources." This is an accurate observation—one of the significant obstacles children in the District's behavioral health system face is the lack of an adequate supply or range of behavioral health supports. Furthermore, services are often fragmented and inaccessible because of the

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[i] *NSCH Interactive Data Query (2016 – 2018). Data Resource Center for Child and Adolescent Health. Accessed November 2, 2020. https://www.childhealthdata.org/browse/survey*
[ii] *Building Community Resilience: Washington, DC. Building Community Resilience Collaborative. March 2018. https://publichealth.gwu.edu/sites/default/files/downloads/Redstone-Center/DC%20BCR%20Snapshot%20-%204.5.18.pdf*

scarcity of a particular kind of service or provider, the treatment location, inadequate transportation, long wait times, and insufficient care coordination. An effective and complete continuum should include promoting behavioral health, prevention of mental illnesses and substance use disorders, early identification, treatment, recovery and rehabilitation services, and long-term supports.

This report offers concrete, actionable recommendations in the six domains that the World Health Organization identifies as necessary to a functioning public health system: leadership and governance, financing, workforce, service delivery, information and communications, and technology. There is also a section addressing the needs of children whose situations require special attention. The recommendations range from including youth and caregivers at every level of decision-making to technical changes to professional licensing requirements, from the addition of specific treatment modalities to investments in technology to support better coordination.

These recommendations were informed by best practices around the country, feedback, and input from expert stakeholders across the District and focus groups conducted with District youth and caregivers. Abbreviated recommendations, along with suggested implementing agencies and entities, are presented below. The recommendations in each chapter have not been ranked in terms of priority and are not presented in any order.

Children flourish when they receive the right behavioral health care at the right time. If the District commits to implementing these recommendations, it can create long-lasting, systemic change that will transform behavioral health care and advance health equity for children now and in the generations to come.

Leadership & Governance

Recommendation	Suggested Implementing Bodies	For more detail, see
1. Review, strengthen, and—where possible—institutionalize collaboration with the community through documentation and assessments.	DBH, DHCF, CFSA, DC Health, DHS, MCOs	PG 40
2. Prioritize and support the development of a sustainable system that routinely captures and analyzes data on prevalence, incidence, severity, risk factors, social determinants, functional outcomes, and access to care for behavioral health conditions.	DBH, DHCF, CFSA, DC Health, DHS, MCOs	PG 40
3. Develop an updated strategic plan for children's behavioral health.	DBH, DHCF, MCOs	PG 41
4. Make all strategic plans, work plans, and performance reports regarding children's behavioral health publicly available in a timely manner.	DBH, DHCF, MCOs	PG 41
5. Establish an Interagency Council on Behavioral Health that aligns with the Collaborative Governance Model.	DC Council	PG 41
6. More clearly define the roles of DBH, DHCF, and other agencies in children's behavioral health and update DC code and regulations, as needed, in light of the upcoming behavioral health reforms.	DBH, DHCF, DC Health, CFSA, OSSE, DC Council	PG 42

Financing

Recommendation	Suggested Implementing Bodies	For more detail, see
1. Plan to move managed care organizations (MCOs) toward a fully integrated corporate model that does not allow MCOs to subcontract behavioral health services.	DHCF, DBH	PG 59
2. Avail primary care with payment and reimbursement infrastructure to optimize integrated care. We recommend the following: a. Enable Psychiatric Collaborative Care Management (PCCM) through CPT Codes 99492–99494. b. Cover discrete Z-codes to promote mental health and prevent mental health disorders. c. Continue adequate funding of DC Mental Health Access in Pediatrics (DC MAP). d. Establish mechanisms to adequately reimburse decentralized care coordination services provided by clinical and nonclinical professionals in settings where families frequent and trust. That should include expansion of Health Homes and HealthySteps.	DHCF, DBH	PG 59

3. Advance value-based, alternative payment methodologies, and/or accountable care models specific to child and adolescent behavioral health.
    a. Establish a pathway for creation and payment of Certified Community Behavioral Health Clinics (CCBHCs).
    b. Develop value-based and alternative payment models that prioritize children's social and emotional health.
    c. Implement VBP arrangements that adjust for social risk when linking quality measures to payment incentives.
    d. Conduct operational readiness assessments across government agencies, providers, and MCOs to prepare for behavioral health managed care carve-in, specifically examining VBP readiness.
    e. Provide education and technical assistance for MCOs, provider organizations, and the relevant staff at government agencies on VBP strategies to ensure a common understanding, consistent use of terminology, and proper implementation.
	DHCF, DBH, MCOs, CSAs	PG 61

4. Strengthen reporting of access to care standards in MCOs.	DHCF, DBH, MCOs	PG 62

5. Implement transparent strategies to enforce network adequacy. Strategies to consider for enforcing network adequacy include:
    a. Monetary penalties for failure to meet network adequacy standards.
    b. A backstop dispute resolution process.
	DHCF	PG 63

6. Require universal contracting for critical providers to ensure initial network adequacy immediately following the carve-in of behavioral health services into managed care programs.	DHCF, DBH, MCOs	PG 63
7. Update provider reimbursement rates that are adjusted annually for inflation, and establish a transparent rate-setting process.	DBH, DHCF	PG 64
8. Require MCOs to use standardized and simplified authorization, billing, and credentialing processes and protocols.	DHCF, MCOs	PG 64
9. Eliminate same-day billing restrictions that hinder children's access to behavioral health services.	DHCF, DBH	PG 64
10. Ensure proper clinical expertise in medical necessity determinations.	DHCF, DBH, MCOs	PG 65
11. Assess all available public and private funding streams, including Medicaid, that can support plans to address the social determinants of children's behavioral health in DC.	DHCF, DBH, DC Health, CFSA, DHS	PG 65

12. Adequately fund the School-Based Behavioral Health Expansion Program. We recommend the following:
    a. Establish sustainable funding mechanisms.
    b. Ensure sufficient clinical and nonclinical staff in all schools.
    c. Right-size grant or contract funding amounts.
    d. Build provider capacity.
    e. Continue investment in program evaluation.
	DBH, OSSE/DCPS	PG 66

13. Adequately invest in technologies that can support and optimize the work of behavioral health service provider organizations, MCOs, and government agencies involved in children's behavioral health.	DHCF, DBH	PG 67

Service Delivery

Recommendation	Suggested Implementing Bodies	For more detail, see

1. Establish the full continuum of psychiatric care for children, including acute care, crisis stabilization, and intensive outpatient care in the District. That includes the following services specifically for children less than 18 years:
    a. Crisis stabilization unit, with an extended observation unit.
    b. Bridging Clinic for youth who are being discharged from inpatient psychiatric units.
    c. Therapeutic group home/community residence.
    d. Intensive outpatient programs.
    e. Partial hospitalization or day hospital.
    f. A local Psychiatric Residential Treatment Facility (PRTF).
	DHCF, DBH, DC Health, CSAs, MCOs	PG 93

2. Improve services for youth at risk for or diagnosed with substance use disorders (SUD). We recommend:
    a. Exploring solutions to improve screening, assessment, referral and treatment, and options for improved integration of prevention and treatment services into easily accessible locations.
    b. Exploring the implementation of other adolescent substance use evidence-based treatments besides Adolescent Community Reinforcement Approach (ACRA).
    c. Standardizing screening tools for SUD.
    d. Integrating or co-locating substance use outpatient services with mental health services.
    e. Improving communication and understanding of available SUD services for youth among primary care providers (PCPs) and other clinical and nonclinical providers.
    f. Increasing evidence-based prevention programs for youth that target the most frequently used substances.
    g. Exploring opportunities for expansion of DC MAP services to include the Adolescent Substance Use and Addiction Program.
	DHCF, DBH, MCOs, PCPs, ASTEP Providers	PG 93

3. Implement models and expand existing models to facilitate integrated care. We recommend:
    a. Piloting the implementation of the PCCM for children and track outcomes.
    b. Relaxing and expanding eligibility requirements for the two types of DC Health Homes.
    c. Establishing a pathway for creation and payment of CCBHCs.
	DHCF, DBH	PG 95

4. Strengthen care coordination through increased training and reimbursement for both clinical and nonclinical providers, as well as improved and standardized directories. The following strategies are recommended:
    a. Ensure that all behavioral health care coordination meets the National Care Coordination Standards for Children and Youth with Special Health Care Needs.
    b. Standardize MCO provider directories, including directory links showing participating providers in any MCO-subcontracted behavioral health administrative organizations.
    c. Update the providers who are accepting new patients in directories monthly.
	DHCF, DBH	PG 96

5. Improve service accessibility through the Medicaid nonemergency medical transportation.	DHCF, DBH	PG 96
6. Establish agreement and accountability on meaningful quality of care measures.	DHCF, DBH, MCOs	PG 97
7. Improve understanding of the beneficiary experience through improved measurement and reporting of the child, youth, and family experiences.	DHCF, MCOs	PG 97
8. Expand school-based behavioral health services.	DHCF, DBH	PG 98
9. Implement service delivery strategies to identify and address social determinants of health (SDOH). That should include SDOH screening for children and families that uses a trauma-informed approach at all appropriate health settings	DHCF, DBH	PG 98
10. Encourage all behavioral health service delivery organizations—across the settings of child care, school, health, and social services—to develop and implement a plan to deliver and measure culturally responsive and trauma-informed care.	DHCF, DBH	PG 99

11. Improve family-centered care. The following strategies are recommended:
    a. Offer educational resources to behavioral health providers with information about family caregiver needs.
    b. Review care management standards, hospital discharge planning, and risk-assessment procedures to ensure that they meaningfully involve family caregivers.
    c. Provide clinical staff with practice guidelines and supervision for how to effectively engage families/natural supports.
    d. Systematically collect information about family/caregiver needs within behavioral health care settings and account for them in treatment plans.
    e. Ensure higher reimbursement rates for family psychotherapy codes.
    f. Expand self-directed home and community based services (HCBS) accessibility to children with behavioral disorders to maximize the opportunity to use home-based supports in lieu of more intensive care options.
	DHCF, DBH, DC Health, OSSE	PG 99

12. Continue strong work with behavioral health screening and strengthen successful connection to evaluation and/or treatment after a positive screen.	DHCF, DBH, MCOs	PG 100

Workforce

Recommendation	Suggested Implementing Bodies	For more detail, see
1. Implement strategies and incentives to create an adequate labor pool of diverse behavioral health professionals for children.	DHCF, DBH, DC Council, MCOs, OSSE, Higher Education Institutes, Provider Organizations	PG 111

2. Incorporate best practices to improve the cultural competence among providers.	DHCF, DBH, DC Health, CSAs, MCOs	PG 112
3. Conduct research to understand and monitor behavioral health workforce turnover in the District.	DHCF, DBH	PG 113
4. Implement strategies to minimize workforce turnover.	DHCF, DBH, MCOs	PG 113
5. Provide adequate support to child-serving behavioral health providers through Medicaid reform.	DHCF, DBH	PG 114
6. Implement strategies and incentives to improve distribution of children's behavioral health providers.	DHCF, DBH, DC Council, DC Health	PG 115
7. Enable integration of peer specialists, community health workers, and other nontraditional behavioral health professionals across settings.	DHCF, DBH, CSAs, MCOs	PG 115
8. Support engagement and recruitment of youth peer behavioral health specialists.	DHCF, DBH	PG 116
9. Incorporate best practices to improve the trauma-informed care and trauma responsive interventions among providers.	DHCF, DBH, CFSA, CSAs, MCOs	PG 117
10. Create and maintain a database to inform behavioral health workforce planning.	DBH, DC Health, DHCF	PG 118
11. Mandate uniform credentialing requirements and a quicker credentialing turnaround time for all MCOs.	DHCF	PG 118
12. Allow supervised practice for people seeking initial licensure waiting to complete national exams or waiting for application approval or denial, and allow provisional practice for people licensed in other jurisdictions while waiting for District license application approval or denial.	DC Health Professional Licensing Boards	PG 119

Information & Communication

Recommendation	Suggested Implementing Bodies	For more detail, see
1. Develop transparent privacy and confidentiality policies and data-sharing agreements among agencies to support information sharing among providers, MCOs, and government agencies.	DHCF, DBH, HIE Policy Board, CRISP DC, MCOs	PG 130
2. Develop a surveillance system for population-level behavioral health data and behavioral health services data for children.	DBH, DHCF, DC Health, MCOs	PG 130
3. Require uniform standards for data collection and minimal standards for reporting.	DHCF, DBH, MCOs	PG 131
4. Develop and periodically update a comprehensive behavioral health awareness strategy for children and families in DC, with leadership from DC youth and families.	Community-Based Organizations, DHCF, DBH, DC Health, OSSE, DCPS	PG 131

Technology

Recommendation	Suggested Implementing Bodies	For more detail, see

1. Implement strategies to improve participation and use of CRISP (the District's designated Health Information Exchange) by behavioral health providers. Strategies include:
    a. Financial incentives for provider adoption and use.
    b. Technical assistance to providers.
    c. Education and guidance for providers and patients.
	DHCF, DBH, HIE Board, CRISP DC	PG 144

2. Develop and improve CRISP functionalities to meet the needs of behavioral health providers and relevant government agencies.	DHCF, DBH, HIE Policy Board, CRISP DC	PG 144
3. Remove barriers and increase incentives to collect and exchange behavioral health data through electronic health record (EHR) systems that are interoperable with CRISP.	DHCF, DBH	PG 145
4. Ensure equitable access to broadband, Wi-Fi, devices, and other components necessary for telebehavioral health use.	DHCF, DBH, Office of the Chief Technology Officer (OCTO)	PG 146
5. Provide technical assistance to the District's behavioral health providers to support the provision of ethical and high-quality telehealth services.	DHCF, DBH	PG 147
6. Encourage use of mobile health (mHealth) by behavioral health providers and MCOs.	DHCF, DBH	PG 147
7. Expedite District licensing requirements to meet the demand for telebehavioral health.	DC Health Professional Licensing Boards	PG 148
8. Ensure timely access to discharge summaries with CRISP.	DC HIE Policy Board, CRISP DC, DC Hospital Association, Hospital Organizations	PG 148

Special Populations

Recommendation	Suggested Implementing Bodies	For more detail, see
For all special populations		
1. Maximize appropriate information exchange among the behavioral health system, foster care system, juvenile justice system, school system, and the Homeless Management Information System.	DHCF, DBH, DC Health, CFSA, DHS, DYRS, ICH, DCPS, OSSE	PG 165
Children with or at risk for Autism Spectrum Disorder (ASD)		
2. Ensure network adequacy for diagnostic and intervention services for ASD.	DHCF, DBH, MCOs	PG 166
3. Identify and implement comprehensive policy solutions that ensure adequate access to the full array of services and providers needed for ASD diagnosis and treatment.	DHCF	PG 167
4. Standardize insurance requirements for making a diagnosis of ASD across the MCOs and increase transparency and access to this information.	DHCF, MCOs	PG 167
5. Secure funding to provide ongoing training and education on ASD for frontline care providers, including primary care providers, early intervention staff, school staff, and early childhood behavioral health professionals.	DBH, DHCF, DC Health, OSSE, DCPS	PG 168
6. Support the implementation of universal, coordinated, and strategic developmental monitoring and screening practices across key agencies within the District.	DBH, DHCF, MCOs	PG 168
Children in foster care		
7. Guarantee the timeliness of service connection and integrate warm handoff best practices between CFSA and DBH for behavioral health services for children in care.	DBH, CFSA	PG 168
8. Ensure there are clear pathways to accessing care for children in foster care residing in the District and Maryland.	DBH, CFSA	PG 169
9. Provide an augmented capitation payment for children in foster care to MCOs to adequately support their increased needs.	DBH, CFSA	PG 170
10. Continue to work on the implementation of evidence-based therapeutic foster care.	CFSA	PG 170
11. Provide full transparency of specific data collection regarding medication monitoring, and publicly report those data regularly.	DBH, CFSA	PG 171
Children who experience homelessness		
12. Systematically identify children and youth using homeless shelters who are in need of behavioral health services.	DHCF, DBH, DHS	PG 171

13. Increase DHCF's and MCOs' participation in the Interagency Council on Homelessness (ICH).	DHCF, MCOs	PG 172
14. Systematically assess housing status of crisis service users.	DHCF, DBH, DC Health, MCOs	PG 172
15. Collect data on youth homelessness beyond annual point-in-time (PIT) prevalence estimates.	DHS	PG 173
16. Ensure that homeless shelter staff are adequately trained in cultural competency, anti-discrimination, anti-harassment, and trauma-informed approaches to protect the safety and well-being of LGBTQIA+ youth and children.	DHS, Youth Sub-Committee on ICH	PG 174
Children who identify as LGBTQIA+		
17. Support therapeutic interventions proven to be effective and appropriate for LGBTQIA+ youth populations, including culturally tailored treatment modalities.	DBH, DHCF, DHS, OSSE, DCPS	PG 174
18. Increase access to integrated behavioral health services for youth in gender transition.	DBH, DHCF, MCOs	PG 175
19. Improve District capacity to make data-informed decisions on behavioral health care for LGBTQIA+ youth.	DBH, DHCF, DC Council	PG 175
20. Improve cultural competency of social and health care service delivery provided to LGBTQIA+ youth.	CFSA, DYRS, CSS, DHS, DBS, OSSE, MPD, DCPS	PG 176
Youth in the juvenile justice system		
21. Increase access to affordable, high-quality behavioral health services and social service supports for justice-involved youth and their families.	DYRS, DBH, MCO, CBOs/FROs, OSSE	PG 176
22. Ensure continuity of behavioral health services and supports upon reentry into the community	DBH, DYRS, and MCOs	PG 177
23. Implement training to individuals and organizations working with at-risk and justice involved youth.	DBH, MPD, DCPS, OSSE, DC Health, CBOs	PG 178
24. Increase peer support and mentoring opportunities for justice-involved youth.	DBH, DCPS, CBOs	PG 178
Transition age youth (TAY)		
25. Increase transition-age youth-specific services and supports.	DBH, DHCF, MCOs	PG 179
26. Develop a system of care for transition-age youth to ensure care continuity.	DBH, CFSA, DCPS, DHS, CBO/FRO	PG 179
27. Increase engagement of transition-age youth in education, service planning and delivery.	DBH, CFSA, DCPS, DHS, CBO/FRO	PG 180

Prenatal to age five		
28. Include Infant and Early Childhood Mental Health (IECMH)-specific MCO objectives that are measurable and supported with adequate financial incentives.	DHCF, DBH	PG 180
29. Ensure coverage and adequate reimbursement rates for evidence-based dyadic and multigenerational models.	DHCF, DBH	PG 181
30. Ensure adequate financing for Perinatal Mood and Anxiety Disorder (PMAD) screening, prevention, and intervention across all settings and providers, regardless of the caregiver's health insurance status.	DHCF	PG 181
31. Develop and disseminate a billing crosswalk for Medicaid behavioral health professionals across provider settings (DC 0:5 to DSM-V and/or ICD-10), along with training on use of that crosswalk. Policy guidance or clarification should also be issued regarding multisession assessment.	DHCF, DBH	PG 181
32. Continue and expand early childhood mental health consultation programs with permanent and stable funding mechanisms to support needed services in child care centers and Pre-K–3/4 classrooms.	DBH, DHCF, OSSE, DCPS	PG 182
Children who speak languages other than English		
33. DBH should make its website more accessible to limited or non-English-proficient (LEP/NEP) individuals.	DBH, OHR, DC Office of Disability Rights, D.C. Office for Deaf, Deafblind and Hard of Hearing	PG 182
34. Expand the bilingual/multilingual behavioral health workforce.	OHR, DBH, DHCF, MCOs, Community Based Agencies	PG 182
35. Contract providers who can provide or translate behavioral health services for children in American Sign Language (ASL).	DBH, DHCF	PG 183
36. Improve data transparency about the language accessibility of services for LEP/NEP individuals.	DHCF, DBH, OHR	PG 184
37. Managed care plans should ensure they have an adequate network of multilingual, child-serving providers and should have policies/guidelines for single-case agreements for LEP/NEP beneficiaries that require behavioral health services outside the MCOs standard network.	MCOs, DHCF, DBH	PG 184
38. Work with the DC Office of Human Rights to have DBH information included as part of the public awareness campaign for language services.	OHR, DHCF, DBH, DC Health, OSSE, DCPS	PG 185
39. Create more bridge service opportunities like DC Health-supported Help Me Grow DC and DC MAP Partnership	DC Health, Help Me Grow, DC MAP, DBH	PG 185

1. INTRODUCTION

The public behavioral health[i] system in the District of Columbia (DC) provides critical services to many children[ii] and families. While governmental and nongovernmental stakeholders have prioritized various improvements to the system in recent years, some children and families continue to have unmet behavioral health needs reflecting extant opportunities for system strengthening.

The goal of this report is to identify recommendations for transforming DC's public behavioral health system for children into a system that provides appropriate, equitable, and high-quality behavioral health services throughout the continuum of care for children in DC. The report's specific aims are to:

- identify components of our vision for the behavioral health system for children, including best practices and exemplar systems and programs in other states;
- describe the current public behavioral health system for children in DC in terms of leadership and governance, service delivery, workforce, financing, information and communication, and technology (this description will largely draw on our previously published paper[1] and fill in necessary gaps);
- analyze gaps between DC's current behavioral health system for children and a model behavioral health system that can meet the behavioral health needs of DC's children; and
- develop prioritized recommendations to strengthen DC's current public behavioral health system for children.

Section 1.2 outlines the systematic process used to develop the recommendations in this report. The recommendations outlined in this report will be strategically valuable for a variety of stakeholders, including executive and legislative policymakers who intersect with behavioral health care needs of children and families. The information contained in this report is also intended to support the work of behavioral health leaders and advocates in the District's communities.

This report is released by Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Health Alliance Network, Early Childhood Innovation Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition. It is the fifth paper in a series of papers that were previously released by the Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Early Childhood Innovation Network, and MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry. This report utilizes information and expands on concepts that were presented in the previous publications. The first paper in the series, Behavioral Health in the District of Columbia for Children, Youth, and Their Families: Understanding the Current System, provided a robust background of the current local public behavioral health system landscape. The second document, Principles and Values to Guide Child and Adolescent Public Behavioral Health Care System Transformation in the District of Columbia, outlined a set of guiding principles to inform future improvements to DC's public behavioral health system as it aims to deliver effective, accessible, and acceptable services and supports for children and families. The third paper, Addressing Children's Behavioral Health Needs Through Changes to DC's Medicaid Program, concentrated

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[i] We use the term "behavioral health" to refer to emotional and mental health as well as substance use and addiction. That term encompasses a continuum of promotion, prevention, early intervention, treatment, and recovery support services. We also acknowledge that learning, intellectual, or developmental disabilities may impact individuals' abilities to function at school, at home, and in the community, and those complex issues often drive families to seek behavioral health assessment and ongoing treatment.
[ii] For the purposes of this report, unless otherwise specified, "children" refer to persons under age twenty-one.

on the transition to a fully managed care environment for Medicaid recipients in DC and continued our focus on uplifting children's behavioral health. Finally the fourth paper, Advancing Children's Behavioral Health During a Time of Transition in DC's Medicaid Program, offered a set of preliminary recommendations that were particularly relevant during the District's ongoing transition to a fully managed Medicaid program.

This report first discusses the landscape surrounding the behavioral health system for children in DC, with each subsequent chapter then discussing one of six system elements. The six behavioral health system elements were adapted from the World Health Organization's health system building blocks:[2]

Leadership and Governance	Ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design, and accountability
Service Delivery	The immediate output of the behavioral health system that encompasses a comprehensive range of services, including prevention, treatment, and recovery services
Finance	The mobilization, accumulation, and allocation of money to cover the behavioral health needs of the people, individually and collectively, in the system
Workforce	All people engaged in actions with the primary intent to enhance behavioral health
Information and communication	The collection, transference, and dissemination of different types of information, occurring at different levels, to meet a wide variety of behavioral health objectives
Technology	The application of organized knowledge and skills in the form of devices, medicines, procedures, and systems developed to solve a behavioral health problem and improve the quality of lives

Each chapter that is dedicated to one of the above health system elements contains four subsections: (1) our vision for what that element should look like in an improved system, (2) the current situation in DC, (3) a gap analysis, and (4) recommendations for improving that element within the system. A final chapter is dedicated to specific special populations (i.e., children with or at risk for autism spectrum disorder, in foster care, experiencing homelessness, identifying as LGBTQIA+, in the juvenile justice system, who are not proficient in English, as well as transition-age youth and children under age five).

1.1 Guiding Values

While one of our previous publications outlines a comprehensive set of values and principles needed to improve DC's behavioral health system, it is worth reiterating in this document that the values of **family-centered care**, **cultural humility**, **racial equity**, and **trauma-informed care** must underpin the behavioral health system for children in DC. Family-centered care recognizes the significant role that families play in making decisions for children and, thus, necessitates active participation between families and professionals in the planning, delivery, and evaluation of health care.[3] Considering the diversity of the population of DC, it is critical that behavioral health practitioners demonstrate cultural humility, which involves practicing a curious and other-oriented interpersonal approach

Family-Centered Care

Cultural Humility

Racial Equity

Trauma-Informed Care

with the intention of honoring others' beliefs, customs, and values.[4] Further, given the significant disparities among racial and ethnic groups in the District arising from decades of systemic racism, the behavioral health system must support equitable access to the full continuum of services to ensure all children's optimal behavioral health. Finally, adverse childhood experiences and adverse community environments are common occurrences for many children growing up in the District, so trauma-informed care must be interwoven throughout the behavioral health system. That requires care systems to recognize and validate the effects of traumatic events experienced by children to provide appropriate interventions.[5]

1.2 Our Approach

Data Sources

A combination of quantitative and qualitative data from peer-reviewed journal articles, grey literature (including whitepapers, government reports, and grant reports), government websites, and stakeholder interviews were utilized throughout this report's development.

The following provides more information on various instances of stakeholder consultations in developing this report:

- **Consultations with thirty-seven individuals representing managed care organizations, behavioral health service providers, professional associations, and advocacy organizations**
  Four stakeholder engagement sessions were held from August 2019 to March 2020 to gather information to guide the development of this report. Representatives from various organizations involved in service delivery or advocacy in DC attended each session. At the sessions, representatives were asked to provide their views on high-priority gaps in the behavioral health system for children in DC and recommendations for improving the system. Information gathered from those stakeholder consultations were used to inform areas of focus and initial recommendations for this report.

- **Focus groups or interviews with nineteen parents/caregivers and sixteen youth**
  Three focus groups for parents/caregivers, three focus groups for youth ages eighteen to twenty-three years old, and two individual interviews with minors were held during March and April 2021. Focus groups and interviews were organized and led by Children's Law Center, Total Family Care Coalition, and Parent Watch. Each focus group was seventy-five minutes, while each individual interview was thirty minutes. All participants had Medicaid insurance, except for one individual who was uninsured. At each focus group and interview, parents/caregivers or youth were asked about their views on the behavioral health issues of children in DC as well as the behavioral health services. Those focus groups and interviews will be referred to as "family engagement" when any findings from the focus groups/interviews are discussed throughout the report.

Methodology

The following describes the process used to develop this report:

1. . Developing a vision for the District's behavioral health system for children
To develop an appropriate vision for DC's behavioral health system for children, we developed a vision for each of the six health system elements, using secondary research and stakeholder consultations. A literature review of both grey and peer-reviewed literature was conducted to identify national and/or international standards, best practices, exemplar systems, and/or evidence-based programs in other states. Exemplary programs/systems were analyzed to identify transferable components for a well-functioning behavioral health system for children in DC. The best practices or exemplar programs/systems that aligned most closely with the identified local needs were included in the vision for the system. Last, the vision for each element of the system was reviewed and adapted, as necessary, to ensure it aligned with our guiding values of family-centered care, cultural humility, racial equity, and trauma-informed care.

Recognizing the limited resources available to any system, the vision subsections of each chapter are not meant to provide a comprehensive picture of an ideal system for DC, but instead they provide an overview of realistic goals for the system that the District should be working toward. Further, given the dynamic nature of the behavioral health system and its context, that vision for the system requires a regular review and updating to maintain its relevance.

2. Defining the District's current behavioral health system for children

The public behavioral health system for children in DC was first defined in terms of the six health system elements described above. That mapping of the District's behavioral health system relied on our previous publication, Behavioral Health in the District of Columbia for Children, Youth, and Their Families: Understanding the Current System. Information gaps were filled using other existing publicly available information (including District agencies' performance oversight reports, government agencies' websites, government contracts, and grant applications). Information was also gathered through stakeholder consultations.

3. Conducting a gap analysis

Elements of the current system were compared to the matching elements of the proposed model system to discern gaps between the existing and desired states. The identification of gaps was also supported by information from stakeholder engagement sessions. Using comparisons between the current system and our envisioned system, as well as information from stakeholders, a list of gaps for each behavioral health system element was prepared. Recognizing the limitations of this process, the list of gaps does not comprehensively outline all gaps in the behavioral health system for children in DC. Further, those gaps are not presented in any particular order in each chapter.

4. Formulating recommendations to address the gaps

Recommendations were developed to address each identified gap, with a few exceptions. Recommendations were formulated using findings from previous research on national/international standards, best practices, exemplar systems, and/or evidence-based programs in other states. Through internal consultations and external stakeholder engagement, initial recommendations were then refined based on considerations of the effectiveness of the recommendations, applicability of recommendations to the District's context, and perceived acceptability of the recommendation.

For each recommendation, "implementing bodies" and "timeline to implementation" were added using our team's best estimation. Further research and stakeholder engagement on the development of each recommendation will allow the implementing bodies and timelines to be more accurately identified. Currently identified implementing bodies and implementation timeline are included to provide readers with a better understanding of how we envision recommendations being implemented. Additionally, each timeline to implementation is based on the following term definitions:
- Short term—less than one year
- Medium term—within two years
- Long term—greater than two years

While we recognize that some proposed recommendations will be easier to implement, the recommendations in each chapter have not been ranked in terms of priority; therefore, they are not presented in any particular order.

1.3 Limitations

The scope of this analysis (which focuses on the public behavioral health system and individuals under age twenty-one) prevents the proposed recommendations from being fully comprehensive solutions toward ensuring optimal behavioral health for all children of DC. However, the recommendations are practicable solutions for improving integral components of the behavioral health system.

Addressing the behavioral health needs of children in DC requires strengthening both the public and private behavioral health systems. However, the public and private health systems in DC largely operate through distinct mechanisms, and recommendations for improving each system are likely to differ substantially. Thus, the scope of this report was limited to the public behavioral health system. The public system was prioritized because it serves children and families who are not only likely to have higher behavioral health needs (as their economic and social conditions serve as a risk factor) but also less resources to access the necessary continuum of services.

Additionally, the behavioral health of children in DC is linked to the entire behavioral health system for individuals who are both under and over age twenty-one. That is particularly evident because a caregiver's behavioral health can greatly affect their children's behavioral health. Therefore, a behavioral health system cannot fully meet the needs of children without also addressing their caregiver's behavioral health. Further, older children may be required to migrate to the adult behavioral health services, and seamless continuation of care will be necessary for ensuring optimal behavioral health. Despite those considerations, this report focuses on DC's behavioral health system serving children under age twenty-one to ensure a manageable scope for analysis. However, it should be recognized that the resulting recommendations may have the potential to also improve the broader behavioral health system that serves all ages.

2. LANDSCAPE

This section aims to establish a broad understanding of the contextual factors that affect the behavioral health of children and families in DC. It will describe key demographics of the overall population that the behavioral health system seeks to serve as well as discuss some of the social factors influencing the behavioral health of children and families. Finally, this section will provide an overview of the behavioral health needs of DC's children and families.

Ongoing Behavioral Health Reform

The behavioral health system for children and families and its surrounding landscape are not only complex but rapidly evolving in the District. In 2019, DC's Department of Health Care Finance (DHCF) announced plans to move toward a fully managed Medicaid program over the next five years. That shift will involve transitioning individuals currently in Medicaid's Fee-for-Service (FFS) program to the Medicaid managed care program. Also, at the beginning of 2020, the DC Section 1115 Medicaid Behavioral Health Transformation Demonstration became effective, which allows the District's Medicaid program to cover more behavioral health services. A key element of the ongoing behavioral health reform is the addition of behavioral health services into the District's managed care contracts beginning October 1, 2023.[6] This "carve-in" effort will serve to improve care coordination and foster whole-person care for DC Medicaid beneficiaries.[6]

The COVID-19 Pandemic

More recently, the health landscape has dramatically changed because of the COVID-19 pandemic. The public health measures connected to the pandemic have resulted in remote schooling for the majority of public schools, increased availability and use of telehealth, and employment changes/losses. Those ongoing changes have the potential to impact children's access to behavioral health services and overall behavioral health.

A national survey found that 14% of parents reported worsening behavioral health for their children, while 27% of parents reported worsening mental health for themselves between March 2020 to June 2020.[7] Even more concerning, the proportion of children's mental-health-related emergency department visits among all pediatric emergency department visits increased and remained elevated between April 2020 and October 2020 compared to the same time frame in 2019.[8] At the District-level, families at Children's National Hospital, in an ongoing community mental health needs assessment survey, have reported alarming new onset of behavioral and emotional health concerns since March 2020 (98% of respondents), with 64% of respondents observing signs and symptoms of anxiety in their children, 60% reporting onset of irritability, and 52% voicing concerns about their children's social health.[iii] Families that responded to the survey also indicated interest in individual- or family-based responses for support, brief one- to two-session approaches that target stress management and coping during the pandemic, and interventions delivered via telehealth.

> *In our family engagement focus groups, one youth shared:*
>
> *"After-school programs or rec centers are places that have been shut down for the pandemic and … it's kind of hard, because sometimes a rec center or, you know, a youth center or whatever is like all that a youth might have as a safe space."*

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iii Data shared from an ongoing community mental health needs assessment survey via email correspondence with Dr. Mackey from Children's National Hospital (August 2020). Reported results based on 52 respondents.

Our family engagement focus groups also support those findings, with many youth speaking about the impact of the COVID-19 pandemic on their mental health. Many community- and school-based resources offering behavioral health support were not available in person to children through much of 2020, creating a gap in needed services.

2.1 Key Demographics of Children & Families in DC

According to the US Census Bureau 2019 estimates, DC has a population of 705,749 individuals, with children under eighteen years of age comprising 18.1% (or 127,901 individuals) of the population. The majority of the District's population is either Black/African American (45.4%) or White (42.4%), and 11.3% of the population identifies as Hispanic or Latino. It is noteworthy that 14% of DC's population was foreign-born (including over 6,000 individuals under eighteen years of age) in 2018, with El Salvador and Ethiopia being the top countries of origin for immigrants.[9] DC's adult population has a relatively high educational attainment, with 91.9% of the population over twenty-four years old having graduated high school, and almost 60% having a bachelor's degree or higher. Households have fairly high access to the internet, with 87.3% of households having a broadband internet subscription. While the District has a high median household income of $92,266, poverty affects 25.6% of individuals under eighteen years old in DC,[10] over twice the national poverty rate of 10.5%.[11] In terms of household structure, 52.1% of children live in single-parent family households out of all children living in family households.[12] It is also notable that approximately 10,816 grandparents live with their grandchildren under eighteen years, of which 24.8% (or 2,678 grandparents) were responsible for those children. The District has also noted a recent decline in the number of children in foster care, ending the 2019 fiscal year with 796 children in foster care.[13]
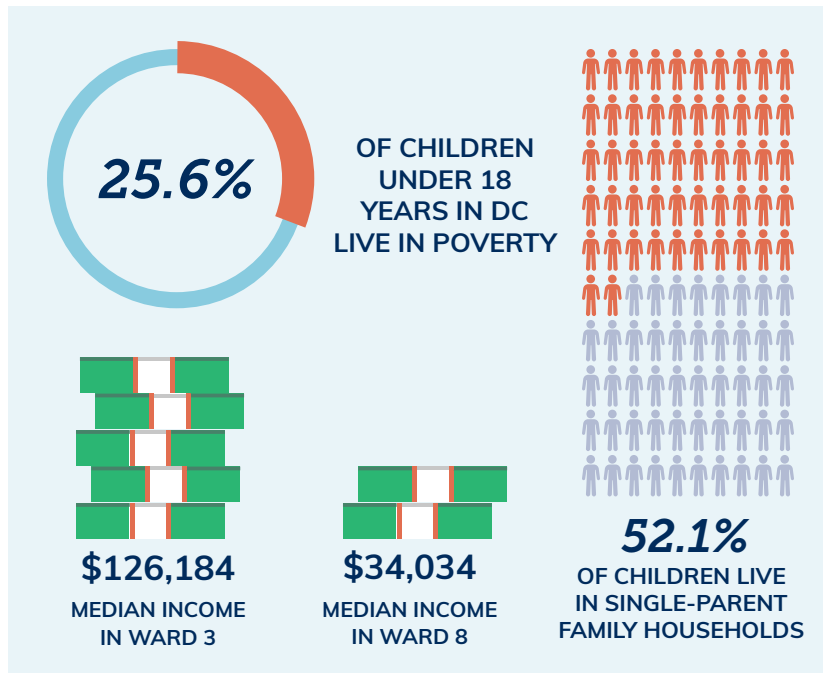
25.6% OF CHILDREN UNDER 18 YEARS IN DC LIVE IN POVERTY

$126,184 MEDIAN INCOME IN WARD 3

$34,034 MEDIAN INCOME IN WARD 8

52.1% OF CHILDREN LIVE IN SINGLE-PARENT FAMILY HOUSEHOLDS

It should be acknowledged that these general District statistics conceal many disparities that are pervasive across the subregions of DC. There are distinguishable trends occurring in the District based on ward. According to five-year (2014–2018) US Census Bureau estimates, the youth population (under eighteen years old) varies dramatically among the eight wards, ranging from 6.2% of the population in Ward 2 to 29.7% of the population in Ward 8.[14] Racial and ethnic composition also varies across wards, with over 90% of Wards 7 and 8 being Black and over 70% of Wards 2 and 3 being White. There is a huge disparity in income and poverty across wards. Median household income ranges from $126,184 in Ward 3 to $34,034 in Ward 8 and similarly, the percentage of youth (under eighteen years old) in poverty ranges from 2.5% in Ward 3 to 46.1% in Ward 8.

2.2 Behavioral Health of Children In DC

There is no District-specific routine surveillance system that collects and disseminates data on behavioral health issues in children. However, there are several national data collection and sharing mechanisms that can be used to gain rough estimates of some of the behavioral health needs of children in DC. Those mechanisms include the *Youth Risk Behavior Survey* (YRBS), the *State of Mental Health in America*, and the *National Survey of Children's Health*. The data of each report has limitations based on their research methodologies and therefore should be interpreted

with caution. For example, the YBRS sample was restricted to students in public and public charter schools and thus does not capture critical populations such as children in private schools or out-of-school children (including those in the juvenile justice system or homeschooled).

Prevalence of Behavioral Health Issues in Children in DC

The DC Health Matters Collaborative—a coalition of DC hospitals, community health centers, and associations—has repeatedly identified mental health as a priority need in the 2013, 2016, and 2019 Community Health Needs Assessment, reflecting that behavioral health persists as a major concern from a community perspective.[15] **Approximately 22% of children (ages three to seventeen years) in DC, which represents over 20,000 individuals, have a mental, emotional, developmental, or behavioral problem.**[16] Forty-seven percent of DC's children (less than eighteen years) have had adverse childhood experiences (ACEs),[17] which are risk factors for developing behavioral health issues. ACEs include experiencing racism, being exposed to violence, and having family members with severe mental disorders or substance use disorders.[18] The majority of individuals experiencing ACEs were Black, non-Hispanic children.[18] Family engagement focus group discussions also pointed to a high prevalence of adverse and traumatic experiences among participants. Trauma was often cited as a major behavioral health concern for DC children by both youth and parent participants, and, as one parent stated, "a lot of them [children] have been through traumatic situations or hard times, and a lot of times, the mental aspect isn't dealt with."

22%
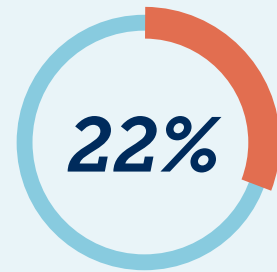
Approximately 22% of children (ages three to seventeen years) in DC, which represents over 20,000 individuals, have a mental, emotional, developmental, or behavioral problem.

Depressive symptoms appear to be prevalent among children in the District. Over 10,000 high school students (33%) reported feeling sad or hopeless almost every day for at least two weeks in the past year.[19] Based on the State Of Mental Health In America Report, approximately 3,000 youth (ages twelve to seventeen) have had at least one major depressive episode in the past year in DC, with 2,000 youth having a severe major depressive episode. Over one in three youth with past-year depression did not receive the mental health services that they needed.[20] While youth who participated in our family engagement focus groups infrequently referred directly to specific diagnoses when describing mental health concerns, symptoms associated with depression—particularly with regard to emotional experience—were frequently described, including hopelessness, anger, loneliness, and shame.

An alarming number of children in the District are also experiencing **suicidal ideation and/or are attempting suicide**, with noticeably higher rates in children who identify as lesbian, gay, and bisexual (LGB). The 2019 DC YRBS found that approximately 29% of middle school students and 19% of high school students seriously considered attempting suicide. Further, 14% of middle school students and 15% of high school students attempted suicide in the past year, cumulatively representing over 19,000 children. In the middle and high school populations, LGB students were more than two times as likely to have seriously thought about, planned to, or attempted to kill themselves.

Substance use among children in DC also appears to be problematic. Approximately 5.42% of youth (or 2,000 individuals between the ages twelve and seventeen) had a substance use disorder in the past year in DC, which is notably higher than the national average of 3.83%.[21] According to the 2019 DC YRBS, an estimated 9% of middle school students and 29% of high school students reported use of marijuana in the past thirty days. Relatedly, in our family engagement efforts, many youth and parents identified marijuana as the drug most frequently used among youth in DC. Some research has linked heavy marijuana use in adolescence to altered brain development, impaired cognition, and poor academic performance.[22] Additionally, 20% of high school students had at least one drink of alcohol in the past thirty days, and 13% of them reported current use of illegal drugs. LGB youth were overrepresented in the

percentage of students who reported substance use in both middle and high school. Notably, in our family engagement efforts, several youth identified substance use as a means of coping with psychological issues.

The prevalence of **disabilities and disability-associated disorders** in children in the District is particularly difficult to discern given the variance in definitions and sample populations. According to the US Census Bureau, 4.2% of the civilian noninstitutionalized population under eighteen years (or 5,421 individuals) have a disability (which was defined as a serious difficulty with four basic areas of functioning—hearing, vision, cognition, and ambulation). However, that is incongruent with the US Department of Education's estimate that over 12,000 students ages six through twenty-one in DC were served under the Individuals with Disabilities Education Act in 2018 (the qualifications for which include having a physical or mental disability that significantly limits at least one of the following: caring for oneself, manual tasks, sight, hearing, speech, breathing, learning, or work).[23] The 2018 *National Survey of Children's Health* estimates that almost 3,000 children, ages three through seventeen, are diagnosed with an autism spectrum disorder in the District. Additionally, approximately 9,500 children, ages 3 through 17, are diagnosed with attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) in DC. The survey also estimated that 4,000 of the children with ADD/ADHD diagnoses did not receive treatment in the past year in DC, reflecting a great degree of unmet need for behavioral health services.

2.3 Social Determinants of Behavioral Health for Children in DC

The Centers for Disease Control and Prevention (CDC) defines the social determinants of health (SDOH) as "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes." The 2018 *Health Equity Report* for DC has identified that, besides clinical care, there are other key drivers of health in the District (such as education, income and employment, community safety, and housing).[24] Research has applied the SDOH definition specifically to behavioral health, noting that social and environmental factors affect individuals' risk for mental health and substance use disorders, their access to behavioral health services, and their behavioral health outcomes.[25] Those determinants of behavioral health can be classified as risk factors or protective factors. For this report, risk factors refer to unfavorable social, environmental, and economic circumstances that are positively associated with behavioral health problems and/or increase the likelihood of negative behavioral health outcomes. Exposures to such risk factors can begin prior to birth and amass throughout the individual's lifespan.[26] On the other hand, protective factors for behavioral health refer to aspects of children's social environment, including their family, peer, school, and neighborhood contexts that are associated with the extent of their developmental resilience. In DC, some protective social determinants of children's behavioral health include elements of their school environment and family support. In contrast, some risk factors include housing situations, neighborhoods, and experiences with racism. Furthermore, children's behavioral health can be affected by their parent/caregiver's employment status, income, and health.

Protective Factors

- The presence of **behavioral health services in the public-school setting** in DC represents a protective factor for many children's behavioral health. Considering the significant amount of time that children spend in school, a school's environment can greatly influence children's attitudes, behaviors, and health outcomes.[27] The majority of children in DC attend public schools, with only approximately 15% of students attending a private school between 2013 and 2017.[28] Among students attending public schools in DC, there is almost equal enrollment in DC Public Schools (54%) and DC public charter schools (46%).[29] In the DC public school system, many children have access to behavioral health services through the Department of Behavioral Health's School Behavioral Health Program, which offers prevention, early intervention, and clinical services to students and their families.[30] Such services can directly improve students' behavioral health but also indirectly elevate school connectedness. A great proportion of DC students appear to feel supported by adults in school, with approximately 70% of students in public middle and high schools reporting that there is at least one teacher or other adult in school whom they can talk to if they have a problem.[19]

- A **positive family climate** also serves as a protective factor for children's behavioral health.[31] Data from the *2018 National Survey of Children's Health* reflects that many parents in DC have strong relationships with their children. Similar to the national average, 65% of children (ages six to seventeen) share ideas or talk very well with their parents. Additionally, given the strong association between frequent family dinners and better child mental health,[32] it is noteworthy that almost three of every four children (ages zero to seventeen) in DC have families that eat meals together at least four days per week. DC also ranked higher than the national average for the proportion of children (ages zero to five) whose parents or family members read, sing, or tell stories to them every day, which are early family routines that support healthy child development (including socioemotional development).[33]

Risk Factors

- Despite the positive attribute of schools, school environments have also been shown to be a source of risk factors for behavioral health issues in children through exposure to violence and bullying. The *2019 District of Columbia YRBS* found that 32.0% of middle school students and 12.7% of high school students were bullied on school property in the past year, which cumulatively represented over 20,000 students in the District.[19] Bullying was also highlighted by our family engagement focus group participants, who frequently cited peer pressure as a factor associated with behavioral health challenges, especially with regard to pressuring children to engage in dangerous substance use behavior. That high rate of bullying can have detrimental short- and long-term impacts on children's mental health, because research has shown strong associations between bullying and mental health problems such as depression, anxiety, and suicidal ideation.[34] Relatedly, within the last decade, DC Council passed the Youth Bullying Prevention Act of 2012 to address bullying at the District level, which requires all youth-serving district agencies (including schools) to adopt anti-bullying policies and implement reporting and investigation procedures.[35]

- **Housing** has also been linked to children's psychosocial well-being.[36] DC has a lack of affordable housing, with over half of renters paying more than 30% of their income on housing.[37] Parental stress over housing insecurity and/or a lack of finances to pay for other basic necessities (such as food or medical care) can contribute to children's poor mental health. The high cost of housing has contributed to homelessness increasing by 34% in the District between 2009 and 2016. In 2017, 1,166 homeless families (of which children comprised nearly 60%) were in DC.[24] Children without stable housing can have traumatic experiences, linked to high rates of behavioral problems, delayed development, as well as attachment and mood disorders.[38]

- Children's exposure to **violence** in their neighborhoods in DC is also concerning. The rate of mortality due to homicide in DC is three times the national average, suggesting poor community safety in some neighborhoods.[24] It is noteworthy that approximately 11% of the homicide victims in DC in 2017 were below eighteen years old.[39] Further evidence of children's high risk of exposure to violence was found by the 2019 DC YRBS, which noted that almost 50% of middle school students have seen or heard people where they live be violent or abusive in the past year. Additionally, District residents are experiencing increased rates of community violence, with homicides due to gun violence increasing 19% from 2019 to 2020.[40] Our family engagement participants also reported that violence was a contributing factor to behavioral health issues among children in DC, and a number of youth mentioned that the issue was concentrated in Southeast DC. Research has shown that exposure to community violence can have poor mental health outcomes for children, especially related to development of post-traumatic stress disorder.[41]

50%

of middle school students have seen or heard people where they live be violent or abusive in the past year.
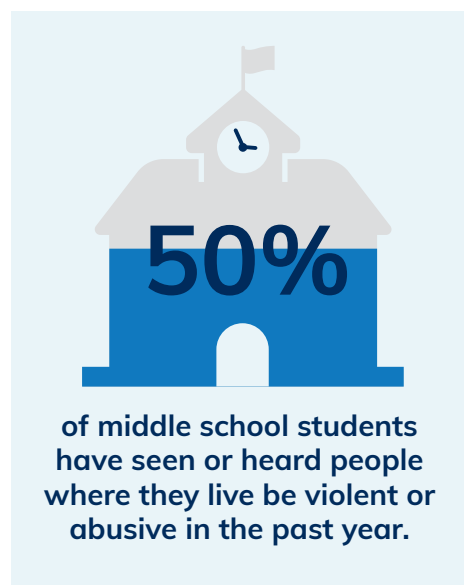
- **Racism** is another social determinant of behavioral health that contributes to many health inequities. Children can experience the outputs of racism through where they live, where they receive education, and their economic situation.[42] Many studies have demonstrated relationships between perceived racism and children's behavioral health.[43] One review found that research has repeatedly linked self-reported discrimination in adolescents and pre-adolescents with low self-esteem, as well as symptoms of depression and anxiety.[43] Racism has been documented in the District, with a 2018 survey finding that Black residents tend to experience less satisfaction and more fear in their daily lives compared to White residents.[44] While research specifically examining the impact of this racism on children in DC is limited, one recent study found that Black adolescents in DC reported an average of over five experiences of racial discrimination per day and that those experiences predicted short-term increases in depressive symptoms.[45]

- **Parental income and employment status** are also important social determinants of behavioral health for children. Those factors impact children's behavioral health through multiple mechanisms. For example, parents who are employed may have access to private health insurance coverage, which allows them to use a different network of behavioral health providers for their children. Similar to employment, household income affects **insurance coverage**, because it determines whether children qualify for public health insurance. In DC, health insurance coverage for children (eighteen years and below) was primarily through employers (44% or 57,300 children) and Medicaid (42% or 55,000 children), with only 8.4% (or 11,000 children) having nongroup insurance coverage.[46] However, despite many children having insurance coverage, the *National Survey of Children's Health* estimated that almost 30% of children in the District were not adequately or continuously insured,[16] which likely translates to a high number of children not being able to access necessary behavioral health services.

  Another mechanism through which income affects children's behavioral health can be linked to poverty rates, which are strikingly high in DC. Over one in every four children below eighteen years in the District are in poverty, which is a known risk factor for many mental, emotional, and behavioral disorders of children.[47] Parental income levels can also impact children's behavioral health through its mediating effect on **parental behavioral health**. Especially for low-income families, poor adult mental health has been shown to impair parenting and affect child development.[48]

- **Behavioral-health-related stigma (whether self-directed, peer, or societal)** is a barrier to seeking help and accessing care,[49] which can lead to isolation and escalation of behavioral health problems among youth. Stigma was frequently cited in our family engagement focus groups as one of the main barriers to youth accessing behavioral health services. Notably, participants who identified as people of color mentioned that stigma regarding behavioral health was highly prevalent in their cultural communities and presented a challenge to those seeking treatment for a mental health or substance use concern. In the same vein, a number of youth expressed that they felt their communities did not prioritize mental health and were not supportive of those struggling with behavioral health concerns.

In our family engagement focus groups, one youth shared:

"When you live like in a low-income neighborhood, I feel like, you know, half the time, most of the time, you're worrying about survival and stuff like that so you're not really like worrying about all, 'oh let me do some self-care and how am I feeling,' you know."

Against the backdrop of ongoing behavioral health reforms, children continue to be exposed to behavioral health risk factors. The complex landscape of children's behavioral health in the District has been considered in the development of all recommendations.

3. LEADERSHIP AND GOVERNANCE

For this report, leadership and governance in the behavioral health system refers to "ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability."[50]

3.1 Vision for the System

Recalling Section 2.3, the determinants of behavioral health for children in DC include factors such as housing, community violence, and parental income, which lie beyond the sphere of the traditional health sector.[51] Addressing behavioral health issues must involve addressing these broad determinants of behavioral health, and therefore, this requires established mechanisms for cross-disciplinary and cross-sectoral collaboration inclusive of nongovernment actors. Governance and leadership of a well-functioning behavioral health system (which encompasses effective oversight, policymaking, system design, and accountability) should be shared by both government and nongovernment actors, with transparent communication and engagement from the community. The following describes our vision for the governance and leadership of the behavioral health system for children from the perspective of both government bodies and the community.

How Government Bodies Should Lead & Govern the Behavioral Health System for Children

Apply a Collaborative Governance Framework

While government bodies traditionally take a leadership role in setting the policy agenda, all participants in collaborative governance influence decision-making and share responsibility for achieving outcomes.[52] The collaborative governance framework is deliberately designed to promote decision-making that is based on consensus, which is distinct from simple coordination across sectors.[53] *Figure B.1* in Appendix B presents the elements of a collaborative governance framework. Notably, a main challenge with this framework is the need to overcome existing power and information asymmetries among organizations in the behavioral health system for children. However, when this framework is implemented within systems of care, research has noted many positive outcomes, such as improved relationships between families and service providers and increased relevance of mental health services.[54] Additionally, intersectoral collaboration enables agencies to coordinate integrated services, avoid duplication of efforts, reduce service deficiencies, and spread cost and risk across several agencies.

Collaborative governance refers to an "arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus-oriented, and deliberative, and that aims to make or implement public policy or manage public programs or assets."

Source: Ansell C, Gash A. Collaborative governance in theory and practice. Journal of public administration research and theory. 2008 Oct 1;18(4):543-71.

Committed Efforts to Meaningfully Engage With Diverse Community Stakeholders

Diverse, inclusive collaborations with community stakeholders, especially families and youth, should be actively sought out.[54] With regards to managed care behavioral health integration, a Center of Health Care Strategies report states, "there is no such thing as too much stakeholder outreach, education, and communication."[55] Input of family members and youth can be obtained from multiple avenues, including focus groups, surveys, advisory councils/committees, and public awareness events that promote social connections.[56] Engagement strategies should account for historical and cultural inequities in representation. Behavioral health government bodies should investigate barriers to family and youth participation and actively identify and implement strategies to improve family and youth input in all their functions. For example, a recent study into building community partnerships for behavioral health equity noted that the "bureaucratic and restrictive climate of decision-making processes often alienated community members."[57] Considering that challenge, strategies to improve family and youth engagement should give familiies and youth the necessary tools to fully participate in the governance process.[54]

How the Community Should Be Involved in the Governance of the Behavioral Health System for Children

Institutionalized Collaboration

The community (inclusive of individual beneficiaries, advocates, and community-based organizations) committed to bringing the voice of lived experiences is a critical component of behavioral health system design and implementation.[58] It is important for their role in governance to be sustainable and clearly defined. Formalizing the roles of community partners through memorandums of understanding and/or similar approaches helps to institutionalize collaboration, such that it is sustained regardless of changes to government leadership.[54]

Shared Leadership for Community Members

Hogan et al (2020) note that community engagement is "not just a set of activities and methods confined to a particular project, policy, or process" but instead "a way of communication, decision-making, and governance that recognizes community members' power and includes them and other stakeholders in identifying problems and making decisions that promote equitable outcomes."[59] Authentically involving community residents with lived experience alongside health and social service organizations in the design of equitable policy and practice has emerged as a key tenet of effective system reform. Community members should be given shared leadership and be empowered to play defined roles in governing the behavioral health system. They should be considered partners in governing the system, instead of an external advisory group. Governance of the behavioral health system should have transparent decision-making processes, where community representatives are given decision-making abilities. This is necessary because when community engagement does not promote the ability to make and implement decisions, that creates frustration that undermines participation,[58] especially for groups who already experience inequities and whose voices need to be heard. Notably, accomplishing shared leadership with the community requires dedicated and persistent commitment from all stakeholders because it can be a challenging and resource intensive process.

Time-Bound Strategic Plan, Annual Work Plans, and Formal Quality Improvement Program

Formal governance structures and documents should guide changes in the behavioral health system over time. The DC government through appropriate interagency collaboration should create a time-bound strategic plan that outlines the long-term goals for children's behavioral health, with input from relevant stakeholders, including families, youth, service providers, and education agencies. In line with this strategic plan, the government should develop fiscal year (FY) work plans that identify goals, budget allocations, human resource requirements, and measures of success. The development of annual work plans allows for flexibility in the governance of the system. All plans should be published publicly to support transparency and promote accountability. In addition to plans, the government should have a formal quality improvement program for behavioral health services for children. This program should set District standards for the quality of services and regularly monitor behavioral health services. It should also include a standardized method for collecting feedback, with optional anonymity, about services and agencies from system users and service providers.

Developing comprehensive plans will be particularly important as DC transitions behavioral health services to managed care. There are many prior examples of managed care behavioral health integration that the District may look to as it plans its own efforts. Indeed, to effectively plan for system transformation, it is important to account for challenges commonly cited by states that have already achieved behavioral health integration, such as confusion and subsequent disruptions in care that occur as a result of the new relationships between managed care organizations (MCOs) and providers.[60,61]

Prioritize the Implementation of Evidence-Based, Evidence-Informed, and Emerging Best Practices Informed by Publicly Available Local Data to Facilitate Transparency and Build Trust

To make informed policy decisions, evaluate system functioning, and establish accountability, there should be routine data collection in the District on the behavioral health issues affecting children, as well as on behavioral health service delivery. Thus, government bodies should prioritize the establishment and implementation of a strong behavioral health surveillance system. There should be adequate government capacity for data collection, analysis, and dissemination to establish regular standardized reporting on behavioral health issues affecting children and the behavioral health services available to children to all relevant stakeholders.[62] Over time, these data become the evidence that informs benchmarks and standards for behavioral health services for children and guides clinical practices.

For evidence-based practices (EBPs) to be successfully implemented in behavioral health services, organizational structures and processes must sufficiently support EBP, and providers must perceive EBPs favorably and possess

the knowledge and skill to deliver them with fidelity.[63] Government leaders should communicate to providers and/or provider organizations how EBPs support organizational goals and needs and provide tangible rewards and positive reinforcement for implementing EBPs.[64] Additionally, EBPs must be acceptable to the community and intended beneficiaries of the service. There should also be policies and dedicated funding in place to allow for testing and scale-up of EBPs in the local context, as needed.[64]

3.2 Current System

This subsection will describe the current governmental role in policy creation, oversight, and regulation of the public behavioral health system for children, as well as the policies and legislation that establish authority, responsibility, and accountability mechanisms within the system. Further, this subsection will examine the roles of the community as critical monitors and drivers of change in DC's current behavioral health system.

Government Bodies

Organizations within the government (including some entities with defined nongovernmental representation) have legal authority to play discrete leadership and governance roles in DC's current behavioral health system for children. *Figure* 3.A highlights the plethora of governmental bodies/posts that perform these roles at the federal, District, and service delivery level and showcases some complexity in the organizational relationships between these bodies/posts. Considering that several aspects of the behavioral health system can fall under many governmental bodies' purview, it should be noted that *Figure* 3.A does not fully encapsulate all agencies involved in the leadership and governance of the behavioral health system but highlights the main agencies. *Table A.1* in Appendix A lists the functions of the main governmental entities shown in *Figure* 3.A, along with the laws and policies that outline these entities' authority and responsibilities.

Federal agencies under the US Department of Health and Human Services influence the local behavioral health system through legislation, regulations, policies, and guidance. In some cases, federal agencies provide a degree of direct oversight to state agencies, such as the monitoring of the DC Department of Health Care Finance's (DHCF) administration of the Medicaid program by the Centers for Medicare and Medicaid Services (CMS). For example, Section 1932 of the Social Security Act requires states to develop a quality strategy that includes access standards and quality evaluation procedures for MCOs contracted by state Medicaid programs, giving CMS oversight of those efforts and the authority to set foundational access standards.[65]

Figure 3.A highlights that two local governmental agencies are central to the public behavioral health system for children: the Department of Behavioral Health (DBH), which oversees the city's public mental health and substance use services, and DHCF, which administers the District's Medicaid plan.[66] The Department of Health (DC Health), specifically the Health Regulation & Licensing Administration, performs a regulatory role through the licensure of behavioral health practitioners and health care facilities. The Coordinating Council on School Behavioral Health represents an intergovernmental collaboration to guide the implementation of the expanded school-based behavioral health system.

Other agencies are also involved in the governance of the behavioral health system through their mandate to serve children who are negatively impacted by certain social determinants of behavioral health. For example, the Department of Human Services (DHS) is responsible for addressing youth homelessness, while the Child and Family Services Agency (CFSA) investigates child abuse or neglect and aims to ensure safe homes for children. In addition to creating laws that can shape the behavioral health system, the DC Council also provides performance and budget oversight to agencies (such as DBH, DC Health, DHCF, DHS, and CFSA) in the executive branch.

Figure 3.A. Government Bodies* Providing Oversight and Regulation to DC's Behavioral Health System for Children

Federal Level

US Department of Health and Human Services
- Centers for Medicare & Medicaid Services
- Substance Abuse and Mental Health Services Administration
- Administration for Children and Families
- Centers for Disease Control & Prevention

District Level

Executive Branch

Mayor
- City Administrator
  - Deputy Mayor for Health and Human Services
    - Department of Health Care Finance
    - Department of Behavioral Health
    - Department of Health
    - Child & Family Services Agency
    - Department of Human Services
    - Department of Disability Services
    - Thrive by Five Coordinating Council
    - Coordinating Council on School Behavioral Health
  - Deputy Mayor for Education
    - DC Public Schools
    - Office of the State Superintendent of Education
    - State Early Childhood Development Coordinating Council
    - Public Charter School Board*
    - State Board of Education*
  - Deputy Mayor for Public Safety and Justice
    - Metropolitan Police Department
    - Department of Youth Rehabilitation Services
    - Office of Human Rights

- DC Medical Care Advisory Committee
- Department of Behavioral Health Planning Council
- Citizen Review Panel
- Office of Administrative Hearings

Legislative Branch
- DC Council
- Committee on Health
- Committee on Education
- Committee on Human Services
- DC Auditor
- Advisory Neighborhood Commissions

Judicial Branch
- DC Court of Appeals
- DC Superior Court

Service Delivery Level
- DHCF Division of Program Integrity
- Office of Managed Care
- Managed Care Organizations
- DC Health Regulation and Licensing Administration

Legend:
- Government Body
- Nongovernmental (NG) Organization
- Governmental Body with NG Representation

*The Public Charter School Board and State Board of Education are independent organizations.

Adapted from: Government of the District of Columbia Organization Chart; Government of the District of Columbia, Mayor Muriel Bowser; 2019

Nongovernmental Influences: Advocates, Community Organizations, and Philanthropic Entities

While government agencies are formally tasked with most high-level leadership and governance roles in DC's public behavioral health system, it is noteworthy that individual advocates, community organizations, health care providers/organizations, as well as local and national philanthropic organizations and individuals are also key leaders of change in the system. Individual advocates often include caregivers and/or persons with lived experiences and community organizations such as professional associations, family-run organizations, advocacy organizations, and formal coalitions that have strong interests in children and/or behavioral health.

Such individuals and organizations have historically driven changes in the system through various mechanisms. For example, several organizations monitor the government's performance of their assigned functions in the public behavioral health system for children to identify areas of suboptimal practices. Many individuals and organizations also identify systemic problems through their direct work with children, families, and professionals who interact with the public behavioral health system. Once issues have been identified, community organizations can then engage in several processes (which can be aligned to each branch of government) for encouraging government accountability and driving changes in system design, oversight, and regulation. Organizations can engage with the executive branch of government directly by appealing to relevant Departments. For example, some organizations are members of government councils (such as the Coordinating Council on School Behavioral Health or DC Medical Care Advisory Committee) and use those councils as avenues to drive change. The community also can use the legislative branch of government to influence legal change and to urge accountability of departments by testifying to the DC Council. Last, community organizations can drive change through the judicial branch by filing cases (including class action lawsuits) at the courts. Based on the outcome of cases, courts may mandate government agencies to make reforms, which can spur legislative and other systemic changes.

Legislation, Plans, and Policies

While *Table A.1* in Appendix A lists some legislation and policy documents related to children's behavioral health, two particularly relevant plans will be highlighted here. DBH developed the Children's System of Care Plan in 2009, which was a three- to five-year plan to redesign the behavioral health system of care for children.[67] Included in the Children's Plan were aims to implement EBPs, expand community-based service capacity for youth and their families, reduce youth placement in residential inpatient treatment, increase availability of early childhood services, increase family involvement in the behavioral health system, and facilitate formal cross-agency decision-making to support the system of care.[67] In 2015, DBH published a performance report for the Children's System of Care Plan, which highlighted system changes, such as an increase in the number of available EBPs from one in 2009, to twelve in 2013.[67] More recently, DBH published a strategic plan in 2019 to improve behavioral health care for all residents (both children and adults). That plan delineates a number of initiatives, which the District plans to fulfill, categorized into five different overarching goals: (1) prevention and early intervention; (2) access to quality services; (3) recovery and resilience; (4) partnership, integration, and coordination; and (5) leadership, innovation, and accountability. Another relevant report is the 2019 Report and Recommendations of the Mayor's Commission on Healthcare Systems Transformation, which includes several recommendations on improving the District's behavioral health system.

3.3 Gap Analysis

A comparison of DC's current leadership and governance for the public behavioral health system for children to our vision highlights several key gaps that are discussed below.

1. Inadequate institutionalized collaborative governance involving the community

*Figure 3.*A also showcases that there are several formalized committees that have codified community representation. For example, the Department of Behavioral Health Planning Council requires that 51 percent of the membership with voting powers be consumers or their family members and their advocates. Similarly, the DC Medical Care Committee has fifteen voting members, with at least eight members required to be beneficiaries or beneficiary advocates. Committee bylaws that set the community membership as the majority are good first steps to ensuring nongovernmental voices are heard. However, additional mechanisms need to be established to ensure that community voices are not only heard but are incorporated in decision-making. The lack of compensation to community members for their time and expertise reflects and emphasizes power and resource differentials between government representatives and nongovernment representatives. These differentials can result in community members not being able to participate to their fullest ability. Additionally, these committees' outputs are sometimes used to advise decision-making, which can ultimately result in community members' efforts being dismissed and, thereby, create frustration that undermines participation.

2. Lack of publicly available updated plans

While an illustration of great strategy and initiative on the part of the District, there remain a number of gaps with regards to the plans indicated in Section 3.1 of the report. First, an updated Children's Plan has not been published in over a decade, which serves to reduce both transparency and opportunities for community engagement and collaboration.[68] In the same vein, there is currently no annual reporting of work plans in place, limiting the degree of transparency and accountability the District has to the public. Second, there are no recent published goals or action plans regarding behavioral health services specific to children. Given that children's behavioral health needs often require treatment that is unique from that of adults,[69] the lack of up-to-date strategies that highlight the need for services tailored to children and consider behavioral health advancements may prove detrimental to the District's youth.

3. Low governmental prioritization for data-driven decision-making and evidence-based practices

The lack of standardized data collection and reporting at the District level, along with insufficient data sharing both publicly and between entities suggest low governmental prioritization for data-driven decision-making and evidence-based practices. Further, regular data-driven performance reviews are associated with increases in data-driven decision-making within government agencies.[70] Data related to children's behavioral health in DC, including service utilization and outcomes data, while sometimes provided in agencies' annual performance oversight responses to the DC Council, is not reported by agencies in a user-friendly manner on a regular basis. Such lack of data reporting prevents the opportunity for both government and nongovernment organizations to use local evidence to enhance behavioral health decision-making.[70]

4. Fragmented leadership and governance

*Figure 3.*A highlights the great extent of fragmentation at the District level across DC's behavioral health system for children, with over five DC departments having some governance role in children's behavioral health. Based on current law, DBH could be identified as the organization primarily responsible for children's behavioral health because its defined purpose, according to DC Code § 7–1141.05, is to:
   1. ensure the provision of high-quality behavioral health services by establishing District-wide behavioral health standards and policies;

2. foster and promote behavioral health education and disease prevention;
3. provide high-quality prevention, treatment, and recovery support services related to mental health disorders, addictions, and the abuse of alcohol, tobacco, and other drugs in the District;
4. develop and maintain an efficient and cost-effective behavioral health care financing system; and
5. implement, monitor, and evaluate the District's strategic behavioral health plan.

However, these roles have some overlap with other District agencies' responsibilities. For example, according to DC Code § 4–1303.01a., CFSA is responsible for "offering appropriate, adequate, and, when needed, highly specialized, diagnostic and treatment services and resources to children and families when there has been a supported finding of abuse or neglect," which overlaps with DBH's purposes (1) and (3) above. Another example is that one of DHCF's responsibilities, according to DC Code § 7–771.03., is to "develop a comprehensive, efficient, and cost-effective health-care system for the District's uninsured, under-insured, and low-income residents," which overlaps with DBH's purpose (4) above. These indistinct responsibilities create blurred lines of authority for children's behavioral health in DC, which leads to inefficiencies in the system. Further, with the District's planned shift of behavioral health services to MCOs, existing ambiguities about leadership and governance for children's behavioral health can worsen.

3.4 Recommendations

1. Review, strengthen, and—where possible—institutionalize collaboration with community through documentation and assessments.

Implementing Bodies: DBH, DHCF, CFSA, DC Health, DHS, MCOs
Timeline to Implementation: Short Term

As much as possible, decision-making about the behavioral health system for children should formally involve youth and family representatives. It is important to note that the community must be integrated into the decision-making process and not just be separate advisory or working groups. Extant collaboration agreements between governmental representatives and community representatives should be reviewed and updated to ensure that they include defined rules, partnership goals, and performance measurements. Existing collaborative groups should be formally, independently, and regularly evaluated to document how stakeholder involvement supports change within the behavioral health system, because that demonstrates that community voices are being heard and valued.

Youth and families should be consulted, with appropriate compensation, to comprehensively determine what they need to be able to fully participate in the behavioral health governance process. Notably, meaningful collaborations with community stakeholders require dedicated funding for stakeholder involvement. In addition to ensuring compensation, government agencies should offer education and training on relevant topics including behavioral health jargon and relevant legal issues to empower youth and families to fully participate in the governance process.[54] Tangible assistance such as stipends, transportation, childcare, and meals can also be used to help facilitate community participation.[54]

2. Prioritize and support the development of a sustainable system that routinely captures and analyzes data on prevalence, incidence, severity, risk factors, social determinants, functional outcomes, and access to care for behavioral health conditions.

Implementing Bodies: DBH, DHCF, CFSA, DC Health, DHS, MCOs
Timeline to Implementation: Short Term

Such a system is necessary to make informed policy decisions, evaluate system functioning, and increase accountability. Interagency collaboration to design and develop a behavioral health surveillance system should be prioritized. Leaders should identify a sustainable source of financing, support the required capacity building, and establish data-sharing agreements to support a behavioral health surveillance system. Recommendation #2 in Chapter 7 provides further details on this recommended behavioral health surveillance system.

3. Develop an updated strategic plan for children's behavioral health.

Implementing Bodies: DBH, DHCF, MCOs
Timeline to Implementation: Short Term

All relevant government agencies should collectively develop an updated strategic plan for children's behavioral health, in collaboration with nongovernmental stakeholders. With the upcoming carve-in of behavioral health services into managed care, it is an opportune moment to create a three-year strategic plan for system improvements that will benefit children's behavioral health.

4. Make all strategic plans, work plans, and performance reports publicly available.

Implementing Bodies: DBH, DHCF, MCOs
Timeline to Implementation: Short Term

All relevant plans and reports regarding children's behavioral health should be made publicly available in a timely manner, because that supports transparency and accountability, as well facilitates both federal and nongovernmental collaborations and investments. Published progress reports are associated with increases in data-driven decision-making.[70] It is important that publicly published information be accessible to those who speak other languages and those who are visually impaired.

5. Establish an Interagency Council on Behavioral Health that aligns with the Collaborative Governance Model.

Implementing Bodies: DC Council
Timeline to Implementation: Short Term

The establishment of an interagency council that is responsible for behavioral health will address the existing fragmentation within the system, in a manner aligned with a collaborative governance framework. The official bylaws of such a council should provide all relevant stakeholder representatives (including government and nongovernment representatives) with formalized mechanisms for discussion, collaboration, planning, and decision-making. This interagency council should have adequate representation of child-serving primary care providers, behavioral health providers, community-based and family-run organizations, parents/caregivers of children who receive services, and educators.

Interagency coordination governed by DC law increases accountability, promotes transparency, and enables systemic improvements. The united efforts of the government and the community facilitated through this council is critical to build a system that adequately meets the need for behavioral health services for District children, youth, and families. We acknowledge and support the establishment of this council as proposed in Bill 24-65, the Interagency Council on Behavioral Health Establishment Amendment Act of 2021, as well as the previous Bill 23-0178, Interagency Council on Behavioral Health Establishment Amendment Act of 2019. We also suggest that this interagency council's scope explicitly include children's behavioral health, with defined accompanying mechanisms (such as a standing committee) to focus on this population.

6. More clearly define the roles of DBH, DHCF, and other agencies in children's behavioral health, and update DC code and regulations, as needed, in light of the upcoming behavioral health reforms.

Implementing Bodies: DBH, DHCF, DC Health, CFSA, OSSE, DC Council
Timeline to Implementation: Medium Term

DBH, DHCF, and other relevant government agencies must collaboratively define their new roles in children's behavioral health, through consultation with appropriate stakeholders such as MCO representatives and service providers.

With the upcoming integration of behavioral health into DC's managed care program, we suggest DBH no longer play the role of service provider (perhaps with the exception of Saint Elizabeth's Hospital) or payer of claims billable services. In defining regulatory roles, it is important for provider organizations to be regulated by only one agency in order to minimize the duplication of regulatory burdens on provider organizations. We recommend that DBH regulate specialty mental health and substance use service provider organizations, as well as standalone low-barrier mental health and substance use service provider organizations. DC Health should continue to regulate primary care organizations and hospitals, but when DC Health regulates any organization providing behavioral health services, its regulatory board must include representatives with behavioral health expertise. All agencies regulating behavioral health services need to continue to undertake joint and complementary rule making when they regulate similar services provided by different types of entities regulated by different lead agencies, as exemplified during the implementation of the 1115 waiver. This streamlining and coordination of agencies' roles has the potential to optimize service delivery and care coordination for children.

Appropriate agencies must identify and update the relevant DC laws and regulations to reflect the new roles and requirements for the integration of behavioral health into DC's managed care program. For example, DBH's regulations are framed from the perspective of DBH as an integrated regulator and payor. Even if DBH continues to be a payor for some services, these regulations need to be reframed for a fully managed care environment with MCOs playing a greater role in care coordination and linkages. It is essential that all relevant DC laws and regulations support smooth transitions between forms of care and providers for children, without interruptions of care or confusion over billing.

4. FINANCING

For this report, health financing refers to the function of the behavioral health system "concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system."[2] With reference to that definition, collective financing will be examined through the government's budget dedicated to the public behavioral health system, while individual financing will be examined through the public insurance programs for children in DC.

4.1 Vision for the System

Government Budget for the Public Behavioral Health System for Children

The District's budget for the public behavioral health system for children should be **sufficient to meet children's evolving behavioral health needs**. There must be adequate financing to support the full continuum of behavioral health care for children of all ages. Additionally, **funding sources should be sustainable** to maintain appropriate, high-quality behavioral health care for all. Considering the dynamic nature of population health, the budget should be informed by routinely collected data on the behavioral health needs of children in DC. Because the behavioral health of children falls under several government agencies' purview, there must be **formal interagency agreements** outlining assigned financing responsibilities for behavioral health services for children. All relevant government agencies should review behavioral health financing strategies regularly to ensure that the financing strategies align with, support, and prioritize the principles of family-centered care, cultural humility, racial equity, and trauma-informed care. Further, government plans for financing behavioral health services for children should support the Institute for Healthcare Improvement's Triple Aim (i.e., simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per-capita cost of care for the benefit of communities).[71]

A Fully Integrated Program with Value-Based Purchasing Strategies

Previous research has linked pediatric integration models to improved behavioral health outcomes in children.[72] A fully managed care program can be seen as a further step towards integrated care. Thus, in a fully managed care program, all **MCOs should be contracted to deliver both physical and behavioral health services** and not subcontract out behavioral health services, because this facilitates the integration of these services at the payment level and possibly the service delivery level.

As noted in a 2014 Commonwealth Fund report,[73] a carve-in purchasing model does not ensure integrated delivery of care because MCOs may be allowed to subcontract behavioral health payment to external organizations. This subcontracting may dilute integration benefits, especially if there are not strong contract provisions and oversight. Contrastingly, those who support subcontracting argue that MCOs lack the expertise to manage behavioral health care, especially for people with serious mental illness and substance use disorders (SUDs). States such as New York[74] and Tennessee[75] have led successful carve-in efforts that allow for subcontracting, although under stipulations such as careful monitoring of subcontractor performance[76] and requirements for subcontractors to operate within MCO

offices to facilitate coordinated management.[73] In Kansas, another example of a state that allowed subcontracts, subsequent review determined that the state was "not sufficiently involved in monitoring MCOs and sharing results with providers" during its transition to a carve-in system and has reported a substantial number of challenges from the process.[77] *Table C.1* in Appendix C highlights features of models in selected states, along with outcomes. Those examples serve to highlight the importance of oversight and accountability when allowing MCOs to subcontract behavioral health management to an outside entity. The National Health Law Program notes that there is no emerging behavioral health integration model across states, with states adopting a variety of models ranging from fully integrated managed care to hybrid integration models.[78] A recent study found that the shift to managed care at the national level led to a modest increase in Early and Periodic Screening, Diagnostic and Treatment (EPSDT) participation for children in Medicaid.[79]

Overall research has found mixed results on the impacts of managed care on quality, access, and costs of health services.[80] That may be because MCOs could be incentivized to limit payments to providers through minimizing service utilization and/or provider reimbursement rates to maximize their profits.[81] That can negatively impact provider networks (and, therefore, access to care), as well as quality of care. To guard against this, in our envisioned system, the government would **require and enforce MCOs' reporting on standard quality of care measures**, including targeted, validated[82] measures specific to behavioral health services for children and behavioral health outcomes. Another countermeasure is **mandated value-based payment approaches that are tied to quality outcomes, including behavioral health outcomes**. Below highlights some common value-based purchasing (VBP) strategies.

Common Value-Based Purchasing Strategies

- **Pay for performance:** Providers are financially rewarded for meeting or improving their performance on pre-established quality measures.
- **Bundled payments:** Payments are based on expected costs for a clinically defined episode or bundle of related health care services.
- **Episodes of care:** Provider is held accountable for the costs and quality of a defined and discrete set of services for a defined period of time.
- **Case rate:** Fixed per-member, per-month rate for every actual user.*
- **Shared savings:** VBP payment model that pays organizations using a fee-for-service (FFS) model but rewards organizations if spending is below the target at the end-of-year.
- **Shared risk:** VBP payment model in tandem with shared savings that penalizes organizations spending more than the target.
- **Capitation:** Fixed per-member, per-month rate for every eligible user.*

Source: <u>Value-based Payment Arrangements in Children's Behavioral Health: A Provider Profile Report</u>, National Council for Behavioral Health, 2018

*According to The Journal of Urgent Care Medicine, the main difference between capitation rate and case rate is that providers receive a flat monthly fee that covers all services with capitation, while they receive a flat fee per visit with case rate.

Billing & Reimbursement

Public health insurance programs in the District, whether administered through FFS or MCOs, must offer **competitive provider reimbursements** to encourage behavioral health providers to participate in public health insurance plans. Practitioners delivering behavioral health care to children and preventive services should be **compensated at a level that is commensurate with the time and effort expended.**[83] A recent report from the National Bureau of Economic Research demonstrates that more competitive Medicaid reimbursement rates are tied to better access to care and outcomes for children.[84] Research showed that for every $10 increase in Medicaid reimbursement per visit, parents were 0.5 percentage points more likely to report no difficulty finding a provider for their Medicaid-insured children.[84] Additionally, the same $10 increase in payment per visit reduced reported school absences among primary school-aged Medicaid recipients by 14 percent.

Provider **reimbursements rates should be updated regularly** to remain competitive in evolving markets. DBH and DHCF, in collaboration with providers and beneficiaries, should also evaluate all newly added billing codes to ensure codes are appropriate for the service required. Additionally, billing processes should be easy to navigate and reimbursements should be timely enough to avoid disruptions to providers' businesses. There should be an **established mechanism for consulting providers on all major billing and reimbursement decisions** (whether operational or strategic).

Additionally, MCOs' coverage limits should be based on national standards of care, which take into account the full continuum of behavioral health care services when defining medical necessity.[85] The criteria for medical necessity should be made transparent to the public, be consistent across MCOs, and be formed by an independent party.

Network Adequacy

MCOs should have **adequate behavioral health provider networks for children.** It is critical for DHCF to not only routinely monitor but also enforce network adequacy. Meaningful measures of behavioral health network adequacy standards should go beyond the federally mandated standards (which include travel time and distance standards)[86] and should have strong correlations with access to and quality of care.[87] The development of new and/or updated local network adequacy standards should involve stakeholder consultation (inclusive of providers and beneficiaries) and consider specific settings, community needs, and resource constraints. All **network adequacy standards should be tied to accountability mechanisms** that are regularly and transparently enforced.

Investment in Addressing Social Determinants of Health

There should be increased investments from government agencies, MCOs, and provider organizations to address the social determinants of health (SDOH) that impact behavioral health in children in DC, including maximized opportunities, where appropriate, under Medicaid and Children's Health Insurance Program (CHIP) to address SDOH. In our family engagement forums, both parents/caregivers and youth from the District identified several socioeconomic factors—including poverty, community violence, and a lack of support from the community and family—that negatively impact children's behavioral health.

Research has found that investment in programs addressing such SDOH in children has yielded positive outcomes for children.[88] Therefore, strategies to improve children's behavioral health must include strategies to address these external factors affecting their behavioral health.

> *In our family engagement efforts, youth were asked to discuss the main mental health challenges currently facing youth in DC, and they shared:*
>
> *"It's just, like, our environment. Like, we try so hard to not be a product of our environment, but even though we try so hard, we are still being judged."*
>
> *"A lot of youth are really stressed with like their environment."*

4.2 Current System

This section will examine collective financing of DC's behavioral health system for children through the government's budget dedicated to the current public behavioral health system. In contrast, individual financing will be examined through the existing public insurance programs for children in DC.

Insurance Programs

*Figure 4.*A highlights the different publicly funded health insurance options for children in DC, which are all administered by DHCF.

Figure 4.A. Public Health Insurance Programs in DC for Children

DC Children

Type of Coverage:
- Private Insurance
- Public Insurance: (Medicaid, Children's Health Insurance Program, Immigrant Children's Plan*)
- Uninsured

Payment Mechanisms:
- Medicaid Managed Care Organizations (MCOs)
  - MedStar Family Choice DC, AmeriHealth Caritas DC, CareFirst Community Health Plan DC
  - Health Services for Children with Special Needs (HSCSN)
- Fee For Service DC Medicaid

Service Providers (Payees):
- Providers within the MCO network, including MHRS** providers
- Providers within the HSCSN network including MHRS** providers
- Providers within the Medicaid provider network, including MHRS** providers

Eligibility:
- • Under age 21
  • DC resident
  • US citizen/eligible immigration status
  • Meet income requirements
    -for children 0-18: Household incomes must be up to 319% of the FPL.
    -for children 19 & 20: Household incomes must be up to 216% of the FPL.
- • Up to age 26
  • DC resident
  • Receiving SSI disability benefits or have an SSI-related disability as defined by DHCF
- • In fostercare with CFSA
  • Receiving long-term care services
  • Receiving emergency medicalcare

Adapted from: Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers, and Recommendations, Georgetown University National Technical Assistance, and Center for Children's Mental Health, May 2014.

* Through the Immigrant Children's Program (a 100% locally funded program), children under age 21 who are not eligible for Medicaid and have income at or below 200% of the FPL are assigned to a managed care organization. See "Immigrant Children's Program," Department of Health Care Finance. Services covered under the Immigrant Children's Program are identical to the services covered under Medicaid for children under age 21 (MCO contract). Additionally, DC Health Alliance is another public health insurance program. It was not included because it serves individuals over age 21 and does not cover behavioral health and substance abuse services. See "Health Care Alliance," Department of Health Care Finance. Note that the CHIP is not a separate program in DC, but instead its funds are used to expand the Medicaid program.

**MHRS- Mental Health Rehabilitation Services

As reflected in *Figure 4.A*, DHCF finances services through contracts with four MCOs and directly through individual providers on an FFS basis. In September 2019, DHCF announced plans to move toward a fully managed care Medicaid program over the next five years.[89] That shift, which involves transitioning individuals currently in Medicaid's FFS program to the Medicaid managed care program, began in October 2020.

DHCF pays fixed capitated rates to the MCOs to finance the delivery of services to MCO-enrolled beneficiaries within the managed care network. In 2019, DC spent approximately $1 billion on MCO services, with 84 percent ($881 million) of that amount funding the full risk-based contracts signed by AmeriHealth Caritas DC Inc., Amerigroup DC, and CareFirst BlueCross BlueShield Community Health Plan DC (formerly known as Trusted Health Plan) and approximately 16 percent ($174 million) funding the risk-sharing contract with HSCSN.[90] For FY 2021, DHCF awarded three new managed care contracts (cumulatively comprising a not-to-exceed amount of approximately $1.49 billion)[91] to AmeriHealth Caritas, MedStar Family Choice, and CareFirst BlueCross BlueShield.[92] For those MCO plans in FY 2021, Table 4.A provides estimates of the monthly "actuarially sound rates" for children, and Table 4.B outlines the behavioral health services that MCOs are required to cover for children. Note that for children diagnosed with severe emotional disturbances and adolescents with substance use disorders who need more intensive in-home or community-based services, the responsibility shifts from the MCO to Mental Health Rehabilitation Services (MHRS) that DBH provides. Table B.1 in Appendix B provides an overview of MHRS. All youth enrolled in Medicaid, whether their care is financed through an MCO or FFS arrangement, are eligible to receive MHRS through the DBH provider network. MHRS delivered through non-MCO arrangements are paid on an FFS basis, even when delivered to MCO-enrolled Medicaid beneficiaries. Note that the District's behavioral health system is undergoing reform, with the aim of adding certain behavioral health services (the list of services to be added are not yet publicly available) into the District's managed care contracts beginning October 1, 2023.[6]

Table 4.A. Enrollment Estimates for Children Proposed for the Base Year in the 2020 MCO Contracts

Rate Cohort	Actuarially Sound Rates	Estimated Total Monthly Enrollees per Rate Cohort*	Total Estimated Monthly Price per Rate Cohort
Children Age <1	$584.69	4,576	$2,675,541.44
Children Ages 1- 18	$240.87	72,499	$17,462,834.13

*Included Medicaid and ICP estimates
Adapted from: MCO MedStar Family Choice Contract, CW83148, Base Period October 1, 2020, to September 30, 2021

Table 4.B. MCO Coverage Requirements for Behavioral Health Services for Children

Behavioral Health Service	MCO's Coverage Requirements
DBH-provided services: community-based interventions, multi-systemic therapy (MST), assertive community treatment (ACT), community support recovery support services	Care coordination, case management, and transportation for enrollees receiving services through DBH
Physician and mid-level visits including: diagnostic and assessment services, individual counseling, group counseling, family counseling, federally qualified health center services, medication/somatic treatment	Services furnished by the MCO's network of mental health care providers
Crisis services	Mobile crisis/emergency services, excluding beneficiaries actively receiving services in a DBH certified entity; the MCO is responsible for care coordination, case management, and transportation (when applicable) for enrollees who are enrolled in a DBH certified entity.

Behavioral Health Service	MCO's Coverage Requirements
Inpatient hospitalization and emergency department services	Inpatient hospitalization and emergency department services
Case management services	Case management services, as described in 42 C.F.R. § 440.169, for individuals identified by DBH as diagnosed with a serious mental illness (SMI) or other chronic behavioral health disorder.
Inpatient psychiatric facility services	Inpatient psychiatric facility services for individuals under age 21 as described in 42 C.F.R. § 440.160
Patient psychiatric residential treatment facility (PPRTF)	PPRTF services for enrollees less than 22 years of age
Access to mental health services	Education regarding how to access mental health services provided by the MCO, as well as the DBH
Pediatric mental health services	All mental health services for children that are included in an Individualized Education Program or Individualized Family Service Plan during holidays, school vacations, or sick days from school
Inpatient detoxification	Inpatient detoxification
Outpatient alcohol and drug abuse treatment	Clinic and other licensed practitioner services; for outpatient rehabilitation services, the MCO is responsible for referrals to DBH.
Behavioral health service to students in school settings*	Services are covered if the following are met: The provider has a sliding fee schedule for billing for children and youth without an IEP; the provider is credentialed as a network provider by the MCO; the provider has an office in the school and provides services in that office; and the provider bills the MCO for the services using the codes provided by DHCF.

Adapted from: <u>MCO MedStar Family Choice Contract, CW83148, Base Period October 1, 2020, to September 30, 2021</u>. Table B: Medicaid Behavioral Health Services, rows 1–6, 8–14.

*A DBH grant has been awarded to supplement community-based organizations to engage in practices that support effective delivery of school-based mental health services but are not reimbursable (e.g., participating in team meetings, consultation with teachers, parent/family engagement, prevention activities, etc.).

Government Budget for the Public Behavioral Health System for Children

It is difficult to accurately assess the current government budget allocation for DC's public behavioral health system for children because costs that are specific to children and/or behavioral health services are not always delineated in budget items (and therefore represent an unknown subset of several budget line items, such as "clinical health services" in CFSA's budget). Given that, the overall budget for the two main agencies involved in the public behavioral health system (DBH and DHCF) are presented in *Figure 4.B.*

Figure 4.B. 2021 Approved Operating Budgets[93] for DBH & DHCF
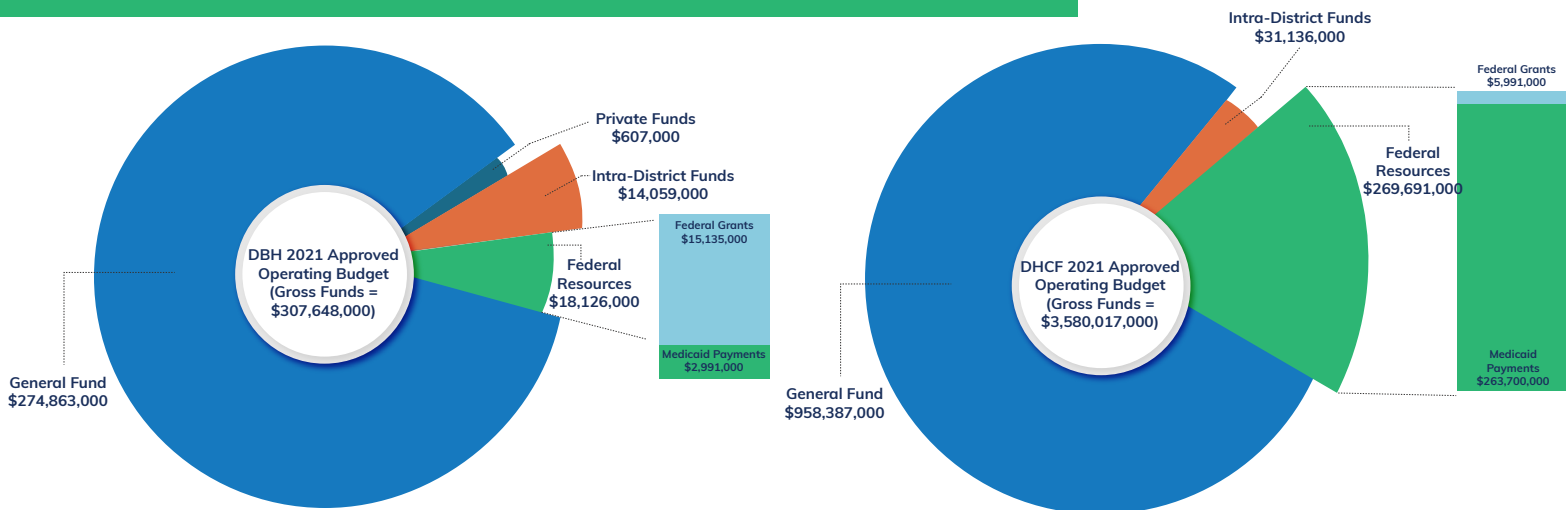
Note: The general fund includes local funds, dedicated taxes, and special purpose revenue funds. Private funds include private grant funds and private donations. Intra-district funds represent payments received for services from other District agencies. Federal grants are grants the District receives from federal agencies, including block grants, formula grants, certain entitlements, and competitive grants. Based on data from **Government of the District of Columbia. FY 2021 Approved Budget and Financial Plan Volume 4 Agency Budget Chapters - Part III.**

Figure 4.B highlights differences in quantity and type of federal funding between DBH and DHCF. Notably, local dollars (which refer to District funds used to cover services not reimbursable by Medicaid) comprise approximately 83 percent of DBH's budget compared to approximately 56 percent of DHCF's budget. DBH's federal budget is primarily grant funding, including the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).[94] Those Block Grants are given for a two-year period and fund DBH programs and community-based organizations (CBOs). *Table 4.C* provides more information on some federal grants awarded to DBH that support behavioral health services for children in the District. For DHCF, the District's Medicaid administrator, a more significant portion of their budget comes from federal resources because Medicaid is a joint federal-state program. DHCF receives a federal payment or "match" for Medicaid based on the amount spent on services and the Federal Medical Assistance Percentage[iv] (FMAP) rate, which is set at 70 percent in the District. In DC, CHIP[v] is administered as part of the Medicaid expansion, instead of as a separate program.[95] The federal government reimburses CHIP spending at a higher matching rate than Medicaid's (known as the enhanced federal medical assistance percentage or E-FMAP). For FY 2020, the federal government covered around 94 percent of CHIP costs (an increase from the planned 90 percent due to emergency legislation), but that dropped to 79 percent in FY 2021, where it will remain.[96] DC Medicaid had an annual budget of approximately $3 billion dollars in 2019 (of which $55.3 million was CHIP spending), with 94 percent of that amount spent on services rendered by medical service providers.[95]

Table 4.C. Selected Federal Grants Awarded to DBH that Support Behavioral Health Services for Children in DC

Grant Number/Title	Grant Purpose	Funding Source	FY2020 Expenditure
6H79SM061903/Positive Transitions Youth – Young Adult/(81PTYA)	Design and implement a youth-focused system of care with Core Service Agencies providing transition-age youth-specific care planning, wraparound, evidence-based practices, and recovery supports.	SAMHSA	$46,757.59

iv *The Federal Medical Assistance Percentage (FMAP) is computed from a formula that takes into account the average per-capita income for each state relative to the national average. The FMAP rate for DC has been set in statute at 70 percent since 1998 for the purposes of Title XIX and XXI of the Social Security Act, but for other purposes, the FMAP rate for DC is 50 percent, unless otherwise specified by law. The Families First Coronavirus Response Act of 2020 (P.L. 116-127) provides a temporary 6.2 percentage point FMAP increase during a public health emergency for each calendar quarter occurring during the period beginning on the first day of the public health emergency period, as defined in Section 1135(g)(1)(B) of the Social Security Act (the Act), and ending on the last day of the calendar quarter in which the last day of such emergency period occurs*
v *CHIP is a joint federal and state program that provides health coverage to uninsured children in families with incomes too high to qualify for Medicaid but too low to afford private coverage.*

Grant Number/Title	Grant Purpose	Funding Source	FY2020 Expenditure
3B09SM010008/State Mental Health Block Grant/(02MHBG)	Funding is used to develop and support community mental health services such as peer services, continued support for clubhouse infrastructure[vi], DBH strategic planning and results-based accountability efforts.	SAMHSA	$548,001.00
5H79SM063426/District of Columbia Social, Emotional and Early Development (DC SEED) Project (91SEED)*	Implement a four-year system of care[vii] to address the highly specific, largely unmet needs of infants and young children (birth–6) residing in DC who are at high imminent risk for and diagnosed with serious emotional disturbance (SED).	SAMHSA	$1,074,332.11
1H79TI081212-01/District of Columbia Changing and Improving Treatment for our Youth (91CITY)	Enhance DBH services for youth (ages 12–18) and transition-age youth (ages 18–25) to provide a comprehensive, family-centered, trauma-informed, evidence-based, coordinated system of care from early intervention through recovery. Provide tobacco use counseling and interventions as a standard of practice. Increase access for youth/transition-age youth and their families to co-occurring substance use disorder/mental health services. Develop and implement education and messaging on making healthy choices regarding substance use and emotional wellness.	SAMHSA	$235,867.99
1H79SM081976-01/ OurTime: Exploration (91EXPL)	Focus on Wards 1 and 6 to increase the self-efficacy and meaningful participation in transition plans of young adults ages 16–25 who have mental health and/or co-occurring substance use disorders. Improve and expand treatment recovery and support services and strengthen evidenced-based practices that address all life domains.	SAMHSA	$156,547.00
5H79SM081976-02/ OurTime: Exploration (01EXPL)	Focus on Wards 1 and 6 to increase the self-efficacy and meaningful participation in transition plans of young adults ages 16–25 who have mental health and/or co-occurring substance use disorders. Improve and expand treatment recovery and support services and strengthen evidenced-based practices that address all life domains.	SAMHSA	$154,568.75

Adapted from Department of Behavioral Health FY20-21 Performance Oversight; Response to Question 12

*DC SEED Project Grant ended in March 2021

Table 4.D highlights DBH's mental health services for children that were funded solely by local dollars over the previous five fiscal years. Additionally, according to DBH, $188.6 million (of which 6 percent or $11.5 million were local funds) was spent on claims-based mental health services for adults and children in FY 2020, reflecting a 30 percent increase in spending on mental health services from FY 2019 to FY 2020.[97] On the other hand, $26.4 million (of which 47 percent or $12.3 million were local funds) was spent on claims-based substance use services for adults and children in FY 2020, reflecting a slight decline from the previous year.

[vi] *Here the term "Clubhouse" refers to rehabilitative services providing an enriched, structured environment for individuals whose lives have been impacted by mental illness as reported by Clubhouse International.*
[vii] *"System of care" refers to "a broad, flexible array of services and supports for a defined population(s) that is organized into a coordinated network, integrates service planning and service coordination and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, and has supportive management and policy infrastructure" as reported by the National Technical Assistance and Evaluation Center for Systems of Care.*

Value-Based Purchasing

DHCF implemented an MCO pay-for-performance (P4P) program in 2017, which included a provision that withholds the 2 percent profit margin for each MCO that is factored into the base per-member, per-month—or capitated— payment rate.[98] The withheld capitated payment amount, or withhold, can be earned back contingent upon performance in three outcomes-based measures: (1) Thirty-day hospital readmissions for all causes, (2) potentially preventable admissions, and (3) low acuity nonemergent (LANE) emergency department (ED) visits (the provision of ED services for nonemergency or low-severity health concerns).[98,99] Each of the three outcomes is weighted at about one-third the value of the withhold and can be earned back in full for a 10 percent reduction in the measure rate from baseline (defined as April 2015 through March 31, 2016).[100] For a 7.5 percent reduction in the measure rate from baseline, half of the weighted value of the withhold can be earned back. For a 5 percent reduction in a measure rate from baseline, an MCO can earn back one-fourth of the weighted value of the withhold.

Under the new MCO contracts, MCOs are required to incorporate value-based purchasing initiatives (which may include any combination of the payment model categories defined by the LAN-APM framework as shown in *Figure 4C*) with providers in its network, with a set target for the total medical expenditures required to be linked to VBP strategies.[91]

Figure 4.C. Health Care Payment Learning & Action Network Alternative Payment Model (LAN-APM) Framework

CATEGORY 1 FEE FOR SERVICE - NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE - LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION - BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coorddination fees and payments for HIT investments)	**A** APMs with Shared Savings (e.g., shared savings with upside risk only)	**A** Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	**B** APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	**B** Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		**C** Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	**4N** Capitated Payments NOT Linked to Quality

Source: "Figure 1: The Updated APM Framework," <u>Alternative Payment Model: APM Framework</u>, Health Care Payment Learning & Action Network and The MITRE Corporation, 2017

Additional clarification about use of the HCP-LAN framework may be needed, because regulators, payors, and providers may have different beliefs about what APM type/level matches a particular payment model. DHCF also aims to incorporate SDOH in its VBP initiatives and has sought community feedback regarding methods through which to accomplish this goal.[101]

Billing & Reimbursement

Under DC Medicaid FFS, DHCF pays providers directly per unit of services provided. For Medicaid managed care, each MCO is responsible for paying a provider network that offers traditional behavioral health outpatient services (e.g., diagnostic assessment, psychotherapy, and psychiatric evaluation and medication management services). If the MCO's network cannot provide a specialty service, the MCO is required to pay for the cost of out-of-network services. The MCO is required to coordinate with out-of-network providers with respect to authorization and payment in those instances. DBH providers are reimbursed on an FFS basis by Medicaid for MHRS and by DBH for locally funded services, including any children's SUD services paid on an FFS basis. In FY 2020, DBH transitioned billing for MHRS and SUD services to DHCF to enable the individual provider agencies to bill Medicaid directly.

Table 4.D. Children's Mental Health Services which are Currently Funded by Local Dollars*

Children's Services Funded with Local Dollars	FY15	FY16	FY17	FY18	FY19
High Fidelity Wraparound	$2,240,912	$3,258,388	$887,916	$616,851	$563,865
Court-Ordered Evaluations	$1,046,544	$1,105,250	$999,667	$893,149	$552,130
School Mental Health Program	$4,915,201	$5,600,889	$6,177,765	$5,314,292	$8,629,644
Primary Project	$367,213	$387,332	$371,618	$409,316	$439,320
Healthy Futures	$601,002	$619,590	$638,753	$658,508	$678,874

Source: **Department of Behavioral Health FY19-20 Performance Oversight Questions**, Response to Question 35, 2020.

The FFS reimbursement rates for behavioral health services are posted on DHCF's website.[102] It is noteworthy that except for behavioral health services provided by hospitals[viii], there is no mandatory process for calculation of rates for behavioral health services, and DHCF typically hires a third party to set rates. DBH provider reimbursement rates are not inflation indexed.

For children and families, the following MHRS services are eligible for Medicaid reimbursement when provided by certified MHRS providers to eligible consumers: community support, diagnostic assessment, mental health therapy (formerly, counseling), medication/somatic treatment, assertive community treatment (ACT), community based intervention (CBI), crisis emergency, child parent psychotherapy for family violence, intensive day treatment services, rehabilitation day services, and trauma-focused cognitive-behavioral therapy. Additionally, according to 22 DCMR Chapter A73, DBH-certified mental health peer specialists, who are employed by DBH-certified community mental health agencies, are authorized to provide Medicaid-reimbursable MHRS to consumers when working under the supervision of a qualified practitioner. These certified peer specialists can also provide other mental health services and support that can be reimbursed through local funds as per the MHRS provider's Human Care Agreement.[103]

Through a recently approved demonstration program ("Behavioral Health Transformation" section 1115(a) Medicaid demonstration), the District received authority to provide new behavioral health services reimbursed by the Medicaid program between January 1, 2020, and December 31, 2024. Authorized services that will directly benefit children include new reimbursement methodologies for youth mobile crisis intervention and specific trauma-targeted services.

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viii *MCOs reimburse District hospitals, as described in Section C.5.29.7.1, per the DHCF FFS rate methodologies determined by DRG base rates, DC Medicaid FFS case weights, and outlier methodologies. The results of the annual rate analysis will be reviewed as a part of annual rate development and will be addressed in the final capitation rates per consideration of final hospital reimbursement requirements. MCOs reimburse District hospitals, as described in C.5.29.7.1, for outpatient services no less than 130 precent of DC Medicaid FFS fee schedule.*

Additionally, under the demonstration program, specific professionally licensed individuals are now eligible to enroll in the DC Medicaid program, including psychologists, licensed independent social workers, licensed professional counselors, and licensed marriage and family therapists. For those providers, Medicaid reimbursement will be available for psychological testing, assessment, diagnostic, and screening services when provided to an eligible beneficiary, with some exceptions.[ix] For eligible Medicaid beneficiaries diagnosed with an SED, SMI, or SUD, Medicaid reimbursement will also be available for counseling, psychotherapy, treatment planning, and care coordination.[102]

Some behavioral health services for children are not Medicaid-reimbursable and are paid for using DBH local funds, including services and supports provided by Child Choice Providers[x] (FLEXN codes), as well as some continuity of care treatment planning and discharge treatment planning for consumers in a hospital or other institutional setting.

Certain services also require medical necessity review and authorization typically from DBH prior to their delivery, including ACT, CBI intensive day treatment service, and residential crisis stabilization. Per DBH Policy 300.1, Level of Care Utilization System (LOCUS) Evaluation, DBH requires that Core Service Agencies complete a Child and Adolescent Functional Assessments (CAFAS) evaluation for each child/youth consumer, which is used to assist in making level-of-care determinations for services requiring prior authorization or reauthorization. MCOs are required to develop medical necessity criteria, which for children ages birth through twenty years of age must reflect EPSDT guidelines.[91]

Claims for behavioral health services can be submitted to DHCF's contracted fiscal agent, Conduent, by paper or electronically using standardized forms. DC providers have the option of billing via web portal, electronic data interchange, or paper. As of 2012, the timely filing period for Medicaid claims is 365 days from date of service. Under the Prompt Payment Act, D.C. Code §31-3132, MCOs are required to pay or deny clean claims within 30 days to satisfy timely filing requirements. It should be noted that this timely filing requirement does not apply to claims that are initially denied, and some providers have previously expressed concern that MCOs were unfairly denying a high rate of claims as a finance management strategy.[100] MCOs are required to pay or deny 90 percent of all clean claims within thirty days of receipt, consistent with § 1902(a)(37)(A) of the Act and D.C. Code § 31-3132. Further, in accordance with 42 C.F.R. §§ 447.45 and 447.46, MCOs must pay 99 percent of clean claims within ninety days of receipt. Behavioral health providers report experiencing periodic challenges with the reimbursement process, which can sometimes delay payments and disrupt business.

Network Adequacy & Timely Access to Care Standards

Under the new MCO contracts, MCO behavioral health services network must include: child psychiatrists, specialists in developmental/behavioral health medicine, child psychologists, social workers (including those specializing in treatment of mental health and substance use disorder), inpatient psychiatric units for children, residential treatment facilities, partial hospitalization and intensive outpatient programs, and coordination and case management service providers. Additionally, the MCO network must include certified early intervention providers for health-related IDEA services to children under age three, as well as providers qualified to perform evaluations for IDEA eligibility and provide health-related IDEA services for children three years of age and older (unless and until DC Public School (DCPS) provides those services).

MCOs are subject to ensuring access to behavioral health services in accordance with the 42 CFR § 438.68 (network adequacy standards) and § 438.206 (availability of services), as well as the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (ensures that behavioral health coverage is on equal footing with medical and surgical coverage) and the District of Columbia Behavioral Health Parity Act of 2018.[91] Current DC Medicaid MCO contracts specify mileage and time provider access standards as within five miles of an enrollee's residence or no more than thirty minutes travel time.[91]

[ix] See Section 9.1 for more information.
[x] Child Choice Provider is an MHRS Core Service Agency with demonstrated ability to provide quality, evidence-based, innovative services and interventions to meet the most complex and changing needs of children, youth, and their families in the District, particularly those who have histories of abuse or neglect. Organizations that have contracts with DBH as Child Choice Providers are eligible to bill DBH using FLEXN codes up to the monthly ceiling provided in their contracts. See Notice of Proposed Rulemaking, Department of Mental Health, 2010.

MCOs Accessibility Requirements Based on Contract

Table 4.E outlines timely access standards for contracted MCOs. DC's Managed Care contracts specify that an enrollee must wait less than forty-five minutes once at the appointment to get services.[91] Phone-based assessment for crisis care must be available within fifteen minutes of request, and medically necessary treatment provided by a qualified mental health professional alongside access to an on-call psychiatrist must be within ninety minutes of assessment completion.[91]

DHCF requires MCOs to establish standards regarding the delay time between enrollee request for an appointment and the date of appointment as well as the in-office wait times for appointments within ninety days of their contract award.[91] MCOs must monitor provider performance in meeting those standards as well as provider requirements set by DHCF and take corrective action, such as through fines, remedial action, and sanctions to address noncompliance.[91]

If they choose, MCOs may set standards for its providers that are more stringent than DHCF requirements.[104] For example, while not required to do so, AmeriHealth Caritas makes public its access to behavioral health care standards, which states that nonemergency urgent psychiatric or mental health care, a level of care not defined by DHCF standards, must be administered by its providers within the same day as enrollee requests.[104]

Table 4.E. Timely Access Standards in MCO Contracts

Provider Type	Appointment Type	Timely Access Standards
Primary Care	New Enrollee Appointment	45 days from enrollment or 30 days from request, whichever is sooner
	Routine Appointment	30 days from request
	Non-Urgent Referrals	30 days from request
	Diagnosis and Treatment of Health Condition (not urgent)	30 days from request
Specialists	Non-Urgent Referral	30 days from request
Pediatrics (EPSDT)	New Enrollee Appointment	60 days from enrollment or sooner to comply with periodicity schedule
	EPSDT Examination	30 days from request
	IDEA Part C Multidisciplinary Evaluation	30 days from referral
	IDEA Part C Treatment	25 days from signed Individualized Family Service Plan (IFSP)
Mental Health	Mental Health Outpatient	-Within 7 days of discharge from a psychiatric residential treatment facility (PRTF) -Within 30 days of discharge from an acute care admission
	Treatment of Psychiatric Crises	Available 24 hours a day, 7 days a week, including holidays.
	Phone-Based Assessment for Crisis Care	Within 15 minutes of request
	Medically Necessary Treatment Provided by a Qualified Mental Health Professional Alongside Access to an On-Call Psychiatrist	Within 90 minutes of assessment completion

Adapted from 2019–2023 DC Medicaid Managed Care Quality Strategy, Table 3.

CSA Accessibility Requirements Based on DC Code & DBH Policies

The DBH standards require DBH-certified behavioral health providers who serve youth to schedule outpatient care for 70 percent of youth who receive acute care within seven days and 80 percent within thirty days.[105] CSA requirements outlined by the DC government include provision of routine appointments to consumers within seven days of original request and same-day interventions, including those involving face-to-face contact, for urgent needs.[106] They also include operation of an on-call system available twenty-four hours a day, seven days a week to respond to all consumer situations, whether emergency or routine (referred to as the "CSA On-Call System").[106] The CSA On-Call System must adhere to the following: (1) provide access to a licensed and qualified behavioral health provider to resolve problems telephonically, (2) provide timely access to a licensed and qualified behavioral health provider for crisis support services including face-to-face interventions, and (3) linkage to crisis support services, such as crisis stabilization services and next-business-day appointments for urgent care.[106]

4.3 Gap Analysis

A comparison of DC's current financing for the public behavioral health system for children to our vision highlights several key gaps that are discussed below.

1. Subcontracting of behavioral health services by managed care organizations does not support integrated service delivery

The upcoming carve-in of behavioral health services into managed care better supports integrated delivery of care, but it does not guarantee it, because under DC code, MCOs are currently allowed to subcontract the management of behavioral health services to another corporate entity.[xi] The benefits of an integrated delivery system may not be fully realized under this model, particularly if behavioral health services are subcontracted to an unrelated corporate entity. While some advantages to subcontracting exist—namely providing support to MCOs with little behavioral health experience and forging partnerships between MCOs and behavioral health organizations (BHOs) when subcontracting with BHOs[107]—there is some evidence that subcontracting adds administrative burden for providers and can drive down usage of behavioral health services when incentives for subcontractors to cut costs exist.[108]

2. Existing financing infrastructure does not fully support integrated and coordinated care at provider organizations

While there are several programs and models implemented to provide integrated and coordinated care in DC, the existing payment and reimbursement structures do not fully support integrated and coordinated care across provider types. The two DC Health Homes models (Health Homes I and My Health GPS, which are discussed further in Chapter 5) have been helpful in the provision of more integrated and coordinated care, but they have not bridged the gaps between primary care, mental health services, and SUD services. Current eligibility restrictions of the DC Health Homes models exclude many children who could benefit from integrated care.

Further, under the current care coordination financing structures, the vast majority of decentralized (occurring outside of MCOs) care coordination is not eligible for Medicaid reimbursement and is paid for through departmental or philanthropic funds, which are often time-limited and not sufficient to cover the full cost of services rendered. Provider organizations have established and trusting relationships with the beneficiaries they serve, and thus it is important for care coordination to be available in those settings.

[xi] According to DC Code § 31–3110, "Each health maintenance organization may provide the treatment required by §§ 31-3103 and 31-3104 directly by its staff or by referring its members to a hospital or other treatment facility that provides those services under a contract or agreement with the health maintenance organization. Nothing in this chapter shall require the alteration of any terms and conditions of the health maintenance organization membership contract relating to prior approval by the health maintenance organization for treatment provided to its members by other treatment facilities."

3. Inadequate structure and support to facilitate adoption of VBP methodologies by all child and adolescent behavioral health providers

As noted in the Report and *Recommendations of the Mayor's Commission on Healthcare Systems Transformation,*[109] VBP is substantially underdeveloped in the District. Beyond limited pay-for-performance measures, uptake of VBP remains small, and that is particularly true for behavioral health services. One challenge to VBP implementation is the lack of concordance on VBP terminology among District providers, MCOs, and government, which perhaps reflects divergences in their understanding of VBP methodologies. That contributes not only to inadequate and/or inappropriate VBP implementation but also presents a barrier to productive discussions on the topic. Additionally, MCOs may not track or measure performance in the same way, and providers often do not have the necessary technological tools to track and measure performance. Addressing those challenges to performance measurement will be critical to the success of VBP approaches.

4. VBP arrangements can disincentivize adequate care for children with complex needs

Reducing payments based on ED readmissions through the P4P initiative creates a strong incentive for MCOs or providers to avoid admitting patients who have characteristics that put them at risk for readmission.[110] Importantly, one such factor is lack of access to quality primary care, and another is socioeconomic need.[110,111] As a study conducted in DC by Mathison and colleagues (2013) has highlighted, while medical need prompting ED use may be low acuity or nonurgent, social needs may be urgent and unavoidable.[111] Thus, by creating incentives to reduce LANE ED visits, there is a risk that MCOs or providers will be disincentivized from treating children with greater social needs who already lack access to care.

5. Network adequacy standards are not being met

Networks are already inadequate, and that may continue to be a challenge without strong oversight and enforcement. In particular, there is a scarcity of behavioral health care providers that are able to provide services for children and youth in DC, particularly for very young children (under five years), families whose first language is not English, and children with Autism Spectrum Disorder or developmental delays, which are among the special populations that must be given extra attention. Currently, there is an insufficient number of child-serving behavioral health providers or providers with training in specific evidence-based treatments (e.g., applied behavior analysis therapy, parent-child interaction therapy, child-parent psychotherapy, dialectical behavior therapy, etc.). That limits the availability of treatment options available to families that are within their plan networks, which results in long wait times for appointments and unmet behavioral health needs.

According to MCO contracts, "failure to maintain a Provider Network that ensures Enrollees have access to covered Mental Health services, as described in section C.5.29.8, may result in DHCF requiring the Contractor to develop and implement a corrective action plan (CAP) to remedy the failure." However, the public is not aware of any enforcement measures (such as penalties) of network adequacy standards for having an inadequate network of behavioral providers, despite recent external reviews[112] documenting network inadequacies. Additionally, current MCO contracts that require MCOs to adhere to the federal laws (§ 438.68, § 438.206, and the MHPAEA) lack sufficient clarity and direction to effectively incentivize payers to improve behavioral health care access. Limited focus on time-and-distance standards, without complementary focus on time to intake, time to therapy, and time to psychiatry, allows payors to say they have adequate networks even when services remain severely inaccessible.

6. Outdated provider reimbursement rates and no established rate-setting process for behavioral health providers

Except for behavioral health services provided by hospitals and Federally Qualified Health Centers (FQHCs), there is no mandatory process for calculating rates for behavioral health services. DHCF typically hires a third party to set rates. Current reimbursement rates for DBH-certified providers were set based on a 2016 cost study and were not inflation indexed. According to the Blue Ridge Academic Group, reimbursement for behavioral health services nationally has been significantly lower than reimbursement for physical health services. One study

found that behavioral health professionals are reimbursed at FFS rates that are 20 percent below the rate for primary care physicians when the time required to evaluate behavioral health is often longer than a basic primary care visit. In addition, reimbursement is often more limited for preventative services and/or behavioral health rehabilitation services.[113]

7. Restrictions and challenges related to the billing and reimbursement processes

As described in Section 4.2, certain services require medical necessity review and authorization typically from DBH or MCOs prior to their delivery. Further, according to the DHCF Behavioral Health Billing Manual Version 1.05,[102] certain same-day service combinations cannot be billed, and same-day prior authorization service combinations will not be authorized due to limitations. Some of those same-day billing restrictions can impede providers from either providing needed services to children in a timely manner or from being reimbursed if they do provide them.

Providers report experiencing periodic challenges with the reimbursement process, which can sometimes delay payments and disrupt business. In 2019, the overall claims denial rate for District MCOs was 8.3 percent.[100] Behavioral health providers report that excessive administrative time is used addressing prior authorizations put in place by public insurers and appealing denials in care. Challenges with navigating the complex and inconsistent reimbursement process can result in providers opting not to accept public health insurance and thereby reduce accessibility to care.

8. MCOs lack uniform credentialing requirements

Each MCO has its own credentialing requirements for behavioral health providers. That results in behavioral health providers participating in duplicative credentialing activities, which increases administrative costs but has no benefit to enrollees.[114]

9. Insufficient data to inform financial decision-making

While some behavioral health data on children is captured through service utilization statistics and the biannual YRBS, there is no routinely collected, publicly available data on the behavioral health needs of all children in DC. Further, government spending on behavioral health services for children is not reported distinctly, and reported spending is not currently disaggregated by demographics (such as age, sex, race, ethnicity, and ward). That limits the government's ability to analyze and adjust financing to promote behavioral health equity.[xii]

10. Heavy reliance on grants limits financial sustainability

Figure 4.B in Section 4.2 demonstrates that federal grants comprise a large amount of funding for behavioral health services in DC. While a grant is a good funding source for testing or piloting a new financial model or program, it is time-bound and presents a challenge for sustainability of models and programs that work well. For example, DC SEED was funded through a SAMHSA System of Care grant, which ended in March 2021. The grant was used to cover participating providers' salaries. As the grant ends and the providing organization transitions to provide DC SEED services through FFS Medicaid, it now has to consider maintaining the workforce.

11. Inadequate investment in social determinants of behavioral health

Through our family engagement efforts, parents and youth identified poverty, violence, poor community support, and a lack of safe spaces as factors negatively impacting children's behavioral health. The persistence of those factors in DC indicates that there is insufficient investment in solutions to address these determinants and protect children's behavioral health in the long-term.

[xii] *According to SAMHSA, behavioral health equity is "the right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location. This includes access to prevention, treatment, and recovery services for mental and substance use disorders."*

12. No sustainable financing structure for school-based behavioral health

School-based behavioral health expansion is currently funded through DBH-issued annual grants. Those grants are not always allocated prior to the start of the school year, despite the need for lead time to hire and train program staff. The short-term and misaligned timing of those grants undermines schools' and providers' ability to deliver services to students in a timely manner and makes it difficult for schools and providers to do the planning and coordination work over the summer that is necessary for the program to be a success. Further, there is no process in place to assess the adequacy of the grant amount. For example, staffing and supervision costs, inflationary cost pressures, and refined billing expectations should be considered to ensure funding levels are adequate to meet the cost of delivering services.

13. Current levels of funding do not support adequate clinical and nonclinical staff for school-based behavioral health

As of the 2021–2022 school year, DBH will have funded at least one full-time clinician in every DC public school, but in some schools more than one clinician will be needed to meet the behavioral health needs of the school community. Further, for behavioral health clinicians to successfully reach students and families in need of their services, school staff must provide communication, coordination, and support to the clinician. Effective partnership between DBH and Office of the State Superintendent of Education (OSSE)/DCPS (education agencies) and between individual schools and their providers is the cornerstone of this program's success. Currently, all participating schools identify an existing staff member to serve as the school behavioral health coordinator, but that position is not supported with any funding, which often limits the capacity of this staff person to provide the support needed.

4.4 Recommendations

Given the overlaps between financing and service delivery of the behavioral health system, we recommend that the recommendations in Section 4.4 and Section 5.4 be considered together.

1. Plan to move MCOs toward a fully integrated corporate model that does not allow MCOs to subcontract behavioral health services.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

To fully realize the benefits of integration, DC should plan to move toward a fully carved-in model where subcontracting is not allowed. We recommend that the ability to subcontract persists during the initial carve-in of behavioral health services, which is planned for FY 2023, to ease the transition and plan for the necessary knowledge transfer. However, in subsequent terms, DC should move toward not allowing subcontracting of behavioral health services and implement an active plan for knowledge transfer from behavioral health subcontractors to the MCOs.

2. Avail primary care with payment and reimbursement infrastructure to optimize integrated care.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Medium to Long Term

Child, adolescent, and family mental health care require team-based care approaches. Those types of care must also support promotion and prevention in addition to treatment (when clinically appropriate in primary care) and timely referral mechanisms when a higher level of care is necessary. We recommend the District enable the following:

- **Psychiatric Collaborative Care Management (CoCM) through CPT Codes 99492–99494.** The CoCM model is an evidence-based framework that integrates a behavioral health care manager and psychiatric consultant into the primary care team with the goal of building primary care provider (PCP) capacity to manage patients' behavioral health conditions. Research demonstrates the model is effective with publicly insured and minority populations and can reduce health disparities. PCCM has dedicated CPT codes used to bill for services on a monthly basis; those codes include 99492 (rate code 5246), 99493 (rate code 5247), and 99494. Of note, billing codes for FQHCs are a different set of codes, which are currently not on the District's Medicaid fee schedule but are used in other states. We also recommend the adoption of these FQHC CoCM codes. Research on the implementation of this model shows that at least fifteen states currently allow for Medicaid reimbursement, including Missouri, New York, Oregon, and Washington.[115]

- **Coverage of discrete Z-codes to promote mental health and prevent mental health disorders.** Health care providers often see children who do not meet the full criteria for a mental health diagnosis but who are experiencing conditions and family circumstances that place them at high risk for developing significant mental health disorders. Families and their health care providers should not have to wait until a child has a full-blown psychiatric diagnosis before effective interventions can be delivered. Further, given the stigma still associated with mental health diagnoses, we should enable

providers with reimbursable codes and services that bolster the promotion and prevention end of the care continuum. To that end, Z-codes in the ICD-10-CM (also known as V codes in the *DSM-5*) are included to account for "other conditions that may be a focus of clinical attention," such as problems related to upbringing, social environment, housing and economics, negative life events in childhood, and education and literacy.[116] While those codes can be billed by providers currently, bills submitted with only Z-codes for a diagnosis (i.e., no other primary mental health disorder or medical condition) are unlikely to be reimbursed. Coverage of Z-codes under Medicaid would allow for children to receive needed care to address significant concerns regardless of whether the child has another mental health concern or condition. California and Oregon are examples of states that incorporate coverage of Z-codes via Medicaid.

- **Continue adequate funding of DC mental health access in pediatrics (DC MAP).**
  DC MAP is a rapidly growing, evidence-based consultation model that supports integrated mental health in primary care and is currently funded by the DC Department of Behavioral Health. The program successfully supports pediatricians in addressing the mental health needs of their patients through real-time access to child psychiatrists, psychologists, social workers, and care coordinators, which frees up DC's specialized mental health resources to serve youth who truly need a higher level of care.

- **Establish mechanisms to adequately reimburse decentralized care coordination services provided by clinical and nonclinical professionals in settings where families frequent and trust.**
  Effective care coordination, provided by individuals who are trusted by the community, is a bedrock of a high-functioning, integrated behavioral health care system. Peers should be recognized as qualified professionals for delivery of nonclinical care coordination services in settings such as pediatric practices, OBGYN, peer-operated centers, family-run organization, and other community settings and should be reimbursed accordingly. To facilitate adequate reimbursement for all care coordination services, it is important that same-day billing restrictions on service delivery and care coordination be eliminated.

  The District should consider adopting financing mechanisms that support the decentralization of care coordinators to environments that children and families frequent on a regular basis and trust (e.g., pediatric primary care, schools, or family-run organizations), rather than housing all care coordination services within managed-care plans. Decentralized care coordination allows for more flexibility in care coordination payment and reimbursement models that will ensure the sustainability and growth of care coordination that is already taking place and working well for families. The following are payment models for decentralized care coordination that we recommend be expanded:

  - **Health Homes:** Eligibility criteria for the two Health Home models in the District should be updated so that more children are eligible for services and care coordination. Currently, children need to have a minimum of three chronic conditions to be eligible for My Health GPS. We recommend relaxing the eligibility requirements to individuals with a minimum of two chronic conditions or individuals with one chronic condition who are at risk of another. Additionally, for both Health Home models (Health Homes I and My Health GPS), we recommend expanding the list of qualifying behavioral health conditions to include any mental health or substance use diagnosis. As permissible, it is also important that DHCF allows and expects MCOs to continue their care coordination services even if an individual is enrolled in a Health Home. For example, if a patient has to seek care outside a Health Home, the MCO care coordination team should be allowed to assist families with that. Those changes allow families to access care coordination services in a timely manner from organizations where they have established trusting relationships.

  - **HealthySteps:** This is an evidence-based national pediatric primary care program that provides infants and toddlers with social-emotional and development support by integrating child development specialists into primary care and strengthening family engagement.[117] HealthySteps is currently

implemented at multiple sites in DC. The model includes "care coordination and systems navigation" as one of its core components, in which a trained member of the community is able to build ongoing relationships with families and connect them to community resources.[118] Given that risk-based MCOs often do not have the care coordination expertise and capacity needed to serve the birth to three population, we recommend reimbursing clinical and nonclinical care coordination services delivered through HealthySteps or otherwise ensuring that any local Medicaid financing of the HealthySteps model adequately compensates for the clinical and nonclinical care coordination components delivered by FQHC and non-FQHC pediatric primary care centers.

3. Advance value-based, alternative payment methodologies, and/or accountable care models specific to child and adolescent behavioral health.

Implementing Bodies: DHCF, DBH, MCOs, CSAs
Timeline to Implementation: Short to Medium Term

- **Establish a pathway for creation and payment of certified community behavioral health clinics (CCBHCs).** Those clinics are designed via federal legislation to provide a comprehensive range of mental health and SUD services to under-resourced individuals and receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of complex populations. Recent data from states that have implemented CCBHCs demonstrate drastic reduction or elimination of waitlists for services within a few years of initiating their CCBHC work. Additionally, each state was able to leverage the model to reach under-resourced populations, with improvements in children's services frequently mentioned as a key advancement. The inclusion of CCBHCs in the District's behavioral health system is important because this model offers nationally standardized services with specific performance measures and expectations, as well as a payment framework outside of the Medicaid rehabilitation option that ensures financial sustainability while broadening the range of services available. As of July 2021, there are over 431 CCBHCs nationwide, and a growing number of states are moving toward implementing the CCBHC model independently via a state plan amendment or Medicaid waiver.[119] With current and emerging opportunities to adopt the CCBHC model statewide, it is critical for the District to establish a plan for organizations to be certified as CCBHCs by October 1, 2023.

- **Develop value-based and alternative payment models that prioritize children's social and emotional health. As** the District considers VBP models, we encourage a focus on advancing value-based or alternative payment models that incorporate a focus on child and family behavioral health, including early childhood social and emotional development. Those may take the form of bundled payments, episodes of care, or other models. Additionally, value-based or alternative payment models should be focused on equity through collaborative and team-based care, disaggregated race/ethnicity data, and incentivizing equitable care by tracking the quality of culturally responsive care a person receives.[120] In particular, we recommend the recent paper, Alternative Payment Models to Support Child Health & Development: How to Design and Implement New Models, as a starting point for design considerations. Additionally, some policy recommendations from *Behavioral Health Provider Participation in Medicaid Value-based Payment Models: An Environmental Scan and Policy Considerations*, which are highlighted below are worthy of consideration. DC should also utilize the major strategies outlined by the Center for Health Care Strategies to increase the number of providers paid under VBP arrangements through MCOs.[121] The first is mandating a standardized VBP model across MCOs. Others include requiring that MCOs make a given percentage of payments through approved VBP arrangements, mandating MCOs to take part in a multipayer VBP alignment initiative, and directing MCOs to initiate VBP pilot projects

that are subject to state approval. Innovation, testing, and stringent evaluation of payment models generates local evidence to inform decisions for financing DC's behavioral health system for children.

Extracted Policy Recommendations from Behavioral Health Provider Participation in Medicaid Value-based Payment Models: An Environmental Scan and Policy Considerations:

- Implement a robust stakeholder engagement process that includes meaningful participation from behavioral health providers and a broad range of state agencies.
- Leverage existing behavioral health system payment models and infrastructure to support VBP goals.
- Adapt VBP models to include policies that further incentivize adoption of VBP for behavioral health services.
- Include sufficient financial incentives and flexibility in VBP models to allow for behavioral health care delivery improvement.
- Implement state policies to track behavioral health VBP models and promote transparency about VBP adoption.
  - E.g., Since 2012, the Texas Health and Human Services Commission has published an annual summary of the VBP plans submitted by MCOs.
- Support alignment and development of meaningful behavioral health quality measures and data-sharing infrastructure to facilitate quality improvement.
  - E.g., Pennsylvania's VBP Steering Committee created a consensus document that identified a small number of standardized performance measures within four domains (outcomes, member experience, social determinants of health, and cost), which could be used within VBP models implemented by primary contractors and their associated behavioral health MCOs.

Source: Behavioral Health Provider Participation in Medicaid Value-Based Payment Models: An Environmental Scan and Policy Considerations, Center for Health Care Strategies Inc. and National Council for Behavioral Health, 2019

- **Implement VBP arrangements that adjust for social risk** when linking quality measures to payment incentives, using methods such as reporting quality-improvement data stratified by social risk level or adding bonuses for reducing disparity rates.[122]

- **Conduct operational readiness assessments** across government agencies, providers, and MCOs to prepare for behavioral health managed care carve-in,[123] specifically examining VBP readiness. That should include an assessment of whether provider organizations have the necessary technological tools to track and measure performance.

- **Provide education and technical assistance for MCOs, provider organizations, and the relevant staff at government agencies** on VBP strategies to ensure a common understanding, consistent use of terminology, and proper implementation. Technical assistance sessions should include the opportunity for feedback from MCOs and provider organizations to clarify strategies needed for payment.

4. Strengthen reporting of access to care standards in MCOs.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Medium Term

Establish additional access-to-care standards specific to behavioral health, including specific metrics for children, and require MCOs to publicly report on those standards on a regular basis. Currently, MCOs must meet the minimum time and distance standards for primary care, specialty care, mental health, and hospital providers of five miles or thirty minutes from the beneficiary's residence. Standards should include time to treatment and

time to follow-up visits (i.e., wait time between appointments, such as time from initial appointment to second appointment) and as recommended by National Association of Community Health Centers,[124] the number of Medicaid patients (overall capacity and new patient capacity) that participating providers are willing to accept. Regular public reporting on such new standards by MCOs may be useful for beneficiaries to find care more easily and more quickly. Standards should be informed by consultations with beneficiaries and providers.

5. Implement transparent strategies to enforce network adequacy.

Implementing Bodies: DHCF

Timeline to Implementation: Medium to Long Term

DHCF should ensure public transparency about MCOs network adequacy standards and compliance measures, as well as publish regular reports on network adequacy. Demonstrated enforcement of network adequacy standards can encourage all MCOs to ensure compliance. Some strategies to consider for enforcing network adequacy include:

- Monetary penalties for failure to meet network adequacy standards.

- A backstop dispute resolution process, whereby independent medical experts (which can be the same experts who review MCOs' medical necessity decisions) determine when patients need to go out of network to receive necessary medical care.[125] That external review should be focused on whether an MCO's available network resources are adequate for a patient's particular needs, rather than on whether the MCO is in technical compliance with regulatory requirements. Such a process can be triggered by a patient's inability to secure a timely appointment or referral.

6. Require universal contracting for critical providers to ensure initial network adequacy immediately following the carve-in of behavioral health services into managed care programs.

Implementing Bodies: DHCF, DBH, MCOs

Timeline to Implementation: Short Term

DHCF and DBH should first require universal contracting for critical providers to ensure network adequacy. That means that any provider who is licensed, credentialed, and willing to accept the plan's contract terms would initially be offered a contract. DBH-certified providers, in addition to other types of providers (i.e., Adolescent Community Reinforcement Approach [ACRA] providers, Adolescent Substance Abuse Treatment [ASTEP] providers, Federally Qualified Health Centers [FQHCs], Psychiatric Residential Treatment Facilities [PRTFs], and hospitals) are included as critical providers. MCOs should be required to offer at least an initial contract to all other child-serving providers to ensure there is an adequate network for children immediately following the carve-in of behavioral health services into managed care programs.

7. Update provider reimbursement rates that are adjusted for inflation, and establish a transparent rate-setting process.

Implementing Bodies: DBH, DHCF
Timeline to Implementation: Short to Medium Term

A critical feature of an effective, integrated system is ensuring behavioral health reimbursement rates are sufficient and on par with reimbursement for physical health conditions. Additionally, it is imperative that reimbursement be adequate for assessment and diagnosis (including medically necessary psychological and neuropsychological testing). We recognize that DC is undergoing a behavioral health reimbursement rate study, which is intended to improve reimbursement rates and rate-setting methodologies. It is important that this rate study prioritizes reimbursement of children's behavioral health services. Additionally, newly established rates must be inflation-indexed, and a formal mechanism for regularly examining and updating rates, rate structures, and rate-setting methods should be established. As a matter of parity, behavioral health services should be adjusted or rebased as frequently as comparable medical and surgical services.

8. Require MCOs to use standardized and simplified authorization, billing and credentialing processes and protocols.

Implementing Bodies: DHCF, MCOs
Timeline to Implementation: Short to Medium Term

Standardized processes ease administrative burden for providers and improve data consistency for district-level analyses. The development of those standardized processes and protocols should involve all relevant stakeholders, and the implementation should involve training providers.

- At a minimum, authorization and utilization management should conform to evidence-based, publicly available, nationally accepted standards of care developed by clinical provider associations or societies. All codes eligible for billing under DC Medicaid FFS should be available for billing by any provider paneled with any MCO.

- Which organization types are eligible for facility credentialing, group credentialing, or individual credentialing should be consistent across all MCOs, and credentialing should use a standardized electronic process or clearing house accessible to all MCOs and all providers and provider organizations.

9. Eliminate same-day billing restrictions that hinder children's access to behavioral health services.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Short to Medium Term

DHCF and MCOs should review same-day billing restrictions and seek input from families to identify restrictions that are hindering access to care. For example, same-day billing restrictions for IEP and non-IEP behavioral health services can prevent a child on an IEP from accessing non-IEP behavioral health services if the need

arises at school. Further, billing restrictions should be updated to ensure that when children see both a medical and behavioral health provider at the same location on the same day (e.g., seeing both an endocrinologist and psychiatrist on the same day), payment is rendered to both providers. That would substantially reduce the burden on parents in having to make multiple visits, reduce children's time out of school, and advance the District's goals of successfully integrating physical and behavioral health care.[126]

10. Ensure proper clinical expertise in medical necessity determinations.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Short Term

DHCF and DBH should ensure that individuals with the proper clinical, developmental, and treatment expertise are involved in the decision-making regarding medical necessity determinations, prior authorization decisions, denials, grievances, and appeals regarding care for children. For example, autism spectrum disorder treatment plans should be determined by specialists within the area of expertise for which they are recommending services (e.g., speech language therapists should determine the number of speech therapy hours recommended) and in ambulatory (medical or mental health) care settings. Additionally, medical necessity determinations must align with publicly available, evidence-based standards, independent from business considerations and consistent with generally accepted standards of care. According to current MCO contracts, any decision to deny a service authorization request must be made by a health care professional who has appropriate clinical experience in treating the enrollee's condition or disease. However, that should be amended such that the credential of any clinician denying care should be at least equal to the credential of the recommending clinician and based on relevant clinical experience. Relatedly, in line with the Mental Health Parity and Addiction Equity Act of 2008, DHCF and DBH must ensure prior authorization requirements for behavioral health services are comparable to or less restrictive than those for physical health services.

11. Assess all available public and private funding streams, including Medicaid, that can support plans to address the social determinants of children's behavioral health in DC.

Implementing Bodies: DHCF, DBH, DC Health, CFSA, DHS
Timeline to Implementation: Medium Term

Government agencies involved in children's behavioral health (including, but not limited to, DBH, DHCF, DC Health, and CFSA) should assess all available public and private funding streams, including Medicaid, to cover assistance with unmet social needs such as housing, nutrition, employment, education, and transportation when developing a strategy for addressing beneficiaries' SDOH. That assessment can be done annually as part of each agencies' budget planning. DC's efforts to address children's behavioral health must prioritize the social determinants of behavioral health. This may include supporting the development of safe spaces, convenient and efficient transportation, safe neighborhoods, strong social connections, and quality education for children in DC. DHCF should particularly examine how federal funding may be able to support this, such as outlined in the recent "Opportunities in Medicaid and CHIP to Address Social Determinants of Health" letter (SHO# 21-001) from CMS.[127]

One relevant project that can benefit from continued funding is the Community Resource Information Exchange (CoRIE) project, which is developing data infrastructure to support coordinated screening and referrals across a range of health, human, and social services in DC. Expanded investments in the CoRIE project will support data analytics to improve health equity; clinical-community linkages; and the integration of community social support, government, and health care. Considering those potential benefits, DHCF should prioritize funding the full implementation and evaluation of this project.

12. Adequately fund the School-Based Behavioral Health Expansion Program.

Implementing Bodies: DBH, OSSE/DCPS
Timeline to Implementation: Short to Medium Term

The goal of the School-Based Behavioral Health Expansion Program is to fully integrate behavioral health resources into school communities. Students, teachers, school leaders, and families should be able to access all three tiers of behavioral health supports at school. Connection to additional behavioral health supports or other kinds of support services outside of the school setting should be seamless. To do that, the school-based behavioral health expansion program must be adequately resourced:

- **Sustainable funding:** Funding for this program should be converted to multiyear contracts with option years to allow schools and providers some stability and capacity to make long-term plans regarding behavioral health resources and support for school communities. That would enable schools and providers to do the planning and coordination work, including the hiring and training of clinicians, over the summer that is necessary for the program to be a success.

- **Sufficient clinical staff in all schools:** As of the 2021–2022 school year, DBH will have funded at least one full-time clinician in every DC public school, traditional and charter. The next phase of expansion must focus on developing an accurate understanding of the behavioral health needs of each school community—teachers, parents, school leaders, and students—and identifying schools that need additional clinicians to meet those needs.

- **Right-sizing grant or contract funding amounts: DBH** set the current per-school grant amount (approximately $70,000) based on estimates developed in 2019. For school year 2021–2022, the DC Council provided a one-time grant enhancement of $8,000 per school to cover additional costs to providers during the ongoing pandemic and transition to in-person learning. As the program enters its fourth year of implementation in FY2022, DBH should work with providers to collect actual cost and billing data from the last few years to assess the true cost of this program. Right-sizing the per-school grant amount is essential to the long-term financial sustainability of this program.

- **School capacity to support behavioral health:** OSSE and DCPS should provide dedicated funding to cover the cost of the additional staff capacity needed to effectively provide program communication and coordination, as well as support to the clinician. That could include funding for the school behavioral health coordinator position, which is critical to supporting the clinician's work. Further, some schools may require additional nonclinical support staff to provide expanded Tier 1 and Tier 2 services and enable deeper and more direct engagement with families.

- **Provider capacity-building:** Over the past two years, DBH has made significant investments in its community of practice (CoP), a collaborative learning environment designed to support the implementation of school-based behavioral health.[128] The CoP brings providers, school staff, and school

leaders together to share best practices, participate in trainings and other learning activities, and take part in specialized practice groups that deepen participants' understanding of what timely access to high-quality support looks like in certain areas of behavioral health. Continued investment in the CoP is essential to building provider capacity and maintaining consistent quality of services across the program.

- **Evaluation:** DBH is also investing in a thorough, multiyear evaluation of the school-based behavioral health expansion program to gain early on-the-ground insight into how the program is working. The evaluation will focus on processes and outcomes at both the system-level and the school-level and ultimately result in a series of reports that describe how the expansion is being implemented over time, the outcomes associated with implementation, and actionable recommendations. That information will then be used to guide policy decisions regarding how to strengthen and improve the program. Continued investment into the evaluation piece will be critical for the program's long-term success.

13. Adequately invest in technologies that can support and optimize the work of behavioral health service provider organizations, MCOs, and government agencies involved in children's behavioral health.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Short to Long Term

Various technologies can be leveraged to improve behavioral health services in DC. For example, the use of interoperable electronic health records (EHRs) to facilitate better care coordination or the use of the District Health Information Exchange system to do population-level data analysis. Specific recommendations around appropriately leveraging the use of technology to benefit the behavioral health of children in the District are included in Chapter 8. However, in general, implementation of those recommendations would require long-term fiscal planning that anticipates the costs of acquiring and/or developing appropriate technologies, providing financial incentives to promote uptake, and providing the necessary technical support for initial and continued implementation.

5. SERVICE DELIVERY

Service delivery or provision is an immediate output of the health system that encompasses a comprehensive range of accessible, high-quality health services with continuity of care. Behavioral health services can be categorized along the continuum of care, ranging from prevention services that target individuals before they develop a behavioral health issue to treatment services for individuals with a diagnosed behavioral health disorder.

5.1 Vision for the System

The behavioral health system for children should deliver high-quality mental health and substance use services along the full continuum of care that meets the evolving needs of children in DC. Service networks should be actively coordinated with accountability and efficiency. All behavioral health services should be based on evidence-based practices and informed by local data on children's behavioral health (including the social determinants of behavioral health). Further, these services should be aligned with the tenets of family-driven, family-centered, youth-guided, and trauma-informed care. Additionally, services must be delivered with cultural attunement and in a manner that promotes racial equity.

Table 5.A. Components of Principles that should Guide Behavioral Health Service Delivery for Children

Principles that Should Guide Service Delivery					
Family-Driven	Family-Centered	Youth-Guided	Cultural Attunement	Trauma-Informed	Racial Equity
• **Families have a primary decision-making role in the care of their own children** as well as the policies and procedures governing care for all children in DC.	• An approach to the planning, delivery, and evaluation of health care that is **grounded in mutually beneficial partnerships among health care providers, patients, and families** (Ahmann & Johnson, 2000).	• Young people have the right to be **empowered, educated, and given a decision-making role** in their own care and in the establishment of policies and procedures governing all youth in DC (Youth MOVE National and SAMHSA).	• Five components: "recognizing the pain of the oppression, involving in actions of humility, serving with high regard, involving commonality, and keeping a 'not knowing position'" (Hoskin, 1999, p. 77).	• "A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for **recovery; recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by	• The elimination of racial disparities such that **race no longer predicts opportunities, outcomes, or the distribution of resources** for residents of the District, particularly for persons of color and Black residents (Council Office of Racial Equity)

Family-Driven	Family-Centered	Youth-Guided	Cultural Attunement	Trauma-Informed	Racial Equity
• Includes: choosing services, setting goals, designing and implementing programs, monitoring outcomes, participating in funding decisions, and determining effectiveness of all efforts to promote the behavioral health of children (Osher, Osher, & Blau, 2006).	• Parents identify **communication, responsiveness, honesty, and emotional support** as being important to the delivery of child- and family-centered care.	• This includes giving young people a **sustainable voice and then listening to that voice.**	• The **synchronization of treatment with the cultural and the social context of the clients** (Falicov, 2009).	fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." (SAMHSA) • A trauma-informed approach is **inclusive of trauma-specific interventions**, whether assessment, treatment, or recovery supports, y**et it also incorporates key trauma principles into the organizational culture** (SAMHSA).	

A Full Continuum of Care of Behavioral Health Services

Mental Health America states that children and families should have **access to a full continuum of mental health supports, which includes promotion of mental health, prevention of mental illnesses and substance use, early identification, treatment, recovery and rehabilitation services, and long-term supports**, as needed.[128] *Figure 5.A* in *Section 5.2* describes the full continuum of care. A full continuum of care must be delivered across sectors and settings, including government, schools, CBOs, and health care facilities as well as nontraditional locations (e.g., faith-based institutions, grocery stores, barbershops, rec centers, etc.). The delivery of services should be integrated in nonstigmatizing locations, where children and families are most likely to engage, even if that requires innovative practice and policy changes. Based on the description of a full continuum of care, our vision for the District's child and youth public behavioral health system includes greater access to behavioral health promotion and prevention services, as well as intermediate levels of care services.

Prevention and Promotion

Prevention services are a fundamental part of promoting healthy development in children and youth and are critical in the prevention of mental health disorders in adulthood. Prevention is defined as "Interventions that occur before the onset of a problem, as well as interventions that prevent relapse, disability, and the consequences of severe mental illness or substance abuse."[130] Promotion is defined as "Efforts designed to enhance an individual's social competence, self-esteem, and sense of well-being."[131] According to SAMHSA, prevention and promotion of mental health takes a public health approach to addressing mental health in which the child's physical, psychosocial, cultural, and social environments are considered, including the child's individual, family, school, and neighborhood

context.[131] That requires developing interventions and services that focus on identifying and addressing risk factors early on while building on protective factors that lean on the strengths and resources that occur naturally in the child's environment to promote resiliency during childhood and adolescence. For example, implementing a parenting/caregiver education program to strengthen the parent-child relationship through building parenting strategies and skills, which can have a positive outcome for the child's developmental trajectory. Prevention programs can be categorized using a tiered model in which a program is universal (applicable to the general population), selective (applicable to a specific group based on biological or social risk factors), and/or indicated (applicable to individuals who are at highest risk, some symptoms of mental health problems that are not yet severe).[131] Some programs may address all three levels of prevention.

The Good Behavior Game: An Evidenced-based, Universal Prevention Program for Children and Youth

The Good Behavior Game is a universal classroom-based prevention intervention program focused on behavior management.[132] It has four core elements: four classroom rules for students to follow; team membership, in which students play the game in teams to build relationships with peers; behavior monitoring by the teacher as well as students monitoring their own and their peers' behaviors; and positive reinforcement. The game is played during independent and group work time, three times a week for 10 minutes ramping up intensity to 30–40 minutes daily. The program's short-term goals include reducing aggressive and disruptive behaviors in the classroom. Longer-term goals focus on reducing likelihood of substance use; providing referrals for academic or behavioral services; and lowering the rates of suicidal ideation, depression, and incarceration. There is a strong evidence base to support the effectiveness of the Good Behavior Program, including being rated as effective by the Office of Juvenile Justice and Delinquency Prevention.[133] It was originally implemented in 41 classrooms across 19 elementary schools in a randomized trial in Baltimore, Maryland, that showed positive outcomes. The program also shows a 25% rate of return on investment and a cost savings of $31.19 for every dollar spent.[133]

There are a number of evidence-based and promising practice promotion, prevention, and early intervention programs across the age continuum. Examples include HealthySteps, Attachment and Biobehavioral Catch-up (ABC), Circle of Security Parenting, Reconnecting Youth, Triple P Positive Parenting, Strengthening Families Coping Resources, Centering Pregnancy, and First Episode Psychosis Programs.[134] Several of those programs are applicable to the prenatal to age five population and are discussed in the Chapter 9. Prevention and early identification services also include leveraging the Early and Periodic Screening, Diagnosis, and Treatment benefit to promote increased behavioral health screening and timely referrals to appropriate treatment.

Substance Use Services

Access to a full continuum of care for children and youth must also include appropriate access to substance use prevention, screening, assessment, referral, and treatment services in integrated and easily accessible locations, such as primary care and schools. The full continuum of substance use services is critical because substance use problems that develop and remain untreated in adolescence can lead to negative health outcomes that persist into adulthood.[135]

Substance Use Prevention
Substance use prevention programs for children can be implemented across a variety of settings and can target specific or combined drug use. One review found that school-based drug-specific prevention programs were effective, with interventions based on a combination of social competence and social influence approaches having protective effects against drugs and cannabis use.[136] The review also highlighted supporting evidence for mass media campaigns and family-based interventions, but the authors noted mixed findings for the effectiveness of internet-based interventions, policy initiatives, and incentives.[136]

Substance Use Treatment
There have been multiple guides and principles outlined on how to treat adolescents with SUD or who misuse substances, such as the TIP 32: Treatment of Adolescents with Substance Use Disorders: Treatment Improvement Protocol (TIP) Series 32, the State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide,

and Identifying Mental Health and Substance Use Problems of Children and Adolescents: A Guide for Child-Serving Organizations. The figure below outlines the principles of Adolescent Substance Use Disorder Treatment from the National Institute on Drug Abuse (NIDA).

NIDA Principles of Adolescent Substance Use Disorder Treatment
1. Adolescent substance use needs to be identified and addressed as soon as possible.
2. Adolescents can benefit from a drug abuse intervention even if they are not addicted to a drug.
3. Routine annual medical visits are an opportunity to ask adolescents about drug use.
4. Legal interventions and sanctions or family pressure may play an important role in getting adolescents to enter, stay in, and complete treatment.
5. Substance use disorder treatment should be tailored to the unique needs of the adolescent.
6. Treatment should address the needs of the whole person, rather than just focusing on the individual's drug use.
7. Behavioral therapies are effective in addressing adolescent drug use.
8. Families and the community are important aspects of treatment.
9. Effectively treating substance use disorders in adolescents requires also identifying and treating any other mental health conditions they may have.
10. Sensitive issues such as violence and child abuse or risk of suicide should be identified and addressed.
11. It is important to monitor drug use during treatment.
12. Staying in treatment for an adequate period of time and continuity of care afterward are important.
13. Testing adolescents for sexually transmitted diseases is an important part of drug treatment.

Adapted from Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide; National Institute on Drug Abuse; 2014

According to these principles and guides, youth should be able to access substance use treatment services through multiple entry points via a coordinated system of care, such that there is "no wrong door." That means that youth should be identified, screened, assessed, and referred through their primary care provider, school system, child welfare system, juvenile justice system, etc., which requires collaboration and coordination between all the systems. Screening and assessment tools should be culturally competent, evidence-based, and standardized throughout the systems. Referrals should be facilitated by those making the referral so that adolescents and caregivers receive help in navigating, accessing, and utilizing the appropriate services, as well as monitoring and follow-up after treatment. For example, a youth primary care team should screen all youth for substance use, administer assessments to those who screen positive, communicate with caregivers about concerns, provide brief interventions, refer to appropriate levels of treatment services if needed, and then coordinate with the youth's school system and caregivers to monitor and follow- up after treatment. That requires investments in training, education, and supportive/consultative services such as in the Massachusetts Child Psychiatry Access Project (discussed below). Adolescents should also be able to access treatment services directly through an adolescent focused outpatient treatment center. Further, in a coordinated system of care, mental health, and substance use services should be integrated or collocated together to decrease stigma and provide easier access for adolescents and their families.

Integrated Care

The World Health Organization defines integrated care as "health services organized and managed so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."[141] Integrated care is associated with improved behavioral health outcomes. For example, a meta-analysis of 35 intervention-control comparisons revealed significantly better behavioral health outcomes for integrated care when compared to usual care.[141] Integrated behavioral health services also help to reduce stigma for individuals who may not have otherwise sought services in a behavioral health clinic.[143]

For children, care integration ensures access to behavioral health services in settings in which they frequent most, such as child care/early learning centers, K–12 schools, and pediatric primary care practices. Behavioral health capacity should exist in primary care settings to promote early identification and intervention for behavioral health issues in children. Children are more likely to go to their primary care provider due to scheduled well-child visits, and therefore a primary care provider is well positioned to detect the early onset of behavioral problems.[144] Child and adolescent mental health specialists should be integrated into primary care practices to provide the necessary knowledge, skills, and support to effectively support PCPs caring for youths with mental health disorders. There are a multitude of behavioral health integration frameworks that allow for a comprehensive, coordinated, and patient- and family-centered system of care.

Elements of Integrated Behavioral Health Care	Strategies For Greater, More Effective Integration of Care
• Care team expertise tailored to the patient population • Share clinical workflow • Systematic patient identification • Treatment monitoring • Leadership alignment • Operational reliability • Business model sustainability • Data collection and use • Patient experience Source: A Framework for Measuring Integration of Behavioral Health and Primary Care; Agency for Healthcare Research and Quality	• Cross-training of PCPs and behavioral health providers • Inclusion of family partner/navigator • Establishment of enhanced referral and care coordination systems • Use of standardized behavioral health and social and emotional development screening tools • Warm handoffs[xiii] • Wellness promotion and prevention as part of the well-child visit • Shared record keeping • Provision of parenting education and support groups • Embedding of mental health consultants in primary care settings Source: The Integration of Behavioral Health into Pediatric Primary Care Settings; National Academy for State Health Policy; 2017

One model of integrated care is the **Collaborative Care Model or the Psychiatric Collaborative Care Management (PCCM) model**, which was previously mentioned in *Section 4.4*. The PCCM model is an evidence-based framework that integrates a behavioral care manager (typically a social worker, counselor, nurse, or psychologist) and a psychiatric consultant (a trained medical professional who can prescribe a full range of medications) into the primary care team.[145] This model utilizes the following approach[146] to help support treatment of patients' behavioral health conditions within the primary care setting:

- Patient-Centered Team Care—primary care providers, behavioral health providers, and all other members of the patent's care team work together effectively using a shared care plan;
- Population-based Care—the care team's caseload is tracked within a patient registry where patient's progress is tracked;
- Measurement-based Treatment-to-Target—personal goals and clinical outcomes within a patient's care plan are routinely measured and adjusted using evidence-based tools;
- Evidence-base Target—treatment plans and therapies are supported by evidence-based research proving effectiveness;
- Accountable Care—Reimbursement is based on quality of care and clinical outcomes.

Over 70 randomized controlled trials conducted across diverse health care settings, with different financing mechanisms and varying patient populations, have established a robust evidence base for a collaborative care approach. Research has demonstrated that collaborative care programs are not only highly effective for patients from ethnic minority groups, but they also can reduce health disparities observed in such populations.[147] However, there is not much research published on implementation of the Psychiatric Collaborative Care model with children as of yet. While the model is not applicable to young children, it fills a gap in the continuum of care for treatment with older children, adolescents, and transition-aged youth who have diagnosed disorders, such as ADHD, anxiety, depression, etc.

[xiii] *According to the Agency for Healthcare Research and Quality, a warm handoff is "transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care."*

The **Certified Community Behavioral Health Clinic (CCBHC)** model is another model that embodies the vision for integrated care. According to the National Council for Mental Wellbeing,[150] a CCBHC is "a specially-designated clinic that receives flexible funding to expand the scope of mental health and substance use services available in their community." CCBHCs are responsible for directly providing (or contracting) nine types of services.[151]

1. crisis mental health services
2. screening, assessment, and diagnosis, including risk assessment
3. patient-centered treatment planning
4. outpatient mental health and substance use services
5. primary care screening and monitoring of key health indicators/health risk
6. targeted case management
7. psychiatric rehabilitation services
8. peer support and family supports
9. intensive, community-based mental health care for members of the armed forces and veterans

In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. CCBHCs were specifically designed to address financing shortfalls by paying clinics a Medicaid rate that is inclusive of their anticipated costs of expanding their service lines and serving new consumers, through a prospective payment system. Unlike CCBHCs, which have this enhanced funding formula, CSAs do not have the financial backing to provide the nine nationally standardized services with specific performance measures and expectations.

Data from states that have implemented CCBHCs demonstrate elimination of waitlists for services within a few years of initiating their CCBHC work and increased care coordination across sectors. Additionally, each state was able to leverage the model to reach under-resourced populations, with improvements in children's services frequently mentioned as a key advancement.[152] New York State reported during the Behavioral Health Commissioners Summit that the implementation of the CCBHC model allowed for an increase in the delivery of behavioral health services for children and adolescents, including home-based, school-based, and crisis services for youth. It reported that 24% of all individuals receiving services were under age 22. Nevada was another state that reported increased access to children's behavioral health services after implementing the CCBHC model, as well as medication-assisted treatment (MAT) services and primary care. Twenty-two percent of organizations participating in the CCBHC demonstration program in 2018 were able to add specialty outpatient child and youth mental health and SUD services; 15% were able to add community wraparound services for children and youth.[153]

The recent *CCBHC Impact Report by the National Council for Mental Wellbeing* highlights that 84% of CCBHCs either are providing direct services within schools or are planning to, 63% engage in suicide prevention for children and youth, 42% provide Mental Health First Aid (MHFA)[xiv] training to middle or high school teachers and staff, and 20% are providing MHFA training to students.[150] That demonstrates the increased relationship and partnerships between child-serving organizations and systems allowing for greater integration of services and increased support for families. Other benefits of the CCBHC model include expansion of the behavioral health workforce in the state and funding for more

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[xiv] According to the <u>National Council for Mental Wellbeing</u>, Mental Health First Aid is a training that gives a person the skills need to identify, understand, and respond to signs of mental illnesses and substance use disorders.

nontraditional workforce (e.g., peer support) due to the allocation of funds to hire staff at a higher salary, thus helping to attract more providers to the state.[152] For example, New York reported being able to hire more child-serving providers.[152]

As mentioned above, implementation of CCBHC has also helped to improve care coordination. Some strategies used by programs participating in the demonstration program include adding additional provider types to care teams; increasing partnerships and contracting with CBOs, schools, juvenile justice bodies, police, and other external groups; expanding targeted care coordination strategies to different populations; and implementing improvements to EHRs and health information technology systems.[150] Those strategies have helped some CCBHCs to better integrate care plans, create linkages with external providers, and receive alerts about clients' care transitions.

Another example of an integrated behavioral health care model currently implemented throughout the country are **Child Psychiatry Access programs**. These collaborative programs require staffing of child psychiatrists to support pediatricians and other PCPs through telephone consultation services.[154] The child psychiatrists are able to provide education, referrals to community mental health services when needed, and other immediate assistance to pediatric PCPs. Each team in a Child Psychiatry Access program is staffed with two full-time child and adolescent psychiatrists, independently licensed behavioral health clinicians, resource and referral specialists, and program coordinators. These programs have increased children's access to and use of mental health services,[155] as well as decreased inappropriate and excessive prescription of psychiatric medication.[156] In addition to allowing for greater use of mental health services, this model provides opportunities for expansion. The expansion of the Massachusetts Child Psychiatry Access Project to support early identification and treatment of substance use in adolescents was provided above as an example.

Care Coordination

According to the Agency for Healthcare Research and Quality, "care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."[157] Care coordination across settings reduces fragmented care and leads to decreased health care costs and improvement in the patient/family experience of care.[158] Care coordinators have different titles and roles in a care team, such as case manager, patient navigator, peer support worker, community health worker, etc. Care coordination is a central tenant for ensuring successful integration of care for children and families across systems. Similarly, effective implementation of integrated care (such as the models mentioned above) enhances care coordination and communication for families. That is especially true for children with complex health care needs and multiple conditions who are often receiving care from and navigating multiple systems, such as the educational system; early intervention; child care; community-based services; advocacy organizations; payers; medical, social, and behavioral health systems; and in some instances, child welfare and juvenile justice systems. Effective care coordination requires a focus on care planning, as well as building collaboration, partnerships, and trusting relationships between all the providers working with the child and family (e.g., PCP, teacher, care coordinator, behavioral health clinician, social worker, etc.). Also, a patient-centered and culturally mindful care philosophy, which takes into account the individual perspectives and needs of the patient and their family, should be incorporated into the process of effective care coordination.

National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN)

Developed by the National Academy for State Health Policy, the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) outline guiding principles and core components of effective care coordination for children, youth, and their families. The foundational standards, which can be applicable to all children, include:

1. Care coordination is based on the premise of health equity, that all children and families should have an equal opportunity to attain their full health potential, and no barriers should exist to prevent children and their families from achieving this potential.

2. Care coordination addresses the full range of social, behavioral, environmental, and health care needs of CYSHCN.

3. Families are co-creators of care coordination processes and are active, core partners in decision making as members of the care team. CYSHCN, families, and care coordinators work together to build trusting relationships.

4. Care coordination is evidence based where possible and evidence informed and/or based on promising practices where evidence-based approaches do not exist.

5. Care coordination is implemented and delivered in a culturally competent, linguistically appropriate, and accessible manner to best serve CYSHCN and their families.

6. Insurance coverage of care coordination for CYSHCN allows for it to be accessible, affordable, and comprehensive.

7. Performance of care coordination activities is assessed with outcome measures that evaluate areas including:
    a. process of care coordination (e.g., number of families with a shared plan of care);
    b. family experience with integration of care across medical, behavioral, social, and other sectors and systems;
    c. quality of life for CYSHCN and families; and
    d. reduction in duplicative and/or preventable health care utilization.

Source: National Academy for State Health Policy; October 2020

Some existing models for delivering care coordination:

- **Health Homes**—an optional Medicaid State Plan benefit for states that integrates and coordinates all primary, behavioral health, acute, and long-term services and supports to treat persons with chronic conditions.[159]

- **High Fidelity Wraparound**—a collaborative, team-based, and structured approach to providing coordinated services and support to families. Families and youth drive the planning.

- **Nonclinical care coordination**—e.g., community health workers (CHWs) and peer support specialists
    - CHWs are trusted and trained individuals who serve as the bridge between health care systems and their communities.[160] There is strong evidence supporting the integration of CHWs into health care teams to provide services such as care coordination and system navigation, leading to improved health care outcomes and reduced costs.[161]
    - Peer support specialists are individuals with lived experience who provide nonclinical strength-based support, education, and connection to services and resources. One type of peer support services is peer recovery support delivered by peer recovery coaches. There is a growing body of evidence to support the effectiveness of peer recovery coaches in reducing substance use and improving outcomes.[162]

- **Help Me Grow**—a national model in which "an information and referral helpline provides parents, physicians, and providers with the knowledge and resources they need to make a difference in the lives of children."[163] There are four main components that make up this model: centralized access point, family and community outreach, child provider outreach, and data collection and analysis.[164]

Intermediate Levels of Care

Intermediate levels of care services or step-down care options refer to acute or intensive services provided in the community or outpatient settings that are critical to the continuum of services. These include:

- **Intensive Outpatient Programs (IOPs)**
  IOPs are several hours of structured programming a week, usually after school and short term.[165] This type of program serves as a transition for youth from residential or inpatient care, as well as serves to reduce the need for inpatient care by providing more intensive services for patients who are not responding to standard outpatient care.

- **Partial Hospitalization Programs (PHPs)**
  PHPs are full-day treatment programs, usually short term and more intensive than IOPs, in which adolescents experiencing acute psychiatric symptoms but not in need of 24-hour care receive group therapy, family therapy, individual counseling, and/or psychoeducational sessions.[166] Research on PHPs has shown they have been proven to prevent future hospitalizations and decrease the length of stay in the hospital.[166] A 2014 study with 35 adolescents demonstrated that the PHP was effective in improving psychological symptoms and resulted in positive self-perceptions of getting better.[167]

- **Youth Crisis Stabilization Units**

  These are bed units, often co-located in a hospital emergency department, in which children and youth who are experiencing acute concerns but do not rise to the level of needing residential treatment are admitted on average for three to five days and receive brief intensive mental health therapy (e.g., one-on-one therapy, family therapy, crisis intervention, psychiatric evaluation, and, if necessary, medication management).[168] They provide a safe, secure, and less-restrictive environment for short-term crisis evaluation and intervention, with the goal of working toward stabilization with both the individual and their family.

One strong clinical example in which these models are currently being implemented is NYC Health+Hospitals/Bellevue Hospital Center in New York. That hospital provides a full range of psychiatric assessment and treatment services across the care continuum. From most to least intensive/restrictive, services include:

1. a hospital-based inpatient psychiatric unit,

2. a hospital-based public school,

3. a hospital-based and exclusively Children's Comprehensive Psychiatric Emergency Program (CCPEP, more information highlighted below),

4. an in-home crisis stabilization program,

5. an outpatient bridging clinic for step-down care and crisis stabilization,

6. a mobile crisis stabilization program,

7. a partial hospitalization program, and

8. traditional outpatient services.

A Model for a Children's Comprehensive Psychiatric Emergency Program (CCPEP)

NYC Health + Hospitals/Bellevue's CCPEP is one of the few existing examples of an adaption of the CPEP model that is specialized to serve children ages zero to 18. It has three main components:

1. **Emergency Evaluation Area (available 24/7):** Children and their families are triaged by an experienced child psychiatric nurse and then seen by a child psychiatrist and a child psychiatric social worker for evaluation and diagnostic assessment.

2. **Pediatric Observation Unit (available 24/7):** Children who present with more severe and acute symptoms can be held overnight or for several days for treatment in the extended observation and brief stabilization six-bed unit. This is a high-quality alternative to triage in medical emergency rooms.

3. **Outpatient Acute Care Services:**

   a. *Interim Crisis Clinic Services:* serves children who do not require inpatient admission but present with issues that require immediate intervention with ongoing monitoring. Children who are evaluated in the CCPEP can be seen for up to five follow-up visits at the CCPEP. That serves as a bridge between emergency evaluation and outpatient follow-up care, particularly when there are long wait times to be seen by a psychiatrist at community outpatient clinics. These services can include medication prescription and monitoring, psychoeducation, brief psychotherapeutic interventions, and family interventions.

   b. *Home-Based Crisis Intervention Services:* These are short-term (six to 12 weeks) in-home and community services to prevent psychiatric hospitalization in at-risk youth.

   c. *Mobile Crisis Services:* This is a team of mental health clinicians who are available to evaluate patients in their homes and are authorized to request emergency medical services transport of those patients to the CCPEP if necessary. This service is utilized when high-risk patients do not attend scheduled follow-up appointments in the Interim Crisis Clinic. This ensures that patients do not fall through the cracks of the emergency management system.

While research on this CCPEP is limited, a study by Gerson et al (2017) examining one year of data found that while 86% of children presented in crisis (emergent or urgent severity of visit), 59% of the patients could be discharged after evaluation, and 13% of patients could be stabilized in the observation unit in under 72 hours.[169] The study inferred that brief stabilization with active treatment is an effective alternative to inpatient admission for some patients. Additionally, the authors suggested that the "availability of child psychiatrists in this program allowed greater ascertainment of suicide risk (and thus hospitalization to mitigate that risk) than occurs in emergency rooms without such staffing."

Source: Children of Bellevue Child & Adolescent Psychiatry, Children's Comprehensive Psychiatric Emergency Program (CCPEP).

Accessibility of Services

As mentioned previously, ensuring access to timely care includes reducing wait times and waitlists, ensuring a robust child-serving provider network and adequate workforce, and multiple pathways for families to enter into and receive care.

Wait Time Standards

Minimizing wait times for appointments is critical, because delays in behavioral health services are associated with prolonged distress, potential exacerbation of the existing problem, an elevated risk of poor outcomes, and a decreased likelihood that patients will keep their appointments.[170] Behavioral health care literature suggests that a new patient psychiatry appointment must be available within 24 hours of scheduling to avoid increased risk of no-shows.[171, 172] Further research suggests that the first therapeutic contact should be made on the same day as intake,[173] and patients should have access to an initial psychotherapy visit within four days to avoid an increase in the likelihood of no-shows.[174] However, evidence-based wait time standards have not been set.[175] Further, the evidence base does not support the broad use of a specific wait time standard for new mental health or primary care patients.[176]

Accessibility Monitoring

It is also advantageous to incorporate real-time monitoring of service availability indicators, such as wait times, into behavioral healthcare EHR systems to detect and resolve problems related to inaccessibility of services as quickly as possible.[177] For example, Seattle Children's hospital redesigned its EHR systems to incorporate real-time monitoring of wait times, which allowed for the rapid trialing of wait-time reduction techniques in both the emergency department and inpatient facility.[178]

Quality of Services

Behavioral health services for children should not only be accessible and comprehensive, but they must also be of high quality. Regularly measuring and reporting care quality informs quality improvement initiatives and makes financial incentives and penalties for performance possible.[179] Additionally, data collected on quality of care needs to include qualitative data and direct beneficiary feedback. As such, efforts to standardize behavioral health care quality measures are ongoing.[179]

Reporting on quality of services

A review of 510 commonly used behavioral health quality reporting systems by Patel and colleagues (2015) demonstrated that 72% were process measures, 21% were outcome measures, and 6% were structure measures.[180] Given that process variables do not necessarily translate to patient outcomes directly, the extent to which those data can be interpreted to improve patient outcomes is limited. Eighty-nine percent of those measures were obtained from administrative claims data, which are subject to variation based on billing codes used in individual settings.[180] The review also revealed that, among quality reporting programs selected, only 28 (5%) unique measures existed, although there was variation in the way that they were framed (for example, readmission within 14 verses 30 days).[180] As such, there is a substantial need for behavioral health quality measures that better translate across settings.[180]

CMS Medicaid/CHIP Child Core Set

The CMS Medicaid/CHIP Child Core Set provides an avenue through which states can measure and report the quality of care provided through Medicaid or CHIP-funded services.[181] Eighteen of the 25 measures in the core set are graded by the Oxford Centre for Evidence-Based Medicine (CEBM) criteria with either an "A" or "B."[181] Those measures are a good start to introducing standardized measures of quality of care to child health care settings.[181] Nevertheless, there is some room for improvement, especially given that there is a lack of behavioral health care quality indicators in the set.[181] Forty-nine states report at least half of those measures, demonstrating that data collected through the core set is becoming widely available.[182] States' utilization of the core set is promising and allows states to benchmark their quality indicators to those of aggregated national data.[181]

National Committee for Quality Assurance (NCQA)

NCQA offers the Distinction in Behavioral Health Integration recognition to primary care practices that meet 18 criteria, including incorporation of behavioral health providers on-site, information sharing with outside organizations for care coordination, use of evidence-based protocols related to behavioral health, and use of quality behavioral health measures to inform care.[183] PCPs who incorporate those measures into practice are likely to contribute to increased behavioral health care accessibility and seamless care transitions.[183] However, PCPs may be disincentivized to acquire and maintain that distinction by the $6,700 initial recognition fee and $2,010 annual reporting fee.[183]

5.2 Current System

The Continuum of Behavioral Health Services

Figure 5.A highlights the behavioral health services and programs available to children in DC with public insurance along the continuum of care. *Table D.1* in Appendix D provides a more comprehensive description of each of the programs in *Figure* 5.A, along with its target population, utilization data, and locations served. Many of the services/programs for children that are included in *Figure* 5.A are covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, which ensures that children under age 21, enrolled in Medicaid, receive comprehensive and preventive health care services, including mental health, developmental, and specialty services.[184] These programs and services are furnished through several types of behavioral health service providers in DC, which are explained further below.

Selected Types of Behavioral Health Service Providers in DC

Service providers are classified according to their funding, services provided, and/or populations served. Provider types in DC include:

- **Pediatric Primary Care Clinics**—clinics that typically provide integrated primary care physical and behavioral health services, along with referrals for acute or sub-specialty services as needed. Some children first have behavioral health conditions identified in primary care settings. Some settings offer behavioral health services with an on-site clinician, and some have access to psychiatric consultation services including DC MAP.

- **Federally Qualified Health Centers (FQHCs)**—community-based health care providers that provide services typically offered in an outpatient clinic and qualify for specific reimbursement systems under Medicare and Medicaid. FQHCs include community health centers, migrant health centers, health care for the homeless, and health centers for residents of public housing.

- **Free-Standing Mental Health Clinics (FSMHCs)**—clinics that offer outpatient care for individuals with a mental illness who are Medicaid eligible. FSMHCs are subject to oversight from DHCF.

- **Health Homes**—specific provider organizations that coordinate care for eligible Medicaid beneficiaries who opt to enroll in a Health Home. Health Homes were implemented through the Affordable Care Act. To be eligible for one of the two types of Health Homes in DC, an individual must be enrolled in Medicaid and have specific health conditions (dependent on the eligibility requirements of the type of Health Home).

- **Core Service Agencies (CSAs)**—nonprofit and for-profit community-based providers that provide mental health and substance use disorder treatment services for DC residents under Mental Health Rehabilitation Services (MHRS). CSAs are subject to oversight from DBH. Child/youth MHRS include: diagnostic/assessment, medication/somatic treatment, counseling, community support, crisis/emergency and community-based intervention.

- **Psychiatric Residential Treatment Facilities (PRTFs)**—certified facilities that are not hospitals and provide inpatient psychiatric services to individuals under the age of 22. There are currently no PRTFs located in DC.

Note: Provider organizations can qualify to be both a CSA and a FSMHC.

Figure 5.A. DC Public Behavioral Health Services and Programs for Children Along the Continuum of BH Care

Promotion/ Prevention	Early Identification	Early Intervention	Outpatient Services	Intermediate Levels of Care	Residential Services	Acute Crisis Intervention & Stabilization		
Services and programs that aim to prevent the onset of behavioral health issues	*Assessing children to determine if additional services/supports are needed.*	*Services for those at-risk for developing a mental health condition*	*Targeted services for those with identified concerns*	*Partial hospitalization or intensive outpatient services*	*Intensive, comprehensive psychiatric treatment away from home on long-term basis*	**Crisis/ Emergency Services** *24-hour services for psychiatric emergencies (e.g., emergency room, mobile crisis team)*	**Extended Observation Unit** *Short-term observation, crisis intervention, and treatment (< 3 days) with full supervision, often in a hospital*	**Inpatient Psychiatric Services** *Comprehensive psychiatric treatment on restricted access units in hospital setting; usually short-term*

Programs:

- 5. HealthCheck Program
- 1. HealthySteps Pediatric Primary Care Program*
- 6. Strong Start
- 7. Early Stages
- 8. Primary Project
- 9. Healthy Futures *
- 10. Parent Infant Early Childhood Enhancement Program (PIECE)
- 3. Home Visiting Programs
- 4. School Mental Health Program
- 2. Substance Abuse Prevention Services *
- 11. Adolescent Substance Abuse Treatment Expansion Program (ASTEP)
- 12. Mental Health Rehabilitation Services (MHRS)
- 13. Health Home Services
- 14. Free Standing Mental Health Clinic Services
- 15. Psychiatric Residential Treatment Facility (PRTF) Services — ALL PRTFS ARE LOCATED OUTSIDE DC
- 12. Mental Health Rehabilitation Services (MHRS)
- 16. Child and Adolescent Mobile Psychiatric Service (ChAMPS) *
- 17. Access Helpline *
- 18. Hospital Emergency Department Services
- 19. Hospital Inpatient Psychiatric Services

Ancillary Services (Care Coordination, Care Navigation, and Integration Support Services)

- 17. Access Helpline
- 20. DC Mental Health Access in Pediatrics (DC MAP)*
- 21. High Fidelity Wraparound
- 22. Help Me Grow DC

Note: Blue text refers to programs restricted to children who are at least below seven years old; *funded mainly through nonbillable services.

Program	Description	Service Location
1. HealthySteps Pediatric Primary Care Program	Primary care services (including social-emotional & behavioral screening and behavior consults) for children 0-3 based on the HealthySteps Model	HealthySteps Sites
2. Substance Abuse Prevention Services	Education on drugs and substance abuse	Prevention Centers
3. Home Visitation Programs	Services to help prevent child abuse/neglect, support positive parenting, improve child health, and promote child development and school readiness for parents and children 0-3	At Home
4. School Mental Health Program	Prevention, early intervention, and clinical services to middle and high school students and their families	Certain DC Public Schools and DC Public Charter Schools
5. HealthCheck Program	Early and periodic screening, diagnostic, and treatment services, including well-child visits at age-appropriate periodic intervals that include developmental/ behavioral assessments	Primary Care Providers (Who Serve FFS or MCO Beneficiaries)
6. Strong Start	Services for children under 3 who have or are at risk for developmental disabilities or delays	At Home or In the Community
7. Early Stages	Screening and early intervention for children 3-6 who have or are at risk for developmental disabilities or delays	Early Stages Centers (2 In DC)
8. Primary Project	Screening and early intervention services to children in PreK through third grade with mild school adjustment issues	Certain Public and Charter Schools and Child Development Centers
9. Healthy Futures	Consultation services to care providers and family members	Child Development Centers
10. Parent Infant Early Childhood Enhancement Program (PIECE)	Screening & therapy services to children ages 0-7	PIECE Site
11. Adolescent Substance Abuse Treatment Expansion Program (ASTEP)	Substance abuse assessment and treatment services using Adolescent Community Reinforcement Approach	Certified SUD Providers
12. Mental Health Rehabilitation Services (MHRS)	Services include diagnostic/assessment, medication treatment, counseling, crisis intervention, and community support for children with severe emotional disturbance diagnosis	CSA, Sub-Specialty and Specialty Providers
13. Health Homes Services	Interdisciplinary teams coordinate care across medical, behavioral, and social service systems for individuals with chronic medical conditions	Certified Health Homes
14. Free Standing Mental Health Clinic (FSMC) Services	Outpatient care for patients through a formally organized psychiatric clinic	Certified FSMHCs
15. Psychiatric Residential Treatment Facility (PRTF) Services	Inpatient care for patients under the age of 22 provided at certified facilities that are not hospitals	PRTFS (All Located Outside of DC)
16. Child and Adolescent Mobile Psychiatric Service (ChAMPS)	Mobile team provides crisis intervention for children 6-17	In the Community, at Schools, or at Home (Mobile Service)
17. Access Helpline	Call service that enrolls individuals in the DBH system of care & assists with consumer transfers between providers. Also, responds to crisis calls and dispatches crisis services if needed	Not Applicable
18. Hospital Emergency Departments (EDs)	Emergency diagnostic and treatment services for acutely ill children	DC Hospitals with EDs that Serve Children
19. Hospital Inpatient Psychiatric Services	Inpatient psychiatric programs for children of varying age groups	DC Hospitals with Inpatient Psychiatric Units for Children
20. DC Mental Health Access in Pediatrics (DC MAP)	Consultations (typically by phone) and trainings to pediatric primary care providers from mental health providers	Not Applicable
21. High Fidelity Wraparound	Care coordination service & collaborative team-based care planning process for children with complex needs	Not Applicable
22. Help Me Grow DC	Information & referral helpline that also provides personalized care coordination individual follow-up for children 0-5	Not Applicable

Note: Blue text refers to programs restricted to children who are at least below seven years old; *funded mainly through nonbillable services.

More information about service delivery can be found in our previous publication, *Behavioral Health in the District of Columbia for Children, Youth, and Their Families: Understanding the Current System*, but it should be noted that there have been several changes to the system since the previous publication. One major change has been the approval of the District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration, which became effective on January 1, 2020. Through that demonstration, DC's Medicaid program can temporarily cover more behavioral health services, including youth mobile crisis services and specific trauma-targeted services. Another major change is the shift of behavioral health services to covered benefits in the District's managed care contracts by October 1, 2023, with the goal of providing whole-person care and strengthening coordination.[6] On the path to this carve-in of behavioral health services, current efforts have been focused on conducting a behavioral health rate study and advancing a recently formed Behavioral Health Integration Stakeholder Advisory Group to support planning.

Evidence Based Practices

With reference to *Table 5.B*, DBH facilitates several evidence-based practices through certified providers. Notably, through the School Mental Health Program, some schools also offer evidence-based practices. While other providers in the District may also offer the services listed below, the following table represents publicly available data on evidence-based practices available through DBH clinics.

Table 5.B. Evidence-Based Practices Provided in the District for Children through DBH

Evidence-Based Practice	Number of Providers	Total Capacity	Total Enrollment*	Medicaid Reimbursable?
Child Parent Psychotherapy (CPP)	4	45	34	yes
Parent Child Interaction Therapy (PCIT)	4	65	32	yes
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	5	89	37	yes
Functional Family Therapy (FFT)	2**	48**	37	yes
Multi-Systemic Therapy (MST)	2	24	15	yes
Trauma Systems Therapy (TST)	2	23	14	yes (but no specific code; uses Counselling code)
Transition Into Independence (TIP)	5	437	359	yes (but no specific code; uses Community Support code)
Adolescent Community Reinforcement Approach (ACRA)	3	140	18***	yes

*These numbers may not be fully representative of the typical program utilization due to the COVID-19 pandemic.
**One FFT provider has informally notified DBH that it plans to close its FFT program so capacity will be reduced to 36.
***Two ACRA providers have indicated difficulty with referrals and retaining the youth once enrolled in their programs.

Source: Department of Behavioral Health FY20-21 Performance Oversight Questions

Substance Use Services

As shown in *Figure 5.A* and *Table 5.B*, DC has three ASTEP providers that administer ACRA to youth experiencing substance use issues. Additionally, DC has four Prevention Centers, which use education campaigns to prevent and delay the onset of alcohol, tobacco, and other drug use.[94]

Accessibility of Services

According to the DC Health Matters Collaborative's 2019 *Community Needs Assessment*, some community stakeholders perceive a shortage of pediatric psychiatrists, child psychologists, drug and alcohol abuse counselors, and fully licensed therapists in the District, while others counter that there is not a provider shortage but an uneven provider distribution. The latter group of stakeholders noted that Wards 5, 6, 7, and 8 are most affected by the distribution disparity. Notably, Anacostia is the only HRSA-recognized High Needs Geographic Health Professional Shortage Area (which specifies geographic regions with a lower provider-per-capita ratio than needed) for mental health providers in DC.[185] *Figure 5.B* shows the distribution of behavioral health inpatient services that accept DC's public health insurance for children ages 18 and under, based on data from the Spring 2021 DC Child & Adolescent Mental Health Resource Guide.

The COVID-19 pandemic has driven recent increases in telehealth.[186] The rise in the number of providers who are offering behavioral health services for children remotely increases accessibility to services by removing transportation barriers. However, that improved accessibility is not true for the entire population, because families without reliable internet access and children with behavioral health conditions that preclude them from responding well to virtual services cannot enjoy this benefit. For example, The Wendt Center noted differences in the way children engage with behavioral health services through telehealth in comparison to in person treatment.[186] The availability of remote behavioral health services in DC is explored further in Chapter 8.

Figure 5.B. Maps* Showing the Location Inpatient Behavioral Services Available for Children (Ages 18 and Under) on DC's Public Health Insurance
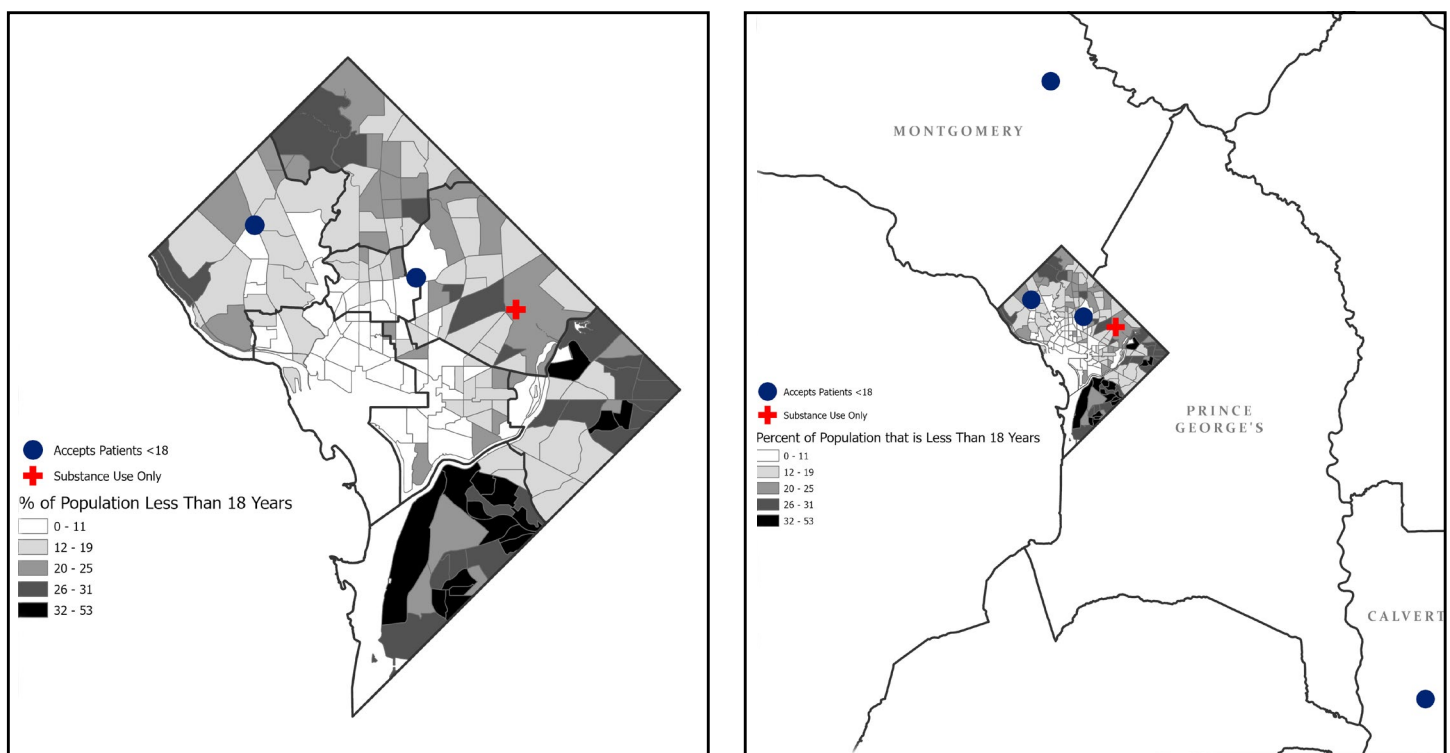
*Maps developed based on data from DC Child & Adolescent Mental Health Resource Guide, Spring 2021

Wait Times

Related to provider network adequacy issues, there are also long wait times for children to access behavioral health services. For fiscal year (FY) 2020, 26% of children newly enrolled in MHRS had to wait over 30 days from enrollment to their first appointment. Other wait times for selected services in FY 2020 and 2019 are shown in *Table 5.C.*

Table 5.C. Wait Times for Selected Services in FY 2019 and FY 2020

FY	Description of Service	Average Wait Time
2019	Number of days between when a family or child's enrollment takes place to a medication somatic service appointment with a psychiatrist	76 Days
2020	Number of days between when a family or child's enrollment takes place to intake appointment	24 Days
2020	Number of days between when a family or child's enrollment takes place to diagnostic assessment	22 Days
2020	Deployment time for ChAMPs	39 Minutes

Adapted from: <u>Department of Behavioral Health FY19–20 Performance Oversight Questions</u>; <u>Department of Behavioral Health FY20–21 Performance Oversight Questions</u>

Of note, DBH has reported that as of February in FY 2021, initial wait times between a family or child's enrollment to either intake appointment or diagnostic appointment has been less than 10 days, with providers citing the role of telehealth in increasing ease of scheduling and attending appointments.[187]

Integrated Care

In recent years, there have been a number of efforts to promote integrated care in the District, including DC MAP and the Integrated Care Technical Assistance (ICTA) program.

DC MAP is a telephonic Child Psychiatry Access Program aimed at improving mental health integration within pediatric primary care in Washington, DC.[188] This program is funded by DBH, and was previously administered by Children's National Hospital and MedStar Georgetown University Hospital. The program has a new vendor as of late 2021. The DC MAP program is modeled after a highly successful program started in Massachusetts (MCPAP) and joins other pediatric psychiatry access programs across the country that are part of the National Network of Child Psychiatry Access Programs. These programs offer pediatric PCPs increased access to child mental health experts and have led to significant improvements in providers feeling better able to address their patient's mental health issues.

DC MAP has four primary missions: 1) Increase collaboration between pediatric PCPs and child mental health specialist; 2) promote mental health within primary care; 3) improve the identification, evaluation, and treatment of child mental health problems; and 4) promote the rational utilization of scarce specialty mental health resources for the most complex and high-risk children. DC MAP offers a wide range of free services, including timely provider-to-provider phone consultation; community resource referrals; care coordination; free one-time face-to-face evaluations for families as needed with a DC MAP mental health clinician; and mental health education and training in primary care. Since launching in 2015, nearly 400 pediatric providers from over 50 practices in the DC area have utilized DC MAP services. As of June 2021, DC MAP received 4,890 consultation requests for 4,230 unique patients. With the transition to a new vendor, DC MAP services may experience changes. The DC Collaborative for Mental Health in Pediatric Primary Care project shall continue to serve as an oversight body in this work to monitor and provide feedback regarding DC MAP.[189] DBH needs to ensure this transition happens with fidelity and quality by providing assistance to the new vendor as well as any necessary oversight.

DC's ICTA program, managed by DHCF and DBH, assists DC Medicaid providers by using data to inform care for patient's medical, behavioral health, and social needs while supporting organization leadership in bringing VBP efforts to fruition.[190] Participation in the ICTA program can be accomplished through individual coaching, webinar sessions, learning collaboratives, and a virtual learning community available at https://www.integratedcaredc.com/.[190] Priority providers for the initiative include Health Homes, DBH, long term services and supports (LTSS), MAT, and free-standing mental health providers as well as FQHCs.[190]

Care Coordination

There are multiple avenues through which families and children on public health insurance receive care coordination. *Figure 5.A* and *Table D.1* in Appendix D highlight some care coordination services provided to special populations of children. Additionally, all Medicaid managed care plans offer some level of care coordination and case management services to enrollees.

High Fidelity Wraparound (HFW)
DBH also offers HFW services to youth at risk for or returning from an out-of-home residential treatment center and/or for youth who have experienced multiple psychiatric hospitalizations.[191] The HFW model provides care coordination and family support by creating individualized plans to help families develop goals, prioritize needs, and implement a transition plan. For FY 2019, HFW served 63 youth, and it has capacity to serve 94 youth.[191]

Natural Supports
Natural supports, which can be defined as "the personal associations and relationships developed in the community that enhance the quality and security of life for people,"[192] frequently play critical care coordination roles in DC. Natural supports may include family members, friends, sponsors, mentors, religious leaders, community members, and/or block captains. Natural supports are often involved in helping individuals initiate contact with the District's behavioral health system and are sometimes the first point of contact when someone experiences a crisis. Beyond that initial assistance, natural supports may also help individuals through treatment and recovery. Unlike formal programs and services, natural supports have personal, trusted relationships with those seeking care, as well as relevant intellectual skills and knowledge from lived experiences. Thus, they may be well-positioned to facilitate care connections and follow-ups. As a testament to their value, natural supports are recognized as one of the 10 core principles in all wraparound processes, which includes intense critical support and aftercare,[192] including DC's HFW.[193]

DC Health Homes
Health Home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social support services. DCHF provides two types of Health Homes:

- **My DC Health Home (Health Home I),** *implemented in January 2016, is a care coordination benefit for Medicaid beneficiaries with mental health care needs. It provides coordination of an individuals' health and social service needs, including primary and hospital health services, mental health care, substance use care, and long-term care services and supports. However, given that my Health Home has an age requirement of 18 minimum, it does not serve a significant number of children and youth. Providers in DC are CSAs or community-based mental health providers that implement care teams that include nurses and PCPs. Health Home providers must pass DBH's Health Home certification process. Current My DC Health Homes include: Anchor Mental Health, Community Connections, Family Matters, Hillcrest Children and Family Center, Mary's Center, MBI, McClendon Center, MedStar Washington Hospital Center/Behavioral Health Service, and Volunteers of America.[194]*

- **My Health GPS (Health Home II),** *implemented in July 2017, is a care coordination benefit for Medicaid beneficiaries (enrolled with an MCO or FFS) with multiple chronic conditions, in which an interdisciplinary team is embedded in the primary care setting to integrate and coordinate primary, acute, behavioral health, and long-term services and supports. Current MY Health GPS providers include: Bread for the City,*

Children's National Hospital, Community of Hope, Medical Home Development Group, Family and Medical Counseling Service, La Clinica del Pueblo, Mary's Center, Providence Health Services, Unity Health Care, and Whitman-Walker Clinic.[195]

Quality of Services

Currently, there is no one standard of measures or metrics for assessing and reporting on quality of care and services across the different agencies and providers of behavioral health services. Medicaid's website provides an overview of each state's rate on quality of care, including that DC.[196] In FY 2019, DC reported 18 of the 21 reported health quality measures in the CMS Medicaid/CHIP Child Core Set. *Table 5.D* includes the child quality behavioral health related measures for DC.

Table 5.D. Child Quality Behavioral Health-Related Measures for FY 2019

Measure	DC Rate	Median Rate	# of States Reporting	Notes
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17—After 7 Days	29.9%	41.9%	44	Higher rates are better for this measure.
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17—After 30 Days	52.3%	66.3%	44	Higher rates are better for this measure.
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Ages 6 to 12—with 1 Follow-up Visit during 30-day Initiation Phase	40.9%	48.6%	40	Higher rates are better for this measure.
Follow-Up Care for Children Prescribed ADHD Medication: Ages 6 to 12—with at least 2 Follow-up Visits in 9 months	50.0%	58.6%	40	Higher rates are better for this measure.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 17	39.9%	62.8%	29	Higher rates are better for this measure.
Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 1 to 17	1.2%	2.6%	42	Lower rates are better for this measure.

Source: <u>Medicaid & CHIP in District of Columbia</u>, Quality of Care in District of Columbia.

The DC DHCF 2019 Annual Technical Report (April 2020) provides an evaluation of the performance of the Medicaid MCOs[xv] to assess the quality, access, and timeliness of health care services beneficiaries in the DC Healthy Families program receive.[197] For the purpose of the report, we are reporting the behavioral health-related measures. The five behavioral health performance measures reported (not specific to children) are shown in *Table 5.E*. Overall, performance varied widely across MCOs, and no positive trends were identified. Additionally, all measures fell below the NCQA Quality Compass Medicaid Averages.

[xv]*Amerihealth Caritas DC, Trusted Health Plan, Amerigroup, and HSCSN*

Performance Measure	Year	ACDC %	AGP %	HSCSN %	THP %
Antidepressant Medication Management—Effective Acute Phase Treatment	2016	47.19	-	17.14	53.89
	2017	52.92	-	29.55	54.92
	2018	45.23	41.63	16.67	48.46
Antidepressant Medication Management—Continuation Phase Treatment	2016	36.55	-	8.57	37.07
	2017	37.79	-	9.09	34.06
	2018	29.77	25.75	5.56	27.65
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2016	36.50	-	NA	38.55
	2017	39.13	-	60.87	36.49
	2018	38.03	23.96	58.82	28.99
Follow-Up After Hospitalization for Mental Illness—Within 7 Days after Discharge	2016	49.91	-	28.10	67.51
	2017	30.73	-	19.01	33.13
	2018	39.14	9.06	26.67	24.10
Follow-Up After Hospitalization for Mental Illness—Within 30 days after Discharge	2016	62.43	-	49.59	74.11
	2017	50.17	-	39.67	46.99
	2018	58.99	18.13	50.00	36.14

ACDC = AmeriHealth Caritas District of Columbia; AGP = Amerigroup District of Columbia; HSCSN = Health Services for Children with Special Needs; THP = Trusted Health Plan; - = results are unavailable as AGP became operational October 1, 2017
Source: Medicaid Managed Care 2019 Annual Technical Report; Qualtrant; 2020

The report also includes data from the *Child CAHPS Survey* (surveys parents/guardians of child enrollees) on experience of care with all four MCOs. Those measures include composite scores on customer service, how well doctors communicate, shared decision-making, health promotion and education, coordination of care, as well as ratings of the health plan, all health care, personal doctor, and specialist seen most often. Overall, the data showed a positive trend in the Shared Decision Making Composite measure and a decline in performance for How Well Doctors Communicate Composite, Health Promotion and Education Composite, and Rating of All Health Care.

DHCF publishes an annual MCO report card that compares Medicaid MCOs in key performance areas such as "keeping kids healthy."[198] Similarly, DBH previously produced a Provider Scorecard that evaluates certified community-based mental health providers.[199] It gives providers a rating on quality and financial performance based on evaluation of quality of services and adherence to federal and District policy and regulations. In FY18, DBH indicated that it was replacing Scorecards with separate compliance indicators and Results Based Accountability indicators. DBH reported that it implemented in late FY 2019 an enhanced performance management system, in which metrics are displayed and monitored using an internal dashboard.[187]

With CMS approval, DHCF implemented the MCO pay-for-performance program in 2017, which is funded through a 2% withhold of each MCO's actuarially sound capitation payments. DHCF used data from the period April 1, 2015, through March 31, 2016, to set the initial baseline. Section 4.2 in Chapter 4 provides more details on the MCO pay-for-performance program.

5.3 Gap Analysis

A comparison of DC's current behavioral health service delivery for children on DC's public health insurance to our vision highlights several key gaps that are discussed below.

1. Gaps in the continuum of behavioral health services

Figure 5.A highlights that DC lacks access to a full continuum of psychiatric care services for children and youth. The following are missing services in the continuum of behavioral health services for children in DC with public insurance:

  i. No intensive outpatient program;
  ii. No partial hospitalization or day hospital;
  iii. No crisis stabilization unit or extended observation unit specifically for children less than 18 years;
  iv. No Bridging Clinic for youth who are being discharged from inpatient psychiatric units without established outpatient therapy and medication providers;
  v. No therapeutic group home/community residence; and
  vi. No local PRTFs.

The lack of intermediate levels of care treatment options means that youth may be served at a level of care that is insufficient for their needs, which leads to costly, avoidable inpatient psychiatric admissions, excessive numbers of patients boarding in the emergency department, patient/family dissatisfaction, and poor patient outcomes. There are also no PRTFs located in the District. Children and their families are inconvenienced by having to travel out of state to Maryland, Virginia, or often farther distances to seek needed services. The lack of a local facility for residential psychiatric treatment was also discussed in our family engagement forums. One parent/caregiver noted, "I know personally trying to navigate the system that as far as residential centers for children that are experiencing needs, to my knowledge, D.C. does not have a residential center … Sometimes if they (children) are lucky, they're going to Maryland. But they're going to Kansas. They're going to Michigan. They're going to Texas."

In addition to the missing services mentioned above, the District also lacks sufficient behavioral health services on the prevention and promotion side of the continuum, including programs that build protective factors to address suicide and suicidal ideation, substance use, problem behaviors, depression, etc. While the District does currently implement several evidence-based prevention and promotion services, such as HealthySteps and Substance Use Prevention Centers, many of those services, particularly for young children and their families, are grant funded and not sustainable. Further, prevention programs face many financial barriers such as lack of reimbursement mechanisms, particularly for community-based settings, and when components are Medicaid reimbursable, they tend to be at lower rates than treatment services.[200]

2. Challenges with substance use treatment options for children in the District

While ASTEP has increased accessibility for substance use treatment by giving adolescents and families the ability to go directly to any ASTEP location for a substance abuse assessment, barriers to substance use treatment for children persist.

The only SUD evidence-based treatment currently provided for youth (ages 12–21) is ACRA, an evidence-based behavioral health intervention geared toward reducing the use of alcohol and illicit drugs and increasing prosocial behaviors.[94] The District currently has three ASTEP locations (in Wards 1, 4, and 6) that provide ACRA, and enrollment is persistently lower than capacity. Current location options can cause barriers to access and utilization of services for youth in other wards, especially for families with limited transportation options.

An additional gap identified is the lack of youth engagement in continuing SUD treatment once started, especially for transition-age youth.[201] With reference to *Table 5.B*, ACRA providers have indicated that they experience difficulties with referrals and treatment continuation, which may explain the low enrollment in services despite the high number of children (5.42% of youth or 2000 individuals between ages of 12–17) estimated to have SUD in the District in the past year. Through our family engagement efforts, some youth cited ineffective behavioral health services as a main reason for treatment discontinuation, which suggests a need to explore the effectiveness of ACRA for children experiencing substance use issues in the District. Of note, ACRA is not a trauma-informed practice, which may limit its effectiveness for many children in DC whose substance use issues are linked to trauma.

Finally, the current process for entering into treatment is time consuming. Youth must be referred to treatment, which requires an intake coordinator to complete an assessment to determine appropriate level of care and treatment options. They utilize the GAIN-I Assessment, which typically takes about three to four hours. That causes a lag time of about two to three weeks before entering into treatment, because assessments are usually broken into two appointments (since youth may lose focus or cannot sit for the full four hours in one appointment or because of other time constraints/administrative burdens).

3. Fragmented behavioral health service delivery

Currently, behavioral health service delivery is highly fragmented, with children who experience more severe behavioral health issues needing to seek care from multiple treatment and supportive service provider organizations. That presents issues for integration of medical records, care coordination, closed-looped communication, and informed decision-making by providers, especially as families move back and forth along the continuum of services.

4. Existing care coordination services do not meet the needs of youth and families

Although many resources currently exist within DC to facilitate access to behavioral health care, as a result of service decentralization and fragmentation, lack of adequate reimbursement methodologies for both clinical and nonclinical providers, and inaccurate directories, current services do not meet the needs of youth and families. These resources vary widely in quality, reliability, eligibility, accessibility, and ease of use.[202] Moreover, these services are not all centralized and often do not communicate or connect with one another, which can lead to siloed service lines and fragmented experiences for families. Existing care coordination services through the HFW and Health Homes serve special populations of youth but are insufficient to meet the needs of all families in DC. Care coordination was identified as one of the top four needs for youth and families within the District, according to the 2019 DC Community Health Needs Assessment. That was supported in our family engagement forums, where a few parents expressed the need for better coordination along the continuum of services, with one parent highlighting the need for more support as a child transitions from inpatient or residential services to community-based services.

Further, care coordination services that do exist are impeded by inaccurate directories. Public lists of agencies that are in-network for beneficiaries and care coordinators can be difficult to find and access (especially when behavioral health benefits are subcontracted through a third-party provider), and lists often include inaccurate details and information. Additional gaps that exist within the current behavioral health system for care coordination include lack of Medicaid reimbursement or payment for both clinical and nonclinical care coordination. Currently, CHWs and/or peer support specialists are underutilized for care coordination in the child and family behavioral health system.

5. Lack of accessibility of behavioral health services

While *Figure* 5.A highlights that there are extant behavioral health services for children in DC across most of the continuum of care, challenges persist with accessing care. For example, the map in *Figure* 5.C highlights that

there are no inpatient behavioral health services for children under age 18 located east of the river for residents in Wards 7 and 8. While most behavioral health care appointments are eligible for managed care's nonemergency medical transport services (NEMT), not all families are familiar with those services or successful with attempts to use NEMT, and MCOs have placed limits on NEMT uses during COVID-19.

Challenges with transportation were also reflected in our family engagement forums, where a number of individuals expressed challenges with accessing services. Several parents/caregivers felt that accessing services is made more difficult by inadequate available transportation, noting that many of the services that their children need are far from their place of residence. As one parent/caregiver shared, "I have problems with getting quality services, unless I transport me and the kids way out of our community." One youth pointed out that safety concerns, particularly in Wards 7 and 8, can translate into transportation barriers, stating that "people don't even feel comfortable going to Anacostia station."

Additionally, schools are one of the main settings in which many children in DC can directly access behavioral health services or be referred to services. However, families are not always aware that those resources are available to them or of the process for seeking a referral for services. Anecdotally, school leaders or individual teachers sometimes put pressure to avoid scheduling treatment during the school day, which undermines the usefulness of school behavioral health services as place-based care.

6. Long wait times reported for behavioral health services

Despite national best practice recommendations for timely access to care, families often encounter long waitlists when attempting to connect with behavioral health services in the District. The waitlist can vary between a few weeks to a few months, with the wait time increasing when specialty services are required (e.g., medication management, substance use services, ABA therapy options, etc.). There are many factors that contribute to those extended waitlists, including but not limited to a lack of licensed or certified behavioral health professionals to meet the needs of the community (both therapist and psychiatrist), low reimbursement rates for behavioral health services, and network inadequacy.

Relatedly, there is a lack of reliable data available to track the timeliness of access to services due to lenient/ nonstandardized data collection guidelines and decentralized data reporting. For example, the *District of Columbia Managed Care Program 2020 Annual Technical Report* only reported wait times for dental providers.[112] Additionally, the data that are available are often aggregated among many diagnoses, making it hard to track/ oversee the types of services that are being provided and the length of time it takes for youth and families to connect to those services.

7. Lack of consumer satisfaction with local behavioral health services

There is some evidence that Medicaid beneficiaries are not satisfied with behavioral health services delivered through MCOs or DBH. Based on NCQA *Health Insurance Plan Ratings 2019–2020 Summary Report*, DC commercial health plans received higher quality and customer satisfaction ratings than DC Medicaid plans. Fourteen DC commercial health plans averaged a 3.4 quality rating and 2.9 customer satisfaction rating, while three Medicaid plans averaged a 2.8 quality rating and 2.3 customer satisfaction rating. Additionally, through our family engagement focus group analysis findings, some youth indicated that they felt the behavioral health services they received were not helpful or made them feel worse.

8. No single standard of measures or metrics for assessing and reporting on quality of care and services

This is true across the different agencies and providers of behavioral health services. There is also a need to develop meaningful qualitative data collection methods to track and assess consumers' perceptions of quality of care and quality of life based on the services they are receiving.

9. Lack of family-centered care

Given that family dynamics significantly impact children's behavioral health,[203] it is essential that behavioral health services for children are family-centered and incorporate the needs of families and caregivers. The following are some areas where the District lacks family-centered behavioral health care practices:

- A number of accounts report a high rate of unnecessary psychiatric institutionalization among DC youth,[204, 205] which may suggest that youth are not provided with enough treatment options that allow them to stay with family and other sources of social support. This also suggests that the criteria being used to determine medical necessity regarding sending children to PRTFs out of the state may not be responsive enough or that additional criteria are needed. Further, there are anecdotal reports that parents and other caregivers are not always engaged when their child is in residential treatment, and when the child returns to the community, the parents do not always know how to implement de-escalation tools the child learned in the facility. The education provided to parents/caregivers regarding their child's diagnosis, treatment options, and behavioral health plan are insufficient.

- There exists insufficient District guidance ensuring that family needs are measured and incorporated into child and youth behavioral health care plans.

- The District does not have an adequate reimbursement infrastructure to support dyadic or family therapy. For example, PCIT and CPP do not have their own specific billing code when billed through managed care. Behavioral health providers will usually bill these dyadic therapies using individual psychotherapy codes because the family psychotherapy reimbursement rate is lower.

- In the District, self-directed home and community based services (HCBS), which allow a patient to pay an aide of their choice, including family members,[206] are only available for adults.[207] Further, they are not available to individuals who qualify for HCBS services on the basis of behavioral health-related disabilities.[207] As a result, full-time family caregivers of children with advanced functional impairment related to behavioral disorders have limited opportunities to be compensated for the care they provide.

10. Insufficient cultural competency among providers to serve DC's diverse population of children

Through our youth engagement efforts, children and youth revealed that the lack of cultural competency among behavioral health providers was a deterrent to accessing or staying in services. Further, children and youth felt that sociocultural differences prevented providers from being able to understand them, and therefore, they felt uncomfortable sharing. The lack of people in the workforce who look like and come from similar communities as Medicaid beneficiaries reinforces challenges with cultural humility and cultural competence.

11. Trauma experienced by the District's children remains inadequately addressed

Many children in DC are exposed to high rates of trauma, including community violence as discussed in Chapter 2, and such trauma could have lasting negative behavioral health effects. While the District offers several trauma-specific EBPs for children and several provider organizations have adopted elements of trauma-informed care, trauma remains unaddressed for many children, including infants and toddlers. Through our family engagement efforts, children's trauma emerged as a major recurring theme discussed by parents/caregivers, with one parent stating, "a lot of them [children] have been through traumatic situations or hard times, and a lot of times, the mental aspect isn't dealt with."

Professionals in any setting where a child may need support after traumatic experiences (all health care settings, schools, child care centers, community centers, recreation centers, faith-based institutions, etc.) need appropriate training to deliver trauma responsive interventions in the frontlines.

12. Social determinants of health are inadequately addressed

Evidence indicates the social determinants of health as causal to the development of behavioral health disorders and an important target for health care providers. However, the support systems within DC's behavioral health care system that identify and address social determinants, such as community violence and poverty, remain inadequate. Our family engagement findings revealed that DC youth experience excessive police force, poor neighborhood conditions, including prevalence of violence within their communities. Poverty emerged as another significant barrier to receiving sufficient support and behavioral health care in our family engagement groups. As one youth expressed, for many experiencing poverty, basic survival needs receive a greater focus than overall well-being, which discourages them from seeking behavioral health care when needed.

5.4 Recommendations

Given the overlaps between financing and service delivery of the behavioral health system, we recommend that the recommendations in Section 4.4 and Section 5.4 be considered together.

1. Establish the full continuum of psychiatric care for children, including acute care, crisis stabilization, and intensive outpatient care in the District.

Implementing Bodies: DHCF, DBH, DC Health, CSAs, MCOs

Timeline to Implementation: Long Term

We recommend the District work toward establishing a full continuum of services for children less than 18 years in need of acute or crisis stabilization psychiatric care that is accessible by children who are uninsured or on public health insurance. Establishing the following services *specifically for children less than 18 years* would allow children to access services that better meet their needs:

I.   Crisis stabilization unit, with an extended observation unit;
II. Bridging Clinic for youth who are being discharged from inpatient psychiatric units;
III. Therapeutic group home/community residence;
IV. Intensive outpatient programs;
V.   Partial hospitalization or day hospital; and
VI. A local PRTF.

We recommend establishing a CCPEP modeled after New York City Health + Hospitals/Bellevue's CCPEP, because that would create services I. and II. Another approach to create a Bridging Clinic would be to expand DC MAP funding to include psychiatry access services for patients discharging from inpatient psychiatry units and the emergency department.

Establishing those new services must involve the creation of competitive reimbursement rates to support missing programs. Models for public-private partnerships should be explored as a means of delivering and financing those additional programs.

2. Improve services for youth at-risk for or diagnosed with substance use disorders (SUD).

Implementing Bodies: DHCF, DBH, MCOs, PCPs, ASTEP Providers

Timeline to Implementation: Long Term

The following are some strategies to consider for improving services for youth at-risk for or diagnosed with SUD:

- Place special emphasis on working with youth, families, and providers to explore solutions to improve screening, assessment, referral and treatment, and options for improved integration of SUD prevention and treatment services into easily accessible locations, such as primary care and schools. There is

also a need to work with youth, families, and providers on identifying and implementing innovative strategies to better engage youth to stay in treatment.

- Standardize screening tools for SUD (ensuring that the tools are culturally competent and evidence-based or at least evidence-informed) and implement them universally at PCPs, in the school system, in the child welfare system, and in the juvenile justice system.

- Substance use outpatient services should be integrated or collocated together with mental health services to decrease stigma and provide easier access for adolescents and their families.

- Explore the implementation of other adolescent substance use evidence-based treatments besides ACRA. A recent review by Fadus and colleagues (2019) noted that there is considerable evidence supporting numerous substance use treatment options for adolescents. EBPs, particularly those that are trauma-informed, should be piloted to determine if they work for DC's youth.

Table 5.F. Adolescent Substance Use Disorder Treatment Recommendations by Fadus et al (2019)

Well-Established Standalone Interventions	Family-based therapy, cognitive behavioral therapy, multicomponent psychosocial therapy
Probably Efficacious Standalone Interventions	Motivational interviewing/motivational enhancement therapy, third-wave cognitive behavioral therapies
Possibly Efficacious Standalone Interventions	12-step programs
Possible Adjunctive Interventions	Pharmacotherapy, exercise, yoga, mindfulness, recovery-specific educational settings, goal setting, progress monitoring
Modifications to Improve Existing Approaches	Digital strategies, culturally based programs

Source: Adolescent Substance Use Disorder Treatment: An Update on Evidence-Based Strategies, Table 1. Adolescent Substance Use Disorder Treatment Recommendations; Fadus et al; 2019

- Improve communication and understanding of available SUD services for youth among PCPs and other clinical and nonclinical providers.

- Increase evidence-based prevention programs for youth that target the most frequently used substances. In particular, education on the negative health effects of marijuana, which is one of the most used substances among youth in DC, is important because individuals under 21 years old have a higher risk for long-term, potentially irreversible cognitive impairments from cannabis use disorder.[22]

- DC should also explore opportunities for expansion of DC MAP services to include the Adolescent Substance Use and Addiction Program at Boston Children's Hospital-Massachusetts Child Psychiatry Access Program (ASAP-MCPAP) Consultation Line.

3. Implement models and expand existing models to facilitate integrated care.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

As discussed in Section 5.1, there are different service delivery models that can support integrated care for children, including Health Homes, CCBHCs, and the PCCM. The following are recommendations regarding those models:

- DC should pilot the implementation of the PCCM for children and track outcomes, with the aim of determining whether the PCCM model is effective for delivering integrated care to all children or special populations in DC. We recommend that any primary care organization that hires a master's-level behavioral health provider should be highly incentivized to adopt and fully implement the CCM model. Recommendation #2 in Chapter 4 outlines the financing infrastructure necessary to support implementation of this model.

- Also outlined in Recommendation #2 in Chapter 4 is the relaxing and expanding of eligibility requirements for the two types of DC Health Homes. That would allow more children to qualify for and benefit from the integrated care provided through these models.

- Additionally, as outlined in Recommendation 3 in Chapter 4, DC should establish a pathway for creation and payment of CCBHCs. A recent survey of 128 CCBHCs nationwide by the National Council for Mental Wellbeing found that CCBHCs expanded access to care and sharply reduced wait times for care.[208] As mentioned in Section 4.4, with current and emerging opportunities to adopt the CCBHC model statewide, it is critical for the District to establish a plan for organizations to be certified as CCBHCs by October 1, 2023.

Further, with the rapidly evolving integrated care landscape, flexibility in corporate structures will be needed. DHCF should ensure that providers, as they enter into contracts with MCOs, are able to assign their rights and obligations under provider participation agreements in the event of mergers, acquisitions, or other types of corporate restructuring. Allowing reassignment at the corporate level facilitates continuity and prevents disruptions in service provision.

Finally, DBH and DHCF should ensure that technical assistance resources and services for behavioral health providers on integrated care (such as the DC Integrated Care Technical Assistance Program) includes children-specific training and targets providers who serve children in the District.

4. Strengthen care coordination through increased training and reimbursement for both clinical and nonclinical providers, as well as improved and standardized directories.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

Care coordination needs vary depending on the complexity of health care needs, as depicted in *Figure 5A*. The following are some recommended strategies to improve care coordination:

- Ensure that all behavioral health care coordination meets the National Care Coordination Standards for Children and Youth with Special Health Care Needs[209] as highlighted *in this chapter*.

- Maximize the use of community health workers and peer specialists to provide care coordination to families. DHCF and DBH, along with CHWs, peer specialists, and relevant provider organizations, should specify and institutionalize the role of this nonclinical workforce in care coordination across various settings. Additionally, the agencies should develop efficient training programs for these roles and ensure they are competitively reimbursed for services.

- As DC moves to carve-in behavioral health services into managed care organizations, it is an opportune and critical time to standardize MCO provider directories, including directory links showing participating providers in any MCO-subcontracted behavioral health administrative organizations. A standardized directory can facilitate easier care coordination in settings external to MCOs. For example, care coordinators at a CBO can more easily support connections to care for any child (regardless of which MCO they belong to) if directories were standardized.

- Directories should also be required to update the providers who are accepting new patients monthly. According to MCO contracts, each MCO must electronically provide one provider directory within 90 days of contract award and then once a month. The directory must identify providers who are not accepting new patients, but that information only needs to be updated quarterly. If the list of providers who can accept new patients is updated only every three months, referrals are negatively affected and patients are connected to care more slowly.

5. Improve service accessibility through the Medicaid nonemergency medical transportation.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

Streamline the Medicaid non-emergency medical transportation (NEMT) service, increase its visibility, and expand the program to cover families who are uninsured or on other public health insurances. DHCF should move toward eliminating the three business days prebooking requirement to maximize service utility for beneficiaries; following the lead of current District MCOs, just-in-time NEMT can now be arranged conveniently through ride-sharing services, for example, Uber or Lyft. DHCF should closely monitor any signs that MCOs are limiting use of NEMT and take corrective action when necessary. Additionally, DHCF should utilize enhanced communication strategies to increase members' awareness and knowledge of those services.

6. Establish agreement and accountability on meaningful quality of care measures.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Short-Term

Broad stakeholder agreement on a set of measures allows the District to benchmark our progress toward a responsive behavioral health care system that meets the needs of children and families in a high-quality and timely manner. The attendant challenge in inclusive, and broad agreement is the potential for outcomes to become narrowly defined and reduced to proxies of cost savings or more easily quantifiable metrics, such as hospitalization and/or emergency department use. Those types of measures, however important, are inadequate for any population of the behavioral health system but especially for children. A comprehensive, fully integrated system will meaningfully improve quality of life and functioning. Therefore, measurement of the system's success must track essential components of a system of care, as well as clinical and functional outcomes, which are distinct from hospital or crisis service utilization.

MCOs should work with DHCF and DBH to propose quality of care standards and measures and increase those standards and enforcement over time. MCOs should be allowed to disqualify/disenroll providers who do not meet quality of care standards agreed upon by DHCF and DBH. Additionally, MCOs should be required to report on quality of care measures that are disaggregated by race, ethnicity, and language. DHCF and DBH should incentivize equitable care by tracking the quality of culturally responsive care a person receives.

7. Improve understanding of beneficiary experience.

Implementing Bodies: DHCF, MCOs
Timeline to Implementation: Long Term

DHCF and the MCOs should jointly develop an enhanced understanding of "beneficiary experience" that encompasses family-reported and youth-reported information to gain insight into the experience that children and youth are having. That will require improvements regarding measurement of the child, youth, and family experience and data collection methods (e.g., qualitative data). DHCF should require MCOs to regularly report on results of enrollee surveys and measures based on key dimensions of the beneficiary experience (including care accessibility and network adequacy), with a specific view to whether the needs of children, youth, and families are being adequately served. DHCF should also employ third-party "secret shopper" firms to use standardized scripts and instruments to review accuracy of MCO provider directories for behavioral health availability, including services specifically for children's behavioral health.

8. Expand school-based behavioral health services.

DBH's school-based behavioral health expansion program increases children and families' access to behavioral health services by providing these services in a place children and families already spend a lot of time: school. Through the school-based behavioral health program, students, teachers, school leaders, and families should be able to access all three tiers of behavioral health supports at school. Connection to additional behavioral health supports or other kinds of support services outside of the school setting should be seamless. To accomplish that, school-based behavioral health services should be expanded to fully meet the needs of all children attending DC's public schools. Given the near universal opportunity to access public PreK–3 and PreK–4 in the District, special attention should be given to how school-based behavioral health services can further flexibly meet the developmental, social-emotional, and mental health needs of young children and their families. Recommendation #12 in Chapter 4 outlines key components of the school-based behavioral health program that need continued and/or enhanced funding.

In addition to those components, it is critical to have effective communications designed to improve awareness of school-based behavioral health services: Students and their families are often unaware these services are available in their school or are unsure of how to access them. Each school develops its own procedures for referring students to its behavioral health clinician, and school leaders share that information with the school community in myriad ways. Effective communications tools explaining what services are available and how those services can help students, families, and teachers should be developed and disseminated to all schools, along with guidance and technical support for effective distribution to all members of the school community. Communications materials should be customizable to allow schools to add school-specific information regarding the clinician and the referral process, with easy self-referral directly to clinicians by students or their parents.

9. Implement service delivery strategies to identify and address social determinants of behavioral health.

DBH and DHCF should create and implement plans to address SDOH and mitigate urgent behavioral health treatment needs. Specifically, behavioral health services across various settings should support meeting children's basic needs, such as housing, food security, education, and transportation.[210] Establishing collaborative relationships between social service, education, primary care, and behavioral health systems helps to foster quick referral protocols and eliminates repetitive intake processes.[211]

There should be SDOH screening for children and families that uses a trauma-informed approach at all appropriate health settings. SDOH screening at routine or emergency health visits must be accompanied by referrals, as necessary, to appropriate support programs/services. The widespread implementation of SDOH screening requires the development of protocols and sustainable financing mechanisms, as well as adequate human capacity in appropriate services/programs to address screening outcomes. As mentioned in Recommendation

#11 in Chapter 4, SDOH screening may be supported by the District's Community Resource Information Exchange (CoRIE) project and, more broadly, the District's designated Health Information Exchange (HIE). The DC HIE should include functionality to analyze aggregated data pertaining to identified SDOH, including socioeconomic status, educational attainment, food stability, health care access, exposure to violence, and housing security. Public reporting on such data will foster cross-system accountability, communication, and planning.

10. Encourage all behavioral health service delivery organizations, across the settings of child care, school, health, and social services to develop and implement a plan to deliver and measure culturally responsive and trauma-informed care.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

According to SAMSHA's Treatment Improvement Protocol Series, No. 59., a "well-defined and organized plan, coupled with a consistent organizational commitment, will enable organizations to initiate and accomplish the tasks necessary to promote culturally responsive services." In line with this, DBH and DHCF should encourage all providers receiving public funding for behavioral health services to develop and implement a plan to ensure that their organization delivers culturally responsive and trauma-informed services. Coupled with supporting such plans, DHCF and DBH should evaluate, standardize, and require reporting on measurements for organizational cultural competence (using for example, National Culturally And Linguistically Appropriate Services Standards, National Committee for Quality Assurance's (NCQA) Multicultural Health Care Distinction, Cultural Competency Organizational Assessment or COA360) and trauma-informed practices (such as TICOMETER). Additionally, the recently developed Self-assessment for Modification of Anti-Racism Tool (SMART), an organizational-level quality improvement tool designed to facilitate discussions about structural racism existing within behavioral health care structures, is a promising measure through which behavioral health care leadership can diagnose and address existing inequities in the service delivery system.[212] Last, DBH should consider offering trainings in the provision of culturally responsive and trauma-informed care that are tailored to DC's local context (which include diverse populations that are highly traumatized).

11. Improve family-centered care.

Implementing Bodies: DHCF, DBH, DC Health, OSSE
Timeline to Implementation: Medium Term

Involving families in the behavioral health care of children through family-centered practices can improve the behavioral health outcomes of children and their communities.[213] Further, taking into account the caregiving needs of parents and other caregivers of children and youth with behavioral disorders can help empower them to better care for themselves and their children.[214] As such, the District should consider the following strategies to improve family-centered care:

- Offer educational resources to behavioral health providers with information about family caregiver needs.[215]
- Review care management standards, hospital discharge planning, and risk assessment procedures to ensure that they meaningfully involve family caregivers.[215] With permission, grant family caregivers access to care plan information.[215]

- Provide clinical staff with practice guidelines and supervision for how to effectively engage families/natural supports.[216] Ongoing engagement of family and natural support facilitates optimal recovery for children. Close and trusting relationships between families/natural supports and children often allow families/natural supports to be the first to recognize both subtle progress and early signs of deterioration, making them strong partners in care provision.

- Systematically collect information about family/caregiver needs within behavioral health care settings and account for them in treatment plans.[215] That may require additional guidance in documenting adult issues in the child's chart, such as linking the adult caregiver chart with the child's as appropriate, to ensure adequate documentation and collection of information. For children with advanced functional impairment, the District can consider using a strategy similar to that implemented by Tennessee's Medicaid agency (TennCare) through its CHOICES in Long-Term Services and Supports program, in which MCOs are required to conduct formal assessment of caregiver needs and take them into account within care plans.[206]

- To support reimbursement dyadic or family therapy, the District should ensure higher reimbursement rates for family psychotherapy codes.

- Expand self-directed HCBS accessibility to children with behavioral disorders to maximize the opportunity to use home-based supports in lieu of more intensive care options that isolate patients from sources of social support.[217]

12. Continue strong work with behavioral health screening and strengthen successful connection to evaluation and/or treatment after a positive screen.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Long Term

Medicaid MCOs should follow behavioral health screening requirements as mandated by the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit and the DHCF. While every child (0–21) should be screened through their pediatric primary care provider annually with a validated tool, we recommend a degree of continued flexibility to allow health care providers to implement screeners that fit their particular practice demographics, infrastructure, and workflow.

Ethical screening practice requires that referrals made for further assessment, diagnosis, and treatment must be immediately available. Ample health care practice-specific training, staff buy-in, and referral mechanisms must be in place to attend to needs that arise from the screening. Effort should also be made to incentivize providers to utilize the appropriate billing modifier to denote a positive screen. Additionally, MCOs should identify beneficiaries with positive screens and work to support successful connections to appropriate levels of care. DHCF should also report those data at a population level to determine trends in behavioral health screening and linkage to evaluation and/or treatment, if indicated.

6. WORKFORCE

For this report, "workforce" is defined as all people engaged in actions whose primary intent is to enhance behavioral health (which is an adaptation of WHO's health workforce definition such that it applies specifically to behavioral health). Based on this definition, the behavioral health workforce includes the wide range of behavioral health care providers (such as child and family psychiatrists, psychologists, social workers, counselors, peer support specialists) as well as health care support staff (such as psychiatric technicians).

6.1 Vision for the System

With reference to our guiding values for DC's Behavioral Health System for Children outlined in Chapter 1 and *Table* 5.A, our goal for DC's behavioral health workforce includes the capacity to deliver family-centered and trauma-informed care, with cultural humility and in a manner that promotes racial equity. Informed by local needs, the behavioral health workforce should be adequate, easily accessible, sufficiently compensated, and trained in evidence-based practices.

A Diverse, Adequate, and Accessible Behavioral Health Workforce

There should be adequate providers in the necessary specialties, across the spectrum of care, within the behavioral health workforce to be able to meet the current and future behavioral health needs of children in the District in a timely manner. For there to be adequate behavioral health providers for children, all MCOs should meet defined behavioral health network adequacy standards, and the government must routinely monitor and enforce those standards, as discussed in Chapter 4. *Table* 6.A highlights provider-to-patient ratios for certain behavioral health professions that have been recommended by professional organizations or in peer-reviewed research. Those ratios are included to provide broad context for our vision for workforce adequacy but are not specific recommendations for District implementation.

Table 6.A Suggested Provider to Patient Ratios for Selected Types of Behavioral Health Providers

Profession	Suggested Ratio	Source
School psychologist	1:500 students	National Association of School Psychologists (NASP)[a]
School counselor	1:250 students	American School Counselor Association (ASCA)[b]
Child psychiatrists	47: 100,000	American Academy of Child and Adolescent Psychiatry[c]
Substance Abuse Providers	1:48 individuals with SUD*	*BMC Health Services Research*[d]

Profession	Suggested Ratio	Source
Applied behavior analysts (providing comprehensive treatment)	8.1:100 children with ASD	Behavior Analyst Certification Board, *Psychiatric Services*[e]
Social Workers	1:250	School Social Work Association of America[f]

[a.] "School Counselor Roles & Ratios;" American School Counselor Association
[b.] "Beyond a Bigger Workforce: Addressing the Shortage of Child and Adolescent Psychiatrists – Pediatrics Nationwide;" David Axelson, MD; April 10, 2020
[c.] "A Needs-Based Method for Estimating the Behavioral Health Staff Needs of Community Health Centers;" BMC Health Services Research; 2013
[d.] "Supply of Certified Applied Behavior Analysts in the United States: Implications for Service Delivery for Children with Autism;" Psychiatric Services; 2020
[e.] "NASW Standards for School Social Work;" NASW
* Data represents necessary provider-to-patient ratio for individuals aged 12 and over; youth-specific data unavailable.

Moving beyond traditional behavioral health providers, DC should embrace an innovative, broader behavioral health care workforce for children that could be utilized more efficiently, effectively, and earlier in the care continuum.[218] That includes leveraging the power of families and peers in the behavioral health care of children by assigning them formal roles, such as family/peer specialists on expanded care teams. Studies have repeatedly found peer workers to be effective in assisting people with behavioral health conditions to connect to, engage in, and be active participants in different types of services across the continuum of care.[219]

Examples of Successful integration of Peer Support Specialists/Community Health Workers

The following are two program examples in which CHWs and peer support specialists have been successfully integrated in care teams and used in behavioral health.

A 2015 pilot program in Texas trained and integrated experienced CHWs into four FQHCs to support behavioral health services delivery to diverse populations. The purpose of the program was to explore the feasibility of CHWs working to support behavioral health in primary care settings.[220] CHWs received a 48-hour behavioral health training that included training on the SBIRT (screening, brief intervention, referral to treatment) model and an overview of behavioral health and common behavioral health issues. CHWs reported screening for behavioral health issues, outreach, and care coordination (e.g., answering telephones, making and tracking referrals, supporting medication management, scheduling office visits, and following up on missed appointments) as the most frequent activities engaged in.

Another example is the Los Angeles County Department of Health Services – Care Connections Program and Whole Person Care Program (WPC).[221] The WPC program embeds CHWs in the primary care setting to provide outreach, engagement, assessment, peer support, accompaniment to appointments, and other care coordination activities to targeted high-risk populations, such as those who are homeless or have SUD. The CHWs are not required to have any specific certifications but receive intensive training from the LA County DHS on core topics such as social determinants of health, motivational interviewing, using DHS assessment and care planning resources, homelessness, incarceration, mental health and SUD, safety, self-care, leadership, and advocacy skill-building.

It is critical that the behavioral health workforce reflects the diversity of the population it serves, especially considering that research has shown that patients who share the same race and culture as their health care professionals have stronger therapeutic alliances and are more likely to stay in treatment.[222] DC's population of children is racially, ethnically, culturally, and linguistically diverse; thus, there should be sufficient diversity alignment between children and providers to provide effective care. Further, given the variation of racial and ethnic composition across DC wards, it is important for diverse behavioral health professionals to be appropriately distributed in the District. That requires sufficient, long-term planning and funding to recruit underrepresented populations into DC's public behavioral health workforce. As an example of such a recruitment strategy, California identified financial support through scholarships and loan forgiveness programs to encourage underrepresented students to pursue careers in shortage areas.[223]

Minimal Workforce Turnover

Behavioral health managers and leaders in DC should support behavioral health professionals such that they have high levels of job satisfaction and low levels of burnout. Previous research has identified insufficient compensation, lack of professional growth opportunities, burnout, and administrative burden as contributors to high behavioral health workforce turnover.[223, 218] Behavioral health workforce turnover is not only costly, but it also affects therapeutic relationships and, thereby, impacts patient outcomes.[224] Some important strategies to retain clinical professionals in underserved areas that were identified by the Oregon Health Policy Board include career ladders, career development, supervision, and merit pay.[223] *Table E.2* outlines some supervision standards for selected behavioral health professions.

To address inadequate compensation packages, DC must implement strategies to evaluate the compensation of all types of behavioral health professionals working in the public health system and work toward providing competitive compensation. That must include routine review and updating of Medicaid reimbursement rates for all providers and services. Additionally, DC's behavioral health workforce retention strategies should be comprehensively reviewed and updated regularly based on data collected from local behavioral health professionals.

Adequate & Appropriate Education for the Behavioral Health Workforce

To provide high-quality services to children, DC's behavioral health workforce should have a solid educational foundation and be well-trained on up-to-date evidence-based and evidence-informed practices related to their profession. Educational and training requirements for behavioral health professions should at minimum meet those of national professional boards. Periodic review of educational and training requirements should be informed by feedback from stakeholders (including youth and families) about gaps in workforce competencies. Adequate education and training of local behavioral health professionals require sufficient qualified educators, integrated/interprofessional training opportunities, learning institutions, and organizational prioritization.[225] Essential continuing education and training for all behavioral health professionals should include cultural competency, cultural humility, family-centered care, multigenerational care, and trauma-informed care. Families and youth who use behavioral health services should have the opportunity to provide input on the content of educational materials on those topics, and these materials should be tailored to DC's context. Continuing education and training for behavioral health professionals should be tied to recertification and should be supported through funding and by organizational leadership.

Educational programs for all professionals that provide behavioral health services for children (including primary care physicians, nurse practitioners, and obstetricians) should be encouraged to develop curricula that emphasizes preventative care, early intervention, the social determinants of health, cultural competency, cultural humility, family-centered care, multigenerational care, and trauma-informed care. Behavioral health workforce training best practices acknowledge the role of trauma on the patient, as well as the potential for services delivered to either reduce or exacerbate traumatic response. Curricula of educational programs for behavioral health professionals should also be kept updated with emerging evidence-based practices, quality improvement strategies, and integrated models of care.[226] With the shift toward integrated care, interdisciplinary education and supervision for professional training (consistent with the WHO Framework for Interprofessional Education and Collaborative Practice) from the variety of professionals who provide behavioral health services for a child should be implemented, because it can reduce fragmentation, enhance collaboration, and improve health outcomes for children.[223] As standardized measurements of treatment response are emerging for child behavioral health, education and training in measurement-based care can promote more targeted interventions and better outcomes.[227]

Data for Behavioral Health Workforce Planning

Representative data regularly collected from the wide cross-section of all types of local behavioral health professionals should inform policy and financing decisions. The sole use of observations and/or anecdotes represents weak evidence to guide decision-making, which can lead to the misuse of limited financial and human resources. Data should be routinely captured to assess the adequacy, accessibility, diversity, and competence of the behavioral

health workforce. Further, data should be used to develop and then evaluate behavioral health workforce recruitment and retention strategies. Such data collection requires a centralized, permanent data infrastructure that can not only collect data from stakeholders (including behavioral health providers, consumers, and health care managers) but also analyze and disseminate that data to inform workforce plans and policy decisions.

While the behavioral health workforce data prioritized for collection should be tailored to DC's context, the minimum data set (refer to *Table 6.B*) to inform workforce planning efforts for the broader behavioral health workforce published by the University of Michigan's Behavioral Health Workforce Research Center does provide a starting point.[228]

Table 6.B Suggested Minimum Data Set Elements to Inform Workforce Planning

Minimum Data Set Theme	Data Elements
Demographics	Name, age, race/ethnicity, sex and gender, sexual orientation, place of birth and residence, military/veteran status, language skills
Licensure and Certification	Type of job-related licenses held, type of job-related certificates held, national provider, identification number, state identification/registration number
Education and Training	Degrees obtained and years of completion, field of study/specialty, completion of other educational programs (e.g., internships), current enrollment in degree program
Occupation and Area of Practice	Primary occupation, area of practice
Practice Characteristics and Settings	Employment status, number of current employment positions, number of hours and weeks worked per year, employment arrangement, use of telehealth, employer practice setting, hours per week spent on activities (e.g., clinical supervision, diagnosis), clinical or patient care provision, employment plans

Adapted from: "Table1. Summary of Minimum Data Set Data Elements for Behavioral Health Workers;" Improving Data for Behavioral Health Workforce Planning: Development of a Minimum Data Set; American Journal of Preventive Medicine; 2018

6.2 Current System

Adequacy & Distribution of DC's Behavioral Health Workforce

While there are several estimates of workforce capacity in DC, it is difficult to assess DC's active and available workforce within the public behavioral health system for children. Recent research suggests that the behavioral health workforce for children is inadequate and that there is also high behavioral health staff turnover in the District.[202] A 2018 US Health Resources and Services Administration (HRSA) report identified insufficient supply of psychiatric nurse practitioners, psychiatric physician assistants, addiction counselors, school counselors, social workers, and marriage and family therapists to meet demands in DC in 2016.[229] Additionally, the shortage of psychiatric providers is further exacerbated by the shortage of licensed psychiatric providers who accept Medicaid insurance. A 2014 journal article indicated that nationally only about 43% of psychiatrists accept Medicaid.[230] A DBH grant application noted that, as of July 2019, there were 21 child/youth-serving MHRS provider organizations, three child and youth outpatient SUD certified provider organizations, one child and youth residential SUD certified provider organization, and one parent with children SUD certified provider organization.[94] That data represents organizations that could have more than one behavioral health professional, but it could be interpreted as the minimum number of professionals in those specialties serving those on public health insurance in DC. Additionally, as of June 2019, DBH had 158 certified peers in the behavioral health system.[94]

Figure 6.A HRSA Designated Mental Health
Professional Shortage Area

Source: Health Resources and Services Administration

The limited available data suggests that the behavioral health workforce in DC is not only inadequate but also unevenly distributed. In DC, there are a total of 10 mental health care Health Professional Shortage Area (HPSA)[xvi] designations, which comprises of one geographic area (Anacostia, shown in *Figure 6A*) and nine facilities (Bread for the City, Community Of Hope, Elaine Ellis Center Of Health, Family and Medical Counseling Service, La Clinica Del Pueblo, Mary's Center For Maternal And Child Care, Unity Health Care, Whitman-Walker Clinic, and Metro Health). As of September 2020, HRSA noted that 28 additional mental health providers are needed to achieve a population-to-provider ratio below the designated threshold in Anacostia. The uneven distribution of mental health workers was also suggested by a 2016 DC Health report that stated that the majority (>50%) of full-time equivalents for psychiatrists were located in Ward 2 and 3.[231] In an effort to address this uneven distribution, DC has established a Health Professional Loan Repayment Program (HPLRP) to repay the loans of eligible health professionals (including licensed and credentialed mental health providers) practicing full-time at HPLRP-certified sites and HPSAs in DC.[232]

Behavioral Health Workforce Training & Licensing

While DBH provides licensing for behavioral health organizations, DC Health through its Health Regulation & Licensing Administration (HRLA) is mainly responsible for the licensing, registration, or certification of behavioral health professionals. Licenses for behavioral health professions are provided by the respective health profession boards (whose members are typically appointed by the Mayor), including the Board of Medicine, Board of Occupational Therapy, Board of Psychology, Board of Social Work, Board of Professional Counselling, Board of Nursing, and Board of Marriage and Family Therapy. With respect to behavioral health professions, according to DC code §3–1205.01, a license is required to practice advanced practice addiction counseling, marriage and family therapy, massage therapy, medicine, naturopathic medicine, occupational therapy, professional counseling, psychology, social work, or speech-language pathology or to practice as an occupational therapy assistant or professional art therapist in the District. Registration is required to practice as a psychology associate, speech-language pathology assistant, or speech-language pathology clinical fellow, while certification is required to practice as an addiction counselor I and addiction counselor II. For some of those professions, the number of active licenses in FY2019 are outlined in Appendix E. The term of licensure and continuing education requirements varies across behavioral health professions. For all health professions, there is a continuing education requirement for two credits in LGBTQ cultural competency. Relatedly, MCOs must ensure that all providers comply with policies and procedures that promote cultural competency as outlined in the DC Language Access Act of 2004.[98,xvii]

DBH administers a Peer Specialist Certification Training Program to certify peer specialists for jobs within the community behavioral health provider network. One of the tracks within the Peer Specialist Certification Training Program is a Youth Peer Specialist Certification offered to current DC residents between ages 18–25 with at least a

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[xvi] *One federal measure of mental health workforce shortages is the Health Professional Shortage Area (HPSA) designation, which can be applied to geographic areas, populations, or facilities that have a shortage of mental health care providers. It should be noted that those designations are not specific to providers for children. Further, the HPSA designations may be based on the population-to-psychiatrist ratio, the population-to-core-mental-health-provider (psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists) ratio, or both.*
[xvii] *According to the Government of the District of Columbia Office of Human Rights, the DC Language Access Act of 2004 requires the District to provide equal access to public services, programs, and activities for DC residents who cannot or have limited capacity to understand or communicate in English.*

high school diploma or GED and who have received services within the "child serving system in the Department of Behavioral Health."[233] To become a certified peer specialist, an individual must complete a classroom training and an 80-hour field practicum and then pass a certification examination. In addition to peer specialists, DBH provides training (that includes best practices for assessment of suicide risk) to the behavioral health professionals operating the Access Helpline.

Behavioral Health Workforce Credentialing

Behavioral health providers need to be enrolled and credentialed with each MCO to provide services to the DC managed care population.[234] According to the DC Medicaid Managed Care Quality Strategy, all MCOs must have written policies and procedures for the credentialing and recredentialing of all network providers, which should, at a minimum, comply with federal, state and NCQA standards.[98] While limited data regarding the average duration of the provider credentialing process are available, one District MCO estimated that the process takes approximately 45 to 60 days in 2020.[235] However, providers may be required to undergo credentialing with both an MCO and its subcontracted managed behavioral health organization if the MCO has chosen to partner with a third party to manage behavioral health coverage.[234] There are no limitations on the number of providers an MCO may contract with for services.

Behavioral Health Network Adequacy for Managed Care Organizations

According to DC's Medicaid Managed Care Quality Strategy, MCOs are required to submit to DHCF a list of all network providers and all provider contracts.[98] An external quality review organization annually performs network adequacy validation (based on time and distance standards for providers, as well as timely access measures). The most recently reported network adequacy validation was published in the *District of Columbia Managed Care Program 2020 Annual Technical Report* and did not provide specific data on behavioral health network adequacy.[112]

6.3 Gap Analysis

A comparison of DC's current workforce for the public behavioral health system for children to our vision highlights several key gaps that are discussed below.

1. Inadequate behavioral health workforce available to children on public health insurance

It is difficult to assess DC's active and available workforce within the public behavioral health system for children due to a lack of published data. However, recent research, including our family engagement efforts, have implied that there is a dearth of behavioral health providers for children across settings. Many youths in our family engagement forums felt that there were insufficient behavioral health services available for children in the District. Further, several parents/caregivers noted that when they were able to identify an appropriate provider, they frequently had long wait times to get appointments. The inability of families on public health insurance to access behavioral health providers without long wait times suggests that there are not enough providers to meet the behavioral health needs of children.

Further, as previously discussed in Gap 5 in Chapter 4, the *DC Managed Care Program 2020 Annual Technical Report* highlights that overall network adequacy standards as defined by MCO contracts are not currently being met.[112] Relatedly, there is no enforcement of network adequacy standards, and no clear monetary penalties exist in contracts for network inadequacy. Additionally, monitoring and review of network adequacy demonstrates clear gaps, amplified by inaccurate in-network provider directories. With the planned carve-in of behavioral health services into managed care programs, those challenges could negatively impact the availability and accessibility of behavioral health services by children.

2. An insufficient labor pool of diverse behavioral health professionals for children

While no data on demographics of the current behavioral health workforce in DC could be found, it is known nationally that there is a lack of diversity among the behavioral health professionals.[226] This national phenomenon aligns with District-level findings from our family engagement efforts, where children expressed that sociocultural differentials prevented providers from being able to understand them; therefore, children felt uncomfortable sharing. They noted that that hinders the building of trust between the provider and the child, which is needed in the therapeutic relationship. One youth stated, "They serve mostly minority youth, but I feel like I see their leaders, I see, like most of the therapists, they're white. And like how could a white person really, I'm not saying it's impossible, but how did they really be culturally competent to serve these people if they don't know what's our lived experience?"

3. Lack of cultural competency among behavioral health workforce

Based on a 2016 community needs assessment conducted by the District of Columbia Healthy Communities Collaborative, members of the DC community indicate that cultural competency is a priority need.[236] Further, a 2018 study revealed a troublesome lack of culturally competent perinatal mental health care access in the District, particularly in Wards 7 and 8.[237]

4. An unevenly distributed behavioral health workforce

The uneven geographic distribution of existing mental health providers further reduces access to critical mental health services to patients in HPSA, particularly in Wards 7 and 8, which are overwhelmingly members of Black and Latinx communities. This geographically uneven distribution increases racial inequities, resulting in even less access for populations in the shortage designation areas. As mentioned in the Current System section above, *Figure 6A* highlights mental health professional shortage areas in the District, mainly located east of the river, which have a larger population of Black and Brown residents. Additional maps, located in the appendix, also highlight the lack of inpatient workforce for children under 18 years of age in Wards 7 and 8. The uneven distribution of the behavioral health workforce is also compounded by the limited transportation options available in Wards 7 and 8 for families to travel to access these services. From our family engagement efforts, several parents/caregivers felt that some of the behavioral health services that they need for their children are not conveniently located. One parent/caregiver shared, "I have problems with getting quality services, unless I transport me and the kids way out of our community."

Complicating that situation, not all licensed mental health providers are qualified or specialize in the unique needs and treatment of children, and provider data may include providers who are no longer practicing or not taking new clients. It should also be noted that those provider shortages and geographic disparities predated the COVID-19 pandemic, and mental health needs have increased during the pandemic.

5. High turnover among behavioral health professionals

There seem to be inadequate and/or ineffective retention strategies for behavioral health providers who serve children on public health insurance in the District. Through our family engagement efforts, parents/caregivers often identified the frequent turnover of providers as a factor negatively impacting services received by children, with one parent sharing, "It seemed like everybody [behavioral health professionals] that I get that's good, they either retire or they get burned out." Previous research has identified supervisory support and emotional exhaustion (a component of burnout) as some of the predictors of behavioral health workforce turnover.[238] High turnover among behavioral health professionals has been associated with increased organizational costs related to hiring and training, as well as decreased service accessibility.[239]

6. Inadequate data for behavioral health workforce assessment and planning

While some behavioral health workforce data is currently collected at the time of license renewal application, it is not published publicly, and it is insufficient to measure the adequacy of the behavioral health workforce for children in DC. Without routine collection of comprehensive workforce data, opportunities to make informed decisions regarding workforce development are limited.

7. Challenges with behavioral health workforce credentialing

Each MCO is responsible for credentialing and recredentialing of its network providers, so providers must undergo separate credentialing processes for each MCO network that they wish to join. Further, providers may be required to undergo credentialing with both an MCO and its subcontracted MBHO if the MCO has chosen to partner with a third party to manage behavioral health coverage. These credentialing arrangements place greater administrative burden on providers and can prove a barrier to entering payer networks, potentially leading to narrower networks. Additionally, MCO contracts require credentialing to be completed within 180 days upon the MCO's receipt of all required documents,[237,xviii] which is an unreasonably long timeframe for providers.

8. Insufficient workforce trained in providing trauma-informed care

With approximately 47% of DC children having experienced a traumatic event,[241] there remains an unmet need for trauma-informed behavioral health care. That is exemplified in school settings, with a number of community leaders acknowledging the lack of trauma-informed practice in DC schools.[242] Additionally, a needs assessment conducted from 2019–2020 by the DC Health Title V team found that, in spite of the mental health expansion led by DBH and work conducted by the Wendt Center for Loss and Healing, there remain gaps in grief and trauma-informed pediatric health care.[243] Similarly, participants in a 2016 community needs assessment indicated that DC's behavioral health care system could be improved by adding services that address trauma and grief.[108]

9. Lack of infrastructure to support the growth and retention of non-traditional workforce

Financial Infrastructure

- Despite authorization of Medicaid reimbursement, challenges still exist for the peer support workforce. Low salaries/low reimbursement rates and difficulty integrating peers into care teams contribute to high turnover rates.

- Peer specialist payment mechanisms embedded within DC Medicaid are restrictive on what services peers are authorized to deliver and, thereby, prevent adequate accessibility. There are limitations on where peers can work in the District and challenges with sustainability for organizations that do not meet those setting qualifications and currently hire peers as a part of their workforce. According to DC Code,[244, 245, 246] certified peer specialists are authorized to provide Medicaid-reimbursable behavioral health rehabilitation services to consumers when working under the supervision of a qualified practitioner. Services provided by certified peer specialists are reimbursable through Medicaid in limited settings or funded through grant and the organization's operational dollars. Services are reimbursed through Medicaid only if they are provided in a community-based MHRS provider or other community-based setting or a residential facility of 16 beds or fewer.

- Natural supports (which are previously referenced in Section 5.2) are key components of DC's behavioral health system. However, the District lacks mechanisms to compensate natural supports for their role in care coordination, especially in times of crises, as well as their role as caregivers for children with severe behavioral health issues. Friedman (2020) notes, "there is danger in utilizing natural supports in lieu of formal services solely for cost-cutting."[247] At the same time, reimbursement of supplemental services utilizing natural supports could improve beneficiary experience, quality, and equity in the system.

Operational Infrastructure

- There are also barriers in supporting peer specialists, CHWs, and other paraprofessionals in team-based clinical care settings. Barriers include a lack of clearly defined roles/scopes of practice for paraprofessionals on the team and a lack of understanding from clinical team members on what peer specialists do and the value they bring with their lived and cultural experiences.

- There is also a need for continued and specialized training for peers and other paraprofessionals in the behavioral health workforce, as well as training for clinical team members on the role of paraprofessionals on their team. A lack of trust, shared language, and communication between paraprofessionals and clinicians on a team can impact the quality of care delivered and limit the growth of this workforce in integrated care settings.

- Relatedly, one local family-run organization has noted that supervision approaches for peer specialists may not always be appropriate for the education level and/or technical qualifications of the peer specialists. That may be due to regulatory burdens associated with reimbursement of peer services through the wrong mechanisms.

10. Challenges with engaging youth and families in peer specialists training

Overall, there is a lack of awareness regarding the availability of the certification programs offered by DBH. Many families and youth with lived experience who may be interested in doing this work are not aware of those opportunities unless connected to it through family-run organizations, which will require greater thought on how these training sessions are made more accessible to the public. Accessibility is also an issue for many families who go through the certification process. The training and exam can feel unattainable to many due to the process being too difficult, including literacy challenges while taking the exam or barriers with cost if they fail and have to pay to take the exam a second time.

There is value in having youth with lived experience to help other youth connect with services and navigate the recovery process. However, there are not enough youth peer specialists. Although DBH offers a youth peer specialist certification track, it has been difficult finding youth to participate for a variety of reasons. In conversation with a local family-run organization, the biggest obstacle for youth participating in peer training is building trust and using the right language to create a youth friendly atmosphere, free of stigma, in which youth feel supported and have the guidance to go through the peer certification process and become a part of the behavioral health workforce. There needs to be an acknowledgement that families and youth who participate in these training programs often experience trauma and have varying levels of experience in the workforce and therefore require a certain level of sensitivity and understanding from the trainer and supervisors.

11. Professional licensing processes limit the behavioral health labor pool

The District's health professional licensing process is inefficient and limits entry to the behavioral health workforce. Not all licensing boards provide opportunities for people to work while waiting to complete licensure requirements, such as passing national exams after graduating from degree or training programs. Endorsement processes, or other similar pathways for people who hold licenses elsewhere to gain licensure in the District, also lack meaningful opportunities for people to work while waiting for licensing board responses after application. Since licensing for both new health professionals and those licensed in other jurisdictions does not include the ability to work while waiting for a license to be issued (or denied), otherwise-qualified health professionals are removed from the pool of the District's behavioral health workforce.

At times, because of those restrictions, people who previously held roles in direct service, including interns in degree programs or those who held paraprofessional roles who become eligible for professional licensing, are forced to discontinue care for people with whom they have an ongoing relationship as part of a behavioral health team. For example, presently, a social worker cannot practice within the scope of any related work before they

attain licensing. Thus, students who maintain work in certain paraprofessional or supportive behavioral health positions and are near the end of their social work degree and board preparation are caught in an untenable position of being fined if they continue to work in related fields, such as peer specialists and CHWs.

The lack of a District license, despite being otherwise qualified and perhaps already having a license application pending, can also lead to organizations choosing not to hire people who otherwise would be the best candidate for a given role. Conversely, people not licensed in the District may choose not to complete licensure, even if qualified, because of their more urgent need for employment and income. The disruptions of transitions from paraprofessional or intern to professionally licensed roles, as well as the disruptions when seeking to hire people who are licensed in another jurisdiction, shrink the District's already thin behavioral health workforce.

6.4 Recommendations

In addition to the recommendations below, we also advise readers to consider the DC Health Matters Collaborative's recently published paper titled Improvements to Behavioral Health Integration and Service Provision in DC – Listening to our Behavioral Health Workforce and Youth, which outlines several recommendations to address behavioral health workforce challenges.

1. Implement strategies and incentives to create an adequate labor pool of diverse behavioral health professionals for children.

Implementing Bodies: DHCF, DBH, DC Council, MCOs, OSSE, Higher Education Institutes, Provider Organizations
Timeline to Implementation: Short to Long Term

Our family engagement efforts revealed that many minority youth preferred behavioral health providers whom they can "relate to," and some expressed that there should be more providers of color to meet this need. That concurs with research findings that many people of color receiving behavioral health care preferred minority providers and treatment in their native language, even though matching clients to clinicians of the same ethnicity was not essential to treatment effectiveness.[224] Further, it is important to note that providers who have similar backgrounds to youth receiving care are more likely to form a strong therapeutic bond with clients and achieve better recovery outcomes as a result.[248]

Some strategies to consider for building an adequate pool of behavioral health professionals are:

- Develop training and summer programs that target minority transitional-age youth,[249] while promoting and providing incentives for work in the behavioral health field.[250] Career ladders should be highlighted in such efforts.[250]

- Develop formal recruitment strategies that extend to culturally and ethnically diverse organizations to foster diversification of the provider workforce.[251]

- Recruit community members, paraprofessionals, and peer mentors to increase the number of staff trained to deliver direct care to clients.[251] Use scholarships and loan repayments for underrepresented students to recruit and retain a diverse workforce.[223]

- Consider offering certification and licensing test preparation at free or reduced cost to District natives, particularly those who represent minority communities. Use pathway or pipeline programs, in which potential candidates for professional training are identified throughout the grade school and college years and introduced to the field at an early age, such as Arkansas's Health Care Student Summer Enrichment Program for Underrepresented Student Populations.[252]

- Area Health Education Centers (AHECs) located in the District should be leveraged to introduce diverse student populations to health care professions.[252] For example, consider building a program similar to the Summer Leadership Institute implemented by Hawaii within its Molokai AHEC, which provides health career presentations, relevant training, and cultural content in return for college credit.[252]

- DHCF may also consider incentivizing recruitment and retention of minority behavioral health professionals by enhancing reimbursement rates proportional to the extent that providers recruit and retain staff who effectively meet the diversity, inclusion, and equity needs of their clients.[210]

2. Incorporate best practices to improve the cultural competence among providers.

Implementing Bodies: DHCF, DBH, DC Health, CSAs, MCOs
Timeline to Implementation: Medium to Long Term

In addition to diversifying and distributing a high-quality children's behavioral health workforce optimally across the District according to need, cultural competency must be reflected in all provider interactions with patients. Respecting the lived experiences and responding to diverse needs of patients allows for building trust, which leads to effective treatment. When trust is absent, treatment is not productive or even abandoned, and patients risk further declining mental and physical health. But when trust is built between patient and provider(s), treatment effectiveness increases, which in turn can also improve provider satisfaction and can reduce burnout and turnover.

Ideally, a workforce will share at least some degree of the diversity of the population it is serving. Regardless of the degree to which this is achieved, all behavioral health providers at all levels and all backgrounds need continuing education on best practices, new research, and meeting the changing needs of the diverse population. Cultural competency, together with cultural humility, is achieved through a combination of training and clinical application with acknowledgement for the need to remain open to ongoing reflection.

- **Require continuing education and training on culturally responsive care, implicit bias, and understanding and dismantling societal and structural racism across the entire spectrum of behavioral health providers,** from psychiatrists and psychologists to peer support and CHWs. For instance, training on the Cultural Formulation Interview offers an evidence-based tool composed of a series of questions that assist clinicians in making person-centered cultural assessments to inform diagnosis and treatment planning.[253]

- **Include cultural competence planning and training as distinct quality of care measures for MCO evaluation purposes**, including tracking and enforcement by DHCF and other relevant agencies. That would include continuing education and training completion on cultural competency by large portions of the behavioral health workforce credentialed by MCOs, if not all, along with measures for applying cultural sensitivities in the communities served. Accessibility to services in multiple languages must also be measured and assured for the diverse population. Consider use of the CLAS framework[254] or similar standards.

- **Credential nontraditional health care providers, including peer support specialists and navigators, and reimburse them for culturally sensitive treatment and modalities.** This policy must also support culturally specific services, including services provided by CBOs that support individual and community well-being. People should have access to a variety of reimbursable and approachable avenues for their health care.[120]

3. Conduct research to understand and monitor behavioral health workforce turnover in the District.

Implementing Bodies: DHCF and DBH
Timeline to Implementation: Short Term

DBH and DHCF should conduct research to understand the organizational-level and individual-level factors contributing to DC's high turnover of behavioral health providers who serve children on public health insurance. Such research should include the collection of data that can be used to estimate the local turnover/retention rate of behavioral health professionals. Relatedly, it will be important for government agencies to establish a process to regularly monitor behavioral health workforce turnover/retention rates.

4. Implement strategies to minimize workforce turnover.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Long Term

Behavioral health workforce retention strategies should be developed based on local research (refer to recommendation above). Further, evidence-informed strategies should be comprehensively reviewed and updated regularly based on data collected from local BH professionals. The following are some strategies to consider:

- **Ease administrative burden**—Minimize and simplify the extensive, perhaps excessive, documentation required from behavioral health professionals who provide services to those with public health insurance. That may be accomplished through reviewing administrative requirements issued by DC Medicaid and eliminating duplicative processes[255] or mandating and/or incentivizing plans to reduce prior authorization requirements for providers who meet specific performance and compliance targets.

- **Implement provider incentives**—Ensure that there are career ladders, supervision, career development, team-based work, continuing education, community amenities, experience-based step pay increases, and merit pay.[223] Research has indicated that immediate, meaningful cash incentives have a greater effect on retention in comparison to longer-term benefits such as retirement contributions.[223] However, nonfinancial incentives, such as employee awards,[257] are also recommended in reducing burnout and turnover.[258]

- **Offer sufficient compensation and fair scheduling**—Conditions for behavioral health professions in the public system should be examined to ensure there are living wages and fair scheduling practices, paid sick time, as well as paid family and medical leave. Additionally, it is critical that value-based payment arrangements accurately calculate costs and sufficiently reimburse nonclinical care positions, including care coordinators, discharge planners, and CHWs. Use of independent contractors should be evaluated to determine whether there are recruitment, retention, or quality differences compared with regular employees, and rates should be structured to allow the best mix of independent contractors, employees, or both on a service-level basis.

- **Improve training for behavioral health workers**—To enhance incentives for retention, consider supporting advanced training for bachelor's-level behavioral health workers and fellowship opportunities for graduate-level staff.[259] Further, given high levels of burnout experienced by behavioral health providers, behavioral health organizations should offer resilience training that may help

reduce burnout symptoms.[257] One such example in DC is the Compassion, Practice, Relationships and Restoration (CPR²) program developed by the Early Childhood Innovation Network and Children's National.[xix] It is important to note that while those training opportunities are important, they cannot replace structural and operational changes that will directly help to reduce burnout. The DC government should provide support to behavioral health organizations that are making structural changes to support workforce retention.

- **Create nonsupervisory expert tracks so people can stay in care delivery and receive adequate compensation for it**—Establishing a tiered payment mechanism that reimburses according to experience and education may further incentivize workforce retention.

- **Improve supervision for behavioral health workers**—Ensure behavioral health workforce is supported through adequate supervision. *Table E.2* highlights a number of maximum staff-to-supervisor ratios and supervision time requirements recommended for specific behavioral health professions. It also remains critical that organizations establish their own supervisor-to-staff ratios and supervision times that work for their context. Additionally, research has noted that supervisors' feedback should be based on live observation of actual practice and client feedback/outcomes in community mental health services,[260] and supervision of therapists should incorporate evidence-based practices, such as modeling and role-play.[261] Supervisors whose teams include peer specialists should receive special training and support to know how to help peers be successful in the behavioral health workforce.

5. Provide adequate support to child-serving behavioral health providers through Medicaid reform.

Implementing Bodies: DHCF and DBH

Timeline to Implementation: Short Term

DHCF needs to identify child-serving behavioral health providers with limited or no experience in the managed care market and provide them with technical assistance and onboarding support during the shift to a fully managed care Medicaid program. Below are examples of support strategies from other states that DHCF and DBH may consider to support reform implementation efforts:

- Virginia's multiphased training strategy in which experts trained and provided feedback to behavioral health providers and administrators in new curricula associated with reform efforts, who then trained providers in each of the state's major regions.[262] Trained providers were positioned as "regional champions" and offered guidance and support to providers in their region who were unfamiliar with the new curricula.[262]

- Texas's behavioral health carve-in preparation strategy in which the state required MCOs to pass a readiness review to demonstrate capacity for providing relevant services.[55]

- New York's strategy in which the Office of Addiction Services and Supports and Office of Mental Health contracted the Managed Care Technical Assistance Center of New York (MCTAC) and Community Technical Assistance Center of New York (CTAC) to provide ongoing training and technical

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[xix] *CPR² provides tools and strategies to help improve participants' capacity to manage stress, burnout and to promote self-care. The program utilizes a pre- and post-test design and begins by assessing participants' stressors and goals. CPR² consists of biweekly, small-group, evidence-based activities designed to enhance skills-building, resilience, and social cohesion. Sessions include mindfulness practices, mood ratings, psychoeducational modules, and reflective journaling. See Newsletter December 2019; Early Childhood Innovation Network; 2019.*

assistance to providers.[263] The co-director of CTAC/MCTAC summarized the organization's role as "a bridge between system transformation and clinical or practice transformation."[263]

6. Implement strategies and incentives to improve distribution of children's behavioral health providers.

Implementing Bodies: DHCF, DBH, DC Council, DC Health

Timeline to Implementation: Long Term

Distributing the full range of child behavioral health providers across the entire District will maximize resources. Psychiatrists and psychologists can be reserved for patients with more intense behavioral health needs, at a costlier reimbursement rate, if an adequate supply of social workers, peer support workers, and other behavioral health providers are available for patients with less intense need. But a deficit of providers in any provider category can affect the optimal service delivery of all. Recommended strategies to improve the distribution of children's behavioral health providers include:

- **Increase funding and promote the District's Health Professional Loan Repayment Program** to expand the reach of children's behavioral health providers in underserved areas. Increased loan repayment can support the recruitment and retention of primary and specialty behavioral health providers as well as nonclinical staff in HPSAs and medically underserved areas, such as Anacostia. Emerging evidence demonstrates that scholarship and loan repayment programs are effective in achieving long-term retention of participants in the communities in which they serve.

- **Recognize and pay behavioral health organizations as teaching clinics.** Treat behavioral health provider organizations that hire recent graduates and provide clinical supervision similarly to reimbursement provided to hospitals and FQHCs for their roles in educating the health care workforce. See community-based training as human capital investment, even when there is turnover as people achieve higher levels of independent practice and licensure.

7. Enable integration of peer specialists, community health workers, and other nontraditional behavioral health professionals across settings.

Implementing Bodies: DHCF, DBH, CSAs, MCOs

Timeline to Implementation: Short to Medium Term

The District has provided strong leadership regarding integration of peer (adult and youth) specialists into MHRS settings through training, certification, and Medicaid reimbursement. Now is the time to advance the next-generation behavioral health workforce by robustly incorporating nonlicensed workforce extenders, including paraprofessionals, peers, navigators, and CHWs into primary care, specialty behavioral health care, early learning, and other community-based settings. Peer-operated centers, family-run organizations, and other natural and informal supports must be recognized for the vital contributions they already make to the lives of District residents with behavioral health conditions and turned to as the necessary complement that they already are to the behavioral health workforce continuum. This type of integration requires adequate reimbursement, compensation, and training/education for this workforce. Integration bolsters accessibility through a team-based approach that includes the individuals whom many community members contact first and trust the most.

More specific examples of integration strategies are:

- Provide ongoing training and refreshers to clinicians and supervisors on the role of paraprofessionals (peers, CHWs, etc.) on the team to help bridge the gap between clinicians and nonclinicians. Provide cross-trainings with both clinicians and paraprofessionals. It is important to build trust and relationships between team members and address stigma regarding staff with lived experience. Such training should promote the sharing of client information between peer and nonpeer staff, as well as cooperative service planning.[264]

- Work with peer specialists to develop clearly defined roles and scope of work on the team that allows them to incorporate their lived and cultural experiences, such as peer specialists providing training to nonpeer team members on issues of recovery, trauma-informed care, advocacy, wellness promotion, etc.[265]

- Ensure strong training opportunities are available for individuals interested in becoming peer specialists, as well as ongoing professional development and training opportunities for current peer specialists. While the role of a peer specialist will differ across settings and teams, a District-wide set of minimum-identified competencies may be beneficial for peer specialists. It is important for such competencies to balance the preservation of peers' unique strengths and technical proficiency.[266]

- Introduce billable mechanisms and funding that is integrated into department budgets to promote the availability and use of natural supports for children who are experiencing acute or chronic behavioral health issues, as well as behavioral health crises.

- Allow sufficient Medicaid billing for the wide range of peer support services. As the government continues to explore avenues for compensating peer specialists, we emphasize the need for Medicaid reimbursable mechanisms.

8. Support engagement and recruitment of youth peer behavioral health specialists.

Implementing Bodies: DHCF, DBH,
Timeline to Implementation: Short Term

A peer specialist specifically for youth may help be a bridge between children and behavioral health providers (such as therapists, psychiatrists, etc.) as well as a bridge between children and parents/caregivers. In that manner, youth peer specialists can build children's trust toward the behavioral health system and their own support network, which may ultimately increase retention in care and improve outcomes. Youth peer specialists are different from adult peer specialists in that they have lived experiences in the child behavioral health system and often in the adult system, which helps them to better support children and youth.[267] Youth peer specialists may be particularly helpful for special populations such as transition-age youth and children who identify as LGBTQAI+.
While DBH does offer a youth peer specialist certification, there are not enough youth becoming certified. Recommendations to increase engagement and recruitment of youth peer behavioral health specialists include:

- Increase awareness and promote DBH youth peer certification opportunities on platforms and in settings that youth mostly frequent, such as social media and in schools.

- Ensure that the peer certification process and exam is accessible and easy for residents. This includes taking into consideration literacy, having someone to guide youth through the process, offering multiple pathways to becoming certified, and opportunities to retake the exam without additional costs.

- Maintain virtual training to improve accessibility. However, in-person trainings should also be offered to accommodate those without reliable access to the internet and technology.

According to Youth MOVE National,[268] —a youth and young adult-led advocacy organization focused on elevating youth and young adult voices, developing national peer standards, and providing technical assistance to states who want to provide peer support— states need to consider the workforce environment and implement youth engagement strategies.[267]

- It is important to develop a continuum of youth engagement activities for youth and young adults with lived experience to create a base of youth and transition-age youth who are prepared to join the youth peer workforce.[267] Youth engagement opportunities can include advisory groups, advocacy groups, informal youth peer support groups, youth summer internships and mentoring programs, and other opportunities to incorporate the youth voice in communities. That also helps to develop youth leadership and advocacy skills.

- Provider organizations and agencies must consider workplace culture through implementing policies and practices that support and welcome youth peer specialists.[267] That includes building trust; placing value on youth-driven care, lived experience, and youth voice; and understanding that for many youth peers, this is their first entry into the workforce and many are still in active recovery. Examples include providing ongoing education opportunities, internal supervision, mentorship, and help for youth peers to develop self-care plans and receive counseling to support retention.

9. Incorporate best practices to improve the trauma-informed care and trauma responsive interventions among providers.

Implementing Bodies: DHCF, DBH, CFSA, CSAs, MCOs
Timeline to Implementation: Long Term

DBH should take the lead in convening a District-wide trauma-informed task force, composed of all the relevant health agencies, along with Justice, Police, Education, Housing, Human Services, and other public serving components of the administration. Community organizations that touch the District population directly or indirectly should also be full members of this collaborative work. The Johnson City Model of Trauma Informed Care offers a successful example of community-wide partnership and evidence-based trauma-informed care at a system level.[269] That includes the training of health professionals at all levels, other community-facing public servants, and even private businesses so that they may better understand the trauma in the lives of their workforce and create more resilient workplaces.

Consequently, all partners in a District-wide trauma-informed task force must then make training and best-practice solutions available to their workforce to apply in their practices. Trauma-informed care is most effective when it is applied across the entire spectrum of population services.[270]

10. Create and maintain a database to inform behavioral health workforce planning.

Implementing Bodies: DBH, DC Health, DHCF
Timeline to Implementation: Short Term

Data collection on the behavioral health workforce in the District should be regular and complete, capturing at least the minimum data set identified by the University of Michigan Behavioral Health Workforce Research Center, summarized in *Table 6.B.*[228] DBH and DC Health should collaboratively establish a data collection approach that could include an annual behavioral health workforce needs assessment along with ongoing data collection during the licensure process. Assessing the current workforce makeup is necessary to assess the gap between current and target workforce levels. Only then can the District make appropriate resource allocations for recruitment, retention, and appropriate distribution of behavioral health providers across the District.

11. Mandate uniform credentialing requirements and a quicker credentialing turnaround time for all MCOs.

Implementing Bodies: DHCF
Timeline to Implementation: Short Term

To make it easier for child-serving providers to join MCO networks, DHCF should require uniform credentialing requirements for all MCOs. As part of that requirement, all MCOs should be required to accept DBH certification as meeting MCO standards and credential DBH-certified behavioral health provider organizations and FQHCs at the organizational level (rather than at the individual staff level). There needs to be a consistent process for determining which organizations are paneled and credentialed through group practice standards and facility standards. Whether or not MCOs are required to credential at the organization or individual level, DHCF should require electronic exchange of provider organization staff records using standardized processes, forms, and formats to be adopted by all MCOs. We support use of Council for Affordable Quality Healthcare as a centralized platform for paneling or credentialing by all MCOs contracted with DHCF.

In addition to standardizing the credentialing requirements and process, we also recommend amending MCO contracts such that credentialing must be completed within 45 to 60 days upon the MCO's receipt of all required documents.

Taking those steps will reduce barriers to joining the MCO networks and support the building of an adequate network of child-serving providers.

12. Allow supervised practice for people seeking initial licensure waiting to complete national exams or waiting for application approval or denial, and allow provisional practice for people licensed in other jurisdictions while waiting for district license application approval or denial.

Implementing Bodies: DC Health Professional Licensing Boards
Timeline to Implementation: Short Term

The District's health professional licensing boards should, by default, allow people seeking initial licensure 120 days from the date of submitting a complete application to work under supervised practice while waiting to complete and pass any required national exam. In the event that a candidate for licensure fails a national exam on their first attempt, boards should, by default, allow at least 90 additional days of supervised practice authorization to make a second attempt and successfully pass the exam.

Implementing supervision for yet-unlicensed recent social work graduates benefits the students, patients, and behavioral health agencies. Recent graduates receive valuable on-the-job mentoring, supervision, and ongoing training. Additionally, allowing new graduates to practice and learn while studying for and saving for their exam can have an equitable impact across the profession. Simultaneously, graduates bring new research and fresh experience to agencies attained in their own education. Patients and the community benefit from the expanded workforce, which increases access to critical behavioral health services and the ability to expand additional programming. That is particularly important because increasing rates of behavioral health diagnoses and lingering effects of traumas including COVID-19 and systemic racism all lend to increased need in the District in the coming months and years. Additionally, the District's health professional licensing boards should, by default, allow people who hold a license in another jurisdiction a provisional right to practice for 120 days while waiting for District license application approval or denial. In the event an applicant is found to have some deficiency meeting District licensing standards, the applicant should be allowed to continue provisional practice for a time period the board believes is reasonable to ameliorate the deficiency, so long as the applicant otherwise remains in good standing with the relevant District board and remains in good standing with the other jurisdiction where the applicant is licensed.

The District's health professionals deliver care within a regional market encompassing the District, Maryland, and Virginia, and the District attracts residents from across the country. With significant expansion of telehealth within behavioral health since the onset of COVID-19 and related national competition to attract people to the District's behavioral health workforce, it is even more important that applicants who hold licenses elsewhere, after applying for District licensure, can begin to practice as soon as possible once hired while giving the licensing board time to complete any application review that it requires.

For the District's behavioral health services reimbursed by Medicaid, the importance of expediting entry to professional practice for those needing professional licenses for the first time or from other jurisdictions cannot be understated. Permission for supervised or provisional licensure is a necessary first step, short of receipt of an issued license, to begin paneling, credentialing, and other activities that link professional care to Medicaid billing and reimbursement for treating District Medicaid beneficiaries.

7. INFORMATION & COMMUNICATION

According to the WHO (2010), "sound and reliable information is the foundation of decision-making across all health system building blocks. It is essential for health system policy development and implementation, governance and regulation, health research, human resources development, health education and training, service delivery and financing."

The information and communication system for a behavioral health system is complex because it requires the collection, transference, and dissemination of different types of information, occurring at different levels, to meet a wide variety of objectives, including individual patient treatment, resource management at health facilities, public health surveillance, health communication, and policy guidance.

Given the growing role that technology plays in information collection/transference/dissemination, there is substantial overlap between Chapter 7 and Chapter 8. This chapter focuses on a broad understanding of information flow and related policies within the behavioral health system for children in DC, while Chapter 8 focuses on the technology used for communication and information-sharing.

7.1 Vision for the System

A **strong behavioral health information system** (BHIS) should connect all relevant partners to ensure that health information users (including health care providers, patients, policymakers, community members, researchers, etc.) have appropriate and timely access to valid, reliable, permissible, understandable, and comparative data.[2] A Health Information Exchange (HIE), which will be discussed in Chapter 8, typically refers to a type of technology that supports the exchange of information and can be seen as critical to a BHIS. A BHIS should support all other building blocks of the behavioral health system for children in DC, because it should have the capacity to collect, store, analyze, and disseminate different types of information (refer to *Table 7.A*) that can be used in:
- Behavioral health service delivery;
- Behavioral health care coordination;
- Behavioral health system policy development and implementation;
- Governance and regulation;
- Behavioral health research;
- Behavioral health human resources development;
- Financing for the behavioral health system; and
- Behavioral health education and training

Policymakers should prioritize implementing a strong information system because it has the potential to reduce health care costs and improve behavioral health outcomes for children.[271] Additionally, a behavioral health information system is a key component for monitoring and promoting **equity**, because it should capture and disseminate critical data, such as service coverage, service use, and health outcomes stratified by sex, race, ethnicity, socioeconomic status, and geographical location.

Table 7.A. Types of Information from Different Levels that Should Be Captured by a Health Information System (HIS)

Health planners and decision-makers require many **different kinds of information**, including:	A HIS should have the capacity to handle **data from different levels of the behavioral health system**, including:
Inputs to the behavioral health system and related processes (policy and organization, health infrastructure, facilities and equipment, costs, human and financial resources)	**Individual-level data** about the patient's profile, behavioral health care needs and treatment, which serve as the basis for clinical decision-making.
Behavioral health determinants (socioeconomic, environmental, and genetic factors) and the contextual environments within which the health system operates	**Health facility-level data** from facility-level records and administrative sources, which enable health care managers to determine resource needs, guide procurement decisions, and develop community outreach. High-quality data from health facilities can also provide immediate and ongoing information relevant to public health decision-making,
Performance or outputs of the behavioral health system (availability, accessibility, quality and use of health information and services, responsiveness of the system to user needs, and financial risk protection)	**Population-level data** are essential for public health decision-making and generate information not only about those who use the services but also, crucially, about those who do not use them.
Behavioral health outcomes (mortality, morbidity, disease outbreaks, health status, disability and wellbeing)	
Adapted from: WHO (2008)	*Adapted from: WHO (2008)*

Successful BHIS implementation is complex and relies on a combination of organizational, technological, and human factors.[272] *Table 7.B* highlights key organizational and human factors that should be present to implement a strong HIS, while *Table 8.A.* (see Chapter 8) highlights the key technical factors that should be present. A successful HIS also requires comprehensive, ongoing evaluation. Overall, an effective BHIS should contain or facilitate the HIS components listed in *Table 7A, 7B,* and *8A.* It should have centralized databases, standardized processes and quality assurance procedures.[273]

Table 7.B Characteristics of Successful HIS Implementation Adapted from Sligo et al., 2017

Organizational Factors	Human Factors
• Visionary leadership of the organization and implementation process	• Perception of the benefits of the HIS by end users
• Communication between levels of the organization and between management, clinicians, and information staff	• Dedicated effort to foster high levels of trust and early engagement with end users
• Central and local government support	• Sufficient time for well-resourced training and testing
• Clear management and governance structures, task orientated structures, and minimal staff turnover	• Ensure public information is easy to access and understand
• Adequate funding to purchase and implement the HIS	

Information Flow From Government Agencies to the Public

Messaging and information from government agencies should be clear in their delivery across all platforms, updated regularly to ensure accurate information at all times, and be user-friendly. Further, given that District residents may enter behavioral health services through several different agencies, it is important that all information sharing from government agencies contain clear and consistent messaging across agency platforms to ensure an any-right-door policy.

Effective government communication is an important tool for eliciting public support for behavioral health initiatives and building trust through increased transparency. Research suggests that distribution of credible information motivates observable behavioral changes within social networks.[274] Quality public messaging, including behavioral health awareness campaigns, is a particularly important link in the personal health education chain, with research showing health and economic benefits from mental health campaigns.[275,276] Public and private stakeholder input is critical in developing and sustaining effective public messaging. Key components of a children's mental health awareness campaign in Maryland are highlighted below.

A Maryland Public Awareness Campaign: Children's Mental Health Matters!

The Children's Mental Health Matters! Campaign has been ongoing for more than 20 years, with the goals of raising public awareness of the importance of children's mental health and substance use; helping reduce the stigma of mental health; and connecting families, educators, and providers throughout Maryland with resources to help children. The campaign is led by two nonprofits, with several government agencies as partners. The following are some activities that the campaign implements to achieve its goals:

- **School Champions:** Maryland schools can sign up to become a School Champion and will receive mental health support resources (including morning announcements, ready-to-go content for social media and publications, and student activities).
- **Community Champions:** Maryland organizations can sign up to be Community Champions that commit to raising awareness through events, education, and advocacy.
- **Resource kits:** These are available for parents, educators, and students.
- **Social media presence:** Through Facebook, Instagram, and Twitter accounts, the campaign shares mental health information and resources.
- **Book club:** This includes conversation prompts to help adults, children, and youth have meaningful conversations about the content presented each month.

According to the campaign's 2021 Wrap-Up Report, over 270,000 students in Maryland were supported through campaign resources.[277] For 2021, there were 472 school champions and 169 community champions. Based on a survey of 2021 champions, nine out of 10 respondents were satisfied or very satisfied with the campaign results.

User-friendly government websites can also be an important avenue for sharing timely information with the public. One exemplary government behavioral health website is HealthyMindsPhilly.org, developed by Philadelphia's Department of Behavioral Health and Intellectual Disabilities Services (DBHIDS), which educates the public and provides screening tools, as well as shares information on crisis services, other behavioral health services, and social support services.[278] According to the website, it is "an online tool and resource designed to support and improve the mental health and well-being of all Philadelphians" and it was "intended to look and feel different than traditional government sites."[279]

Information Flow From Service Providers to the Public

Effective information-sharing and communication from service providers to the community increases patient-centered care and shared decision-making and improves patient satisfaction. Communication from service providers to the public should align with principles outlined in *Table* 5.A. (i.e., family-driven, family-centered, youth-guided, cultural attunement, trauma-informed, racial equity). To ensure alignment with those principles, community

members should be involved in the process of deciding what information is shared and how it is communicated to their broader community.

Service organizations should ensure information is clear, concise, easily understandable, and accessible, taking into consideration what platform or tool is best to use and format and whether information is needed in multiple languages. There are a number of platforms and tools that providers can use to share information and communicate effectively with their consumers, including information technology, social media, service provider webpages, mobile devices, etc.

When sharing information via websites, the WHO suggests that organizations design compatible content, which means ensuring webpages work on multiple platforms and browsers; can be adequately displayed on different types of devices (e.g., smartphones, tablets, laptops, etc.); and takes into consideration file sizes for users with slow internet connection or low bandwidth.[281] When utilizing various information technology platforms or mobile devices, service providers must ensure compliance with HIPAA laws and state privacy laws and use appropriate safety measures when communicating electronically, particularly for unencrypted forms of communication (i.e., typical emails and text messaging).[279] An example of effective information sharing through the use of information technology is allowing consumers access to their EHRs and health data, which strengthens consumers' ability to be an active voice in their care and make informed clinical decisions.[283] The use of EHRs and other health technologies will be explored further in Chapter 8 of this report.

Information Flow Among MCOs, Service Providers, and Government Agencies

Clear, consistent communication among government agencies, MCOs, and providers is necessary for the optimal functioning of the behavioral health system. Government agencies should prioritize provider and MCO engagement to guide initial decision-making and continually optimize implementation of best practices. In that regard, government agencies should offer technical support to service providers, with the opportunity for feedback, especially during any behavioral health reform efforts, to promote a shared understanding.

Intermediaries between government agencies and service providers can be important for facilitating communication. For example, Philadelphia's DBHIDS established an EBP coordinating body to serve as a government/provider intermediary during its behavioral health system reform efforts.[284] EBP coordinators provided technical and financial support resourced by DBHIDS to providers to promote EBP implementation.[284]

Building trustworthy data-sharing tools and issuing specific guidance about the nature of collaboration and data-sharing expected from providers also fosters information-sharing between governing agencies and providers.[285] Guidance offered to providers should include information about the provider's role in data sharing, a clear definition of the relevant public health problem(s) to be addressed, and the impact of data sharing on service delivery and service users.[286] Further, clearly defining who has access to which data under federal and local health information privacy laws and regulations can help to avoid confusion that may unnecessarily impede data sharing.[287]
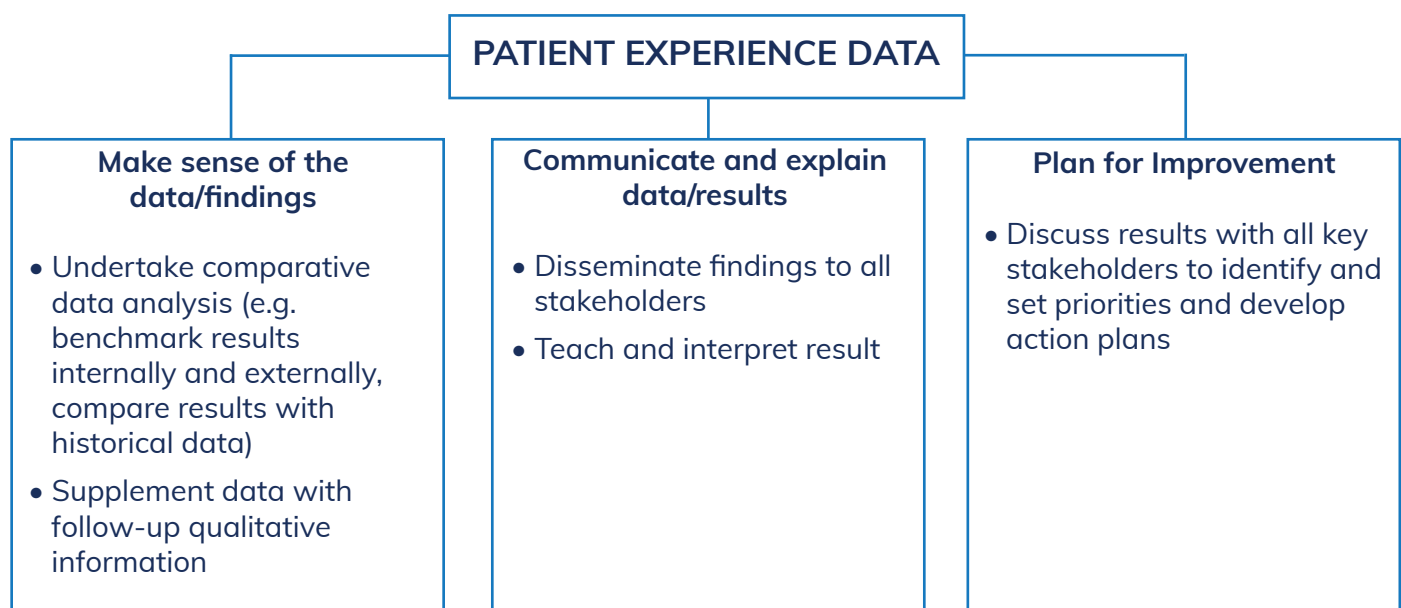
Feedback From the Public to Government Agencies, MCOs, and Service Providers

Communication from the public to service providers, MCOs, and/or government agencies is critical for iterative improvements toward an efficient, effective behavioral health system. An ideal behavioral health system should include routine formal measurement of customer satisfaction that is used to inform provider feedback and technical assistance. Further, patients who provide meaningful input through specific feedback and engagement efforts should be compensated for their time and efforts.

On a related note, CMS has issued a final rule for states to implement a quality rating system (QRS) for Medicaid and CHIP (42 CFR § 438.334), though states do not have to comply with that requirement until CMS finalizes and releases specific guidance. As of February 2021, 13 states currently have a rating system, of which patient experience can be one measure.[288] The primary goal of a QRS is to help inform beneficiaries of MCO products, and a secondary goal is to improve health plan performance, including financial incentives such as bonuses and auto assignment for enrollees not selecting a specific plan. This customer satisfaction data should also be directly incorporated into MCO-required Quality Improvement Plans and inform agencies' technical assistance to providers and MCOs to improve customer satisfaction.[216]

Once feedback is collected, it is critical that it is used to inform health care decisions. In that regard, *Figure 7.C* presents a framework that documents steps to be taken when using such data through three overarching processes.[289]

Figure 7.C. A Framework for Understanding and Using Patient Experience Data to Improve Health Care Quality

PATIENT EXPERIENCE DATA

Make sense of the data/findings	Communicate and explain data/results	Plan for Improvement
• Undertake comparative data analysis (e.g. benchmark results internally and externally, compare results with historical data) • Supplement data with follow-up qualitative information	• Disseminate findings to all stakeholders • Teach and interpret result	• Discuss results with all key stakeholders to identify and set priorities and develop action plans

Kumah E, Osei-Kesse F, and Anaba C. Understanding and Using Patient Experience Feedback to Improve Health Care Quality: Systematic Review and Framework Development. *Journal of Patient-Centered Research and Reviews*, 2017;4(1):24-31.

Finally, it should be noted that eliciting retrospective feedback from the community is not a substitute for proactively engaging community stakeholders in decision-making processes. Section 3.1 describes our vision for meaningful engagement with community stakeholders at the leadership level in more detail.

7.2 Current System

The District has made significant strides in its health information system. In 2018, DHCF developed a five-year roadmap called the *State Medicaid Health IT Plan for 2018-2023* in fulfillment of a requirement by the Centers for Medicare and Medicaid Services.[290] That plan outlines the following four priority areas for better connecting residents and providers with health information: supporting transitions of care; collecting and making effective use of social determinants of health data; providing analytics for population health; and leveraging HIE for public health.

Figure 7.D. highlights three main groups of entities that information moves between in the behavioral health system for children in DC, along with examples of the media and facilitating bodies that transfer information between the entities. *Figure 7.D.* is not comprehensive but is meant to provide a snapshot of some media and facilitating bodies for information transfer between and within entities. Also, it should be noted that while it appears that there are existing routes for the flow of information between all types of entities, some of those routes do not exist for all organizations within an entity type. For example, all service providers do not use an electronic health record system that facilitates the flow of patient data to government agencies. The limitations of those "information routes" are explained in subsequent paragraphs.

Figure 7.D. Information Flow in DC's Current Behavioral Health System for Children

Electronic health records
Meetings, Shared datasets, Emails

Government agencies
involved in providing behavioral
health services to children

Ombudsman Offices
Consumer satisfaction survey
Testifying to DC Council
Public meetings

Electronic health records
Data reports
DHCF Provider Portal
Meetings, Emails

Agency Websites
DHCF Provider Portal
Provider Notices
Meetings, Emails

MCO websites
Individual consultations
Social media
Public Meetings
Mail, Email, Text

Agency websites
Social media
Public reports
Public meetings
Mail

**Managed Care Organizations
& Behavioral Health
Service Providers***

Children and families
who have public insurance
or are uninsured

MCO grievance & appeal systems
Consumer satisfaction surveys

Electronic health records
Health Information Exchange
Meetings, Emails

KEY

→ Flow of information between entities

↶ Flow of information within entities

*MCOs and service providers have some distinct communication mechanisms with government agencies and children but are grouped together in this diagram for simplicity.

From Government Agencies to the Public

There is no standard platform to communicate behavioral health information to the public. Each agency develops and maintains its own community engagement strategies, which often include both online information sources and paper-based communication. Online communication engagement requires DC residents to have access to WI-FI or broadband and a device. It also requires a level of technology literacy, such as navigating the different webpages and social media platforms.

Agency Websites: Most agencies have their own website, where they regularly post information, updates, and resources. However, those websites contain information for a variety of stakeholders and may not be easy for families and youth to navigate. According to DBH's *Open Government Report* in 2014, DBH provides timely updates to the public on its website, including information on new initiatives, descriptions of services; public events/meetings; and a twice-yearly report on service costs, utilization, and access to mental health services.[291] DBH also uses its website to post announcements regarding contract opportunities and funding availability for grant initiatives. Additionally, DBH is required to respond to Freedom of Information Act (FOIA) requests and uses the FOIAXpress software to process FOIA requests and share information.

Several agencies collectively maintain the DC Support Link website, which serves as a behavioral health resource link, where individuals can connect to supports and services in the District. Additionally, DBH maintains the DrugFreeYouthDC website to provide information and resources to youth and families in all eight wards on drug prevention. DC also has an open data webpage called Open Data DC to promote data transparency and accountability. The webpage includes different story maps, data sets, and web maps for use by agencies and the public, but it is difficult to navigate.

Social Media Engagement: In terms of public communication, several agencies use social media platforms (including Facebook and Twitter) to share information with DC residents. For example, OSSE, DBH, and DHCF all have Facebook pages. The deputy mayor for Health and Human Services, the mayor, DBH, and DC Council regularly provide updates via Twitter.

Public Hearings: Agencies also provide the public with information regarding performance each year. That information is provided to the DC Council and then posted on the DC Council website for the public to access. However, there are sometimes delays with the provision of this information on the DC Council's website.

From the Public to Government Agencies and Service Providers

Currently, there is no systematic or standard way for families and youth to give feedback on their experiences with accessing and utilizing behavioral health services in the District or to provide input for service planning.

Feedback on Behavioral Health Services

Provider organizations and managed care organizations have different methods for collecting feedback directly from consumers. AmeriHealth implements one-week follow-up pulse surveys via text message (with questions such as "How long did you have to wait for a visit?" or "Are you satisfied with the visit?") as a tool for beneficiaries to give feedback. MCOs collect patient satisfaction and experience data (qualitative and qualitative) using various processes. MCOs currently use the Agency for Healthcare Research and Quality (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS). That survey collects data from consumers on their experiences with receiving services (i.e., in-person care or telehealth) or related to specific conditions.[292] Additionally, in accordance with 42 C.F.R. § 438.400, each MCO has its own grievance and appeal system for consumers. Further information on feedback on behavioral health services can be found in Section 5.2.

With respect to DBH programs and services, certain consumers may also have the opportunity to provide feedback through DBH's annual consumer satisfaction surveys conducted through the Consumer and Family Affairs Administration. Additionally, the DBH Ombudsman Office is intended to serve as a neutral and confidential

intermediary to support District residents who use DBH programs or services or work with its certified providers. Residents can file a complaint (informal process) with the DBH Ombudsman Office or a grievance (a formal written process established by federal and District law) with the Consumer and Family Affairs Administration.[293] Similarly, DHCF has the Office of the Health Care Ombudsman and Bill of Rights, which consumers can contact to file complaints about their health plan or provider.[294] The Office of the Health Care Ombudsman and Bill of Rights acts as a neutral body that can assist with resolving problems concerning health care bills, health coverage, and access to health care.

DC residents are also given the opportunity to provide testimony to the DC Council regarding their experiences with the different agencies, but that requires some procedural knowledge and available time to deliver testimony during regular business hours.

From Service Providers to the Public

There are a number of ways in which service providers communicate information to the public. One obvious method is direct communication to their patients and families. Another method is posting updates on their webpages. There are several guides service providers put together to help families navigate and access resources. For example, Resilient Communities DC, funded by DC Health, contains information for Wards 7 and 8 on resources available in their communities related to a variety of areas, such as mental and physical health, housing, food, child care, as well as information and resources related to COVID-19.[295] Another example includes the DC Health Check Child and Adolescent Mental Health Resource Guide (maintained by DC MAP) in which individuals can look up mental health resources by location and insurance type.[296] Individuals can also search for resources (e.g., social services) by type of resource and zip code using the Aunt Bertha Connect or UniteUS tools, in which service providers (e.g., community based organizations, nonprofits, hospital providers, etc.) provide information.[297]

Between Service Providers and/or Government Agencies

Information relevant to the behavioral health of children in DC is shared between service providers and/or government agencies through multiple mechanisms, such as electronic health records and other Health IT. Please see the technology section for more information.

Privacy Laws

There are different rules in DC for behavioral health information that are stricter than HIPAA. The District Mental Health Information Act places some limits on sharing mental health information that are more stringent than HIPAA for District providers, though these restrictions have been significantly reduced through a series of amendments in recent years.

Additionally, 42 CFR Part 2 governs substance use treatment, and it is separate from and more stringent than HIPAA, and DC cannot make any changes to federal law. That helps to protect individuals from discrimination and stigma but also hinders providers in knowing who is in substance use treatment. DHCF has secured CMS matching funding to contract for CRISP DC to develop a consent management solution to document when an individual has granted permission to disclose or redisclose information about their participation in substance use treatment, consistent with 42 CFR Part 2, which may help more provider organizations to adopt use of HIE or to share instead of simply receiving information. This e-consent procedure also enables providers in the SUD system of care to see information from physical health providers and for physical health providers to see select substance use treatment data.

A comparison of DC's current BHIS to our vision for the BHIS highlights several key gaps that are discussed below.

1. Insufficient leadership support and investment for the district's behavioral health information and communication systems

The District has shown some leadership support for behavioral health information and communication systems, as reflected by the dedicated information technology units led by Chief Information Officers within both DBH and DHCF, as well as the *State Medicaid Health IT Plan for 2018–2023*. The many challenges with the information system specifically for behavioral health for children reveal inadequate investment from leaders of the public behavioral health system in DC. Government agencies have not exhibited or facilitated the organizational factors listed in *Table 7.A* for successful implementation of a well-functioning BHIS.[298] Further, there has been insufficient oversight to ensure that each organization involved in collecting, analyzing, storing, and/or disseminating information has the necessary financial and human resources.

2. Lack of standardized data collection methods and reporting standards leading to inadequate and poor-quality data for providers and government agencies

There is no one standard method or metrics used to collect and/or report on several types of information that are critical for the effective planning of the behavioral health system for children. That includes data on the active behavioral health workforce, service usage/health outcomes data stratified by sex, race, socioeconomic status, ethnic group, geographical location, etc. Although behavioral health providers are collecting some of that information, it is not aggregated or analyzed in a way that makes it readily useful for the public, policymakers, providers, and others to make better clinical care, health systems, or policy decisions. Furthermore, it is difficult to track or navigate real-time availability of services and where to access specific services.

3. No well-known, user-friendly, public platform to communicate behavioral health information for children

While government agencies generally maintain their own websites and social media accounts, they are often difficult to navigate because the published information targets a variety of stakeholders. The DC Support Link website was created as a centralized "information hub" for accessing information on behavioral health resources, but it is not user-friendly, especially for adolescent users. Further, through our family engagement efforts, children were unable to point to specific places to access information about behavioral health services, with some dubiously stating that school or online may have information about services. That suggests that even though there are multiple sites with information on behavioral health resources, the sites are not well-known.

4. Lack of public awareness on child behavioral health services and issues

Our recently conducted focus groups also revealed that both youth and parents are lacking information not only about the availability and quality of behavioral health services for children in DC but also behavioral health disorders. Most children felt they were uninformed or underinformed about available services. Some parents/ caregivers felt that children were not sufficiently educated about behavioral health, including the issues that they can face and healthy coping strategies. That was supported by one child who stated, "a lot of people are experiencing mental health and not seeking help because … they don't know that they're going through a mental health episode." Overall, these findings suggest that current methods of communication to the public from both government agencies and service provider organizations are not effective and/or sufficient.

5. Insufficient engagement of community organizations in behavioral health communication for families

Government agencies, MCOs, and behavioral health service providers do not maximally engage with natural community intermediaries on their potential role as communicators of behavioral health information and resources to families. Community centers, recreation centers, family-run organizations, family support groups, family success centers, faith-based institutions, family strengthening collaboratives, and public libraries interact with DC families regularly and may even be the first point of contact when children experience behavioral health issues. Thus, these organizations are poised to share accurate information on the public behavioral health services in DC to connect children to care. However, some community organizations have expressed that current resources dedicated to maximizing their involvement in behavioral health communications are insufficient and/or not sustained.

7.4 Recommendations

1. Develop transparent privacy and confidentiality policies and data-sharing agreements among agencies to support information sharing among providers, MCOs, and government agencies.

Implementing Bodies: DHCF, DBH, HIE Policy Board, CRISP DC, MCOs
Timeline to Implementation: Long Term

One strategy within the District's *State Medicaid Health IT Plan for 2018–2023* that should be prioritized to enhance information sharing and communication is the development of "transparent policies that align with privacy and security best practices and undergo review on an ongoing basis." DHCF, DBH, the HIE Policy Board, CRISP DC, different provider types (including behavioral health providers), and MCOs should work together to develop clear regulations and guidance on patient data (including behavioral health data) that can or cannot be shared, the level/types of data each can have access to, and how the data can be used. In particular, to improve information sharing from behavioral health providers, clear guidance and exchange policies around behavioral health data sharing will need to be implemented. That will require updates to the District's privacy laws and standardization across different organizations on interpretation of HIPAA. It will also require education to residents, providers, and payers once guidance has been developed. Further, DHCF and CRISP are in the midst of a project to build consent management options into the District's designated HIE, which will require additional education and technical assistance.[xx] Finally, we acknowledge the need for data sharing among agencies' information systems (such as CFSA and ICH information systems), however this recommendation also has technological implications, which are explored in detail in Chapter 8.

2. Develop a surveillance system for population-level behavioral health data and behavioral health services data for children.

Implementing Bodies: DBH, DHCF, DC Health, MCOs
Timeline to Implementation: Long Term

Such a surveillance system is needed for transparency and accountability and to support research and planning by all. The surveillance system should facilitate routine, ethically sound data collection in the District on the behavioral health issues affecting children, as well as on behavioral health service delivery. It is important for community members to be meaningfully involved in the development of the data collection process to ensure that these processes are respectful and reflective of the community's needs. This system can provide local measurements of prevalence, incidence, severity, risk factors, social determinants, functional outcomes, and access to care,[62] with data disaggregated by race, ethnicity, age, and geographic location as appropriate. At a minimum, data should be routinely collected on key indicators and case definitions for surveilling substance abuse and mental health that were identified by the Council of State and Territorial Epidemiologists' Workgroup for Substance Abuse and Mental Health Surveillance.[299]

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xx *Please see Chapter 8, Recommendations 1 and 2 for further details.*

There should be adequate capacity for data collection, analysis, and dissemination to establish regular standardized reporting to all relevant stakeholders.[62] Over time, this data should become the evidence informing benchmarks/standards for behavioral health services for children and guiding clinical practices. While data sources for this surveillance system can include the biennial data from the Youth Risk Behavior Surveillance System and data from appropriate indicators monitored through the DC Healthy People framework, additional sources need to be identified and/or created. The DC Health Information Exchange should be used to the greatest extent possible as a single, shared data reference source and should become a source of information for collaborative learning and system analysis and planning. This surveillance system should include a public repository for appropriate population-level data to facilitate transparency and encourage data-driven decision-making throughout the District.

3. Require uniform standards for data collection and minimal standards for reporting.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Short Term

DHCF should require MCOs to adopt uniform standards for data requests and provide a standard format and process of data collection to be used by all MCOs and providers. Behavioral health data collection within the MCOs must be able to represent the unique issues and metrics of the specific behavioral health patient population, as well as work toward a greater understanding of publicly insured populations under an integrated managed care system. The data reported by MCOs should include metrics specifically targeting children and families, including dollars per child spent on behavioral health services and service utilization rates for children. Additionally, data should be stratified by sex, race, age, socioeconomic status, and geographical location, when possible. Public reporting about collected metrics should be frequent enough—perhaps quarterly—for DHCF, MCOs, provider organizations, and members of the public to call for a change of course if performance appears to be falling short. To ensure closed loop communication and transparency with the public on how the data collected is used, such as with beneficiary experience surveys (e.g., CAHPS), data should be regularly published and shared back with beneficiaries. Further, government agencies, MCOs, and behavioral health providers must ensure equitable access to this information, particularly for those who do not have sufficient access to technology.

4. Develop and periodically update a comprehensive behavioral health awareness strategy for children and families in DC, with leadership from DC youth and families.

Implementing Bodies: CBOs, DHCF, DBH, DC Health, OSSE, DCPS
Timeline to Implementation: Short Term

To lead this endeavor, we recommend establishing a multisectoral workgroup specifically concentrated on information and communications issues related to children's behavioral health. Members of this workgroup must include relevant CBOs, government agencies, specialists in health communication/health education, service providers, and parents/caregivers and youth who can reflect real health literacy needs of the community.

An annual children's behavioral health campaign can address gaps in public awareness regarding the availability of behavioral health services for children in the District, including a variety of nongovernmental messengers with

the appropriate training and sustained resources to share this information and how to access these services. Such a campaign can also aim to increase behavioral health literacy, especially around behavioral health problems and their treatments, among parents/caregivers and youth. Any information provided needs to be updated regularly to ensure accuracy and, thereby, build trust.

This campaign should target parents/caregivers, educators, and youth separately and must involve multiple types of communication media (written and electronic) in different settings (schools, health care facilities, recreation centers, church groups, libraries, and communities). Maryland's Children's Mental Health Matters! Campaign highlighted in Section 7.1 provides some examples of how to implement a District-wide behavioral health campaign across community and school settings. It is critical for DC families and youth to be leaders in the development of this campaign to ensure the most appropriate communication tools and media are used. Additionally, development must also include individuals who speak languages other than English to assure the campaign is accessible and reaches a broader audience

This campaign must be consistent and recognizable across platforms, both public and private, throughout the District. In this regard, we recommend creating a dedicated website for children's behavioral health, which can have a URL related to the campaign's slogan to improve ease of recall. An excellent example is Philadelphia's Healthy Minds Website, which was highlighted in Section 7.1. In addition to this recommended website, all relevant DBH, DHCF, DOH, and other government websites should be coordinated and updated so that they relay consistent, clear, accessible, easily understood messages and provide user-friendly links to helpful sources where patients and families can take action or find providers and other helpful resources.

8. TECHNOLOGY

For this report, "technology" refers to the application of organized knowledge and skills in the form of devices, medicines, procedures, and systems developed to solve a behavioral health problem and improve quality of lives (WHO, 2008).

Technology has become a fundamental part of delivering behavioral health services, especially during the COVID-19 pandemic where a greater emphasis has been placed on telehealth services. Technology not only supports telehealth, but it also impacts the ways in which behavioral health information and data are stored, viewed, and shared by service providers, government agencies, and the public.

8.1 Vision for the System

Proper use of technology in the behavioral health system for children in DC can have several benefits, including a reduction in administrative burden for providers, better care coordination for families, and more timely service delivery for children. In light of such benefits, our vision for the behavioral health system for children in DC includes maximal use of technology, where appropriate, in a manner that respects privacy and confidentiality of patients and adheres to the guiding values outlined in Chapter 1.

The following paragraphs discuss our vision for four areas of technology that are particularly relevant for children's behavioral health. More generally, some key technological factors that should be present to implement a strong behavioral health information system are highlighted below.

Table 8.A Characteristics of Successful Health Information System Implementation
(Adapted from Sligo et al., 2017)

Technological Factors
• Existing information, communications and technology infrastructure must be able to assimilate the new system.
• Good "fit" between the needs of the users and the technology before, during, and after HIS implementation, which is balanced against the requirement for interoperability
• Adequate design, testing, prototypes and the ability to adapt the technology as required
• HIS should be easy to use, clear and understandable, easy to learn to operate, flexible, have easy navigation with easy-to-remember tasks, easily customized, have quality interface design, and require little training.

Health Information Exchange/Health Information Technology

Health Information Exchange (HIE) is beneficial in that it improves data sharing across systems and helps to reduce fragmentation of information and communication. It improves the flow of information and communication among residents, service providers, payers, and public health agencies. Overall benefits for HIE include improved patient-centered care, improved transitions of care and care coordination, reduced health care costs, improved ability to access and analyze valuable clinical data, reduction or elimination of duplicative or unnecessary procedures or tests, improved

patient monitoring and disease management, greater access to population health, etc.[300]

The goal of implementing a comprehensive HIE/Health Information Technology (HIT) system is to achieve full interoperability, which is the capacity to send and receive meaningful health information from multiple sources between different systems and locations.[283]

> **HIE is the electronic movement of health-related information among organizations according to nationally recognized standards.**
>
> **Source: National Alliance for Health Information Technology (2008)**

Types of Information Needed to Support an Interoperable HIS

- **Individual longitudinal health data:** An individual's complete health record, including both provider-generated (e.g., medical visit records) and person-generated (e.g., wellness, fitness and socioeconomic) data

- **Within episodes of care:** Data from medical devices, labs, billing, EHRs and quality reporting

- **Between care settings:** Episode of care data that seamlessly moves from one care setting to another (e.g., from hospital A to hospital B or from a hospital to a post-acute care provider)

- **Marketplace:** Population health and research data that enables: 1) a feedback loop to providers, helping them deliver improved, personalized care; and 2) marketplace innovation

Source: Sharing Data, Saving Lives: The Hospital Agenda for Interoperability; American Hospital Association; 2019

Behavioral Health and HIE/HIT

The exchange of health information and data is vital in enhancing behavioral health care, especially as the behavioral health care landscape moves toward greater integration with primary care and other health settings. Behavioral health providers should have access to comprehensive clinical information across medical and behavioral health care to be able to understand the whole person, increase bidirectional exchange between physical and behavioral health care teams, and improve ability to address co-occurring physical and behavioral health conditions.[301] That includes access to visit notes, discharge summaries, notifications of encounters outside their practice setting, and medication history (e.g., compliance, prescriptions, pharmacy contact information, etc.).

One such method of increasing HIE and HIT for behavioral health providers is through the increased adoption of certified EHRs, which is discussed in greater detail in the next section. Additionally, one literature review found that the highest use of HIS occurred at sites that incorporated workflow in the design of the HIE and identified proxy users.[302] Proxy users could include nurses, social workers, peer support workers, and other provider types. Increased participation of HIE among behavioral health organizations requires provider buy-in and engagement, increased technical assistance, education and outreach, and financial incentives to buy necessary data systems and technology.

According to SAMHSA and the Office of the National Coordinator (ONC) for HIT, critical HIT components to support behavioral health include consent management, such as data segmentation for privacy[xxi] and privacy management, medication management, clinical decision support (integrating behavioral health screening and assessment tools with behavioral health treatment planning), system access controls (managing data access rights), and secure communication tools that facilitate direct exchange.[303] SAMHSA developed a free, open source tool to integrate with EHR and HIE systems to help facilitate data segmentation and consent management called *Consent2Share* (C2S).[304] C2S was designed to be in compliance with federal and state privacy laws including 42 CFR Part 2, which helps to support the exchange of sensitive behavioral health information. It has two major components: Patient Consent Management, "a front-end, patient-facing user interface which allows patients to define their privacy policy and provide informed consent," and Access Control Services, "a backend control system designed to integrate with

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[xxi] *Data segmentation for privacy is: "the process of sequestering from capture, access or view certain data elements that are perceived by a legal entity, institution, organization, or individual as being undesirable to share." See Find Resource for Behavioral Health IT; Health IT Playbook; The Office of the National Coordinator for Health Information Technology; 2018*

EHRs and HIESs and provide privacy policy configuration, management, decision making and policy enforcement."[304] In addition to behavioral health privacy laws, HIE/HIT must also consider privacy and data-sharing laws specific to children and youth and should include child and youth providers in developing and testing technologies.[298]

Two examples of states that have increased use of an HIE for behavioral health include Arizona and New York which are discussed further below.

Strong HIE Adoption by Behavioral Health Providers in Arizona and New York

Arizona developed an HIE system specific to behavioral health care called the **Behavioral Health Information Network of Arizona (BHINAZ)**, sponsored by seven nonprofit behavioral health organizations. The BHINAZ system collects, stores, and shares data from a wide range of behavioral health service providers, including substance abuse programs, crisis professionals, general mental health practitioners, and children's behavioral health specialists, in three separate repositories for clinical data, documents, and patient consent.[305] Although the behavioral health network is a separate HIE system, it connects to that of the state's physical health care HIE system, which does not collect data related to 42 CFR Part 2, to allow for bidirectional exchange between physical and behavioral health data that can be shared. The BHINAZ system was designed to take into account behavioral health privacy laws by developing a secure method for collecting consent within the BHINAZ's EHR system that allows patients to opt in to the HIE for 365 days or until they turn 18. The BHINAZ network also developed an education program for providers, which included materials on how to gain patient buy-in and permission; the importance, benefits, and how to use it for both the patient and provider; privacy and security measures taken; etc. To ensure that providers would not only participate in the BHINAZ system but also use it, the BHINAZ network provided assistance on how to embed the behavioral health HIE system into existing organizations/provider workflow to make the system a part of daily practice, as well as partnering with providers to pilot different aspects such as how the data is structured, interfaced, and used.

The **Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)** is a HIE system developed by the New York State Office of Mental Health (OMH), which uses HIPAA-compliant web applications to allow for sharing Medicaid billing claims and encounter data and state health administrative data.[306] Data is gathered from New York state psychiatric center health information database; OMH Child and Adult Integrated Reporting System (CAIRS) database; Assisted Outpatient Treatment database; Department of Health Health Home and Care Management database; and from data entered by providers on screening and assessments, safety plans, etc. Evaluation of the PSYCKES program revealed a resulting 30% reduction in quality concerns and $2.9 million in pharmacy cost savings.[306] To facilitate implementation of the PSYCKES, the New York State OMH developed a variety of training materials, including short how-to videos, user guides, regularly updated guidance, and webinars. Those training materials include information such as enabling access to client-level data, using the system in a clinical setting, etc. The OMH also implemented a Quality Improvement Collaborative focused on supporting best practices.

Electronic Health Record (EHR) Systems

EHRs are an important part of a strong BHIS. As highlighted by the Agency of Healthcare Research and Quality, EHRs for children require special considerations because this population has unique health care needs and requires interoperable exchange of data.[307] As such, data within an EHR system for children and adolescents should be exchangeable across sectors and settings, including primary care, child welfare, school, and behavioral health systems. The evidence base widely supports integrated EHR as an effective tool for promoting care coordination and collaboration between physical and behavioral health providers.[308,179] To facilitate such integration efforts, relevant government agencies should have

> *An EHR refers to health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.*
>
> **Source: National Alliance for Health Information Technology (2008)**

consultations with a variety of health professionals, including child behavioral health professionals, to understand and address concerns, such as differences in information-sharing procedures and differences in confidentiality standards across disciplines.

Collection of data through EHR should be used to inform clinical decision-making.[308] It is important for data collected to include sex, race, age, socioeconomic status, and geographical location, when possible, to allow for stratification by subpopulations as this facilitates rapid identification of health disparities.[179] Additionally, EHRs should provide accurate billing code guidance as this can reduce administrative burden.

Further, EHR measures should directly capture patient health outcomes and treatment process fidelity measures to assess treatment quality.[180] Treatment process fidelity measures monitor the extent to which providers are following treatment protocols, which may prove useful in issuing provider feedback as well as differentiating between patient outcomes attributed to provider error and those determined by the protocol itself. An example of successful leveraging of EHR data for quality improvement is that of the New York City Regional Electronic Adoption Center for Health (NYC REACH) program, which developed one-page dashboards issuing provider feedback regarding EHR use and clinical quality outcomes.[309] Providers using the dashboard have consistently reported that it is helpful in assessing their EHRs.[309]

Given that costs related to EHR system purchase, installation, and training are the primary barrier to EHR uptake for behavioral health providers, especially in small practices,[310] EHR system implementation efforts should include technical assistance that reduces installation and training costs for providers. In addition, clinical training programs should be modified to meet real-world computer literacy demands elicited by EHR systems.[311] Training should also teach providers how to incorporate EHR into daily workflows to maximize care quality, for example, by engaging clients through screen-sharing while taking notes, using EHR information to facilitate conversations about treatment adherence, or generating graphs to evaluate treatment progress.[311]

Telehealth

A strong telehealth system should be user-friendly, minimize barriers to health care access, and ensure the same level of patient confidentiality as in-person health care services. To maximize telehealth's potential to increase value in health care, its design should be patient-centered, allowing patients to view, share, and upload records while assisting providers in managing information and relationships with service consumers.[312] Telehealth platforms should also allow the addition of natural supports to the health care visit as appropriate to facilitate care management and coordination.[312] Further, telehealth systems should allow similar functions as an in-person visit, where possible, including registration, diagnostics, therapy, and care coordination as necessary at a low cost.[312] While telehealth

> *Telehealth is defined as the delivery and facilitation of health and health-related services including medical care, provider and patient education, health information services, and self-care via telecommunications and digital communication technologies.*
>
> **Source: NEJM Catalyst (2018)**

should increase the convenience and timeliness of services, quality must not be sacrificed, because it should also remain based upon scientific knowledge and as effective as in-person care.[312] In that regard, the organizational structures and procedures necessary for effective and sustained telehealth delivery should be established, including mechanisms for quality monitoring.

An effective telehealth system should also take into account the inequitable access to digital resources, such as reliable internet access, that persists across socioeconomic divides.[313] Given the consequences of unreliable broadband access on remote education and telehealth resources during the COVID-19 pandemic, states have taken various measures to use 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act funding to invest in an accessible broadband structure.[314] For example, Missouri used $5.25 million to purchase hotspots for FQHCs and Community Mental Health

Centers, specifically for the purpose of improving access to telehealth. Vermont contributed $17.4 million to build the necessary infrastructure to connect private residences and businesses to high-speed internet and has created a temporary subsidy program to help qualifying households to pay for internet services.

Mobile Health (mHealth)

Given the ubiquity of smartphones, especially among younger generations, behavioral health care providers and health system administrators should maximize use of mobile health (mHealth) technology as appropriate for service delivery, education, and administrative functions. The benefits of mHealth extend beyond the patient-provider interaction, allowing for portability and flexible features that can be personalized to the condition and circumstances. mHealth is also a platform to address inequity in behavioral health care, since location and accessibility to providers are not primarily relevant in mobile health.[315] It is a great way to increase access to services among under-resourced populations, reduce costs, and improve patient experience.[316] As a complement to therapeutic interventions and medication, it is a relatively inexpensive component, costing only the expense of apps and provider interactions, if warranted.

> **Mobile health, or mHealth, refers to the use of smartphones, tablets, and other mobile and wireless devices in both public health and health care.**
>
> Source: mHealth and FDA Guidance; Health Affairs; 2013

mHealth tools are valuable at all stages of behavioral health care, can be one-directional or two-way, and can be self-managed or professionally linked. At the initiation of care or as an introduction to behavioral health services, mHealth can increase comfort in an anonymous or semi-anonymous setting and alleviate stigma by offering gentle introductions to behavioral health service objectives. Web-assisted therapy, support and information in between therapy sessions, web-assisted self-help, and real-time survey completion and biometric data are all beneficial tools to patients in treatment. In fact, researchers have found that app-based homework and Ecological Momentary Assessment (an updated version of the personal diary) activities have better participation rates than pen-and-paper homework for younger patients,[317] given their reliance and ease of use of smartphones and technology. Biometric sensors available through smartphones and wearable sensors allow for tracking, diagnosis, and management of various physiological conditions. In particular, electrodermal metrics and heart rate variability allow for the data collection on rates of stress and anxiety; the opportunity to better manage mental health conditions are welcome advances that result in improved well-being and quality of life.[318] mHealth tools, such as text messaging support, can even benefit patients and providers as treatment comes to a close, improving long-term outcomes and maintaining gains.[319]

mHealth also holds an opportunity for optimizing a value-based payment system of behavioral health managed care. Whereas traditional fee-for-service behavioral health and physical health are built upon reactive, symptom-based care, mHealth utilizes monitoring of health habits, biometrics, and other symptoms in real time that can be reviewed, analyzed, and applied to treatment to improve outcomes, reduce negative consequences, and benefit well-being.[320] Regulatory frameworks must be able to preserve patient-provider communication security, without compromising access.

Text-Based Behavioral Health

A form of mhealth is text-based behavioral health, which refers to the use of a mobile device to exchange text messages with a behavioral health provider.[321] Examples include Talkspace and Sanvello.[321] Given the popularity of text messaging as a mode of communication, especially among youth, text-based behavioral health holds great potential to increase the accessibility of behavioral health services to young people. Text-based behavioral health services have consistently shown therapeutic benefits for a wide range of behavioral health diagnoses.[322,323] A review of mobile mental health studies showed that text messaging was used in a wide range of mental health situations, notably substance abuse (31%), schizophrenia (22%), and affective disorders (17%). Text messages were used in four ways—reminders (14%), information (17%), supportive messages (42%), and self-monitoring procedures (42%)—and in combination.[324] However, given that texting is a relatively new medium of therapy and that there are unique risks for confidentiality breaches inherent to mobile-based therapy platforms, establishing clear guidelines and regulations is particularly important.

Health Information Exchange/ Health Information Technology [325]

DHCF leads the state's health IT policy and strategies in collaboration with several organizations. The DC HIE, which is governed by DHCF under DCMR 8701.2, is a system of HIE entities that provides tools and collates information from multiple sources to support secure electronic exchange of health information. HIE organizations are not required to participate in the DC HIE, but if they choose to, they can participate as either:

1. Registered HIE entities, which are organizations that demonstrate that they meet or exceed core minimum privacy, security, and access requirements for health information exchange identified by DHCF and District stakeholders in the DC HIE Rule; or

2. Designated HIE Entities, which is an organization that applies and is selected to support the development and maintenance of HIE services among the District Registered HIE entities and participating organizations in the District.[326]

Chesapeake Regional Information System for our Patients (CRISP) DC is the District's designated HIE, which works with the DC government and providers to implement HIE services such as:

- **Encounter Notification Service (ENS):** This tool sends real-time alerts to providers when their patients are admitted or discharged from the hospital. It can be tailored to the provider organizations.

- **Patient Care Snapshot and Query Portal:** This tool provides health information such as a patient's recent visits, procedures, and medications, in addition to a detailed list of organizations, providers, and care managers who have an existing relationship with the patient. The portal allows for providers to access more in-depth clinical information on their patients from across institutions.

- **eCQM Tool and Dashboard:** This is an electronic clinical quality measurement tool and dashboard for assessing performance against key measures. It allows providers to calculate and report clinical quality measures (CQMs).

There are different levels of uptake of the CRISP HIE among service providers in DC. Some providers upload their panel and can see data that is being received but are not sending data from their own health records. There are also progressive levels of full data sharing. Most organizations are not sharing mental health clinical data, but some are. DHCF and CRISP track progress of District-wide HIE adoption and use through development of an interactive tool. Currently, the tracker includes licensed clinical social workers but does not list other behavioral health provider types. However, according to an October 2020 report, Enlightened Inc., which provides technical assistance to organizations on HIE, was working with 42 behavioral health organizations, 31 of which are participating with CRISP and can view data, and five of the 31 can send and share clinical data.[327] Currently, when a patient is discharged from the hospital, CRISP is used to send real-time notification to the next care provider, and the hospital sends more detailed transitions of care information several days to a few weeks later.[109]

Electronic Health Record Systems

There are a number of different tools and EHRs that health care providers in the District currently use. EHR adoption in the District increased significantly after the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. As of 2018, 89% of District physicians and every District acute care hospital, FQHC, and long-term care facility utilize EHRs. However, the number of different EHR systems in use makes it difficult to share information across the behavioral health care system and results in redundancies. Behavioral health provider organizations were not included in the eligibility for HITECH financial support to adopt or expand use of EHRs, which has delayed mental health and addiction treatment provider adoption of EHRs, especially Certified EHR Technology (CEHRT) that meets national standards for data exchange interoperability.

Each government agency involved in the provision of behavioral health services to children uses its own information systems (and therefore requires regular interagency meetings and communication to coordinate care across agencies).[187] For example, CFSA stores data from behavioral health assessments in its data management system, FACES, while DBH uses several different EHR systems. Saint Elizabeths Hospital uses Avatar as the EHR system. DBH uses Incedo as its medical billing software from which some patient data can be extracted. Additionally, DBH uses the Integrated Care Application Management System (iCAMS) and the District Automated Treatment Accounting System Web Infrastructure Technology System (DATA WITS) as its EHR systems for mental health services and substance use services, respectively.[66] Currently, most DBH mental health provider organizations use iCAMS. DBH configured iCAMS so it receives files from Partially Integrated Providers, which allows the aggregation of data from external sources. Partially integrated provider organizations use their own EHR systems and send data to iCAMS. Furthermore, many community-based provider organizations and FQHCs use a different EHR system called EClinicalWorks (eCW). When looking at the number of consumers served, most consumers are serviced by organizations that use private EHRs. Unlike iCAMS, eCW is configurable at the provider level, because each organization owns their own license.

One specific example of the use of iCAMS by DBH staff co-located at CFSA is to connect children directly with DBH Core Service Agency (CSA).[187] There have been several challenges with the iCAMS system since its introduction. Some provider organizations experience difficulties with iCAMS's limited functioning capabilities that do not allow providers to customize iCAMS for their own organizational needs. That is challenging because some provider organizations do not have the ability to buy their own EHR system because it is not built into their costs or rate setting. They also do not always have the staff to do their own data analytics or systems work. Current behavioral health data exchange between providers occurs manually, often via fax.[328]

Data Warehouse

This is the ability to aggregate data from multiple data sources including from EHR and financial systems. At a systems level, the District does not currently have the transparency to understand how behavioral health is operating. The current process for populating the data warehouse is insufficient. This is a challenge across multiple agencies (DBH, DC Health, DHCF).

Community Resource Information Exchange (CoRIE)[329]

The District of Columbia is in the process of implementing the CoRIE project to increase capabilities of the DC HIE. It is a joint project between the DHCF, the DC Primary Care Association (DCPCA), the DC Hospital Association (DCHA), and CRISP DC. The project aims to streamline social determinants of health data sharing in a standardized format to allow for a more consistent way for data to be shared between health and social service providers and systems. The project would integrate existing technological systems used by CBOs, as well as standardized SDOH screening tools and referral processes used by health care providers and MCOs. This system would close the communication loop between health care providers and CBOs and help to ensure follow up with patients through patient alerts.

Certified EHR Technology

On a federal level, EHR standards have been established and enforced through the ONC Health IT Certification Program, established under authority granted by the Public Health Service Act (PHSA).[330] CEHRT requirements have been used for a number of federal EHR use and interoperability incentive programs, including Promoting Interoperability Programs (PIP).[330] DC currently participates in PIP, for which use of CEHRT is a condition that providers must fulfill to receive incentives. However, the final year for program participation is 2021. The ONC's 2021 Open Notes rule will update and expand the operating standards and data-sharing requirements for EHRs to become or remain ONC Certified.

Telehealth

Due to the COVID-19 pandemic, the District has made significant progress in advancing telehealth delivery and guidance during this past year. Many of the telehealth regulations that were relaxed during the public health emergency were made permanent through DHCF rulemaking, and the FY21 Budget Support Act made updates to the

DC Code of Law (See DC Code of Law 29 DCMR § 910). Some changes include allowing reimbursement for services when the individual receiving care is in the community and not in a health care facility and allowing reimbursement for audio telehealth. With the increase in telehealth use, the District must ensure families are provided with additional support to access cellphones with talk and data plans, Wi-Fi in homes, and internet broadband service capable of delivering tele-video for telehealth services. MCOs are also responsible for ensuring reimbursement of telehealth services as written in their contracts: "Telemedicine C.5.28.33.1 The Contractor shall cover and reimburse healthcare services delivered through Telemedicine, in accordance with 29 DCMR § 910." Before the COVID-19 pandemic, the District supported telehealth reimbursement practices, having passed the D.C. Telehealth Reimbursement Act of 2013, which requires Medicaid to "cover and reimburse for healthcare services appropriately delivered through telehealth if the same services would be covered when delivered in person."[331]

mHealth

Currently, the use of mHealth applications and tools in the District of Columbia are not widespread and not reimbursed or a part of the Medicaid fee schedule. The use of those types of technologies for behavioral health is relatively new in the District. For example, AmeriHealth Caritas DC, an MCO contracted in the District, partnered with Mindright to provide text-based coaching to youth ages 13–25, particularly youth with Medicaid and/or impacted by trauma. Mindright is a low-barrier access point to engage youth in emotional support services. The service was formally rolled out with enrollees in July 2021 but was piloted with AmeriHealth's youth wellness advisory council pre-pandemic with overall positive feedback. Because coaching is not a Medicaid reimbursable service, AmeriHealth provides this service as a value-added benefit to its enrollees. Youth using Mindright, have access to coaches (supervised by licensed clinicians) via text anytime they like to discuss support strategies related to topics such as managing stress and depression. Coaches are able to connect youth with AmeriHealth's care coordination team if clinical services are needed and are able to escalate to school-based mental health providers and ChAMPs when necessary. AmeriHealth has also recently partnered with Ginger[332] to provide on-demand mental health support to its enrollees.[333] Ginger offers text based coaching as well as mindfulness, counseling, and psychiatric services via telehealth. The telehealth services offered are Medicaid reimbursable, and AmeriHealth covers the coaching as value added services for its enrollees.

Additionally, the District has made progress in the use of mHealth for pregnant and new mothers. The DHCF partnered with text4baby, in which expectant or new mothers can register to receive free text messages with information about caring for their babies' and their own health.[334] AmeriHealth Caritas DC has also partnered with Babyscripts (also partners with George Washington University and MedStar Washington Hospital Center OB practices) to provide a remote monitoring maternal health care app to its pregnant enrollees.[335] The digital tool recently added a maternal mental health component to its app that provides depression screenings and perinatal health resources. Improvement on health outcomes is measured by using the HEDIS measures. Mayor Bowser also recently announced, during the fourth annual National Maternal and Infant Health Summit, a partnership with Canopie to provide free access to its research-based maternal mental health program and app focused on prevention and treatment of perinatal mood and anxiety disorders.[336] Further, a comprehensive study of Wyoming Medicaid's Due Date Plus app used by enrolled pregnant women estimated a 3:1 return on investment (ROI) based on cost avoidance. Benefits of participation included earlier initiation of prenatal visits and fewer preterm births.[337] Preterm births are correlated to a host of physical, behavioral, and intellectual complications throughout childhood and into adulthood, so reducing preterm births has widespread health and economic consequences.

Last, to advance the use of mHealth technologies in the District, the George Washington University established an mHealth Collaborative, an interdisciplinary group that has received grants from government, industry, and private foundations to develop and test mobile health applications for improving health.[338]

8.3 Gap Analysis

1. Different data systems with functional limitations

In stakeholder interviews, behavioral health providers reported challenges with current behavioral health data exchange, including exchanging data manually through fax.[325] They also reported that data is often stored across multiple systems, including iCAMS and DataWITS, which do not offer data sharing capabilities.[325] The District does not have a true BHIS because behavioral health information processing is fragmented, with different health care organizations and government agencies using different information systems. That produces multiple, parallel information streams for specific facilities and populations that are not integrated. The issue of integration is especially challenging for many behavioral health providers who are not using certified EHRs.

2. Insufficient adoption of the District's HIE and EHRs by behavioral health providers

There is insufficient uptake among behavioral health providers in participating in the District's HIE system, CRISP DC. The National Council's Behavioral Health Organizations' Adoption of Health IT and Readiness for Meaningful Use survey explored reasons for low adoption rates of EHRs by behavioral health providers.[339] Providers' two main reasons were lack of financial incentives and lack of trained health IT staff. That was particularly true for smaller behavioral health provider organizations that shared concerns around administrative burden and lacking the resources to implement and maintain an EHR system. Another concern expressed was the need for specific technical assistance that addresses behavioral health providers' needs and incorporates use of EHR into practice.[339] Additionally, MACPAC's report Integrating *Clinical Care through Greater Use of EHRs for Behavioral Health* outlines similar barriers to adopting CEHRT among behavioral health providers, such as the lack of guidance/assistance on which EHR product to purchase that will best meet the needs of their behavioral health practice and costs related to purchasing and installing the system and training staff.[337]

3. The District's HIE functionalities do not fully align with behavioral health providers' and agencies' needs

The following outlines key missing functionalities in CRISP, the District's HIE:

- **Privacy and data-sharing laws:** Federal law and regulations limit the exchange of behavioral health data/information without a patient's express consent. Additionally, 42 CFR Part 2 rule limits/prohibits the sharing of substance use information. Current HIE and EHR systems in the District were not designed with security components for handling confidential behavioral health information and would need an explicit behavioral health consent form built into the system for patients to either opt in or out of sharing their behavioral health information, as well as data segmentation, which enables the patient to choose which information can be shared. Although CRISP gives patients the ability to opt out of sharing their behavioral health information, it does not yet allow data segmentation, in which patients can choose specific information to share. Therefore, if a patient does choose to opt out, none of their health information will be shared. CRISP does not accept or share any SUD information and also currently lacks the capabilities to electronically capture and manage the necessary written consents.[341] However, DHCF and CRISP are in the midst of a project to build consent management technology into CRISP to overcome this barrier.

- **Care coordination, social determinants of health, and social services:** CRISP does not support care coordination between behavioral health providers, CBOs, social service organizations, and physical care providers. To facilitate greater care coordination using Health IT, CRISP needs to include a standard system to facilitate referrals between multiple entities in which the patient receives services. The CoRIE project mentioned in the Current System section of this chapter is currently working on streamlining social determinants of health data sharing and integrating CBOs' data collection systems into CRISP, but it still needs to develop the functionality that would allow for use of SDOH and behavioral health screening results to connect with CBOs.

- **Population health data analytics:** There is a separate set of software tools that reconfigure data out of EHR and claims data to help people understand how the individuals enrolled in their practice are collectively experiencing their health services and care (for example, how to understand chronic disease management and current acute-level situations). There is currently very little available to all District provider organizations that work for behavioral health at a population and systems level.

4. Inadequate District-specific research and guidance on mHealth in behavioral health care

While apps and other mobile technology is plentiful, little to no connection has been made to formalize mHealth within the District's health system as a formal aspect of behavioral health care. Organizations, such as AmeriHealth Caritas DC, have begun to implement use of digital tools for behavioral health that serve as a low-barrier access point to resources and coaching (i.e., Mindright and Ginger mentioned in Section 8.2) that can increase engagement and utilization of behavioral health services. However, those opportunities are early in their implementation and strategies to increase buy-in among enrollees, and providers are essential for scalability. Further, many of the services, such as coaching, are not currently Medicaid reimbursable.

The District could encourage more research into mHealth best practices that parallels this growing field. While mobile apps have multiplied immensely and cellphone use among the general population and adolescents especially has become almost universal, quality research of mobile apps and other mHealth tools is severely lacking.[315] Seeing as mobile technology is not bound by District boundaries, this gap is not unique to DC but is relevant to the utilization of any tools in a clinical setting or with quality metrics of an MCO. As the District explores avenues for growth in mHealth, there will be a need to update relevant policies and financing structures. There is no ability to bill for mHealth services outside of telehealth.

5. Disparities in access to broadband, Wi-Fi, and mobile devices affect sustainable access to telebehavioral health

While DC has made great progress in closing the digital divide[342] through initiatives such as DC-Net, DC Broadband Education Training and Adoption,[343] and Tech Together,[344] critical gaps remain. In particular, a great deal of progress that the District has made in promoting digital access has been accomplished through temporary federal funding.[343] Given the time-limited nature of this funding, the long-term future of the District's digital infrastructure is prone to falling into the longstanding pattern of digital disparities fostered by systemic inequities. More generally, there is a dearth of published literature on the factors enabling digital disparities in DC and potential mechanisms for reducing them.

Of note, the digital divide was exposed and exacerbated during the COVID-19 pandemic,[345] prompting the District's more recent attempts to reduce disparities in access to the internet and technology. One such initiative is Internet for All for DC students, which provides eligible children access to one year of free at-home internet and is dependent on funding from the CARES Act. According to the American Community Survey 2019 one-year estimates, approximately 7.6% of DC households did not have an internet subscription.[346] While one-year of internet will be beneficial to many children, it does not represent a sustainable solution for telehealth access.

6. Limitations on telebehavioral health created by licensure requirements

One of telebehavioral health's most impactful benefits is the ability to connect people with behavioral health providers at a distance. However, federal and state licensing laws may limit the geographic scope of telebehavioral health by only allowing patients access to providers who have a current license in the jurisdiction where they reside.[xxii] However, the COVID-19 pandemic brought the need for both more behavioral health services and for people to be able to access them in a safe manner to avoid exposure to the coronavirus. That required federal and

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state governments to take actions to allow for this necessary expansion, which included waiving the previously stringent licensing requirements to allow providers to treat people remotely in other states.

During the public health emergency in the District, DC Health waived the licensure requirement for health care providers who held an appropriate license in good standing in another jurisdiction.[347] This allowed providers licensed elsewhere to connect with District residents even if the provider was not licensed in Washington, DC. It allowed the reach of telebehavioral health to grow and become more accessible for District residents. Now that the public health emergency has ended in the District, the licensing waiver has expired.[xxiii] However, the DC Council is looking to take legislative action that may extend the period of licensing.[348] That could impact many providers' ability to continue to provide the virtual services that they have been delivering for the past year due to needing to be licensed within the District. That also puts the continuum of people's behavioral health care at risk, as well as future access to more expansive and accessible telebehavioral health services.

7. Timely access to discharge summary information within CRISP is insufficient to meet District residents' needs

Currently, the time it takes for providers to receive detailed discharge information from hospitals through the EHR is insufficient to meet District residents' needs.[109] This process is often too slow, taking anywhere from a few days (on average five days) up to a month.[109] The HIE Policy Board, CRISP Inc., DC Hospital Association, hospital providers, and DHCF are currently working to address this gap through potential improvements to clinical and technical workflows. According to findings submitted by the HIE Policy Board Operations, Compliance, and Efficiency (OCE) subcommittee from an analysis conducted in October 2019, only about half of discharge summaries were submitted through CRISP within 48 hours, and discharge summaries are not always complete.[349] The time it takes for community-based behavioral health providers or other health professionals involved in a patient's care to receive critical information regarding discharge can delay timely access to follow-up care as well as impact care coordination and effective transition of care planning.

The HIE Policy Board OCE Subcommittee found that the main reason for the delay in discharge information being shared with CRISP is that hospital providers, due to national standards, have up to 30 days to finalize and sign encounter notes.[350] However, through the Promoting Interoperability program, CMS requires patients to have access to their electronic health information via a patient portal within two business days of discharge; therefore, unfinalized data is already being shared.[350] Further, CRISP policies do not currently allow for the exchange of unfinalized summaries.[350]

8.4 Recommendations

1. Implement strategies to improve participation and use of CRISP by behavioral health providers.

Implementing Bodies: DHCF, DBH, HIE Board, CRISP DC

Timeline to Implementation: Long Term

Strategies should include:

- **Financial incentives:** Provide financial incentives through the use of grants or other funds to support behavioral health providers adoption and use of HIE. Since behavioral health providers were left out of the CMS Meaningful Use EHR incentives, other alternative means should be developed at the state and local levels. Those could include providing grants to cover the cost of buying an EHR or establishing rate-setting methodologies that support creating a position for a dedicated IT staff person, particularly for smaller organizations.

- **Technical assistance:** Although technical assistance has been offered through Enlightened Inc., further technical assistance and education on specific behavioral health workflows and implementation should be offered to providers. Education to providers should also include development of use-case scenarios specific to behavioral health and adolescent health information.

- **Education and guidance:** Both should also be provided to patients regarding HIE, opt-in/opt-out consent options, and privacy laws and rights using clear and concise language. Similarly, primary care providers and other non-behavioral health providers should receive education on behavioral health privacy and data-sharing laws to understand what information can and cannot be shared and how to have conversations with people they serve to consent to share all, some, or none of their protected health information, with a bias toward helping people to understand the benefits of data sharing. IT vendors will also need education on privacy laws and how behavioral health data should be managed when developing tools for HIE, particularly as it relates to 42 CFR Part 2.

As DHCF and the HIE Policy Board update the State Health IT Plan for the next five years, a greater emphasis should be placed on behavioral health data sharing and technologies.

2. Develop and improve CRISP functionalities to meet the needs of behavioral health providers and relevant government agencies.

Implementing Bodies: DHCF, DBH, HIE Policy Board, CRISP DC

Timeline to Implementation: Medium Term

- **Privacy and data sharing:** Given recent changes to regulatory guidance and federal requirements, such as the open notes rule mandated by the 21st Century Cures Act and changes made to 42 CFR Part 2 regulations through the CARES Act, and as new changes occur, CRISP DC, DHCF, and the HIE Policy Board will need to continuously enhance CRISP system functions and capabilities to reflect these changes. That will require the District to update its own HIE policies as new regulatory guidance

is released. Providers will need technical assistance to update their electronic systems, workflows, and privacy notifications to adjust as each of those changes occurs. A public awareness campaign explaining the changes, including how they impact consumers; what they need to know; as well as when, how, and what consent is obtained, should also complement those changes.

- **Care coordination, social determinants of health, social services, and other organizations/public agencies:** Develop the capability of the CRISP system to integrate CBO and social service organizations' data to facilitate care coordination and decrease duplicative reporting. For example, the CRISP system should have the capabilities to allow all care team members, including paraprofessionals (e.g., peer support), to be able to view, report, and share information. When documenting, practitioners (including care coordinators, case managers, and peer navigators) should include detailed notes and information, such as services the family has already received, engagement strategies that have already been tried with the family, what has worked well, what has not worked well, barriers specific to the family, etc. Similarly, the CRISP system should be used to facilitate information and data sharing across other child-serving systems, including CFSA, DYRS, ICH, school systems, etc. That may include developing data-sharing agreements and adopting a universal consent form but will also require alignment across agencies and organizations. By integrating data and increasing information sharing across systems, this will help to bridge the gap across systems of care, reduce duplicative screenings and other procedures, and reduce administrative burden for providers by having one system to access information.

- **Population health data analytics:** For providers and government agencies, it is important for CRISP to facilitate aggregated data collection, analysis, and publication to facilitate system-level learning. Part of the steps to achieve that involves cost (e.g., developing or buying and implementing the necessary technology tools, hiring, training, and retaining staff), as well as having the workforce and policies in place to respond to the data analytics and group-level data.

3. Remove barriers and increase incentives to collect and exchange behavioral health data through EHR systems that are interoperable with CRISP.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

Interoperable patient data can streamline patients' service utilization and improve patients' experience. Given this, all EHRs used by BH providers should be interoperable with appropriate systems, especially the District's HIE. To encourage certified EHR adoption by behavioral health provider organizations, the DC government should provide financial incentives. We recommend the following EHR-related recommendations based on the findings from a national BH roundtable on *Using Information Technology to Integrate Behavioral Health and Primary Care* be considered:

- EHR systems need to be enhanced to include clinical decision support related to behavioral health, such as clinical decision support for Medicaid-assisted treatment and treatment recommendations based on screening and assessment results. Specific fields related to treatment plans, goals, and referrals should be included instead of one section for progress notes, as well as specific language and terminology related to behavioral health to support behavioral health documentation in EHRs. That may also require rebalancing expectations regarding creation of unique documentation for each person

served, which supports person-centered care versus use of standardized documentation elements consistent with evidence-based or evidence-informed standards of care.

- As of July 2021, the United States Core Data for Interoperability (USCDI) released new standards for data classes and data elements that should be included in EHR systems and the HIE, as mandated by the Cures Act. Examples include clinical notes (i.e., Consultation Note, Discharge Summary Note, History & Physical, Procedure Note, Progress Note); care team members (i.e., Care Team Member Name, Care Team Member Identifier, Care Team Member Role, Care Team Member Location, Care Team Member Telecom); goals (i.e., patient goals, SDOH goals), medications, problems (i.e., SDOH Problems/ Health Concerns, Date of Diagnosis, Date of Resolution); assessment and plan of treatment;[xxiv] etc.[351] The rule also requires patients to have direct access to their electronic health information. Behavioral health providers, primary care providers, and other providers that maintain EHRs will need to ensure compliance with this rule to increase interoperability across EHR systems, which will help to increase patient access to their digital health data as well as increase care coordination.

- Develop standards and functionality to manage referrals within EHR systems and across care settings. Examples include appointment reminder features, alerts to providers regarding missed appointments and prescriptions not refilled, scheduling real-time referral appointments, etc. The ability to assign an individual to manage follow-up for the patient should also be developed.

4. Equitable access to broadband, Wi-Fi, devices, and other components necessary for telebehavioral health use.

Implementing Bodies: DHCF, DBH, Office of the Chief Technology Officer (OCTO)

Timeline to Implementation: Long Term

While the District's efforts to make technology more accessible are important, it is essential that long-term investments are also made to address the underlying structures enabling the digital divide. Further, there are a number of often-overlooked components necessary for effective telehealth service delivery that must be addressed.

- Conduct local, community-based research that identifies the underlying mechanisms enabling persistent disparities in DC's digital access.

- Partner with libraries or community organizations to provide safe, private, and comfortable spaces for telehealth users who are experiencing homelessness, experiencing housing insecurity, or otherwise lack access to these spaces.[352]

- Partner with local technology developers to create innovative and sustainable solutions to telehealth use barriers, such as the development of low-cost broadband and Wi-Fi technology.

- Subsidize mobile device repair and trade-in programs.[353]

- Identify and encourage adoption of Culturally and Linguistically Appropriate Service Standards relative to telehealth services and provide guidance for their use.[352]

[xxiv] Includes SDOH Assessment Structured evaluation of risk (e.g., PRAPARE, Hunger Vital Sign, AHC-HRSN screening tool) for any Social Determinants of Health domain such as food, housing, or transportation security. SDOH data relate to conditions in which people live, learn, work, and play and their effects on health risks and outcomes. See United States Core Data for Interoperability; the Office of the National Coordinator for Health Information Technology; 2021

5. Provide technical assistance to the District's behavioral health providers to support the provision of ethical and high-quality telehealth services.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Short Term

With increasing use of telehealth services, the government must establish the organizational mechanisms, including technical assistance to providers, needed to sustain the delivery of high-quality, evidence-based, and equitable telehealth services. The need for technical support was highlighted in a recent study examining behavioral health provider perspectives on the use of telehealth in Michigan.[354] The study concluded that further training in service provision can improve quality of care. Another relevant study evaluated a systems-wide telehealth training for behavioral health providers, which included information on evidence-based practices, ethical factors, technology considerations, documentation processes, determining when telehealth is appropriate, and crisis management planning.[355] That research noted that behavioral health providers were interested in continued training opportunities beyond an initial telehealth training.[355] Further, considering that the use of telehealth for behavioral health services for children has therapeutic limitations and physical limitations,[356] technical assistance must include tailored support to behavioral health providers who serve children.

6. Encourage use of mHealth by behavioral health providers and MCOs.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

DHCF should consider innovative ways to expand access to Medicaid reimbursable behavioral health services through mobile technology. Those could include partnering with organizations currently piloting behavioral health digital tools in the District to examine data on cost savings and improved outcomes. DBH and DHCF should also regularly review the technological landscape, including mHealth tools, to determine what is available, applicable, and appropriate to behavioral health service delivery for children. That should also include regularly published guidance to behavioral health providers and MCOs on how to integrate mHealth into health promotion and behavioral health treatment. Providers in the District's behavioral health managed care system should permit and encourage mHealth tools using the 3 Security Rule standards as articulated by the American Psychiatric Association, employed appropriately and reasonably. They should cover administrative, physical, and technical safeguards.[357] The District or MCOs should offer regular training to providers on optimally integrating mHealth tools into their practice at the beginning, middle, and end of behavioral health care to increase utilization of this community benefit and improve patient outcomes where they can be directly applied to care.[324]

7. Expedite District licensing requirements to meet the demand for telebehavioral health.

Implementing Bodies: DC Health Professional Licensing Boards

Timeline to Implementation: Short Term

With the expansion of telebehavioral health due to the pandemic, maintaining and continuing the growth of service delivery via telehealth has necessitated changes in licensing policies to preserve the accessibility to behavioral health services that cross District borders.[358] To address the limitations created by current licensure requirements in the District, the DC health professional licensing boards could take several approaches.

First, some advocates have been pushing for states to extend pandemic rules regarding cross-state licensure. Arizona, for example, made permanent rules based on pandemic protocols that allow for out-of-state medical providers to practice telehealth for residents so long as they register with the state and their home-state licensing is in good standing.[359] Therefore, the District in line with Arizona could make the temporary COVID-19 licensure waivers permanent and allow professionals outside of the District to be able to waive in and serve District residents as long as they are in good standing in their home state.

Second, DC health professional licensing boards should also consider adopting the model of expedited endorsement.[360] That would require the licensing boards to set criteria that would allow those who qualify to receive a license to practice in the District at an accelerated rate.[360] For example, in Iowa, if a person qualifies for expedited endorsement per the set criteria, they submit fewer application items as part of the licensure process, thus allowing a more speedy acceptance to practice in Iowa.[361] The average amount of time taken to receive an Iowa license is 60–90 days.[362]

Regardless, as recommended in Chapter 6, while the DC health professional licensing boards are reviewing licenses of individuals who hold one in another jurisdiction, by default those awaiting review should be allowed a provisional right to practice for 120 days while waiting for District license application approval or denial. That will allow applicants who hold licenses elsewhere to begin practice as soon as possible while giving the licensing board time to complete any application review that it requires.

8. Ensure timely access to discharge summaries with CRISP.

Implementing Bodies: DC HIE Policy Board, CRISP DC, DC Hospital Association, Hospital Organizations

Timeline to Implementation: Short to Medium Term

To increase timely access to follow-up care and facilitate effective transition planning and care coordination, hospitals need to reduce the amount of time it takes to send a patient discharge summary from hospital EHRs to the CRISP system for next-care providers to access. The HIE Policy Board OCE Subcommittee, CRISP, DHCF, DC Hospital Association, and hospital providers have explored several strategies to standardize hospital discharge summary information and increase real time access to this information upon discharge, and are continuing to work to improve the necessary clinical and technical workflows.

The HIE Policy Board OCE Subcommittee suggested the following transition of care data elements should be prioritized for exchange in the District Designated HIE to facilitate an effective transition of care at the time of discharge: discharge diagnosis, discharge medications, reason for visit, and medication allergies.[xxv] Hospital organizations should ensure at a minimum that those data elements are made available within 48 hours of discharge, in alignment with federal guidance that requires patients to have access to their electronic health information within 48 hours of discharge. The District should adopt that new timing expectation as providers transition to the USCDI file format for this type of information.

[xxv] For additional details regarding the HIE OCE's plan for prioritizing and phasing in transition of care data elements, see Recommendation on Transition of Care Data Elements; District of Columbia Health Information Exchange Policy Board; 2020.

9. SPECIAL POPULATIONS

There are specific populations of children within the District who require special consideration and tailored behavioral health services due to social and environmental risk factors, as well as increased barriers to accessing quality care.

Each subsection of this chapter will discuss one of eight special populations of children in DC, as follows:

- 9.1 Children With or At Risk for Autism Spectrum Disorder
- 9.2 Children in Foster Care
- 9.3 Children Experiencing Homelessness
- 9.4 Children Who Identify as LGBTQIA+
- 9.5 Youth in the Juvenile Justice System
- 9.6 Transition Age Youth
- 9.7 Prenatal to Age Five
- 9.8 Children Who Speak Languages Other than English

This will be followed by a final subsection highlighting recommendations for these special populations. While these populations will be discussed separately, it is important to note that there are significant intersections among these special populations. Additionally, many special populations have complex behavioral health needs, which cross numerous agencies with separate objectives for the child or family. Therefore, developing a well-functioning system of care[xxvi] is essential to break down silos and better meet the behavioral health and related needs of children.

Although this chapter focuses on eight key subpopulations of children, it does not comprehensively capture all subpopulations of children who require special consideration. Other special populations include, but are not limited to, children who are hard of hearing, children who are not literate, children who are refugees, and children with parents/caregivers who are veterans.

9.1 Children With or At Risk for Autism Spectrum Disorder

A current landscape of behavioral health services available for children with or at risk for Autism Spectrum Disorder (ASD) is outlined in a report titled Current Landscape of Behavioral Health Services for Children with Autism Spectrum Disorder Insured by Medicaid in Washington, D.C. by the Community Mental Health CORE (Collaboration, Outreach, Research, Equity) at Children's National Hospital. Some key landscape features that were highlighted in the report are noted below.

In 2017, the Individuals with Disabilities Education Act (IDEA) estimated that the prevalence of ASD at 1.3% for youth ages 3–21 in D.C., while the National Survey of Children's Health (NSCH) estimated the figure at 2% for youth ages 3–17 in 2017 and 2018.[363] More data is needed to estimate the current prevalence of ASD in children with D.C. Medicaid.[363] In 2012, the CDC estimated that the ASD prevalence in youth covered by D.C. Medicaid was 0.65%.[363]

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xxviAccording to Painter et al. (2018), a system of care (SOC) framework provides a coordinated continuum of community-based services and supports for at-risk youth. It incorporates meaningful partnerships with youth and families and addresses individual cultural and linguistic needs through a supportive infrastructure.

Recognizing limitations of currently available data and assuming that the actual prevalence is between 0.65% and the general D.C. youth ASD prevalence reported by NSCH of 2%, we would expect that there are likely between 585 and 1,800 youth covered by D.C. Medicaid with ASD.[xxvii]

In D.C., access to ASD evaluations are critically limited by extensive wait times, delayed referral processes, insurance gaps, and low reimbursements for D.C. FFS Medicaid. According to the DC Collaborative for Mental Health in Pediatric Primary Care, the average wait time for a formal ASD diagnostic evaluation is three to 24 months.[364] However, experts recommend that the wait time between referral and ASD diagnosis remain at or below five months.[365] That is critical because early identification of ASD in children is important to ensuring improved outcomes later in life.[366] Further, barriers to accessing ABA services present one of the greatest gaps in care for children with ASD in the District, largely related to the limited number of ABA providers who accept D.C. Medicaid.

To create a pathway to care within the school setting, D.C.'s Office of the State Superintendent of Education (OSSE) administers Strong Start, Early Stages, and special education and related services within public schools. Strong Start provides evaluations for developmental delays and implements early intervention services for children 0–3 years old. Early Stages provides Individualized Education Program (IEP), special education, and related services as needed for children ages 3–5. The public school system continues IEP and special education services for children with ASD throughout grade school.

Through a recently approved demonstration program ("Behavioral Health Transformation" section 1115(a) Medicaid demonstration), the District received authority to provide new behavioral health services and enroll specific professionally licensed individuals to be reimbursed by the Medicaid program between January 1, 2020, and December 31, 2024. The waiver left an unchanged current policy relative to ASD services, due to explicit language in the District's 1115 waiver that states, "services associated with screening or treatment of Autism Spectrum disorders by these behavioral health care providers is not included."[367] However, the District is taking initial steps to address that through the Neurobehavioral Health Program Enhancements, included in DHCF's fiscal year 2022 budget. That enhancement will allow licensed practitioners to bill Medicaid's FFS program independently for providing neurobehavioral health-related procedures.

Additionally, to address the barriers highlighted above, particularly the need for a public-private District task force for ASD, the DC Autism Collaborative (DC-AC) was launched in summer 2020. The DC-AC is a multidisciplinary, public-private coalition of community organizations and District-wide convening groups, local government agencies, health care professionals, health insurance plans, advocacy organizations, and parents to strategically address barriers to ASD care and advocate for solutions that will increase early and equitable access to high-quality ASD diagnosis, treatment, and coordinated care. Based on a needs assessment survey conducted in early fall 2020, four subgroups were created (Policy; Developmental Monitoring, Screening, and Evaluation; Education, Outreach, and Engagement; and Early Childhood Transition Points). While the DC-AC addresses the need for a District-wide task force, it currently relies on philanthropic funding and therefore will need more sustainable funding mechanisms to continue.

9.2 Children in Foster Care

According to the American Academy of Pediatrics, behavioral health is the largest unmet health need for children and youth in foster care nationally.[368] That is due to a variety of reasons, such as experiencing ongoing and complex trauma; lack of stable presence of—or relationship with—at least one nurturing, responsive caregiver; disruptions in routines or constant life transitions; family relationship problems; and increased use of psychotropic medications for this population. Recent local statistics support high behavioral health needs among youth in foster care—in the District, 95 children, or 14% of all children in foster care (mostly females), have required psychiatric hospitalization, and 28 children, or 4% of all children in foster care, having spent time at a psychiatric residential treatment facility in FY 2020.[xxviii] While

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DC has noted a recent decline in the number of children in foster care, with 693 children in foster care in December 2020 compared to 1,542 children in FY 2012, it remains important to ensure that this population continues to receive accessible, high-quality behavioral health services.[369, 370] DC Medicaid, currently through its FFS program, extends coverage to foster youth under age 21 who meet eligibility criteria, including DC residency, U.S. citizenship or eligible immigration status, and enrollment in DC foster care under CFSA custody.

In 2018, CFSA implemented the Mental Health Redesign, a change in practice to attempt to expedite and improve access to mental health treatment by providing in-house services to children in foster care.[371] Under the redesign, there are two main components to CFSA's behavioral health services for children in care.

- First, CFSA's Office of Well Being (OWB) now provides four dedicated in-house therapists as well as one psychiatric nurse. OWB screens, assesses, diagnoses, and provides short-term mental health treatment to children entering care.[xxix] It is important to note that CFSA in-house services are meant to be short-term (three to six months with the ability to extend to 12 months) mental health treatments that children need when they first enter or re-enter foster care.[371] In FY 2020, CFSA in-house mental health clinicians served 90 children.[370]

- The second component of CFSA's behavioral health services is for children in care who are determined by the CFSA in-house team to need more or longer-term services. If so, the child will be referred to DBH for behavioral health services. CFSA currently contracts with MBI Health Services, LLC., a DBH Core Service Agency. In FY 2020, 16 of the 90 children receiving in-house services were referred to MBI.[370]

For a child in care to be connected with behavioral health services, they must complete several steps.

- First, a child in care must receive a mental health screening and assessment, which are conducted in-house at CFSA. In FY 2020, 16% of the children entering care who were eligible for mental health screening did not receive the screening within 30 days of entry into care.[370] And for the 84% of children who did receive a screening within 30 days of entry into care, it is unclear when exactly they received the screening.[370] The longer it takes to screen a child, the longer it takes to execute the next steps in the behavioral health continuum for children in care.

- The second step, which is the time to link children with a provider, is typically short. Children referred to DBH are typically linked to a CSA on the same day of receipt of the referral.[369]

- The third and final step is the time of linkage to receipt of the first service. That is where a majority of issues in access delays arise. In FY 2020, 141 children and youth involved in foster care were referred for mental health evaluations through DBH. However, in FY 2020 the time to link for receipt of a first service with DBH was 41 days.[372] As for CFSA, the average time between mental health evaluations and the delivery of services is 28 days in FY 2020.[370]

It is important to note that part of CFSA's redesign can involve switching providers for children in care. Switching providers disrupts therapeutic alliance, can cause a loss in treatment momentum, and impacts the outcomes of behavioral health treatment.[373] In practice, the child will be doing well with the CFSA provider but then must transition to a DBH provider because the maximum amount of time OWB can serve a child has been met. CFSA and DBH know this transition is coming; however, it still takes a long time to link the child with a new provider. It is not only a lapse in treatment because of connection time, it is also a lapse in services, because the child has experienced a loss of one provider and must build rapport with another provider. It is imperative to note that children in care are already struggling with loss; therefore, other types of transitions and changes are more difficult with which to cope. Adding another loss (that of the therapist) in the child's life, due to bureaucracy, does not contribute to the therapeutic healing process.

The feeling of loss due to access delays in behavioral health can make it difficult for a child to stay engaged in behavioral health services. In discussion with stakeholders who have expertise in this area, it can be very difficult, especially for older youth, to re-engage in behavioral health services when there are delays in connecting them with

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xxix *The CFSA in-house services include a variety of therapy modalities including child-centered play therapy, grief and loss therapy, cognitive behavioral therapy (CBT), Trauma Systems Therapy (TST), Functional Family Therapy (FFT), Trauma Focused Cognitive Behavioral Therapy, Multisystemic therapy, child parent psychotherapy, and Parent Child Interaction Therapy (PCIT).*

providers. It is also unclear that CFSA is achieving its own goal of avoiding significant delays connecting children to necessary behavioral health treatment. As of now, a child does not receive CFSA-delivered treatment substantially more quickly than if the child was simply referred to a DBH provider.[xxx] Additionally, there is the complication that the child still may be subject to transfer to a DBH provider later on, which could result in disruption to continuity of care. That process ultimately moves further away from the goal of quickly connecting a child to necessary behavioral health services.

In addition to DBH clinicians and the internal CFSA mental health therapists, there are other services in the CFSA behavioral health system, including prescribing psychotropic medicine to children in care. Historically, at the national level, overprescribing psychotropic medication has been prevalent among youth served by the foster care system,[374] [375] and anecdotally, that has been noted in the District. Experts have called upon child welfare systems to mitigate this problem by improving screening, assessment, and treatment planning, carefully taking into account safety concerns surrounding polypharmacy and overmedication.[376] For example, it has been shared that the current short appointment times of psychiatry can be extremely problematic, because it is very difficult to properly evaluate how medication is impacting a child and what changes need to be made. In addition, experts have emphasized the importance of shared decision-making and informed consent as well as prescription quality monitoring, which can help to alleviate polypharmacy and overmedication.[376]

Additionally, CFSA in collaboration with DBH provides substance use treatment. However, of the children in care who require substance use treatment, a very small percentage voluntarily receive initial treatment or engage with services. In FY 2020, 50 foster youth were referred by an Adolescent Substance Abuse Treatment Expansion Program (ASTEP) provider for a substance use assessment. Of the 50 youth, only seven agreed to assessments, of whom only five showed up to their appointments.[370] The current system for substance use treatment uses the Adolescent Community Reinforcement Approach, or A-CRA, and has substance use specialists who respond to any in-house substance use referral and provide substance use screening to determine the appropriate level of care needed.

Children from DC in foster care can also access crisis mental health services and supportive services. In recent years, CFSA has made several changes to the services it offers. Prior to FY 2019, both biological and resource parents had access to CFSA's Mobile Crisis Stabilization Services run by Catholic Charities. However, in FY 2019, CFSA and Catholic Charities refocused the services solely on resource parents.[377] That significantly reduced the number of calls that came in for Mobile Crisis Stabilization Services.[xxxi] At the end of FY 2020, due to underutilization, CFSA ended its contracted services with Catholic Charities and brought the services in-house under the Resource Parent Support Unit. For FY 2020, CFSA and its partners received 69 calls requesting crisis mobilization services (of which 45 calls resulted in a dispatch of services to the youth's location).[370] Further, CFSA partners with Courtney's House to provide trauma recovery to survivors of child sex trafficking and those at risk of sex trafficking, which includes 24-hour crisis intervention services.[370]

Other services CFSA offers include peer support to parents with children currently in the foster care system, with a goal of reunification. The peer specialists lead groups focused on topics such as fatherhood, co-parenting, addiction, and coping with mental health issues. Finally, to support older youth through intensive transformative mentoring and life coaching, CFSA partnered with the Department of Youth and Rehabilitation Services (DYRS) Credible Messenger Initiative.[370] Credible Messengers, who are full-time staff, foster daily intensive support through activities such as evening group sessions, support circles, and crisis intervention, with 24-hour support available.[370]

It is noteworthy that CFSA places some children in foster care in Maryland due to the small geographic borders of DC and the unique makeup of housing options. Children in foster care placed in Maryland foster homes remain eligible for services in DC and can also receive services from a CFSA-contracted mental health service provider in Maryland.[370]

[xxx] According to the _Department of Behavioral Health FY20-21 Performance Oversight Responses_ and _CFSA FY20-21 Performance Oversight Responses,_ it currently takes 28 days for service to begin in-house at CFSA and 41 days for a child to be connected with DBH behavioral health services.
[xxxi] In FY19, the mobile crisis stabilization service received 41 calls, 16 of which required the dispatch of services. That was a significant drop as compared to FY18, where there were 219 calls and all required a dispatch of services.

While availability may dictate short-term care planning, attention should also be paid to the complications these cross-boundary services can cause in the longer term. Issues and concerns include distance between placement and service provider or school services and the increased stress of long commutes during an already stressful time; placement instability and the consequence of either changing service providers or acquiring transportation; and transition of services upon reunification—this is not an ideal time to change providers, yet location and transportation options may limit the ability to continue with the current provider.

9.3 Children Experiencing Homelessness

According to the Metropolitan Washington Council of Governments, 1,420 children (below 18 years old) in DC experienced homelessness in 2020.[378] Over the past few years, the District has made significant strides in addressing and reducing homelessness, with a particular focus on youth homelessness to prevent adult homelessness. In 2014, the DC Council passed the End Youth Homelessness Act of 2014 and the LGBTQ Homeless Youth Reform Amendment Act of 2014. DC also established an Interagency Council on Homelessness (ICH) to help inform and guide strategies on meeting the needs of individuals and families who are homeless or at risk of becoming homeless in the District. To that end, ICH developed a comprehensive plan, called Solid Foundations DC, to end youth homelessness by 2022.[379] The Solid Foundations DC planning group is composed of DHS, ICH, an ICH Youth Committee, and a Youth Action Board that includes youth with lived experience of homelessness. In addition, DC Code 4-753.01 establishes a Continuum of Care for homeless individuals and families including crisis intervention, outreach and assessment, temporary shelter, permanent supportive housing for eligible individuals and families experiencing chronic homelessness, and services to reduce risk of homelessness for LGBTQIA+ youth.[377]

1,420
children in DC experienced homelessness in 2020.

The plan identified several of the special populations focused on in this report as being at greater risk of becoming homeless, including gay, lesbian, bisexual, pansexual, or queer/questioning youth; child welfare system-involved youth; and justice system-involved youth, who make up 31%,[381] 21%, and 24% of youth experiencing homelessness in DC, respectively.[382] Youth with unmet behavioral health needs were also identified as being at greater risk for homelessness. Additionally, homeless youth were more likely to experience higher rates of substance use and high levels of mental health disorders, as well as increased rates of suicidal ideation, suicide attempts, and deaths by suicide.[383] Some of the strategies identified to end youth homelessness in the plan include partnering with youth-serving agencies, DBH, and DHCF to increase behavioral health engagement and continuity of services through expanding services in nontraditional settings and identifying opportunities to ensure services are billable by Medicaid.[379]

DHS leads the District's response in addressing youth homelessness. DHS has a total of 210 beds to serve transition-aged youth (ages 18–24 years old) experiencing homelessness (of which 100 beds are specifically for youth who identify as LGBTQ).[384] If capacity is reached at youth-specific facilities for transition-aged youth (which occurred at two facilities in FY 2020), youth are referred to an adult program.[384] Sasha Bruce House, which has capacity to serve 15 youth, is the sole shelter bed facility for children below 18 years old. DC does not have any beds specifically reserved for youth under 18 years old who identify as LGBTQIA+. DHS provides direct grants to CBOs, which include Sasha Bruce, Latin American Youth Center, and Zoe's Doors. Those organizations provide services such as youth drop-in centers, which also provide help to access a variety of behavioral services (e.g., crisis intervention, conflict resolution, counseling services, etc.). Within housing facilities and drop-in centers, case managers are tasked with linking youth to community-based providers for behavioral health services.

DHS also provides the Youth HOPE program to transition-age youth who are homeless or at risk for becoming homeless.[385] Services include family counseling and mediation, workshops on mental health and supportive services, short-term crisis intervention and counseling, and short-term case management. LGBTQIA+ youth experiencing homelessness can also receive services, such as mental health services, substance use treatment, medical care, crisis intervention, and case management from housing programs offered through the Wanda Alston Foundation (i.e., Wanda's House in Ward 7 and Alston's Place in Ward 1) and the Supporting and Mentoring Youth Advocates and Leaders (SMYAL) Housing Program.[386, 387] Also available is Wayne Place, a transitional housing program funded through DBH and CFSA that offers educational and job training for transitional-age youth who would otherwise be homeless.[388]

Many of the programs for homeless youth are funded through local dollars, with some District providers receiving federal dollars to fill in funding gaps.[389] Additionally, the District was awarded $4.28 million dollars through the Department of Housing and Urban Development for the Youth Homeless Demonstration Program in FY 2020.[390]

A number of gaps exist in the behavioral health support system currently in place for children experiencing homelessness. As the ICH identified, housing stabilization services for precariously housed youth coupled with conflict resolution, skill development, and referrals to other community services could divert 5% of young people from homelessness, although the District does not currently offer such a program.[383] Further, due to the lack of homeless shelters specified for youth, many young people experiencing homelessness must use supports designed for adults, which may be unsafe.[383] A needs assessment conducted in 2020 noted that individuals experiencing homelessness found accessing DBH services difficult, given the extra steps required for enrolling in or recertifying for DC Medicaid without a home address.[391] Those steps were particularly challenging for individuals experiencing homelessness who had SUD, given that the disorder can affect decision-making capacities required for those tasks.[391] Further, despite the fact that LGBTQIA+ youth make up over 30% of the total number of youth experiencing homelessness, only 9% of youth housing programs have expertise in working with LGBTQIA+ youth.[392] As discussed further in Section 9.4, there is a need for targeted cultural competency training within homeless services given the challenges LGBTQIA+ youth face when using existing supports within the District. Many of these challenges highlight the need for additional research identifying factors that enable youth homelessness, which could help to strengthen the development and implementation of interventions to address youth homelessness.

In 2015, the District was one of the first cities to begin implementing an annual census documenting demographical data of unaccompanied youth experiencing homelessness.[383] Additional data on DC residents experiencing homelessness is available through the Homeless Management Information System. However, the full potential of District-level data to inform youth homelessness interventions has not yet been realized.

The current data infrastructures in place within the behavioral health, criminal justice, and foster care systems are siloed from the HMIS system. However, there are a number of models of data integration between HMIS and health care and social service systems within other states that have facilitated improved care coordination. The best examples of that type of integration utilize a central data warehouse or repository, working across sectors to establish secure data sharing protocols; those are discussed later in this chapter.[393]

It is important that relevant data are made available to care coordinators, homeless service providers, advocates, and other stakeholders who are essential to planning and coordinating efforts to end youth homelessness. In addition, making relevant homelessness and housing instability data publicly available, for example, through a real-time[394] online dashboard serves to inform local stakeholders in their efforts to address homelessness and increase public awareness and engagement with this problem.[395] While the DC Youth Count census data describing homelessness experienced by DC youth[382] is a critical step toward informing future interventions, there are limitations to this type of annual, point-in-time (PIT) data, which often inaccurately portray the state of homelessness given the transitory nature of the problem.[396]

Data suggest that homeless shelters can be unsafe for LGBTQIA+ youth, and instances of anti-LGBTQIA+ harassment, discrimination, and assault are not uncommon in these settings.[397, 398] There is a strong association

between health disparities faced by LGBTQIA+ populations and such experiences of victimization.[399, 400, 401] Relatedly, perception of safety is among the most robust predictors of suicidality and suicidal behaviors in transgender and gender nonconforming (TGNC) individuals.[402] As such, efforts to improve youth behavioral health outcomes should ensure that LGBTQIA+ youth feel safe when using DC homeless shelter services by enacting structural safety measures and adequate staff training. Below illustrates how homeless shelters can be made safe for LGBTQIA+ youth.

Safe Shelter Components

- Individuals are assigned to shelter accommodations (e.g., use of gender-specific restrooms) that feel safest to them based on their gender identity.
- Shelter staff do not disclose an individual's transgender status to other staff or clients.
- Physical accommodations allow adequate safety, including:
  - Restroom stalls that can be locked.
  - Shower and restroom doors/curtains that do not have large gaps, allowing adequate privacy.
  - Reasonable accommodations to requests for alternate shower or sleeping arrangements.
  - Monitoring of shower doorways or entrances to control entrance and exit as appropriate.
  - Availability of beds located close to night staff.
- Staff use preferred pronouns.
- Information about District anti-harassment and anti-discrimination policy is widely available and posted in spaces that are visible to staff and clients.

Source: **"Model Policy & Legal Guide for Homeless Shelters & Housing Programs,"** **Transgender Law Center, 2016**

9.4 Children Who Identify as LGBTQIA+

This report uses the term LGBTQIA+ to describe individuals who identify as non-heterosexual or non-cisgender but may use other terminology that matches the source being referenced to maintain fidelity to research findings. We acknowledge and respect that appropriate inclusive terminology has been evolving.

LGBTQIA+ youth are at heightened risk for a number of adverse experiences, including homelessness[403] and peer victimization.[404] While representing 6.2% and 12.3% of DC's middle and high school youth population,[405] respectively, gay, lesbian, bisexual, pansexual, or queer/questioning youth in DC make up 31% of individuals experiencing homelessness under age 24 in DC[381] and are at increased risk for behavioral disorders, as demonstrated by both national and local data.[403, 405] In the same vein, data from the 2019 DC YRBS survey shows that LGB youth are more likely to report suicidal ideation, suicide attempts, and substance use than their heterosexual, cisgender peers.[19]

Based on those increased risks, this population warrants specialized services to increase protective factors. Despite the heightened need for supportive services for DC's LGBTQIA+ youth, there are currently only a few programs and services dedicated to this population, mostly available through CBOs and hospital-based clinics. Further, existing supports are often inaccessible to LGBTQIA+ youth. As an illustration, a survey conducted by the health policy Kaiser Family Foundation found that twice as many transgender individuals (not specific to youth) in DC were uninsured than in the general population.[406] Because of heightened behavioral health needs met by a small supply of services, many of the District's behavioral health services that are tailored to the LGBTQIA+ community experience high volume and cannot accept new patients. Further, 3.4% more people identifying as LGBTQ reported being unable to see a doctor because of cost than non-LGBTQ individuals.[405]

Preventive services are also scarce. Although stressors common to the LGBTQIA+ experience, such as peer or family rejection and homelessness, are inseparably linked to behavioral health outcomes,[407] there is currently no District-

wide mechanism in place for systematically identifying LGBTQIA+ youth at risk for behavioral health concerns, such as the FAPrisk screening tool created by The Family Acceptance Project.[408] The FAPrisk screening tool is an evidence-based instrument proven to be highly accurate in predicting depression, suicide, and substance use risk in LGBTQ youth,[409] which can be integrated into the workflow of health professionals serving youth to identify the need for behavioral health services and inform service delivery and referral.[410] Relatedly, the need for safe spaces (defined as "a supportive and affirming environment for lesbian, gay, bisexual, trans/transgender, and queer (LGBTQ) students"[411]) was identified in family and youth engagement efforts through this project. The Trevor Project reports in its *2021 National Survey on LGBTQ Youth Mental Health* that access to safe spaces is linked to lower suicide attempt rates within the LGBTQIA+ youth population.[412] Further, there was a recent report that a number of LGBTQIA+ youth experiencing homelessness in the District claim having been victimized by homeless services staff or consumers as a result of discrimination and inadequate cultural competence training within those settings.[413]

The Trevor Project reports in its 2021 National Survey on LGBTQ Youth Mental Health that

Access to safe spaces is linked to lower suicide attempt rates within the LGBTQIA+ youth population.[412]

In addition to culturally tailored service settings, there is a need for treatment modalities tailored to the behavioral health needs of the LGBTQIA+ youth population. Specifically, evidence supports the use of behavioral health interventions that are designed to meet the needs LGBTQIA+ youth, such as adapted versions of commonly used treatments (e.g., Transgender Affirmative Cognitive Behavior Therapy) and other evidence-based interventions (e.g., Effective Skills to Empower Effective Men) that target sexual and gender minority stress[xxxii] as a driver of behavioral health risks in LGBTQIA+ youth.[414] However, a review of DBH-supported services and the wider behavioral health care system in DC reveals that these services are not currently provided in the DC area.

In 2005, through the Office of Gay, Lesbian, Bisexual and Transgender Affairs Act of 2005, the District established the Mayor's Office of Gay, Lesbian, Bisexual, and Transgender Affairs (MOGLBTA).[415] That office was created with the goal of empowering LGBTQ residents, addressing their concerns, and providing resources for at-risk LGBTQ populations through connecting LGBTQ residents to services and resources, hosting events, providing community grants, and advocating for beneficial programs and policies.

DCPS has also established a number of important initiatives to support LGBTQ youth, including the LGBTQ School Liaison program, which recruits school staff and places them in advocacy roles for LGBTQ youth attending DCPS.[416] Recruited LGBTQ school liaisons are trained in policy, health awareness, resources, and District events.[416] They distribute educational information, engage families of students, and coordinate LGBTQ school-based events.[416] Further, in 2011, DCPS submitted a plan to create an inclusive school community for LGBTQIA+ students and staff. Critically, this plan acknowledges heightened behavioral health risk within the LGBTQIA+ population and calls for DCPS to partner with DBH to provide Question, Persuade, Refer (QPR) suicide prevention trainings and a workshop offered by the Trevor Project focusing on LGBTQIA+ youth suicide prevention for school staff.[416] It also calls for DCPS to provide a workshop to school social workers informing them of community resources for LGBTQIA+ youth and training on its LGBTQ anti-bullying and anti-discrimination policies to all school administration and staff. Also important, it presses DCPS to offer skill-building resources for parents to foster family acceptance, which is critical to youth behavioral health.[417]

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xxxii *According to Heredia et al (2021), "minority stress theory suggests that LGBTQ communities are at greater risk for mental and physical health problems because they face greater exposure to social stressors related to prejudice and stigma. Minority stress theory differentiates between distal (e.g., rejection, prejudice, and discrimination) and proximal (eg, internalized queer-negativity, expectations of social rejection, and perceived need for identity concealment) stress factors that accrue overtime, leading to chronically high levels of psychological distress, ineffective coping, and high-risk health behavior." See LGBTQ-Affirmative Behavioral Health Services in Primary Care; Primary Care: Clinics in Office Practice; 2021.*

Through a LGBTQ Health and Wellness Initiative grant from the Washington AIDS Partnership, Children's National established a Youth Pride Clinic, which provides comprehensive primary and mental health care to LGBTQ youth and young adults, ages 12–22. Other services include hormone replacement therapy, sexually transmitted disease/sexually transmitted infection treatment and PrEP (HIV prevention pill), individual and family therapy for transgender youth, and support and education about LGBTQ issues for families. The clinic care team includes a pediatrician, psychotherapist, and health educator. It also offers LGBTQ cultural competency training to health care providers in the District. As an extension of Children's National, the Youth Pride Clinic accepts DC Medicaid Managed Care insurance as well as a number of private plans within DC, Maryland, and Virginia.[418] Children's National also operates the Positive Reevaluation of Urogenital Differences (PROUD) Clinic, which specializes in treating differences of sexual development, providing resources to families and services such as psychological and psychosocial support, hormonal therapy, surgical reconstruction, etc. The PROUD clinic has an interdisciplinary team that includes a psychologist, psychiatrist, geneticists, endocrinologist, urologist, and gynecologists.

The Gender Development Program at Children's National provides developmental gender evaluation and consultation services for a broad range of gender diverse, transgender, and gender exploring children and adolescents.[xxxiii] Through its partnerships with the Divisions of Endocrinology and Pediatric Gynecology, as well as Adolescent Health, the Gender Development Program provides multidisciplinary youth gender care in the DC region, following the World Professional Association for Transgender Health (WPATH) Standards of Care.[419] The Gender Development Program also has a subspecialty program serving gender-diverse and transgender youth with neurodevelopmental differences through the Gender and Autism Program. The Gender Development Program and related multidisciplinary services accepts DC Medicaid Managed Care insurance as well as many of the private plans within DC, Maryland, and Virginia.

Whitman-Walker Health is a CBO with expertise in LGBTQ health services and HIV. It provides free mental health services to youth ages 13–24, including individual and group therapy, peer support and education, and a focus on trauma recovery and LGBTQ identities. Whitman-Walker accepts DC Medicaid Managed Care and FFS plans[420] and offers sliding-scale discounts for patients who are uninsured or under 200% of the federal poverty level.[421]

The DC Center for the LGBT Community offers individual and group trauma-informed mental health support services for LGBTQ survivors of violence and crime in the District. To receive services, the individual has to be at least 18 years. Individuals seeking services under age 18 are referred to Whitman-Walker or SMYAL. The counseling services provided are grant funded and free to those who are in acute crisis or do not have insurance or ability to pay. The program works with individuals to find providers in-network for those with insurance. Services include intake, triage, crisis stabilization and counseling, individual and group psychotherapy, continuity of care services, and social and peer support workgroups.

9.5 Youth in the Juvenile Justice System

In 2019, 1,550 youth under age 21 were involved with the District's juvenile justice system, down from 1,937 in 2017.[422] DYRS estimates that in 2018, 17% of youth involved in juvenile justice were 18–21 years old, 75% were 15–17 years old, and 8% were 14 years old or younger.[423] Juvenile-justice-involved populations experience significant need for behavioral health services. Research has established that juvenile-justice-involved youth experience a greater prevalence of SUD than their peers.[424] Further, an analysis of Medicaid claims data and Juvenile Social Files (JSF) conducted by the Criminal Justice Coordinating Council (CJCC) for the District of Columbia found that 96% of juvenile-justice-committed youth in DC met at least one DSM-V diagnosable behavioral health condition.[425]

1,550 YOUTH

In 2019, 1,550 youth under age 21 were involved with the District's juvenile justice system

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xxxiii *The Gender Development Program was founded in 1997 at Children's National, and at the time of its founding, it was one of the first pediatric programs nationally for gender-diverse and transgender children.*

In 2020, the CJCC released the *A Study of the Root Causes of Juvenile Justice System Involvement* report, which found that some of the greatest factors impacting involvement include homelessness, childhood maltreatment, and experiencing ACEs. The analysis highlighted that 10.7% of justice involved youth in DC experience homelessness, 19.2% reported abuse, 49.1% reported neglect, 50.5% were suspended, 35.7% have comorbid disorders, 38.2% were eligible for an IEP, 6.4% have a psychotic disorder, 14.6% exhibit externalizing mental health disorder diagnosis, and 88.3% had Medicaid insurance for greater than one year.[426] In that report and in the CJCC virtual public meeting, "Responding to COVID19 and the Call for Racial Justice: A Conversation with Juvenile Justice Agencies," there was an acknowledgement of the need to address systemic racism in the juvenile justice system and criminalization of Black youth, given that justice-involved youth are predominantly Black (91%).[427] Additionally, the need for alternative strategies, such as de-escalation, conflict resolution, mediation, etc., were discussed to reduce school suspensions and use of courts. The Root Causes Analysis also conducted interviews in which it identified barriers to accessing services, such as the need to engage and market services and programs to families, ensuring that the person engaging families is culturally competent, ensuring that justice-involved youth continue to receive services in the community once they exit the system, increasing access to behavioral health and social service supports to families of justice-involved youth, helping youth and their families to navigate services, and minimizing requirements to participating in programs.[425]

DYRS is the agency that oversees justice-involved youth. The agency implements the Positive Youth Justice approach, which includes a focus on restorative justice, behavioral health, life skills development, conflict resolution, and relationship building. For court-involved youth, behavioral health staff are available on-site to provide behavioral health screenings and assessments, address behavioral health needs, monitor youth at risk for suicide or self-harm, and connect youth to evidence-based treatments, such as multisystemic therapy (MST) and functional family therapy (FFT).[428] MST is an evidence-based treatment currently provided through DBH for youth ages 12–17. In conversation with stakeholders who have expertise regarding the District's juvenile justice system, MST was acknowledged as something that is "desperately needed" for kids in the system and a critical way to keep children at home, in their community. However, there is currently only one provider organization providing MST, which is not enough to meet demand. Relatedly, the shortage of child- and adolescent-specific behavioral health providers (explored further in Chapter 6) also impacts justice-involved youths' access to behavioral health services in DYRS.

Another important gap highlighted through stakeholder feedback was the disruption in continuity of care for youth who enter into DYRS. Stakeholders shared that once a youth enters into DYRS, their Medicaid coverage ends. DYRS pays for and provides services. If a youth was receiving services with a particular community provider prior to entering DYRS, they go through the screening and evaluation process again and, if determined to need services, will receive a new provider through DYRS. That disrupts the relationship and trust building that has happened with the previous provider. Furthermore, youth who receive services at the Youth Services Center also experience a disruption in services and relationships if they transition to New Beginnings. Last, stakeholders expressed the need for alternative forms of therapy (e.g., art therapy) to be more widely available to youth and to increase engagement in services at DYRS. While the court decided to end oversight of DYRS due to significant improvements and progress made, the report highlights gaps in delivering behavioral health services that still need to be addressed, particularly regarding the quality of assessments, treatment, and discharge-related services as well as timeliness of services.[429]

There are a few additional behavioral health programs offered to justice-involved youth through partnerships with several government agencies, including DBH, CFSA, DHS, and MPD.

- The Alternatives to the Court Experience (ACE) Diversion Program is a partnership between DHS, Court Social Services (CSS), the Metropolitan Police Department (MPD), the Office of the Attorney General (OAG), the DBH, and community-based service providers.[430] It assesses the needs of the diverted youth who commit low-level delinquency offenses, links youth and their families to individually tailored support and behavioral health services, and monitors successful program participation. The program's goal is to address underlying issues that cause the negative behaviors and prevent the youth from reoffending and getting a juvenile record. Entry into the program is through referrals from MPD or OAG.

- Parent and Adolescent Support (PASS) is a program for youth ages 10–17 who commit status offenses.[431] The program aims to reengage youth in school, increase family functioning, and decrease the likelihood of future involvement in the juvenile justice system for status or delinquency offenses. The program, with support from DBH, utilizes evidence-based approaches such as strength-based intensive case management, FFT, and Transition to Independence Process (TIP). Families are not eligible for PASS if they have an open case with CFSA or if the youth has an active case with CSS or DYRS. During FY 2020, PASS served 364 youth; 191 received intensive case management, 77 received PASS Crisis and Stabilization Team services, and 96 received FFT services.[384] In addition, PASS staff served 63 youth diverted to DHS' ACE diversion program due to an influx of truancy and delinquency cases.

- The Family Court Social Services Division, also known as the District's juvenile probation agency, serves youth awaiting trial and those on probation. Part of its service offerings includes the Child Guidance Clinic, which provides clinical services (e.g., individual and group psychotherapy, screenings and evaluations, outpatient programs, etc.) to youth ages 11–18 and their families.

- The Juvenile Justice Initiatives Juvenile Behavioral Diversion Program (JBDP) is a mental-health-based specialty court through the D.C. Superior Court Juvenile Division.[432] It provides intensive case management and mental health services to youth under age 18 in the juvenile justice system who have serious mental health concerns and includes comprehensive monitoring and addresses emotional, behavioral, and substance use needs. There are three tracks based on eligibility: pre-plea (first time, nonviolent youth), predisposition (youth entering a plea), and post-disposition (youth with medium level offenses, offered probation). Services are provided through the DBH provider network and supervised by CSS. In 2020, 57 youth participated in the program, 30 of which received CBI services and 15 received HFW services, but the program also has seen a decrease in participation in the program since the COVID-19 pandemic began.[372]

9.6 Transition Age Youth

Generally in the District, transition-age youth (TAY) refers to the 16–25 year old population. Nationally, TAY usually have high rates of mental health disorders but often do not receive services due to challenges with engaging this population, reluctance to begin or to continue treatment, and low mental health literacy rates.[433] In the FY20–21 Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant application, the District recognized that there were unmet service needs for TAY, including the need for seamless provision of behavioral health services and recovery supports as they transition into adulthood, especially for TAY who are involved with multiple systems.[94] With the District's two distinct child-serving and adult-serving behavioral health systems (which includes different providers and funding streams), many youth who receive behavioral health services in the child-serving system often discontinue services as they enter into adulthood. Furthermore, adult behavioral health services are not often tailored to meet the unique needs of the TAY population, can be disruptive to the TAY, and forces them to adjust to new providers and treatment plans. Recognizing that need, DBH proposed the following initiatives for TAY:[94]

- Healthy Transitions/Our Time—focused on filling service and treatment gaps available for young adults 16–25.
- Our Time Exploration—focused on filling service gaps that address the integration of substance use disorder and mental health treatment services specifically for young adults 16–25.
- It's Time to Let Help In—focused on reducing stigma around mental health,
- First Episode Psychosis/Youth Blossom Program—early interventions to address first psychotic break for
- Transition Age Youth Housing—supportive independent housing for young adults 18–25.
- TAY Supported Employment—focused on connecting young adults 16–25 with career-focused employment.
- TAY Professional training—focused on training DC providers who work with the TAY population to better connect and work with young adults.

In FY20, DBH received several grants from SAMHSA to develop a SOC for TAY; increase access to behavioral health services and recovery supports; to provide education and counseling; reduce stigma; and increase community knowledge and support through expanding and strengthening services offered to TAY.[372] DBH reported in its FY20–21 performance oversight response that due to less-than-anticipated spending and COVID-19, there was a delay in awarding contracts. Further, the grants for Positive Transitions Youth, Young Adult, and Our Time Exploration have ended with the recognition that additional planning will be needed to deliver services to TAY.

The Department of Behavioral Health currently implements two evidence-based services specific to TAY: TIP and Adolescent Community Reinforcement Approach (A-CRA).[434] A-CRA is described in Chapter 5, regarding substance use treatment for youth, and is focused on ages 12–21, which misses the 22- to 25-year-old population. The TIP model provides services to TAY, ages 14–29, who have emotional and behavioral health challenges. Services are provided in the TAY's natural environment and include the individual and their family in planning and preparing for the transition into adulthood.[434] There are currently five TIP providers: Community Connections, Wayne Place, MBI, the PASS program, and Life Enhancement Services program. TIP is Medicaid reimbursable using the Community Support code H0036 but without any enhanced rate to implement services tailored to meet model fidelity.

According to a local family-run organization, there needs to be greater engagement of TAY in the District and development of services and programs in which the TAY feel supported, are free of stigma, and are provided with the skills and knowledge needed to engage in their own treatment and recovery planning. There also needs to be greater coordination between child- and adult-serving behavioral health providers.[435] Services for transition-age youth must address mental health and psychosocial needs specific to the unique needs of youth transitioning into adulthood. Those services must be trauma-informed and community and youth driven and include mentoring/peer support. For example, Cornerstone, a small-scale randomized controlled trial and qualitative study in a New York outpatient mental health clinic, was designed to develop and test a mental health intervention specific to transition-age youth with serious mental health conditions to improve mental health symptoms, mental health service use, stigma, trust, and life outcomes.[433] It includes the following components: a licensed master's level clinician who serves as a case manager; a peer mentor, called the recovery role model (RRM); in vivo community-based practice; and knowledge and skills-based groups. Peer support models, discussed in Chapters 5 and 6, have also gained support nationally in supporting this population.

9.7 Prenatal to Age Five

Infant and early childhood mental health (IECMH) strongly impacts a child's behavioral health and well-being, even into adulthood. Quality, evidence-based Prenatal-to-Five programs and community resources are essential tools in this relational health that build strong, supportive, and positive relationships with a primary caregiver in infancy and early childhood, one of the strongest predictors of healthy emotional state.[433] Prenatal-to-Five programs offer a solution-focused approach promoting safe, stable, and nurturing relationships (SSNRs) that can turn off the body's stress machinery, proactively promote skills essential to respond to future adversity, and promote future resilience.[436]

Birth rates in the District have declined from 56.4 per 1,000 population in 2010 to 48.8 per 1,000 population in 2018, similar to decreasing U.S. birth rates.[437] Yet, DC Action notes that the percentage of District population under three years of age has increased 20% in five-year averages in the same time frame.[438] According to DHCF, 44% of all births in 2018 were financed by the District, with 35% of all births to women enrolled in Medicaid.[439] With a shifting DC population, infant and early childhood behavioral health services and the network adequacy to provide those services must reflect the needs of this population and expand to better serve the District. DC offers several programs with behavioral health services for infants. One such program is HealthySteps, an evidence-based, team-based pediatric primary care program implemented at multiple DC sites that promotes the health, well-being, and school readiness of babies and toddlers through full integration of behavioral health education and services into primary care, with an emphasis on families living in low-income communities.

A number of IECMH programs involving the primary caregiver(s) are also offered in DC. Dyadic therapies, including PCIT and CPP through DBH's Parent Infant Early Childhood Enhancement Program, Mary's Center, MedStar Georgetown University Hospital, and Community Connections (DC SEED). PCIT is currently reimbursed by MCOs, whereas CPP is reimbursed through both MCOs and MHRS. Additionally, the Early Childhood Innovation Network's Family Well Being Program offers CPP to families as part of its full range of services;[xxxiv] Children's National Hospital's Early Childhood Behavioral Health Program and Medstar Georgetown University Hospital also offer both CPP and PCIT to families. Although those services are covered through DC Medicaid, DC does not currently use a specific dyadic billing code for PCIT through either MHRS or MCOs. In contrast, CPP does have a specific billing code when billed through MHRS.

Perinatal mood and anxiety disorders (PMADs) can impact an infant's or child's behavioral well-being. Pediatric practices across the District perform PMAD screenings, such as the Edinburgh Postnatal Depression Scale (EPDS), when possible, and the District reimburses for up to four PMAD screens in the baby's first year.[440] Expansion of PMAD screenings and referrals in many inpatient and outpatient health settings is occurring at a rapid pace throughout the city. Screening followed by information and resource sharing along with connections to behavioral health services can prevent escalation to more severe PMAD conditions; network adequacy and provider availability are essential to complete this loop.

Preventive services for at-risk children/families reduce the incidence of more serious mental conditions later, offering healthier development and costing the health care system less. Z-codes and other at-risk diagnosis codes allow for the implementation of evidence-based preventative services but are currently not financed in DC.[xxxv] Parent Cafes, mindfulness programs, and support groups are valuable resources to parents and caregivers and deserve sustained investment by DC and MCOs. In as much as the infant and young child are completely linked to their caregiver, parents or other important guardians in a child's life must be incorporated into the behavioral health care of infants and young children.

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) do not correspond to the DC Medicaid billing system. A crosswalk[xxxvi] is needed for behavioral health professionals to provide clear and concise assessments and diagnoses that correlate to the billing system in the District. Once developed, the crosswalk can be disseminated and trainings offered to behavioral health providers. It is also critical that multisession assessments be supported in MCO billing where appropriate. Assessments of infant or young children, family dynamics, and certain conditions require more time for assessment than may be possible in one visit.

IECMH carries beyond the family unit and health care environment and into the learning system as well. Child care and early learning environments are valuable partners in capturing behavioral health concerns early. In doing so, the deeply rooted patterns of school failure in under-resourced communities can be stopped before they begin, thus improving educational opportunity and later economic prosperity. DC's Early Childhood Mental Health Consultation Project (Healthy Futures Program) and the Early Childhood Innovation Network's Early Childhood Mental Health Consultation for PreK3/4 (ECMHC) are two evidence-based models providing IECMH and other related behavioral health consultation to early learning environments.[xxxvii]

[xxxiv] Other services include the Strengthening Family Coping Resources (SFCR).
[xxxv] See Chapter 4 for discussion of gap analysis and recommendations.
[xxxvi] A crosswalk is a tool that provides links between DC:0-5 diagnoses and the common state Medicaid agency DSM-5, ICD-10, and ICD-10 codes. The Zero to three national organization has developed one at https://www.zerotothree.org/resources/1540-crosswalk-from-dc-0-5-to-dsm-5-and-icd-10, in addition to many state crosswalks such as Colorado's at https://www.cbhc.org/wp-content/uploads/2021/08/DC0-5-Memo_FAQ_-Crosswalk.pdf.
[xxxvii] Healthy Futures program is funded by DBH, operates in childhood development centers as well as homes, and offers child- and family-centered consultation services to care providers and family members that promotes social emotional development, reduces challenging behaviors, and provides referrals for additional services. ECMHC is a project of the Early Childhood Innovation Network and provides on-site consultation to teachers and leaders at AppleTree Centers.

9.8 Children Who Speak Languages Other Than English

Approximately 5% (26,400 people) of DC residents five years or older are classified as limited or non-English proficient (LEP/NEP).[441,442] According to 2012 data, the top four languages spoken by LEP/NEP children and adults in the District are Spanish, followed by Amharic/Ethiopian, French, and Chinese. Many LEP/NEP individuals are concentrated in Wards 1 and 4.[439] In DC, 7% of LEP/NEP individuals are children ages 5–17. Among children ages 3–17 in DC, roughly 7–10% live with LEP/NEP parents, and approximately 4% of children ages 0–17 live in households where no one 14 years or older speaks English proficiently.[442] Slightly less than half of LEP/NEP households in DC are classified as low income (< 100–200% of federal poverty level).[442]

LEP/NEP individuals have legal rights to access health services in their native language. In accordance with the Language Access Act of 2004, the District passed laws that any agency, department, or program that renders services to the public must provide language services to LEP/NEP persons who seek the services offered by the covered entity.[443] DBH has a policy to ensure that all DBH-certified agencies offer language accessible services.[444] The DC Office of Human Rights (OHR) oversees implementation of language access programs for all District agencies, including DBH.[445] OHR organizes its work into four areas: enforcement, compliance monitoring, technical assistance, and community engagement of these services.[444] DBH providers are required to establish and maintain a viable language access policy and services, which are offered at no cost to the LEP/NEP consumer. The DBH policy also stipulates that DBH providers are required to report quarterly on the number of LEP/NEP consumers served (and what languages services were provided in), the frequency with which LEP/NEP individuals come in contact with DBH providers, and the number and type of languages the agency staff speak.[444] In addition to oversight and enforcement by OHR, there is a Language Access Coordinator within DBH who oversees the development, implementation, and enforcement of many of the language access policies and plans within DBH and their contracted community providers. Informal complaints can be filed with the Language Access Coordinator. Formal complaints regarding language access issues are filed with the DC Office on Human Rights or in accordance with the DBH Consumer Grievance Procedures in 22A DCMR Chapter 3.[444]

There is a dearth of multilingual, child-serving behavioral health professionals within the District, especially those serving non-Spanish speaking populations. There are a limited number of agencies that specialize in treating specific populations, such as the Latinx community, although these agencies also suffer from workforce shortages and often have extended wait times for services. This system gap is even more prevalent when LEP/NEP families seek specific types of behavioral health services (e.g., psychiatric care) or when LEP/NEP families fall within multiple "special population" categories (e.g., autism services for a LEP/NEP children, counseling services for children 0–5 years from a LEP/NEP family, LEP/NEP new mothers experiencing perinatal mood or anxiety disorders, LEP/NEP children in the foster care system, etc.).

It is noteworthy that LEP/NEP children enrolled in Medicaid have limited access to multilingual child-serving behavioral health providers. According to the June 2021 version of the *Child and Adolescent Mental Health Resource Guide*, 76 agencies serving DC children offer mental health counseling in a language other than English; however, only 38 of those agencies (50%) accept some form of DC Medicaid.[296] While not necessarily representative, according to the website Psychology Today accessed in July 2021, 49 child and/or adolescent serving counselors near the DC metropolitan area speak a language other than English; however, only four counselors (8%) accept some form of DC Medicaid. Though those two directories may not include a fully comprehensive listing of all the child-serving multilingual providers in the District, they serve as a reasonable indicator showcasing the limited language appropriate services that are accessible to LEP/NEP children enrolled with DC Medicaid.

76 agencies serving DC children offer mental health counseling in a language other than English; however, only 38 of those agencies (50%) accept some form of DC Medicaid.[296]

In the absence of multilingual clinicians, there are a few different pathways that LEP/NEP consumers can access interpretation and translation assistance for behavioral health services at no cost. They can call the DBH Access Helpline and a staff member will connect them with live interpretation using a language translation phone line.[446] If the consumer is enrolled with a DC Medicaid MCO, they are entitled to free translation and interpretation through their insurance coverage. Each managed care plan has a language translation phone line that the consumer or family can contact.[447, 448, 449, 450] Through managed care benefits, consumers can arrange in-person interpretation services for set appointments, though those services must be scheduled with at least three to five days advance notice (depending on the MCO policy). DBH-certified agencies also should have access to telephonic language translation services so that they can triage or meet the needs of LEP/NEP consumers who seek services with a community mental health agency; in practice, that often does not work smoothly.

Even with translation resources available, it can be difficult and time consuming for LEP/NEP children, families, and individuals to access services via phone translation or in-person interpreters. The pathways for accessing translation services are not always clearly communicated to families and can be difficult to navigate, especially without the assistance of someone who has English proficiency. Often LEP/NEP individuals are directed to call a phone number that may have automated phone trees in the LEP/NEP individual's nonpreferred language, or the phone line may be answered by staff who do not speak the consumer's preferred language. In cases like that, the staff member is then tasked with identifying the consumer's spoken language and dialing in an interpreter who can translate, which can be a time-consuming and frustrating process. Hiring bilingual/multilingual staff can help to mitigate the barriers to arranging telephonic or in-person translation services. Additionally, it's important to consider cultural competency and varying levels of health literacy during the language translation process, because the norms and stigmas around accessing behavioral health services vary across cultures, which may pose an added level of challenge for LEP/NEP children and individuals seeking behavioral health services.

9.4 Recommendations

All recommendations from Chapter 5 apply to the populations referenced in this chapter. Some recommendations that are particularly important to emphasize for the identified special populations include the facilitation of integrated care, trauma-informed care, addressing social determinants of health, and promoting equitable access to care.

Additionally, as is recommended in Chapter 3, government leaders, MCOs, and behavioral health providers should strengthen their relationships with the community. This includes bringing in individuals that are representative of special populations into the decision-making about the District's behavioral health system for children.

For All Special Populations

1. Maximize appropriate information exchange among the behavioral health system, foster care system, juvenile justice system, school system, and the Homeless Management Information System.

Implementing Bodies: DHCF, DBH, DC Health, CFSA, DHS, DYRS, ICH, DCPS, OSSE
Timeline to Implementation: Long Term

Improved information-sharing among these different systems can enhance cross-sector collaboration and reduce system silos. Youth-serving agencies should collaboratively establish protocols for data-sharing, referrals, and consent for release of information, with clear guidance around HIPAA and FERPA laws.

The District's designated HIE—CRISP DC—can be leveraged as a technology to facilitate this information exchange in the following ways:

- If other agencies' information systems were interoperable with CRISP, behavioral health professionals could benefit from data that provide a more comprehensive picture of their patients' history, which would facilitate more tailored care and referrals. Further, this interoperability will be beneficial when a child transfers to a new behavioral health provider, because comprehensive clinical information (behavioral health records from behavioral health professionals in community-based organizations, school, CFSA, etc.) can be easily transferred.

- If accessibility to appropriate health data in CRISP was expanded to other agencies, health data could be utilized in settings outside of health care. That would be beneficial to ensure whole-person care is delivered as children move between different systems and settings. Even now, expanded use of CRISP could allow a social worker in CFSA to follow up on children who were admitted or discharged from emergency departments or psychiatric residential treatment facilities through use of Encounter Notification Service. With some further work to ensure privacy and security protocols were aligned, communication and diagnostic/identification reciprocity between the health care sector, educational sector, and early intervention sector could make it easier for families who have a child with a classification of ASD in one system to receive acknowledgement in another system.

Examples of Interagency Data Sharing in California	
Contra Costa County, California	**Alameda County, California**
Contra Costa County Health Services Division's Whole Person Care pilot integrates HMIS, behavioral health, public health nursing, and emergency medical services data systems into a central data warehouse. Some data from that warehouse is shared directly to providers through EHR patient charts. Data is also made available to program managers to inform reporting and strategic planning efforts. **Source: "Catalyzing Coordination: Technology's Role in California's Whole Person Care Pilots," California Health Care Foundation, April 2019.**	Alameda County's Social Health Information Exchange (SHIE) was made possible through data agreements across local health and homeless systems of care, binding all participating providers by HIPAA law. HIV and behavioral health data is only shared upon patient consent. Individuals' medical, behavioral health, housing, incarceration, crisis response, and social services data were collected and integrated into the SHIE central repository, which is made accessible across sectors. The SHIE system also notifies providers when a client is admitted into or released from the emergency room, inpatient care, or jail. Finally, SHIE data is used by the county for the purpose of equity-focused data analysis. **Source: "Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness," California Health Care Foundation, July 2021.**

Children With or At Risk for ASD

The Current Landscape of Behavioral Health Services for Children With Autism Spectrum Disorder Insured by Medicaid in Washington, D.C. by Children's National Hospital[xxxviii] outlines a more comprehensive list of recommendations that we fully endorse, but the following are highlighted as high priorities:

2. Ensure network adequacy for diagnostic and intervention services for ASD.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Short Term

While MCOs are required to have network adequacy for ASD evaluations and intervention, there remain significant gaps in care. Additional information is needed to understand how DHCF is monitoring and ensuring network adequacy and why certain Medicaid MCOs are not accepted by different care providers. The District should ensure that all appropriately qualified providers are enrolled with all MCOs. In addition, DC should ensure there are behavioral health service providers available to care for children with co-occurring ASD and behavioral health issues, as this is common and requires intervention.

[xxxviii] See pages 17–25 of the *Current Landscape of Behavioral Health Services for Children with Autism Spectrum Disorder Insured by Medicaid in Washington, D.C.* report.

3. Identify and implement comprehensive policy solutions that ensure adequate access to the full array of services and providers needed for ASD diagnosis and treatment.

Implementing Body: DHCF

Timeline to Implementation: Medium Term

DC identified the need to develop comprehensive solutions for ASD services and providers during the Section 1115 Medicaid waiver process. In other states, approaches have included a Medicaid State Plan Amendment as recommended by CMS, systematically addressing training and workforce shortages and identifying innovative approaches through telehealth. The District should use upcoming planned changes to the public behavioral health system, including behavioral health services as covered benefits in the District's Medicaid managed care contracts, as an opportunity to work with families, providers, communities, and other stakeholders to determine and begin implementation of a core set of ASD policy changes. With the addition of a Neurobehavioral Benefit to DHCF's FY 22 budget, the District has taken steps to begin planning comprehensive ASD policy solutions and allowing for broader access to ABA services. We are supportive of that policy movement and encourage broad stakeholder engagement as implementation advances.

ASD policy reform is also needed for MHRS providers to allow this provider type to develop plans of care that address issues specific to ASD. In this manner, MHRS providers can facilitate better whole-person care for children with ASD and co-occurring behavioral health disorders, such as SED. Policy reform should include the addition of ASD diagnostic and treatment codes to MHRS. Additionally, as the current MHRS provider network is not experienced in delivering ASD-related services, further capacity development in terms of training and staffing will be needed.

4. Standardize insurance requirements for making a diagnosis of ASD across the MCOs and increase transparency and access to this information.

Implementing Bodies: DHCF, MCOs

Timeline to Implementation: Short Term

The different MCOs have varying or unclear standards for what documentation is required to substantiate an ASD diagnosis. These discrepancies make it difficult for providers to know what documentation is needed and for families to understand what to look for in an evaluator or in written evaluation results. Moreover, an ASD identification from a school-based evaluation that includes a DSM-5 diagnosis and corresponding comprehensive psychoeducational assessment should be considered sufficient for MCOs to initiate insurance-covered treatment services.

5. Secure funding to provide ongoing training and education on ASD for frontline care providers, including primary care providers, early intervention staff, school staff, and early childhood behavioral health professionals

Implementing Bodies: DBH, DHCF, DC Health, OSSE, DCPS
Timeline to Implementation: Short Term

Individuals in these roles frequently refer children with suspected or diagnosed ASD for specialty services. Parents and caregivers of children with ASD must also be educated about ASD and engaged as partners in their children's care. The District should also look to fund models that improve access to clinical expertise, such as ECHO Autism, which has been successful in other jurisdictions.

6. Support the implementation of universal, coordinated, and strategic developmental monitoring and screening practices across key agencies within the District.

Implementing Bodies: DBH, DHCF, MCOs
Timeline to Implementation: Short Term

Universal developmental monitoring/surveillance should be adopted by systematically integrating the CDC's "Learn the Signs. Act Early." materials across agencies in the District to promote increased awareness of developmental milestones across stakeholders. Routine universal ASD screening, and potentially two-stage screening, should be implemented in programs that target young children. Screening efforts should be coordinated with organizations that can provide technical assistance and support screening implementation while ensuring that identified children can be quickly seen for comprehensive ASD evaluations.

Children in Foster Care

7. Guarantee the timeliness of service connection and integrate warm handoff best practices between CFSA and DBH for behavioral health services for children in care.

Implementing Bodies: DBH, CFSA
Timeline to Implementation: Short Term

There needs to be a seamless transition from removal to assessment for behavioral health needs and to treatment. Whether all of those components happen in-house at CFSA or in collaboration with DBH, there must be capacity to serve this population. The system, as currently designed for children in care, requires multiple steps to initially connect a child to a behavioral health provider. The shortest amount of time to connect a child with a CFSA in-house therapist is 28 days, and that assumes they are screened, linked, and begin services on the first day the child comes into care. That is an unlikely scenario. As noted above, in FY 2020, 16% of children were not screened within 30 days of care (the exact screening time is not reported), and the average time to begin services with a CFSA in-house therapist is 28 days. Therefore, for those 16% of children, they are facing a two-plus month minimum delay on services. A child in care needing to access DBH services will be met with longer—but not substantially longer—delays, as discussed in Section 9.2.

Those delays in care can be detrimental to a child in care, especially when factoring in that removal from one's home can be traumatic in and of itself. Therefore, CFSA and DBH should explore ways to make connections to behavioral health services more timely for children in care and to minimize expected disruptions in care, including updating policies on initial evaluation of children's health that have not been updated since September 2011, well before the behavioral health redesign.[451] This effort will allow CFSA to better inform its policies around timely screening and connection to services based on feedback over the last three years. CFSA and DBH should also collaborate to establish an efficient and effective information-sharing system that will ensure children are not delayed in receiving services due to inaccessibility of behavioral health records or other information vital to a child's treatment.

Additionally, children coming into care have typically faced other adverse experiences and have behavioral health needs that a short-term solution like the OWB is not designed to meet. Therefore, CFSA should continue to offer in-house services but should integrate the warm handoff model between itself and DBH in every referral.[452] A warm handoff will allow the child to be involved in the transition from one behavioral health professional to another. This may ease the stress of having to endure another change. Children thrive from consistent relationships. While there is the importance of a quick connection, there is also a relational aspect in behavioral health services that can be appropriately addressed through a proper warm handoff. A child will not have to abruptly change a trusting, consistent relationship with an in-house CFSA therapist, which can be stressful in and of itself, but instead will be able to ease into a new long-term relationship with a DBH behavioral health professional.

8. Ensure there are clear pathways to accessing care for children in foster care residing in the District and Maryland.

Implementing Bodies: DBH, CFSA, DHCF
Timeline to Implementation: Short Term

DHCF has still not announced the timeline to transition the 10% of children and youth currently served by the Medicaid FFS program to the MCO program.[453] However, in considering the best way to go about this process, DHCF must ensure the behavioral health needs of children—and foster children in particular—are prioritized. The ability to readily access behavioral health services in DC and Maryland is crucial for this particularly vulnerable population.

In considering the transition from FFS to MCOs, there must be clear pathways to accessing care across the District as well as in Maryland, where 65% of DC foster children resided in FY 2020.[xxxix] Children placed in Maryland continue to be eligible for services in the District, but that is often impractical and inconvenient for many caregivers and families. Children need to be placed with services near where they are located. With the transition from the FFS program to managed care and the carve-in of behavioral health services into MCOs, children in Maryland will struggle to be connected with the appropriate behavioral services due to the lack of behavioral health organizations in Maryland that accept DC Medicaid. DHCF needs to take extra steps to ensure that DC foster children have access to behavioral health services in Maryland. The network adequacy time and distance standards need to be applied based on the child's outpatient home, not simply based on the District street address the family may have.

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xxxix *According to* the CFSA FY2020- FY 2021 Performance Oversight Responses, *451 of the 693 children in care with placed Nation Center for Children and Families in Maryland.*

9. Provide an augmented capitation payment for children in foster care to MCOs, to adequately support their increased needs.

Implementing Bodies: DBH, CFSA, DHCF
Timeline to Implementation: Short Term

Children in foster care are disproportionately more likely to have developmental, medical, and/or behavioral disorders than nonfoster Medicaid children.[454] Because foster children have higher levels of chronic health conditions, it is important that MCOs are paid higher capitation rates for this eligibility category to cover their necessarily higher costs. If the capitation rates are not higher, plans would have increased pressure to reduce health care utilization for foster children to remain profitable.[xl]

10. Continue to work on the implementation of evidence-based therapeutic foster care.

Implementing Body: CFSA
Timeline to Implementation: Short Term

In 2019, CFSA began a contract with a new provider to offer specialized therapeutic placements to children in care. There have been challenges with the new provider, including high staff turnover and inadequate staffing leading to a lack of communication, coordination, and challenges in providing therapeutic support and services.[455] Because this is a new program, there is an opportunity for CFSA to develop lessons learned as well as expectations. CFSA is and should continue to incorporate these lessons into more effective implementation of specialized therapeutic placement moving forward.

Additionally, CFSA has begun a pilot program, Professional Resource Parent Program (PRPP), to employ professional foster parents to further meet the need of therapeutic placements.[456][457] Professional foster parents are full-time, salaried positions. They do not work outside the home and are trained and able to provide 24/7 services in a therapeutic home setting. Like therapeutic foster homes, professional foster parents receive specialized training and additional resources to support placement stability, including an in-house mental health services support team, in-house transportation services, and crisis intervention services available over the phone.

Both therapeutic foster homes and the PRPP allow a child with high behavioral health needs to heal and recover in a home setting instead of a residential or institutional setting. Providing therapeutic homes and professional foster parents is a good start. CFSA needs to continue these processes until there are sufficient resources to support foster care children with high behavioral needs with top tier services.

[xl] *According to Palmer et al (2017), Kentucky saw a decrease in outpatient utilization when children were transitioned to managed care; however, foster care children experienced less decrease, possibly due to the 28.9% enhanced capitation rate accounting for their higher need. See Medicaid Managed Care and the Health Care Utilization of Foster Children; Inquiry; 2017.*

11. Provide full transparency of specific data collection regarding medication monitoring, and publicly report these data regularly.

Implementing Bodies: DBH, CFSA
Timeline to Implementation: Long Term

Children in foster care have a documented higher rate of psychotropic medication use; however, transparency in this area is completely lacking. The District needs to adopt a framework that can provide effective oversight for the use of psychotropic medication by children and youth in foster care. To do so, the District must establish publicly available data that will allow medication utilization to be monitored among District foster care children and will provide a clear indication on any needed changes in policy or access to alternative treatments, where warranted. In developing an effective monitoring framework, the District may look to New Jersey, which uses existing data from its child welfare, Medicaid, and children's behavioral health entities, to gain a clear understanding of psychotropic medication use and psychosocial interventions.[458]

The District may also look to Texas, which in 2005 was the first state to develop a best practice guide, *Psychotropic Medication Parameters for Foster Children (Parameters)*, for oversight of psychotropic medications for children in foster care.[459] As part of the process, Texas' Health and Human Services Commission and Department of Family and Protective Services convened an advisory committee of child and family advocates, foster parents, providers, youth in foster care, and human services professionals to help guide its strategy concerning psychotropic medications. Since *Parameters*' release in 2005, the use of psychotropic medication has steadily declined.[459]

Children Who Experience Homelessness

12. Systematically identify children and youth using homeless shelters who are in need of behavioral health services.

Implementing Bodies: DHCF, DBH, DHS
Timeline to Implementation: Medium Term

While recent data describing the number of children and youth experiencing homelessness who were engaged through DBH outreach efforts is limited, available information suggests that only a small fraction of youth experiencing homelessness[460] are engaged through DBH's Homeless Outreach Program (HOP).[461] HOP is the only homeless shelter outreach program provided by DBH that is available for children experiencing homelessness.[462] High rates of intensive behavioral health service use, such as psychiatric hospitalizations, after spending time in homeless shelters suggest that homeless families and children should be systematically screened for behavioral health risks while engaging with homeless shelters to address and prevent need for later intensive services.[463] It may also be the case that shelters need to adopt strategies that mitigate exacerbation of behavioral health risk factors. It would be helpful to make publicly available current behavioral health screening data within District homeless shelters and to implement District-wide protocols within homeless shelters to ensure children who are experiencing homelessness are screened for behavioral health conditions.

DBH may consider partnering with DHCF and DHS to provide targeted outreach services for children in homeless shelters, including behavioral health assessment, providing service referrals as needed, and ensuring those services are Medicaid billable. It is important that there are behavioral health services tailored to meet the needs of LGBTQIA+ youth of color who experience homelessness. A similar approach, through which nurse care coordinators systematically visited homeless shelters to provide behavioral health screenings for children, was shown to be both feasible and necessary through a pilot study conducted in Jacksonville, Florida.[464] In this study, 33% of children over five years old who were screened using the Strengths and Difficulties Questionnaire (SDQ) were identified as needing behavioral health services, almost five times the rate of those screened by the SDQ within the general population.[464]

13. Increase participation in the Interagency Council on Homelessness (ICH) by DHCF and MCOs.

Implementing Bodies: DHCF, MCOs
Timeline to Implementation: Short Term

Given the increased behavioral health risk of children and youth experiencing homelessness, special attention should be taken with regards to their behavioral health service needs. Entities involved in their behavioral health care delivery, payment, and governance, including DHCF and MCOs, who are currently not represented within the ICH,[465] should ensure partnership and collaboration with the ICH. In addition to the ICH Medicaid work group's focus on developing and implementing a new Medicaid permanent supportive housing case management benefit, outcomes of this partnership should entail: increased service connectivity; improved homelessness prevention efforts for those using inpatient care; and improved targeting of available housing resources, such as through coordination of Medicaid services with housing supports.[466]

14. Systematically assess the housing status of crisis service users.

Implementing Bodies: DHCF, DBH, DC Health, MCOs
Timeline to Implementation: Short Term

Emergency and crisis response providers (such as ChAMPS, hospital EDs, etc.) should routinely assess the stability of the client's housing situations and connect children and families to appropriate housing resources in the same way they take into consideration other social risk factors. This can be achieved, for example, by requiring that crisis response providers use Certified EHR Technology—in which the core data set, the United States Core Data for Interoperability (USCDI), measures housing status.[467] Work is underway to implement Z-codes social determinants of health screening, following the work of the Gravity Project, in the DC Designated HIE, CRISP DC, could also be useful to support this work.

Based on stakeholder feedback, strategies to consider when assessing the housing situation of children:

- With appropriate supports and resources in place, housing assessment should be included as a standard part of care during triage in the ED.

- When assessing housing needs, the individual doing the assessment should be mindful of language, sensitivity, and stigma.
  - Ask caregivers about housing status separate from the child, because the child may not be aware of the situation.
  - Use language such as "stable living environment" or "housing instability" instead of "homelessness."
  - Questions could include: How many times in the past year have you moved? Are you concerned about where you will be living in the next month?

15. Collect data on youth homelessness beyond annual PIT prevalence estimates.

Implementing Body: DHS

Timeline to Implementation: Long Term

Collect real-time data on youth homelessness outcomes that can be used by relevant stakeholders, including homeless service providers, to measure and inform performance. Consider using youth homelessness outcome measures similar to those which the Seattle Human Services Department uses to inform quality-based payments to homeless services providers, including:

- Successful diversion from homelessness.[468]

- Milestones to success or specific actions taken by providers to address housing barriers, such as helping obtain identification needed to complete a housing application.[468]

- Obtainment of permanent housing.[468]

- Housing stability or whether an individual is still living in permanent housing three months after obtaining it.[468]

- Reentry into homelessness after obtaining housing.[468]

- Racial disparities demonstrated in the distribution of individuals experiencing homelessness.[468]

Given the transient nature of homelessness, this data should be collected frequently and made available in real time, ideally to the general public through an easy-to-understand data dashboard to maximize its utility to the community.[395]

16. Ensure that homeless shelter staff are adequately trained in cultural competency, anti-discrimination, anti-harassment, and trauma-informed approaches to protect the safety and well-being of LGBTQIA+ youth and children.

Implementing Bodies: DHS, Youth Sub-Committee on ICH
Timeline to Implementation: Short Term

A number of accounts on both local[413] and national[397, 398] levels suggest that homeless shelters are unsafe for LGBTQIA+ youth, especially those identifying as transgender.[397] A national survey revealed that nearly half of transgender individuals experiencing homelessness have reported leaving homeless shelters due to maltreatment, preferring to sleep on the streets than in a hostile or unsafe environment.[397] Further, traumatic experiences, such as harassment and peer victimization faced by LGBTQIA+ youth are strongly linked to later behavioral health outcomes.[399] As such, it is important that the District ensure adequate training for shelter staff on cultural competency, anti-discrimination, anti-harassment, and trauma-informed practices to better serve LGBTQIA+ youth and avoid increasing behavioral health risks. As described in Section 9.3, shelter staff should be enabled to enforce anti-harassment policies, and shelters should have safety measures incorporated into their structures.

Children Who Identify as LGBTQIA+

17. Support therapeutic interventions proven to be effective and appropriate for LGBTQIA+ youth populations, including culturally tailored treatment modalities.

Implementing Bodies: DBH, DHCF, DHS, OSSE, DCPS
Timeline to Implementation: Medium Term

As public health and behavioral science experts have noted, disproportionate exposure to stigma-related stress during childhood and adolescence is the most plausible explanation for behavioral health disparities in the LGBTQIA+ population.[469, 470] Given the role that these kinds of stressors play in the development of behavioral health concerns among many LGBTQIA+ youth, successful therapeutic interventions for this population must effectively address stigma-related stressors. Interventions tailored to the LGBTQIA+ population are purposefully designed to do this, leading many to call for their wider use.[471, 472] While there remains a need for studies comparing the efficacy of LGBTQIA+ tailored interventions to evidence-based, nontailored treatments,[473] existing evidence suggests that tailored treatments are very effective[473] and individuals identifying as LGBTQIA+ frequently prefer them,[474] helping to address barriers to treatment-seeking.[472]

For this reason, we recommend that DBH support behavioral health clinician training in evidence-based treatment modalities that are tailored to the needs of LGBTQIA+ youth, such as Transgender-Affirming Cognitive Behavior Therapy (TA-CBT) and Effective Skills to Empower Effective Men (ESTEEM).[414] Further, we encourage DBH to support evaluation services for gender-diverse and transgender youth because the standard of care for gender-affirming medical treatment requests requires careful assessment for medical treatment readiness.[419] We also encourage DHCF to ensure that these services are Medicaid billable.

Other evidence-based interventions that can address the behavioral health needs of LGBTQIA+ youth include the FAPrisk screening tool developed by the Family Acceptance Project, which has proven to be accurate in

predicting depression, suicide, and substance use risk in LGBTQ youth[409] and can be integrated into the workflow of health professionals serving youth to identify need for behavioral health services and inform service delivery and referral.[475] Health and social service agencies serving youth in DC should encourage service providers to use the FAPrisk to better identify LGBTQIA+ youth who are in need of behavioral healthcare service referral.

In instances where tailored interventions have not yet been developed, it is suggested that other evidence-based practices that have been proven effective within LGBTQIA+ youth and child populations be used in their place. For that reason, we suggest supporting the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program treatment modality, which is the only known,[476] widely available intervention shown to be effective in significantly reducing substance use in the LGBTQIA+ youth and children through longitudinal data.[477]

18. Increase access to integrated behavioral health services for youth in gender transition.

Implementing Bodies: DBH, DHCF, MCOs,
Timeline to Implementation: Long Term

There is a need for increased integrated care services or interdisciplinary clinics for youth in gender transition to address and support the physical, social, emotional, and mental health needs of youth and their families. For example, it would be helpful to have an endocrinologist and behavioral health provider involved in appointments to increase multidisciplinary care for youth in gender transition. Some examples include Children's National's Gender Development Program (mentioned in Section 9.4) and the Youth Pride Clinic (mentioned in Section 9.4).

19. Improve District capacity to make data-informed decisions on behavioral health care for LGBTQIA+ youth.

Implementing Bodies: DBH, DHCF, DC Council
Timeline to Implementation: Medium Term

As the use of electronic health records and data-informed medical decision-making becomes more common, collection of sexual orientation and gender identity (SOGI) data is critical to eliminating health disparities experienced by LGBTQIA+ youth.[478] As such, it is imperative that the District's efforts to improve local behavioral health outcomes take into account the need for standardized, consistent collection and use of high-quality SOGI data in health care and social service settings by:

- Undertaking efforts to increase the use of Certified EHR Technology within health care systems, given that USCDI core data set embedded within these systems collects standardized SOGI data.[479]

- Involving LGBTQIA+ youth in data collection improvement efforts within the District, such as those taken by the ICH Youth Data and Performance Measures Work Group.

- Ensuring that service providers collect SOGI data in a culturally competent manner and encouraging the use of the National LGBTQIA+ Health Education Center (NLHEC) materials[480] to reference best practices.

- Implementing value-based care practices that reward providers for closing gaps in behavioral health outcomes for LGBTQIA+ youth.

20. Improve cultural competency of social and health care service delivery provided to LGBTQIA+ youth.

Implementing Bodies: CFSA, DYRS, CSS, DHS, DBS, OSSE, MPD, DCPS
Timeline to Implementation: Medium Term

Improving the cultural competency with which District services are provided serves to minimize the risk of LGBTQIA+ youth receiving discriminatory treatment that discourage use of needed supports, including behavioral health care. As such, youth-serving agencies in the District can improve cultural competency of service providers in the following ways:

- Ensure that youth-serving agency staff are trained in LGBTQIA+ cultural competency and nondiscrimination best practices as well as basic suicide prevention skills, such as those taught by the Question, Persuade, Refer gatekeeper training.[481]

- Ensure a culturally competent health care workforce, encouraging providers to use NLHEC as a free resource (using continuing medical education (CME) credits offered through NLHEC courses as incentives where appropriate) and the standards of care[xli] developed by WPATH, which specifically identify key competencies and roles of mental health professionals working with children or adolescents with gender dysphoria as well as considerations and guidelines for psychological assessment and intervention.

- Ensure that accurate information about LGBTQIA+ behavioral health issues are made available for youth and their families in youth-serving agency locations.[481]

- Establish a District-wide LGBTQIA+ cultural competence model to inform service delivery.[481]

- Facilitate opportunities for LGBTQIA+ youth in DC who are interested in behavioral health to enter the behavioral health workforce.[482]

Youth in the Juvenile Justice System

21. Increase access to affordable, high-quality behavioral health services and social service supports for justice-involved youth and their families.

Implementing Bodies: DYRS, DBH, MCO, CBOs/FROs, OSSE
Timeline to Implementation: Long Term

While the District has implemented a number of diversion programs that also address behavioral health, youth currently in DYRS custody need greater access to high-quality and timely behavioral health services. In discussion with stakeholders who have expertise with the District's juvenile justice system, they highlighted the following:

- There needs to be a greater number of child- and adolescent-specific providers who are trained to provide trauma-informed services, MST, youth-specific treatment for problem sex behaviors, and grief counseling services to youth in DYRS. There will need to be greater financial investment in technical assistance and training to increase the number of providers certified to provide these services.

[xli] *Please note that a new version is due out December 2021. "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People," The World Professional Association for Transgender Health, 2012.*

- DBH and DYRS should work together to expand access to a number of services for justice-involved youth including co-occurring treatment services (MH/SUD) and residential SUD services when needed. In discussion with stakeholders, it was highlighted that when a youth in DYRS needs residential substance use treatment, the current option is a facility in Pennsylvania called Abraxas. Options for residential SUD treatment for justice-involved youth should be centrally located in the District and should be considered to allow for youth to remain in the District and near their families.

- DYRS should also use funds to contract with alternative therapy providers to better engage youth in treatment services, especially for youth who do not respond well to traditional forms of therapy. These services (e.g., pet and art therapy) should be widely available and not used as a form of reward.

- Develop a system to monitor and track timely development and implementation of appropriate treatment plans for youth at DYRS needing services. Treatment plans should incorporate all relevant data.

- A systematic process for collecting and reporting data on quality of behavioral health services should be implemented. This should include data on wait time to receive evaluation and treatment services, referrals, and types of services delivered. DYRS should also work with youth and their families to collect feedback on their experience of receiving these services.

22. Ensure continuity of behavioral health services and supports upon reentry into the community

Implementing Bodies: DBH, DYRS, and MCOs
Timeline to Implementation: Long Term

Reentry into the community should involve support with case management; navigating insurance requirements; and linkage to high-quality, community-based behavioral health programs. In particular, youth who were receiving services in DYRS and/or their families need to be assisted with enrolling in Medicaid and linking to appropriate services within the community prior to community reentry. For youth who meet criteria to have suspended Medicaid eligibility reinstated, the reinstatement process should be automatic. Youth and their families should also be included in the treatment planning process.

The family environment and stressors prior to the youth's reentry should also be addressed. That could include addressing behavioral health and social service needs of the family through connecting families to available resources and services, and helping them to navigate service requirements.

23. Implement training to individuals and organizations working with at-risk and justice involved youth.

Implementing Bodies: DBH, MPD, DCPS, OSSE, DC Health, CBOs
Timeline to Implementation: Long Term

Train school staff, police, and juvenile justice staff in working with youth with behavioral health challenges. Some examples include:

- Working with DCPS, MPD, and OSSE staff on how to interact in a way that supports recovery and de-escalation strategies.[483]

- Addressing biases and systemic racism through cultural competency, anti-racism, and implicit bias trainings, and linking those activities to long-term and structural adjustments that promote multicultural organizational success.

- Helping school staff to identify behavioral health challenges and appropriate resources, which in turn could help to reduce suspensions/expulsions and reduce the criminalization of Black youth.

- As outlined in *A Unified Vision for Transforming Mental Health and Substance Use Care*, training law enforcement officers in recognizing signs and symptoms of MH/SUD as well as in de-escalation models (e.g., Law Enforcement Assisted Diversion, and Mental Health First Aid).[207]

24. Increase peer support and mentoring opportunities for justice-involved youth.

Implementing Bodies: DBH, DCPS, CBOs
Timeline to Implementation: Long Term

Based on the findings of the CJCC's *Root Causes* report, it is recommended that the District pilot a community-based, cross-age peer mentoring program. This program would have high school students provide one-on-one or group mentoring to elementary and or middle school youth. The high school students would be supervised by program staff who would help maintain the structure of the program and provide guidance to the high school students. This type of program is rated as a "promising practice" by CrimeSolutions.gov, which is operated by the Department of Justice, and provides reliable resources on specific justice-related programs and practices to inform practitioners and policymakers. These mentoring programs are evidence-based, developmental models that promote psychosocial growth in both the mentors and mentees. Additionally, the programs can be tiered by allowing elementary mentees to participate through high school, progressing from mentees in elementary, mentors-in-training in middle school, and mentors in high school.[425]

25. Increase transition age youth-specific services and supports.

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Implementing Bodies: DBH, DHC, MCOs
Timeline to Implementation: Long Term

As described in Section 9.6, DBH currently implements two evidence-based behavioral health treatments for transition age youth, one of which is not trauma-informed and the other misses the 22– to 25-year-old population. DBH and MCOs should explore new evidence-based behavioral health services specific to TAY that can be implemented in the District. New services developed and implemented should address social determinants of behavioral health and trauma and incorporate youth voice. DBH should also explore whether current evidence-based services for children and adults can be tailored to meet the specific needs of TAY. Furthermore, to increase services, DBH and the MCOs should ensure there are a sufficient number of community-based providers who are certified to provide TAY specific behavioral health support. To support increased services, there also needs to be sustainable funding opportunities.

To ensure continuity of care and seamless navigation of services, there should be dedicated care coordination or case management staff who help families transition from children's behavioral health services to TAY services, from TAY services to adult services, from pediatric primary care to adult primary care, and from school-based services to community-based services. That should also include warm handoffs and closed referral loops from the current provider, whom the individual has a relationship with, to the new provider.

26. Develop a system of care for TAY to ensure care continuity.

Implementing Bodies: DBH, CFSA, DCPS, DHS, CBO/FRO
Timeline to Implementation: Long Term

Secure sustainable funding to build a coordinated system of services across agencies and organizations in the District to meet TAY's specific needs. TAY need to be recognized as distinct from child- and adult-serving systems, with specific reimbursement mechanisms. Some strategies include:

- Identifying divisions within each agency that specifically address the issues of TAY.
- Similar to the development of ICH, developing a coalition or council specific to TAY. Many agencies are planning or implementing some services for this population already, but a coalition or council will ensure that it is a coordinated effort and increase communication between all of the relevant sectors impacting TAY.

27. Increase engagement of TAY in education, service planning, and delivery.

To increase utilization of behavioral health supports, there has to be sufficient mechanisms in place to engage the TAY population and increase awareness of available services and resources. Additionally, to engage this population, providers and organizations must meet TAY where they are, recognizing that engagement and outreach for this population will look different from that of children and adult strategies. Some strategies to increase engagement include:

- Ensuring that information sharing, outreach, and engagement in services is conducted by trusted individuals such as peers with lived experience and at locations that are comfortable and easily accessible by TAY, as appropriate. For example, utilizing CBOs, churches, recreational centers, and other community supports that TAY frequent as TAY service hubs, in which a TAY can receive information and supports related to a number of their needs at one location (e.g., physical health, behavioral health supports housing, food, and employment supports).

- Creating comprehensive and easily accessible information in the form of a resource guide, memes, infographics, website, etc. that promotes all of the transitional services available to youth on local, state, and federal levels. Consult with the TAY committee and youth development leads as to the best ways to format, distribute, and display this guide, such as using social media platforms. Also, ensure there is dedicated staff to update these resources.

- Developing an education/promotion plan to highlight and spread awareness of TAY programs to youth, young adults, and families in the District. DBH has implemented a number of TAY services and programs of which residents may not be aware. Along these lines, the DBH webpage currently lists tabs for adult services and children, youth, and families. There needs to be an additional tab listing TAY-specific services and descriptions to make information more transparent and accessible to the public.

- Increasing engagement of youth in peer support and mentorship programs. See Chapter 6 recommendations.

Prenatal to Age Five

28. Include IECMH-specific MCO objectives that are measurable and supported with adequate financial incentives.

This includes IECMH promotion and prevention requirements, and encouraging an IECMH-specific Performance Improvement Plan for each MCO. IECMH benefits the MCOs in addition to the Medicaid system and the community, by reducing intervention rates later or costlier treatments for behavioral health diagnoses not addressed at the preventative or early intervention stage. Value-Based, Alternative Payment Methodologies are discussed in more detail in Chapter 4, Financing.

29. Ensure coverage and adequate reimbursement rates for evidence-based dyadic and multigenerational models.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Short Term

Implement specific billing codes and enhanced rates for current covered services, such as PCIT and CPP. Ensure Medicaid coverage of additional evidence-based IECMH treatment, such as Attachment and Biobehavioral Catchup (ABC). DHCF and DBH have included review of CPP and PCIT rates in a Medicaid rate study begun as of late summer 2021 and are considering ABC, which we fully support. Flexibility in delivery of those services must be encouraged to allow for further advancement of culturally competent and trauma-informed care for this population, as well as contribution toward value-added services.

30. Ensure adequate financing for PMAD screening, prevention, and intervention across all settings and providers, regardless of the caregiver's health insurance status.

Implementing Body: DHCF
Timeline to Implementation: Short Term

Screening tools are ideally administered prenatally, at any postnatal visits for the mother, and additionally when parents are present for infant well-child visits throughout the first year and any ED and other specialized care received for the infant. Consider a psychiatry consultation program for pregnant and postpartum women, such as Massachusetts MCPAP for Moms.[484] Screenings are an important tool in identifying PMADs, and must be supported by prompt access to specialized treatment for perinatal behavioral health concerns that is readily available within the community, and culturally and linguistically representative of the population served.

31. Develop and disseminate a billing crosswalk for Medicaid behavioral health professionals across provider settings (DC 0:5 to DSM-V and/or ICD-10), along with training on use of that crosswalk. Policy guidance or clarification should also be issued regarding multisession assessment.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Short Term

Crosswalks are tools that providers can use to link diagnostic categories such as the DC:0-5 to a different diagnostic tool such as the DSM or ICD-10, often linked to state requirements for reimbursement. While ICD-10 may streamline all reimbursable activities for behavioral health, they are based in adult behavioral health diagnosis and, therefore, do not take a developmentally informed perspective of the unique issues for infant and early childhood mental health concerns and diagnoses. A simple crosswalk tool will allow for assessment using the age-appropriate diagnostic criteria and tools to detect disorders in this age group; more effective treatment planning; use of a common language for professionals across disciplines; and a consistent process for establishing medical necessity for reimbursement of services.

32. Continue and expand ECMHC programs with permanent and stable funding mechanisms to support needed services in child care centers and PreK3/4 classrooms.

Implementing Bodies: DBH, DHCF, OSSE, DCPS
Timeline to Implementation: Short Term to Medium Term

Currently, ECMHC is implemented in 57 child development centers and 18 home providers in the District through DBH's Healthy Futures program and in eight public charter preschools with the use of philanthropic funds.[372][485] Early childhood mental health consultation is a supportive service that builds teacher, staff, program, and schoolwide capacity to promote social-emotional development, improve challenging behaviors occurring in the child care or education settings, and provide support by embedding psychologists in early child care centers and education settings. This model provides many other benefits including addressing staff well-being through providing support and consultation to teachers and staff. The integrated, team-based approach to care helps reduce some of the burden placed on clinicians. It also promotes positive mental health of young children and their caregivers through providing upstream services, which can help to alleviate the need for acute clinical care later on in development. The District should explore opportunities for continued support and expansion of this program, which will also require an adequate and robust workforce to sustain this effort.

Children Who Speak Languages Other Than English

33. DBH should make its website more accessible to LEP/NEP individuals.

Implementing Bodies: DBH, OHR, DC Office of Disability Rights, D.C. Office for Deaf, Deafblind and Hard of Hearing
Timeline to Implementation: Short to Medium Term

Though DBH has historically scored exceptionally well in its implementation of language access programming by the OHR, it was noted in the most recently published report that DBH is lacking in language accessible materials listed on its webpage.[106] DBH should comply with OHR's recommendations to enhance the language accessibility of its website to LEP/NEP individuals by posting translated information. Additionally, DBH should include on its webpage all the places/pathways that families can access interpretation services—including via Access Helpline, MCOs, and through community agencies.

34. Expand the bilingual/multilingual behavioral health workforce.

Implementing Bodies: OHR, DBH, DHCF, MCOs, Community Based Agencies
Timeline: Long Term

DBH and community-based agencies should make reasonable efforts to hire both clinical (e.g., LCSW, LPC, psychologist, MD/DO, psychiatric NPs, etc.) and nonclinical staff (e.g., community support workers, care navigators, etc.) who are proficient in the languages spoken by District residents. The workforce should offer the full continuum of services to all beneficiaries, including children and families. Reasonable efforts should be made to hire a multilingual workforce from local communities. Additionally, reasonable efforts should be taken to offer these

services near or within the geographic regions of the District where the LEP/NEP communities reside (e.g., services for the Spanish-speaking population within Wards 1 and 4).

The District should invest in bilingual/multilingual behavioral health personnel. Provider organizations that demonstrate strong language capacity should be paid differential rates by the MCOs. That should incentivize provider organizations to offer language skills and training.

Workforce recruitment practices should be modified to hire and retain bilingual/multilingual personnel, and when possible and appropriate, bilingual/multilingual community members should be considered to fill workforce needs. Please reference Recommendation 1 in Chapter 6 for strategies that can be used to implement this.

35. Contract providers that can provide or translate behavioral health services for children in American Sign Language (ASL).

Implementing Body: DBH, DHCF
Timeline: Short to Medium Term

DBH currently contracts with Deaf REACH, an agency that provides ASL interpretation for adults. DBH should contract with an agency that can provide similar services for children (under 18 years). DBH can consider forming a partnership with VocoVision, an agency that has partnered with schools to offer mental and behavioral health support to children in ASL.

In addition, DBH and DHCF should mandate all MCOs contract with the following local resources that offer therapeutic services to children that speak ASL:

- Gallaudet University's Psychology Clinic (including all clinicians affiliated with the Parent Child Interaction Therapy Clinic)
- Deaf Counseling Center
- Kennedy Krieger Institute's Deafness-Related Evaluations and More (DREAM) Clinic

36. Improve data transparency about the language accessibility of services for LEP/NEP individuals.

Implementing Bodies: DHCF, DBH, OHR
Timeline: Short to Medium Term

The following strategies allow greater transparency about language accessibility, which can promote services delivery modifications to better meet the needs of children who speak languages other than English:

- According to the *2019–2023 DC Medicaid Managed Care Quality Strategy*, Medicaid enrollees may voluntarily disclose their primary language during enrollment and that information is shared with MCOs to ensure they provide culturally and linguistically appropriate services to members. Therefore, in line with CMS External Quality Review Protocols,[486] the District's independent external quality review organization should evaluate the linguistic appropriateness of MCO services and ensure it is reported on in their annual *MCO External Quality Review Annual Technical Report*. As mentioned in Recommendation 2 in Chapter 6, use of the CLAS framework[254] or similar standards can facilitate easier measurement of language accessibility.

- OHR should anonymously summarize and publish consumer complaint data on a quarterly basis. That data should be shared with DBH and DHCF leadership, as well as any named community-based provider as applicable, to strengthen the feedback loop between consumer experience and services being offered. The public should also have access to these data to inform decision making when seeking services and for advocacy purposes.

37. Managed care plans should ensure they have an adequate network of multilingual, child-serving providers and should have policies/guidelines for single-case agreements for LEP/NEP beneficiaries that require behavioral health services outside the MCOs standard network.

Implementing Bodies: MCOs, DHCF, DBH
Timeframe: Medium Term

When LEP/NEP consumers receive services from a bilingual (and culturally competent) clinician who is fluent in their preferred language, it helps to reduce the time of treatment, build trust between the clinician and client, and can increase treatment adherence and efficacy. When available, it is best practice to link LEP/NEP consumers with clinicians who are qualified to render services in the consumers' preferred language. MCOs should have policies and guidelines in place to ensure network adequacy for children who speak languages other than English.

Each MCO should have an identified process to request the establishment of a single-case agreement and/or enhanced payment contract when a beneficiary who speaks a language other than English requires a specialized service that is outside the MCO's standard network. It is noteworthy that there are many bilingual/multilingual clinicians in the District who are private-pay and/or operated through out-of-network benefits offered by commercial plans. This should be a special consideration as MCOs develop policies, specifically related to the potential of enhanced payment contracts.

38. Work with OHR to have DBH information included as part of the public awareness campaign for language services.

Implementing Bodies: OHR, DHCF, DBH, DC Health, OSSE, DCPS
Timeframe: Long Term

If a behavioral health awareness campaign is established, ensure that the webpage and materials are translated and posted in multiple languages (reference Recommendation 4 in Chapter 7: Information & Communication). The behavioral health awareness campaign should comply with the Migration Policy Institute best practices for multilingual websites. Guidelines include ensuring high-quality translation of materials, easily accessible, and culturally competent.

39. Create more bridge service opportunities like DC Health-supported Help Me Grow DC and DC MAP Partnership.

Implementing Bodies: DC Health, Help Me Grow, DC MAP, DBH
Timeline: Short, Medium, and Long Term

Until the multilingual workforce shortage can be addressed, the DC government should consider implementing more opportunities for bilingual providers to provide short-term bridge care for children and families. Currently, DC Health supports an expansion grant that partners DC MAP with Help Me Grow DC to employ a bilingual (English and Spanish) psychotherapist part-time who has expertise in early childhood and perinatal mental health. This expansion program offers families access to short-term services (typically one to six sessions) until they are linked with ongoing care in the community, which often can take six-plus months due to extended waiting lists. It is recommended that this expansion program between DC MAP and Help Me Grow DC is continued. Additionally, the DC government may consider creating additional expansion programs to provide short-term bridge services for other special populations with already limited service options that often have extended wait times (e.g., therapy for LEP/NEP LGBTQ+ youth).

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APPENDIX

Appendix A

Table A.1. The Governance & Leadership Roles of Selected Government Bodies in DC's Behavioral Health System for Children

Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Centers for Medicare and Medicaid Services (CMS)	According to federal regulations, CMS must review and approve all contracts that states enter into with managed care organizations (MCOs), including contract provisions that incorporate standards for access to care. In addition, each state must submit to CMS its quality strategy, which includes these standards, and must certify that its MCOs have complied with its requirements for availability of services. Further, each state must submit to CMS regular reports describing the implementation and effectiveness of its quality.[xlii] Finally, CMS requires states to work with its Medicaid MCOs and Children's Health Insurance Program (CHIP) to ensure that the Mental Health Parity and Addiction Equity Act is applied to behavioral health services.[xliii]	Social Security Act § 1932[1] 42 CFR 438[xliv] 42 CFR 440 42 CFR 456 42 CFR 457[xlv, xlvi] 80 FR 19418	
Substance Abuse and Mental Health Services Administration	Leads public health efforts to advance the behavioral health of the nation through programs, policies, information and data, funding, and personnel. [xlvii]	Helping Families in Mental Health Crisis Act of 2013, H.R.3717[xlviii] 42 CFR 8[xlix] 42 CFR Part 2[l]	

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xliii *Centers for Medicare & Medicaid. Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans. Federal Register; 2016. Accessed May 10, 2021. https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of*
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Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Administration for Children & Families	Promotes the economic and social well-being of families, children, individuals and communities with funding, strategic partnerships, guidance, training, and technical assistance.[li]	81 FR 61293 (45 CFR chapter undefined)[lii]	
Centers for Disease Control and Prevention (CDC)	Works toward eliminating diseases and ending epidemics through data analytics, lab capacity, and public health expertise.[liii]	Title 42 – Public Health	CDC Regulations
Department of Healthcare Finance (DHCF)	Administers the Medicaid program, programs for immigrant children, the State Child Health Insurance Program and Medical Charities (a locally funded program); DHCF also serves as the State Health IT Coordinator and leads health IT and health information exchange (HIE) policy for the District.	Title XIX of The Social Security Act DC Official Code Chapter 7D. Department of Health Care Finance. §§ 7-771.01 – 7-771.11	Medicaid State Plan Medicaid Managed Care Quality Strategy 2020 State Health Innovation Plan
DC Medical Care Advisory Committee (MCAC)	Reviews Medicaid's operations and offers advice for improvements directly to the DHCF leadership. The MCAC consists of no more than 15 voting members, with at least eight members being beneficiaries or beneficiary advocates and no more than seven members being health care providers (or representatives of providers). The MCAC also has four sub-committees through which nonmembers (including other nongovernmental organizations) can provide input.	Social Security Act § 1902 Code of Federal Regulations (42 CFR 431.12)	DC MCAC By-Laws and Procedures
DHCF Division of Program Integrity	Conducts audits and reviews of providers within DC's Medicaid program and investigates alleged violations of policies, procedures, rules, or laws.[liv]	Code of Federal Regulations (42 CFR 431.10, 42 CFR 447.202, 42 CFR 455, 42 CFR 438, 42 CFR 456, 42 CFR 1001) DC Official Code Chapter 8. Medicaid Provider Fraud Prevention. §§ 4-801 – 4-805	

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[liv] About DHCF. Government of the District of Columbia. Accessed February 1, 2021. https://dhcf.dc.gov/page/about-dhcf

Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Office of Managed Care	Monitors MCO obligations in providing appropriate, timely, and quality care to managed care eligible persons.[lv]		Medicaid Managed Care Contracts
Department of Health (DC Health)	Works to improve perinatal, childhood, and adolescent health outcomes so every child in DC is healthy and able to thrive.[lvi]	DC Official Code Chapter 7A. Functions of the Department of Health, §§ 7-731 – 7-744.01	DC Health Systems Plan 2017
Health Regulation & Licensing Administration (HRLA)	Licenses and certifies health care facilities for compliance with state and federal health and safety standards and licenses health professionals.[lvii]		
Department of Behavioral Health (DBH)	Provides prevention, intervention, and treatment services and supports for children with mental and/or substance use disorders (including emergency psychiatric care and community-based outpatient and residential services).[lviii]	Department of Mental Health Establishment Amendment Act of 2001, DC Law 14-51 \n\n Department of Behavioral Health Establishment Act of 2013	DC DBH Strategic Plan 2019
Department of Behavioral Health Planning Council (BHPC)	Advises the DBH in identifying behavioral health needs in DC, planning and implementing person-centered behavioral health services, communicating to the public about DBH, as well as monitoring and evaluating the allocation and adequacy of mental health and substance abuse services in DC.[lix]	Mental Health Service Delivery Reform Act of 2001 \n\n State mental health planning council, 42 U.S. Code § 300x–3	DC BHPC Bylaws
Department of Human Services (DHS)	Provides youth homelessness services, as well as protection, intervention, and social services to help reduce risk and promote self-sufficiency in vulnerable families (including interim disability assistance, subsidized child care, Temporary Assistance for Needy Families and the Supplemental Nutrition Assistance Program).[lx]	Powers and duties of Department of Human Services, § 44–1302. \n\n DC Official Code Chapter 7A. Services for Homeless Individuals and Families, § 4-751.01 et seq.	

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Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Department of Disability Services	Responsible for the oversight and coordination of all services and supports provided to qualified persons with developmental disabilities in DC through its Developmental Disabilities Administration (DDA). The Youth in Transition Services Unit specifically coordinates activities that promote movement from school to post-school.[lxi]	DC Official Code Chapter 7C. Department on Disability Services (DDS) §§ 7-761.01 – 7-761.13 The Rehabilitation Act of 1973 (Rehab Act)	
Child and Family Services Agency (CFSA)	Investigates reports of known or suspected child abuse, assists families in overcoming difficulties that endanger their children, provides safe out-of-home care when a home presents danger, and re-establishes permanent homes for children.[lxii]	DC Official Code Part C. Child and Family Service Agency, § 4-1303 et seq	Initial Evaluation of Children's Health Policy Placement and Matching Policy Transition Services for Youth Policy Substance Abuse Treatment Policy Resource Parents Policy Resource Parents Training Policy Educational Services Policy All CFSA policies
Thrive by Five Coordinating Council	Works to measure progress of District and community-level initiatives focused on improving maternal and infant health outcomes (including behavioral health outcomes) and promoting healthy child development from birth to age 5.[lxiii]		Thrive by Five Coordinating Council Mayoral Order
District of Columbia Public Schools (DCPS)	DCPS is a system of neighborhood, matter-of-right schools with some selective school options, and it is required to serve all students in DC.[lxiv]	DC Official Code Chapter 1A. District of Columbia Public Schools § 38-171 et seq.	DC Public Schools' strategic plan for 2017-2022 DCPS District-Wide Bullying Prevention Policy

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[lxiii] Thrive by Five Coordinating Council. Government of the District of Columbia. Accessed February 1, 20201. https://thrivebyfive.dc.gov/page/thrive-five-coordinating-council
[lxiv] District of Columbia State Board of Education. Understanding the DC Public Education Landscape. Accessed February 1, 2021. https://sboe.dc.gov/sites/default/files/dc/sites/sboe/multimedia_content/public%20education%20governance%20%28web%29.pdf

Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Office of the State Superintendent of Education (OSSE)	OSSE serves as the District's liaison to the U.S. Department of Education and works closely with the District's traditional and public charter schools. Some of its key functions that can be linked to behavioral health: providing resources to assist the District's most vulnerable student populations, providing transportation to school for District children with special needs, and increasing health and physical education awareness.[lxv]	Public Education Reform Amendment Act (PERAA) Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400 (2004) The Youth Suicide Prevention and School Climate Survey Amendment Act of 2016, DC Law 21-0120.	OSSE Mental Health Guidelines 2018
State Early Childhood Development Coordinating Council (SECDCC)	Improve collaboration and coordination among entities carrying out federally funded and District-funded pre-K and other early childhood programs.[lxvi]	Pre-K Enhancement and Expansion Act of 2008, DC Law 24-9.	
Public Charter School Board	Provides oversight to public charter schools that are managed by independently run nonprofit organizations called local education agencies (LEAs).[lxvii]	District of Columbia School Reform Act of 1995	DC PCSB Policies
Metropolitan Police Department	Investigates child abuse and neglect, often through collaboration with CFSA; offers youth engagement through summer enrichment programs like the Jr. Police Academy, school year partnerships like the Youth Advisory Council, and clubhouse activities at the Metropolitan Police Boys and Girls Clubs,[lxviii, lxix]	*DC Official Code Chapter 1. Metropolitan Police §§ 5-101.01 – 5-133.21*	

[lxv] *About OSSE. Government of the District of Columbia. Accessed February 1, 2021. https://osse.dc.gov/page/about-osse*
[lxvi] *State Early Childhood Development Coordinating Council (SECDCC). Government of the District of Columbia. Accessed February 1, 2021. https://osse.dc.gov/service/state-early-childhood-development-coordinating-council-secdcc*
[lxvii] *Who We Are. Government of the District of Columbia. Accessed February 1, 2021. https://dcpcsb.org/about-us/who-we-are*
[lxviii] *Children's National Medical Center. Policy for the Identification and Reporting of Child Victimization. Accessed February 1, 2021. https://childrens-national.org/-/media/cnhs-site/files/departments/child_victim_model_project_child_victimization_policy.pdf?la=en&hash=6DFAA56C879F2ACFD-42964C1B46D4774A21217F7*
[lxix] *Youth Outreach. Government of the District of Columbia. Accessed February 1, 2021. https://mpdc.dc.gov/page/youth-outreach*

Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Department of Youth Rehabilitation Services (DYRS)	Responsible for the supervision, custody, and care of young people charged with a delinquent act in DC in one of the following circumstances: • Youth who are detained in a DYRS facility while awaiting adjudication.[lxx] • Youth who are committed to DYRS by a DC Family Court judge following adjudication.[lxxi] DYRS oversees DC YouthLink, a coalition of community-based organizations that deliver an array of services (including behavioral health services) for youth and families.[lxxii]	Department of Youth Rehabilitation Services Establishment Act of 2004 Omnibus Juvenile Justice Act of 2004	The DYRS Approach: Alcohol and Substance Abuse Treatment The DYRS Approach: DC YouthLink and Community-Based Rehabilitation
DC Council	The Council's central role as a legislative body is to make laws; however, its responsibilities also include oversight of multiple agencies. Specifically, Council committees review the performance of government programs and agencies to ensure they are serving their established purposes and operating under pertinent regulations and budget targets.[lxxiii]	DC Official Code Part A. The Council. §§ 1-204.01 – 1-204.13	Rules Of Organization And Procedure For The Council Of The District Of Columbia - Period 24.
DC Office of Administrative Hearings	The office decides cases involving Medicaid and other public benefits; public space; rent control; professional and business licenses; and building, health and fire code violations, among others.[lxxiv]	DC Official Code Chapter 18A. Office of Administrative Hearings. § 2-1831 et seq.	Office Of Administrative Hearings Rules Of Practice And Procedure
Advisory Neighborhood Commissions (ANC)	The ANC is a collection of locally elected representatives who advise the District and federal governments on matters affecting their neighborhoods, such as health services, budget, safety, planning, sanitation, social services, education, recreation, streets, and zoning. In addition to providing recommendations for improving city services, they monitor resident complaints and conduct neighborhood improvement plans. While the District and federal governments are not required to follow all ANC recommendations, they are required to give them great weight.[lxxv]	DC Official Code Part A. General. § 1-309 et seq.	

[lxx] *District of Columbia Government Child, Youth & Family Serving Agencies Washington, D.C., District Of Columbia. DC Support Link. Accessed February 13, 2021. https://washington.dc.networkofcare.org/mh/content.aspx?cid=3039*
[lxxi] *Youth Population Snapshot. Department of Youth Rehabilitation Services. Accessed May 6, 2021. https://dyrs.dc.gov/page/youth-snapshot*
[lxxii] *Department of Youth Rehabilitation Services. 2018 DYRS Annual Report; Accessed February 1, 2021. https://dyrs.dc.gov/sites/default/files/dc/sites/dyrs/page_content/attachments/DYRS2018_AnnualReport_WEB.pdf.*
[lxxiii] *About the Council. Council of the District of Columbia. Accessed February 1, 2021. https://dccouncil.us/about-the-council/*
[lxxiv] *Office of Administrative Hearings. Government of the District of Columbia. Accessed February 1, 2021. https://oah.dc.gov/*
[lxxv] *About ANCs. Government of the District of Columbia. Accessed February 13, 2021. https://anc.dc.gov/page/about-ancs*

Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
DC Court of Appeals	The equivalent of a state supreme court, the DC Court of Appeals is authorized to review decisions made by the DC Superior court. It may also review contested case decisions made by the DC government and answer questions of law made by federal and state appellate courts.[lxxvi]	DC Official Code Part C. The Judiciary §§ 1-204.31 – 1-204.34	
DC Superior Court	The divisions of the Superior Court with strongest linkages to the behavioral health system for children are the Family Court Operations Division and the Family Court Social Services (CSS) Division. The former receives and processes cases such as child abuse and neglect, juvenile delinquency and mental health and habilitation, while the latter is the District's juvenile probation agency.[lxxvii]	DC Official Code Part C. The Judiciary §§ 1-204.31 – 1-204.34	

*Not a comprehensive list of legislation or policies related to the authority and responsibility of governmental bodies

[lxxvi] *GW Law Library: Library Guides: District of Columbia (D.C.) Law: Courts. GW Law. Accessed February 13, 2021. https://law.gwu.libguides.com/DC/courts*
[lxxvii] *Superior Court of the District of Columbia. Superior Court of the District of Columbia 2018 Family Court Annual Report; 2018. Accessed November 11, 2021. https://www.dccourts.gov/sites/default/files/Family-Court-2018-Annual-Report.pdf*

Figure B.1. A Model of Collaborative Governance

Institutional Design

Participatory Inclusiveness, Forum Exclusiveness, Clear Ground Rules, Process Transparency

Starting Conditions

Power-Resource-Knowledge Asymmetries

Incentives for and Constraints on Participation

Prehistory of Cooperation of Conflict (initial trust level)

Collaborative Process

Trust-Building

Commitment to Process
-Mutual recognition of interdependence
-Shared Ownership of Process
-Openness to Exploring Mutual Gains

Face-to-Face Dialogue
-Good Faith Negotiation

Intermediate Outcomes
-"Small Wins"
-Strategic Plans
-Joint Fact-Finding

Shared Understanding
-Clear Mission
-Common Problem Definition
-Identification of Common Values

Outcomes

→ **Influences**

Facilitative Leadership
(including empowerment)

Extracted from Ansell, C., & Gash, A. Collaborative Governance in theory and Practice. Journal of Public Administration Research and Theory, 18, 543-571. (2008). https://doi.org/10.1093/jopart/mum

Table C.1. Selected States' Successes and Challenges With Their Behavioral Health Carve-in

State	Behavioral Health Integration Approach	Successes	Challenges
Washington	Washington state uses a fully integrated managed care (FIMC) model, in which all populations receive both physical and behavioral health coverage through the managed care plan. In this system, MCOs may subcontract with managed behavioral health organizations (BHOs) to manage behavioral health coverage.[lxxviii] The transition to FIMC in Washington was phased by region from 2016 to 2020.[lxxix]	• Increased encounter data facilitated proactive patient engagement.[lxxx] • Significant improvements in a number of behavioral health outcomes.[lxxxi] • MCOs standardized claims processing, minimizing administrative burden.[lxxxii] • Early Warning System feedback loop and triage process addressed early implementation issues.[lxxxiii]	• Provider systems reconfigurations related to the transition to FIMC contributed to some delays in claim submissions.[lxxxiv]
New York	New York provides FIMC for the general population, as well as specialty plans (called a Health and Recovery Plan) for individuals with a serious mental illness (SMI) or substance use disorder (SUD).[lxxxv] MCOs may choose to subcontract with BHOs to manage behavioral health benefits.[lxxxvi] Individuals with SMI or SUD are able to opt into a nonspecialty plan if preferred.[lxxxvii] Implementation of New York's carve-in was phased by population and region and began in 2015.[lxxxviii]	• Real-time hospital utilization data collected through New York' electronic HIE has helped improve treatment for high-risk patients.[lxxxix] • Value-based purchase (VBP) arrangement pilots reported improved patient health outcomes and provider readiness to participate in future VBP initiatives.[xc] • Healthcare Effectiveness Data and Information Set (HEDIS) measure use has helped to inform provider whole-health initiatives.[xci]	• Provider workforce shortages have presented challenges in meeting demand associated with behavioral health system reform efforts.[xcii]

[lxxviii] *National Health Law Program. An Overview of Physical and Behavioral Health Integration; 2020. Accessed November 11, 2021. https://healthlaw.org/wp-content/uploads/2020/01/NHeLP-BH-Integration-FINAL.pdf*

[lxxix] *Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf*

[lxxx] *Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/*

[lxxxi] *Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf*

[lxxxii] *Regional Health Alliance and Washington State Health Care Authority. Delivery of Whole-Person Care in Southwest Washington: Report on the First 90 Days of Fully Integrated Managed Care; 2016. Accessed November 11, 2021. https://www.hca.wa.gov/assets/program/early-adopter-report.pdf*

[lxxxiii] *Regional Health Alliance and Washington State Health Care Authority. Delivery of Whole-Person Care in Southwest Washington: Report on the First 90 Days of Fully Integrated Managed Care; 2016. Accessed November 11, 2021. https://www.hca.wa.gov/assets/program/early-adopter-report.pdf*

[lxxxiv] *Regional Health Alliance and Washington State Health Care Authority. Delivery of Whole-Person Care in Southwest Washington: Report on the First 90 Days of Fully Integrated Managed Care; 2016. Accessed November 11, 2021. https://www.hca.wa.gov/assets/program/early-adopter-report.pdf*

[lxxxv] *National Health Law Program. An Overview of Physical and Behavioral Health Integration; 2020. Accessed November 11, 2021. https://healthlaw.org/wp-content/uploads/2020/01/NHeLP-BH-Integration-FINAL.pdf*

[lxxxvi] *Soper, MH. Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators. Center for Health Care Strategies; 2016. Accessed November 11, 2021. https://www.chcs.org/media/BH-Integration-Brief_041316.pdf*

[lxxxvii] *National Health Law Program. An Overview of Physical and Behavioral Health Integration; 2020. Accessed November 11, 2021. https://healthlaw.org/wp-content/uploads/2020/01/NHeLP-BH-Integration-FINAL.pdf*

[lxxxviii] *National Health Law Program. An Overview of Physical and Behavioral Health Integration; 2020. Accessed November 11, 2021. https://healthlaw.org/wp-content/uploads/2020/01/NHeLP-BH-Integration-FINAL.pdf*

[lxxxix] *Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf*

[xc] *Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/*

[xci] *Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/*

[xcii] *Smyth, A. System Change and Service Providers: Opportunities and Challenges in Addressing Unmet Needs. Behavioral Health News, January 1, 2019. Accessed November 11, 2021. https://behavioralhealthnews.org/system-change-and-service-providers-opportunities-and-challenges-in-addressing-unmet-needs/*

State	Behavioral Health Integration Approach	Successes	Challenges
Arizona	Arizona has opted to integrate behavioral health services into managed care for the general population while contracting with specialty plans through regional behavioral health authorities (RBHAs) that cover both physical and behavioral health for individuals with SMI.[xcii, xciv] Arizona phased the implementation of its carve-in efforts by geography and population, beginning with individuals who have SMI.[xcv] The transition began in 2014 and lasted until 2018.[xcvi]	• Partnerships between RBHAs and BHOs to create data collection platforms led to improvements in care management capacity.[xcvii] • HIE use, including real-time hospital data alerts, helped inform high-risk patient care.[xcviii] • Significant increases were seen in provider participation in state HIE.[xcix]	• One MCO experienced issues with unpaid claims, credentialing errors, service reductions, and staff layoffs related to the transition.[c]

[xcii] National Health Law Program. An Overview of Physical and Behavioral Health Integration; 2020. Accessed November 11, 2021. https://healthlaw.org/wp-content/uploads/2020/01/NHeLP-BH-Integration-FINAL.pdf

[xciv] Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf

[xcv] Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf

[xcvi] Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf

[xcvii] Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/

[xcviii] Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/

[xcix] Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/

[c] Smith AD, Edwards BC, and Frederick D. The Transition of Behavioral Health Services into Comprehensive Medicaid Managed Care: A Review of Selected States. National Council for Behavioral Health. June 2020. Access November 11, 2021. https://www.thenationalcouncil.org/wp-content/uploads/2020/07/Transition_of_BH_Services_into_Comprehensive_Medicaid_Managed_Care_Final_June_2020.pdf?daf=375ateTbd56

Table D.1. Public Behavioral Health Programs for Children in DC

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Mental Health Rehabilitation Services (MHRS) program/DBH	Child/youth MHRS include: 1) Diagnostic/ assessment 2) Medication/ somatic treatment 3) Counseling 4) Community support 5) Crisis/emergency 6) Community-based intervention[ci]	Children and youth age 0–22 with severe emotional disturbance (SED) or SMI diagnosis.	Number of children (0-20) served: • FY 2015 – 5060 • FY 2016 – 5512 • FY 2017 – 4807 • FY 2018 – 3821 • FY 2019 – 3692[cii] These numbers were not reported for FY 2020.	• Access Helpline • Contact a CSA directly • DC Jail or pretrial services[ciii] • Provider- or self-referral from Medicaid MCO/Fee-for-Service (FFS)[civ] • Referral from hospital staff, DYRS, CFSA, Child and Adolescent Mobile Psychiatric Service (ChAMPS), or School Based Health Providers (SBHP)[cv, cvi] • Once an individual is assigned and enrolled with a CSA, a diagnostic assessment is scheduled[cvii]	As of July 2019, there were 21 child/youth-serving MHRS providers. MHRS Providers include DBH-certified Core Service Agencies (CSAs) and subspecialty and specialty providers.

[ci] *State Plan for Medical Assistance Under Title XIX of the Social Security Act. Department of Health Care Finance. Government of the District of Columbia. 2015. Accessed November 11, 2021. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DHCFStatePlanAttach3-1bSup3_1_0.pdf*

[cii] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*

[ciii] *Acosta J, Blanchard JC, Pollack CE, Benjamin-Johnson R, Adamson DM, Gresenz CR, and Saloner B. WORKING PAPER: Guide to the Behavioral Health Care System in the District of Columbia. District of Columbia Department of Mental Health; August 2010. Accessed November 11, 2021. https://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR777.pdf*

[civ] *Wotring JR, O'Grady KA, Anthony BJ, Le LT, Rabinowitz LA, Yoon LS, and Rotto K. Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers, and Recommendations." Department of Behavioral Health; May 2014. Accessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf*

[cv] *Department of Behavioral Health. MHRS Bulletin: CSA Response to CFSA Initial Referrals. Government of the District of Columbia; 2013. Acessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dslbd/publication/attachments/Bulletin%20%20%23%2096%20CSA%20Response%20to%20CFSA%20Initial%20Referrals.pdf*

[cvi] *Department of Behavioral Health. Department of Behavioral Health FY18-19 Performance Oversight Questions. Council of the District of Columbia; 2019. https://dccouncil.us/wp-content/uploads/2019/04/dbh.pdf*

[cvii] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Psychiatric Residential Treatment Facility (PRTF)/DBH	A nonhospital treatment center that provides inpatient services to Medicaid-eligible children under 21 years of age in agreement with a State Medicaid Agency[cviii]	Medicaid-eligible children and youth under age 21[cix]	Number of children/youth receiving treatment in a PRTF: • FY18 – 81 (44 new admissions)[cx] • FY19 – 81 (43 new admissions)[cxi] • FY20 – 97 (36 new admissions)[cxii]	DBH PRTF Placement Review Committee is responsible for certifying medical necessity for the PRTF level of care for placements or continued stays to be funded by Medicaid FFS. DHCF approves prior authorizations only if medical necessity has been confirmed by the DBH.[cxiii]	There are no PRTF providers in the District.
HealthCheck or Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/ DHCF	DC HealthCheck offers services such as free check-ups, including developmental and behavioral assessments, and medically necessary care.[cxiv] It also offers provider trainings and fosters collaboration between sectors.[cxv]	Children from birth to 21 years enrolled in DC Medicaid[cxvi]	Number of children/youth eligible for EPSDT who received at least one initial or periodic screen • FY18 – 57,528[cxvii] • FY19 – 59,535[cxviii] Number of children/youth eligible for EPSDT who were referred for corrective treatment • FY18 – 54,441[cxix] • FY19 – 38,273[cxx]	State Medicaid agencies are required to inform Medicaid-eligible youth and children under age 21 about EPSDT services and arrange for EPSDT service provision.[cxxi]	N/A

[cviii] Wotring JR, O'Grady KA, Anthony BJ, Le LT, Rabinowitz LA, Yoon LS, and Rotto K. Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers, and Recommendations." Department of Behavioral Health; May 2014. Accessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf

[cix] Wotring JR, O'Grady KA, Anthony BJ, Le LT, Rabinowitz LA, Yoon LS, and Rotto K. Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers, and Recommendations." Department of Behavioral Health; May 2014. Accessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf

[cx] Department of Behavioral Health. Department of Behavioral Health FY18-19 Performance Oversight Questions. Council of the District of Columbia; 2019. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2019/04/dbh.pdf

[cxi] Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf

[cxii] Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf

[cxiii] Turnage, W. Responses to Fiscal Year 2018-2019 Performance Oversight Questions. Council of the District of Columbia; 2019. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2019/04/dhcf.pdf

[cxiv] Government of the District of Columbia. Health Check. 2020. Accessed November 11, 2021. https://www.dchealthyfamilies.com/Documents/DC1/HealthCheckBrochureEnglish.pdf

[cxv] McCourt School of Public Policy. "Helping Doctors Care for DC's Most Vulnerable." November 24, 2019. Accessed November 11, 2021. https://live-guwordpress-mccourt.pantheonsite.io/news/helping-doctors-care-for-dcs-most-vulnerable/

[cxvi] Government of the District of Columbia. Health Check. 2020. Accessed November 11, 2021. https://www.dchealthyfamilies.com/Documents/DC1/HealthCheckBrochureEnglish.pdf

[cxvii] Centers for Medicare and Medicaid. Annual EPSDT Participation Report—District of Columbia FY: 2018. U.S. Department of Health and Human Services; 2018. Accessed November 11, 2021. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

[cxviii] Centers for Medicare and Medicaid. Annual EPSDT Participation Report—District of Columbia FY: 2019. U.S. Department of Health and Human Services; 2019. Accessed November 11, 2021. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

[cxix] Centers for Medicare and Medicaid. Annual EPSDT Participation Report—District of Columbia FY: 2018. U.S. Department of Health and Human Services; 2018. Accessed November 11, 2021. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

[cxx] Centers for Medicare and Medicaid. Annual EPSDT Participation Report—District of Columbia FY: 2019. U.S. Department of Health and Human Services; 2019. Accessed November 11, 2021. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

[cxxi] Early and Periodic Screening, Diagnostic, and Treatment. Medicaid. Accessed May 26, 2021. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Parent Infant Early Childhood Enhancement (PIECE) Program/DBH	Individual, family, art therapy, play therapy, and parents' psychoeducational group. Evidence-based practices offered are: Child Parent Psychotherapy (CPP) and Parent Child Interaction Therapy (PCIT).	• Children ages 0–7, who present with social, emotional, and disruptive behaviors that cause impaired functioning. • Mothers who have been identified as experiencing mental health challenges that impact early attachment and parenting of their infant child.	Children served: • FY 18 – 215 (35 children receiving CPP and 23 children receiving PCIT) • FY 19 – 205 (24 children receiving CPP and 23 children receiving PCIT) • FY 20 – 296 (DBH did not report a breakdown between CPP and PCIT in FY 20).[cxxii] (Note: caseload capacity is 150 clients with each clinician carrying up to 25 cases.)[cxxiii]	• Referral from physician • Access Helpline[cxxiv]	N/A
Healthy Futures/DBH	Child and family-centered consultation services to care providers and family members that build their skills and capacity to promote social-emotional development, prevent escalation of challenging behaviors, and increase appropriate referrals for additional assessments and services.	Consultations provided to child development centers and home child care providers, as well as directly to children and families.	1,825 young children had access to consultation across the 61 Healthy Futures sites.[cxxv]	The point of entry is through the child development centers and home providers that offer Healthy Futures.	61 sites in FY 2019 (42 child development centers and 19 home providers)[cxxvi] Sites are located in every Ward with a concentration in Wards 4 and 8.

[cxxii] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*
[cxxiii] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*
[cxxiv] *Child & Adolescent Mental Health Resource Guide. HealthCheck Training & Resource Center. Accessed May 27, 2021. https://www.dchealthcheck.net/resources/healthcheck/mental-health-guide.html*
[cxxv] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*
[cxxvi] *Behavioral Health in the District of Columbia for Children, Youth, and Their Families: Understanding the Current System. Children's Law Center. 2019. Accessed November 11, 2021. https://childrenslawcenter.org/resources/behavioral-health-district-columbia-children-youth-families-understanding-current-system/*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Healthy Steps/ DC Health	An evidence-based national model pediatric primary care program that provides infants and toddlers with social-emotional and development support by integrating child development specialists into primary care and strengthening family engagement.[cxxvii]	Families with infants and toddlers[cxxviii]	In 2019, HealthySteps DC administered 350 parental behavioral health interventions and supported over 2,000 screenings to assess child development and behavioral health.[cxxix]	Families can access Healthy Steps at the applicable sites: • Unity Health Care – Minnesota Avenue Health Center • Unity Health Care – East of the River Health Center • MedStar Georgetown – Medstar Georgetown University Hospital (MGUH) Pediatrics/Kids • MedStar Georgetown – MedStar Medical Group at Fort Lincoln • Children's National – Children's Health Center at THEARC • Children's National – Children's Health Center Anacostia	There are two HealthySteps sites in the District, located in Ward 8.[cxxx] There are plans to expand to four additional sites at Unity Health Care and MedStar Georgetown.[cxxxi]
Primary Project/DBH	Screening and early intervention services to children identified with mild school adjustment issues in pre-kindergarten through third grade.	Children with mild school adjustment issues in pre-kindergarten through third grade	DBH did not report on Service Utilization & Service Capacity.	Accessible through the public schools and child development centers that provide this project	Certain public schools and child development centers (DBH did not report which schools.)

[cxxvii] *Valado T, Tracey J, Goldfinger J, and Briggs R. HealthySteps: Transforming the Promise of Pediatric Care. The Future of Children. 2019;29(1):99-122.*
[cxxviii] *Human Resources & Services Administration. District of Columbia - 2020 - III.E.2.c. State Action Plan - Child Health - Annual Report. Accessed May 27, 2021. https://mchb.tvisdata.hrsa.gov/Narratives/AnnualReport3/258318d0-8dbe-46fd-9a77-385b6753e1c7*
[cxxix] *Weerasingha-Cote T. Testimony Before the District of Columbia Council Committee on Health February 20, 2020. Accessed November 10, 2021. https://childrenslawcenter.org/resources/oversight-testimony-dc-health-0/*
[cxxx] *Our Sites: Find a HealthySteps Site Near You. HealthySteps. Accessed May 27, 2021. https://www.healthysteps.org/sites*
[cxxxi] *Our Sites: Find a HealthySteps Site Near You: Washington, DC. HealthySteps. Accessed November 11, 2021. https://www.healthysteps.org/who-we-are/the-healthysteps-network/healthysteps-practice-directory/?location=Washington+DC*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Adolescent Substance Abuse Treatment Expansion Program (ASTEP)/ DBH	Substance abuse assessment and treatment services using Adolescent Community Reinforcement Approach. Every adolescent accessing substance abuse treatment is screened for indicators of a mental health disorder using the Global Appraisal of Individual Needs.	Children under age 21 or up to 22 years of age with a SSA determination of disability, with an Axis I diagnosis of a substance use disorder, who meet insurance and income restrictions, and are a resident of DC at the time of treatment.[cxxxii]	In FY 20, 50 youth in foster care were referred for an assessment by an ASTEP provider.[cxxxiii] DBH does not report total numbers for Service Utilization & Service Capacity.	Adolescents in need of treatment may refer themselves to treatment, or they may be referred by a parent, guardian, doctor, teacher, social worker, mentor, or friend.	ASTEP network provider As of July 2019, 31 certified SUD providers include three child and youth outpatient providers, one child and youth residential provider, and one parent with children provider.
Child and Adolescent Mobile Psychiatric Service (ChAMPS)/ Catholic Charities of Washington Behavioral Health Services & DBH	1) Provides on-site crisis assessments to determine the mental health stability of a youth and their ability to remain safe in the community 2) Assists in the coordination of acute care assessments and hospitalizations when appropriate 3) Conducts post-crisis follow-up interventions up to 30 days after the initial crisis intervention to ensure linkage to DBH mental health providers for ongoing treatment, including longer-term mental health or substance use rehabilitative services	Children ages 6–17, as well as children ages 18–21 if they are in the care and custody of the DC Child and Family Services Agency.[cxxxiv]	In FY 19, 1,125 youth were served.[cxxxv] In FY 20, 710 youth were served.[cxxxvi] In FY 19, the average response time was 32 minutes, with the shortest response time at 31 minutes and the longest response time at 1 hour 35 minutes.[cxxxvii] In FY20, the average response time was 39 minutes. The longest response time was 2 hours, 39 minutes, and the shortest time was 1 minute.[cxxxviii]	Any parent or provider in any setting can initiate crisis emergency services for crisis situations.	The mobile team provides services where the child is located. It is available 24 hours, seven days a week.

[cxxxii] Acosta J, Blanchard JC, Pollack CE, Benjamin-Johnson R, Adamson DM, Gresenz CR, and Saloner B. *WORKING PAPER: Guide to the Behavioral Health Care System in the District of Columbia. District of Columbia Department of Mental Health; August 2010. Accessed November 11, 2021. https://www. rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR777.pdf*

[cxxxiii] Donald, B. *Performance Oversight Hearing Fiscal Year 2020-2021. Council of the District of Columbia; 2021. https://dccouncil.us/wp-content/up-loads/2021/03/FY20-21_CFSA_POH_PreHearing_Responses_FINAL2.pdf*

[cxxxiv] Millar, M and Rieke A. *Re-Routing Behavioral Health Crisis Calls from Law Enforcement to the Health System. DC Health Matters Collaborative; 2021. Accessed November 11, 2021. https://www.dchealthmatters.org/content/sites/washingtondc/Re-Routing_Crisis_Response_white_paper_May_2021.pdf*

[cxxxv] Department of Behavioral Health. *Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Colum-bia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*

[cxxxvi] Department of Behavioral Health. *Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Colum-bia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*

[cxxxvii] Department of Behavioral Health. *Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Colum-bia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*

[cxxxviii] Department of Behavioral Health. *Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
School-Based Behavioral Health (SBBH) Program/ DBH	The program's goal is for all public schools and public charter schools to provide a full array of behavioral health supports at three tiers: • Tier 1 encompasses mental health promotion and prevention for all students; • Tier 2 includes focused interventions for students at risk of developing a behavioral health problem; and • Tier 3 is comprised of intensive support/treatment for individual students who are experiencing a behavioral health problem. DBH identifies CBOs that, through funding from DBH, have the capacity to provide all tiers of services. DBH works with DCPS, OSSE, and the Public Charter School Board (PCSB) to match CBOs with individual schools. Once a school has been successfully matched with a CBO, a full-time CBO clinician is placed in the school to provide full-time behavioral health services.	Pre-K through grade 12 students in DC Public Schools and DC Public Charter Schools	As of 2021, there are 251 schools being served by SBBH programs[cxxxix] • 116 DCPS • 133 charter schools • 2 DYRS schools	The School Strengthening Tool and Work Plan guide the development and implementation of integrated and comprehensive behavioral health services, designed specifically for that school community.	251 public and public charter schools

[cxxxix] *Materials for Coordinating Council on School Behavioral Health October 18, 2021, Meeting. Access October 18, 2021. On file with the Children's Law Center.*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Strong Start DC Early Intervention Program (DC EIP)/ OSSE	Early intervention services and supports for children birth to three and their families who are District residents. Each eligible child and their family participate in the development of an Individualized Family Service Plan (IFSP) – for providing early intervention services.	Children under the age of 3 who have or are at risk of having developmental disabilities or delays All services are provided at no cost regardless of the family's income, insurance, and legal or employment status.	In FY 20, there were 1,890 referrals to DC EIP,[cxl] and 1,089 were found eligible as a result of referral.	Primary points of entry are from Clinics.[cxli] The other points of entry include: • CFSA • Child development centers • CBOs • Hospitals • Medicaid MCOs • Other • Other government agencies • Parent/family • Physician's offices	In FY 20, there were seven providers of DC EPI, DC EIP and MCO are the only source of payment options allowed by the program: • Coastal Healthcare • Kids in Motion • Milestone Therapeutic Services • National Therapy Center • Playwell • Strong Start • Little Feet and Hands
Early Stages/ DCPS	All children referred to Early Stages receive a developmental screening. If necessary, the child will receive a more in-depth evaluation and services. Early Stages can recommend specialized instruction, speech/ language therapy, physical therapy, occupational therapy, psychological services, and behavioral support services For eligible children, an Individualized Education Program (IEP) is developed Early Stages offers a variety of professional development workshops certified by OSSE.	Children between the ages of 2 years 8 months and 5 years 10 months	In FY 20, 2,827 children were screened. Of those, 605 (21.4%) were recommended for further evaluation.[cxlii]	Parents/caregivers can contact the center directly. A child care provider, teacher, doctor, or other professional may contact the center with a concern. (Early Stages then contacts parents/ caregivers to begin the process.)	Early Stages Centers (two available in DC)

[cxl] Young, S. Response to Fiscal Year 2020 Performance Oversight Questions. Government of the District of Columbia, Offices of the State School Superintendent of Education. 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/03/FY20-POH-Narrative-v7.2.pdf
[cxli] Young, S. Response to Fiscal Year 2020 Performance Oversight Questions. Government of the District of Columbia, Offices of the State School Superintendent of Education. 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/03/FY20-POH-Narrative-v7.2.pdf
[cxlii] District of Columbia Public Schools. FY20 Performance Oversight Questions. 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/03/DCPS-FY20-POH-Oversight-Responses_Final.pdf

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Parent & Adolescent Support Services (PASS)/DHS	Several evidence-based approaches to supporting families, including: • Strength-based intensive case management • Functional Family Therapy (FFT) in partnership with DBH • Transition to Independence Process in partnership with DBH All youth receiving PASS services have access to community support services such as mentoring, tutoring, and after-school programming.[cxliii]	Open to families with DC youth ages 10–17 who are committing status offenses Families are not eligible for PASS if they have an open case with CFSA or if the youth has an active case with CSS or DYRS.[cxliv]	As of January 31, 2021, PASS is serving 112 youth, which includes 71 youth receiving PASS Intensive Case Management (ICM), 17 youth receiving services from the PASS Crisis and Stabilization Team (PCAST), and 24 youth receiving therapeutic services from the PASS FFT team.[cxlv]	This is a voluntary program. Referrals can be made by using this PASS Referral form or by email, fax, or phone.[cxlvi]	Offered through DHS.
DC Mental Health Access in Pediatrics (MAP)/DBH	A team of mental health professionals (including psychiatrists, psychologists, social workers, and care coordinators) answer mental health-related inquiries about specific children (e.g., questions about appropriate community resources or medication), as well as provides education and technical assistance for primary care providers (PCPs) about identifying and addressing mental health issues in primary care.	PCPs	Since its inception, 358 PCPs have enrolled in DC MAP. Of that number, 123 remained active in FY 20. Since DC MAP started in May 2015 through December 2020, DC MAP has received a total of 4,066 consultation requests generated from primary care settings.[cxlvii]	N/A	See the Service Utilization & Service Capacity column. Note: As of November 2021, DC MAP's new vendor is Paving the Way.

[cxliii] *Department of Human Services, Parent and Adolescent Support (PASS) Intensive Case Management. Access November 11, 2021. https://dhs.dc.gov/service/parent-and-adolescent-support-pass-intensive-case-management*
[cxliv] *Committee on Human Services. 2021 Performance Oversight. Council of the District of Columbia. 2021. Accessed November 11, 2021. https://dc-council.us/wp-content/uploads/2021/02/DHS_2021-Performance-Oversight-Pre-Hearing-Responses.pdf*
[cxlv] *Committee on Human Services. 2021 Performance Oversight. Council of the District of Columbia. 2021. Accessed November 11, 2021. https://dc-council.us/wp-content/uploads/2021/02/DHS_2021-Performance-Oversight-Pre-Hearing-Responses.pdf*
[cxlvi] *Department of Human Services. Parent and Adolescent Support Services (PASS) Program Referral Form. Accessed November 12, 2021. https://dc-gov.seamlessdocs.com/f/PASSREFERRAL*
[cxlvii] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
High Fidelity Wraparound/ DBH	Care coordination service and is a collaborative team-based care planning process where the family and the team implement, track, and adapt an individualized Plan of Care (POC) to achieve positive outcomes in the home, school, and community.[cxlviii]	A child or youth with complex emotional needs who are at-risk of out-of-home placement or juvenile involvement with the courts for the family[cxlix]	• FY18 – 53 youth referred (new entry) 50 youth served, • FY19 – 45 youth referred (new entry), and 63 youth served. • FY 20 – 41 youth referred (new entry), 93 total youth served.[cl] The average length of stay of youth and families enrolled in wraparound in FY 20 was 10 months.[cli]	Children and youth are currently referred by a DBH-certified Core Service Agency, the Juvenile Behavioral Diversion Program, the Office of the Attorney General, Here Opportunities Prepare You for Excellence (HOPE) Court or the child or youth's family. Once a referral is received, DBH's Wraparound Committee reviews the case presentation. Referral can be received through the program's website, wraparound.cftm@dc.gov or by calling the Access Helpline. Children and youth who are involved in multiple systems and are at risk of out-of-home placement are accepted into the program.[clii]	Children who meet the criteria for wraparound support are connected with DBH's contracted service provider, MBI Health Services (MBI).[cliii] The current contract was awarded to MBI for $1.1 million dollars, currently funded with local dollars.

[cxlviii] Department of Behavioral Health. High Fidelity Wraparound Care Planning Process. 2014. Accessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/340.10-TL-260.pdf
[cxlix] Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf
[cl] Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf
[cli] Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf
[clii] Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf
[cliii] Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Access Helpline/ DBH	24-hour call service staffed by behavioral health professionals who respond to crisis calls and dispatch crisis services if needed; enroll individuals in the DBH system of care; assists with consumer transfers between providers, and provides authorization for specialty services. The Access Helpline also includes a "Warm Line" and is certified in suicide prevention. Language interpretation services are available.	District residents (any age).	FY 2020 – number of answered calls was 67,005.[cliv]	N/A	N/A
Help Me Grow DC/ DOH	Information line and integrated district-wide system providing perinatal support and early identification of developmental and behavioral concerns for children under the age of 5.[clv]	Children ages 0–5 living in DC	Not reported	Referrals may come from health care and service providers through a Help Me Grow referral form (paper or online), or a parent or caregiver may also self-refer by dialing 1-800-MOM-BABY.	N/A

[cliv] *Bazron, B. Mental Health and Substance Use Report on Expenditures and Services. District of Columbia Department of Behavioral Health. 2021. Accessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MHEASURES%20January%202021.pdf*
[clv] *Child & Adolescent Mental Health Resource Guide. HealthCheck Training & Resource Center. Accessed May 27, 2021. https://www.dchealthcheck.net/resources/healthcheck/mental-health-guide.html*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
DC Prevention Centers/ DBH	DC has four Prevention Centers that use education campaigns to prevent and delay the onset of alcohol, tobacco, and other drug use. The services provided by the centers include: • Community education: education on current, relevant drug use/access information • Community leadership: builds the prevention capacity of current and emerging leaders and identifies potential Community Prevention Networks for data-driven planning • Community change: working with the networks in action plan development and implementation	District children (anyone under age 21)	FY19 – prevention centers held 368 activities across the city reaching 33,511 adults and youth through planned prevention strategies.[clvi] During FY20, the DCPCs served approximately 9,950 District residents through their 225 activities. Specifically during the COVID-19 pandemic (March through September 2020), the DCPCs implemented 127 activities that reached 3,664 individuals.[clvii]	N/A	Four DC Prevention Centers that each serves two District wards: 1) Latin American Youth Center (Wards 1 & 2) 2) National Capital Coalition to Prevent Underage Drinking (Wards 3 & 4) 3) Sasha Bruce Youth Work, Inc. (Wards 5 & 6) 4) Bridging Resources In Communities (Wards 7 & 8).[clviii]
My DC Health Homes/ DHCF	Interdisciplinary teams coordinate a full array of health and social service needs, including primary and hospital health services, mental health care, SUD care, and long-term care services and support.	People with Medicaid who have: • Two or more chronic conditions • One chronic condition and are at risk for a second • One serious and persistent mental health condition	As of February 25, 2020, there are six My DC Health Homes providers, and a total of 1,251 beneficiaries are enrolled in the program.[clix]	N/A	CSAs, which have hired nurses, primary care liaisons, and others with social and health-related backgrounds

[clvi] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*

[clvii] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*

[clviii] *Prevention Services. Government of the District of Columbia. Accessed November 11, 2021. https://dbh.dc.gov/service/prevention-services*

[clix] *District of Columbia Health Care Finance. FY19-20 Performance Oversight Questions. Access November 18, 2021. On file with the Children's Law Center.*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Health Homes 2 or MyHealth GPS (MHGPS)/ DHCF	Multidisciplinary teams within the primary care setting coordinate care across medical, behavioral, and social service systems. Covered services include: • Care coordination • Comprehensive case management • Health promotion • Comprehensive transitional care, • Individual and family support services • Referrals to community and social support services	FFS and MCO beneficiaries with three or more chronic conditions (Note: Beneficiaries who are eligible for a program that provides case management services, such as the Elderly and Persons with Disabilities (EPD) Waiver, The Intellectual and Development Disabilities (IDD) Waiver or the Child and Adolescent supplemental security income (SSI), are not eligible for the MHGPS program).	As of June 2020, My Health GPS has served more than 5,000 enrollees.[clx]	N/A	As of June 2020, the My Health GPS program works with 10 providers: • Bread for the City • Children's National Health System • Community of Hope • Medical Home Development Group • Family and Medical Counseling Service • La Clinica del Pueblo • Mary's Center • Providence Health Services • Unity Health Care • Whitman-Walker Clinic

[clx] *Department of Health Care Finance. Letter about MyHealthGPS. Government of the District of Columbia. Accessed November 11, 2021. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/ITA%20MHGPS%20Summary%20%289.30.2020%29.pdf*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Individualized Education Program (IEP)/ OSSE	A written statement for each child with a disability that is developed, reviewed, and revised in accordance with federal law. The IEP guides a special education student's learning. It describes the amount of time that the child will spend receiving special education services, any related services the child will receive, and academic/behavioral expectations.	Students between ages 3 and 22	As of October 7, 2020, 14,797 public and public charter students had an IEP.[clxi]	DCPS has a Child Find policy which includes public outreach, free and comprehensive screening, complete documentation of referrals, and timely evaluation. A child can be referred to an evaluation for an IEP by family, third-party, educational professionals, etc.[clxii]	The IEP team is a group of individuals including: • The parent(s) • At least one general education teacher • At least one special education teacher; • A representative of the LEA who is qualified to provide, or supervises the provision of, specially designed instruction • An individual who can interpret assessment results and the related instructional implications; • Other individuals, at the discretion of the parent or the LEA, who have knowledge or special expertise regarding the child, including related services personnel, if appropriate • The child, if appropriate

[clxi] *Office of the State Superintendent of Education. Organizational Structure. 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/03/Binder1-1.pdf*
[clxii] *District of Columbia Public Schools. Child Find Guidelines. 2020. Accessed November 11, 2021. https://dcps.dc.gov/sites/default/files/dc/sites/dcps/page_content/attachments/ChildFindGuidelines-Version02-Final2-26-20.pdf*

Appendix E

Table E.1. DC Licensing Information for Selected Behavioral Health Professions[clxiii]

Board	License Type	Active Licenses Between October 2018 to February 2020
Medicine	Medicine and Surgery (MD, inclusive of psychiatrists)	10,919
Psychology	Psychologists	1,343
	Psychology Associate	114
Social Work	Graduate Social Worker	1,327
	Independent Social Worker	46
	Independent Clinical Social Worker	3,423
	Social Work Associate	62
Professional Counseling	Licensed Professional Counselor	1,223
	Licensed Graduate Professional Counselor	324
	Certified Addiction Counselor I	95
	Certified Addiction Counselor II	171
Marriage & Family Therapy	Licensed Marriage and Family Therapist	130

[clxiii] *DC Department of Health. DC Department of Health Performance Oversight Response to Question 80. 2020. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2020/02/doh.pdf*

Table E.2. Suggested Supervision Standards by Behavioral Health Profession[clxiv]

Profession	Suggested Supervisor-to-Staff Ratio Maximum	Suggested Weekly Supervision Minimum
Community Health Worker (CHW)	1:6[clxv]	There is no known national standard. However, research indicates that organizations generally report regular individual supervision time and team meetings for CHWs, at least biweekly.[clxvi]
Child Welfare Caseworker	1:5-7[clxvii]	• Two hours per week for new caseworkers.[clxviii] • While there are no known national quantifiable supervision standards for child welfare caseworkers, a survey conducted by the National Association of Social Workers found that nearly half of child welfare caseworkers meet with supervisors once a week or more.[clxix]
Social Worker	National standard not recommended.[clxx]	No known national standard.
Licensed Professional Counselor	No known national standard.	• Trainees: One hour of supervision is provided weekly, plus one additional hour if the trainee provides more than five hours of services, plus one additional hour for every additional five hours of services provided in a week.[clxxi] • Trained staff: One hour of supervision is provided weekly, plus one additional hour if the staff member provides more than 10 hours of services.[clxxii]
Certified Peer Support Specialist	1:8[clxxiii]	One hour per 20 hours of services is provided.[clxxiv]

[clxiv] *These rations are included to provide broad context for our vision for workforce adequacy but are not specific recommendations for District implementation.*

[clxv] *Brooks B, Davis S, Frank-Lightfoot L, Kulbok P, Shawanda P, and Sgarlata L. Building a Community Health Worker Program: The Key to Better Care, Better Outcomes & Lower Costs. American Hospital Association; 2018. Accessed November 11, 2021. https://www.aha.org/system/files/2018-10/chw-program-manual-2018-toolkit-final.pdf*

[clxvi] *Sinai Urban Health Institute. Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings. 2014. Accessed November 11, 2021. https://chwcentral.org/wp-content/uploads/2014/01/CHW-BPG-for-CHW-programs-in-health-care-settings.pdf*

[clxvii] *Salus, M. Supervising Child Protective Services Caseworker. U.S. Department of Health and Human Services. 2004. Accessed November 11, 2021. https://www.childwelfare.gov/pubpdfs/supercps.pdf*

[clxviii] *Salus, M. Supervising Child Protective Services Caseworker. U.S. Department of Health and Human Services. 2004. Accessed November 11, 2021. https://www.childwelfare.gov/pubpdfs/supercps.pdf*

[clxix] *National Association of Social Workers. "If You're Right for the Job, It's the Best Job in the World." 2004. Accessed November 11, 2021. https://www.socialworkers.org/LinkClick.aspx?fileticket=Mr2sd4diMUA%3D&portalid=0*

[clxx] *Association of Social Work Boards. Model Social Work Practice Act. 2013. Accessed November 11, 2021. https://www.aswb.org/wp-content/uploads/2013/10/Model_law.pdf*

[clxxi] *Board of Behavioral Services. Important Answers to Frequently Asked Questions. 2020. Accessed November 11, 2021. https://www.bbs.ca.gov/pdf/publications/mft_faq.pdf*

[clxxii] *Board of Behavioral Services. Important Answers to Frequently Asked Questions. 2020. Accessed November 11, 2021. https://www.bbs.ca.gov/pdf/publications/mft_faq.pdf*

[clxxiii] *Centers for Medicare and Medicaid Services. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services. 2010. Accessed November 11, 2021. https://downloads.cms.gov/cmsgov/archived-downloads/MedicaidGenInfo/downloads/NC-10-004-Att.pdf*

[clxxiv] *Montana's Peer Network. Behavioral Health Peer Support Specialist Service Best Practices Guide 2020. 2020. Accessed November 11, 2021. https://mtpeernetwork.org/wp-content/uploads/2021/05/BHPSS-Services-Best-Practices-Guide-2020.pdf*

Profession	Suggested Supervisor-to-Staff Ratio Maximum	Suggested Weekly Supervision Minimum
Registered Behavior Analyst	1:10[clxxv]	Five percent of hours are spent providing services.[clxxvi]
Substance Abuse Counselor	No known national standard.	One hour per week[clxxvii]
School Psychologist	Faculty-to-student ratio in school psychology programs should be no greater than 1:12.[clxxviii]	One hour per week for the first three years of full-time employment, followed by periodic supervision, peer review, and professional development efforts.[clxxix]

[clxxv] *Kazemi E and Shapiro M. A Review of Board Standards Across Behavioral Health Professions: Where Does the BCBA Credential Stand?. Behavior Analysis in Practice. 2013;6(2):18-29.*
[clxxvi] *Gray, N. 10 Things Every RBT Should Know. TIIBA. 2020. Accessed November 11, 2021. https://www.tiiba.org/career-tips/10-things-every-rbt-should-know*
[clxxvii] *Substance Abuse and Mental Health Administration. Clinical Supervision and Professional Development of the Substance Abuse Counselor. US Department of Health and Human Services. 2014. Accessed November 11, 2021. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4435.pdf*
[clxxviii] *National Association of School Psychologists. Proposed 2020 Graduate Preparation Standards. 2020. Accessed November 11, 2021. http://www.nasponline.org/assets/documents/Standards%20and%20Certification/Standards/Draft_2020_NASP_Grad_Prep_Standards.pdf*
[clxxix] *Fischetti B and Lines C. Views From the Field. The Clinical Supervisor. 2004;22(1):75-86.*