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Behavioral Health in the District of Columbia for Children, Youth & Families: Understanding the Current System

Children's Law Center

Children's National Health System

District of Columbia Behavioral Health Association

Contents

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PREFACE

The public behavioral health services delivery system in the District is highly fragmented. People who need care, service providers, government leaders, and other stakeholders are regularly unaware of what resources are available and how to access those resources. There can be confusion when a service or level of care is needed, about whether it exists. A variety of groups are having conversations to help overcome these challenges, but those conversations – and the proposed solutions generated – are also fragmented.

We need a common reference point that describes the current state of the children's public mental health service delivery system, and we hope this document provides that information. A common reference point regarding the current state will not explicitly identify challenges or gaps, propose solutions or services, or assign responsibility for how that might be carried out. We know those steps will be needed as following activities and intend to publish further papers related to gaps, challenges and solutions in the near future, but first we want to make sure we have a sufficiently accurate and complete 'lay of the land.' Our organizations are committed to advancing a public behavioral health system that has a robust array of promotion, prevention, early intervention, and treatment services. We acknowledge that a significant focus of this paper is on the treatment end of the continuum, with inclusion, where applicable, of prevention and early identification components of the system.

Children's Law Center, Children's National Health System, and the DC Behavioral Health Association, both individually and collectively, look forward to continued engagement with stakeholders throughout the city to advance highly accessible, comprehensive and high-quality behavioral health care services for the District's children, youth and families.

EXECUTIVE SUMMARY

Children's Law Center, Children's National Health System, and the DC Behavioral Health Association are committed to ensuring the District of Columbia has a full array of high-quality behavioral health services that are easily accessible for children, youth, and families. We recognize this has been a long-standing priority for governmental and non-governmental stakeholders, that many improvements have been made to the system, and that stakeholders continue to focus on improving the public mental health system of care in DC. Acknowledging this as a large, complicated, and systemic issue, we believe it is critical that all stakeholders in DC have a clear understanding of how the current public mental health care system is designed to work. With this foundational knowledge, we can turn to areas for improvement and solutions.

This paper is intended to provide the grounding and basic understanding from which we can move forward collectively.

The District of Columbia has a complicated behavioral health care system, involving numerous agencies, entities, and organizations – governmental and non-governmental – that contribute to providing services and care for publicly-insured residents. We provide a grounding of the current system below with a particular focus on children and youth; though we recognize the overview does not describe every nuance and detail. Other organizations have provided reviews and recommendations of the system over the last seven years. While some information and details have changed, we commend the following reports for further background information and have significantly utilized information from the following reports to inform this paper: *Improving the Children's Mental Health Care System in the District of Columbia* (Children's Law Center, 2012)[1] and *Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers and Recommendations* (The Georgetown University National Technical Assistance Center for Children's Mental Health, 2014).[2]

This paper also touches on many of the efforts the District has taken to improve the quality and access of mental health services for children, youth and adolescents through legislation, increasing funding in the budget for mental health resources, and creating task forces and groups to develop solutions to current issues facing the system. Future papers will explore the many areas of opportunity and growth that the District should examine, such as the decline of Core Service Agency providers and timely access to services, the lack of care coordination between systems and agencies, and the quality of services.

GLOSSARY

Community Based Organizations (CBOs): CBOs include any public or private provider of mental health services. This includes CSAs, FQHCs, and hospitals.

Core Service Agencies (CSAs): CSAs are nonprofit and for-profit community-based providers that serve as the clinical home for enrolled consumers. CSAs provide mental health and substance use disorder treatment services for residents in the District under Mental Health Rehabilitation Services.

Federally Qualified Health Centers (FQHCs): FQHCs are 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, healthcare for the homeless, and health centers for residents of public housing.

Free-Standing Mental Health Clinics (FSMHCs): FSMHCs offer outpatient care for individuals with a mental illness who are Medicaid-eligible. FSMHC services are a limited benefit, so individuals with more complex needs or more serious mental illness may also need MHRS services.

[1]Children's Law Center's previous mental health reports can be accessed at https://www.childrenslawcenter.org/resource/childrens-mental-health-reports. *See*, Children's Law Center Improving the Children's Mental Health System in The District of Columbia.

[2] Wotring, J.R., O'Grady, K.A., Anthony, B.J., Le, L.T., Rabinovitz, L.A., Yoon, I.S., Rotto, K. (2014). Behavioral health for children, youth and families in the District of Columbia: A review of prevalence, service utilization, barriers, and recommendations. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Hospital-Based Clinic: A hospital-based clinic refers to services provided in hospital outpatient departments that are clinically integrated into a hospital.

Medicaid Fee-For-Service (FFS): Medicaid providers are paid for the service provided by unit.

Mental Health Rehabilitation Services (MHRS): The mental health services provided by the DC Department of Behavioral Health to Medicaid-eligible individuals with serious emotional disturbance or serious mental illness. These Medicaid Rehabilitation Option (MRO) services are an expanded benefit, including services such as community support services, Community Based Interventions (CBI), Assertive Community Treatment (ACT), adult rehabilitation day services, and other activities not supported at lower levels of care, such as FSMHCs or the outpatient services now often offered by FQHCs.

Medicaid Managed Care Organization (MCO): Medicaid managed care provides care for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations.[3]

Primary Care: Primary care clinics are a common entry point to receiving a referral for mental health services as primary care providers practice general medicine. Increasingly more primary care providers, including FQHCs, offer some type of integrated behavioral health services onsite, which can be beneficial for mild or moderate acuity mental illness but usually are not appropriate for serious emotional disturbance or serious mental illness.

Children and Youth: For purposes of this paper, unless otherwise specified, defined as persons under the age of 21.

BACKGROUND

A robust public behavioral health care system with high-quality, culturally competent and easily accessible services that span the promotion, prevention, early intervention, and treatment continuum is critical to advancing the health and well-being of children and families in the District of Columbia. These services are different depending on the unique age and need of the child and her family. We must continue to advance – with inclusivity and urgency – high-quality behavioral health care systems if we are to close gaps in mental health care equity that continue to persist. A recent study in the International Journal of Health Services found significant racial and ethnic disparities in accessing mental health care for children and young adults.[4] Recognizing that the children, youth and families served by the public behavioral health care system in the District are primarily individuals of color, approaching improvements to our system as a matter of equity is fundamentally necessary. Furthermore, children are disproportionately at risk for developing social and emotional problems when exposed to adverse childhood experiences[5], and/or living in an adverse environment with stressors, and without buffers such as adequate adult support. Stressors include poverty, abuse or neglect, homelessness/foster care, and children born with

[3] *See* Managed Care. https://www.medicaid.gov/medicaid/managed-care/index.html (last visited Feb. 4, 2019).
[4] Marrast, L., Himmelstein, D., Woolhandler, S. (2016). Racial and Ethnic Disparities in Mental Health Care for Children and Young Adults: A National Study. International Journal of Health Services, Volume: 46 Issue: 4, page(s): 810-824. Article first published online: August 12, 2016.
[5] For more information on adverse childhood experiences, please visit: American Academy of Pediatrics, Adverse Childhood Experiences and the Lifelong Consequences of Trauma at https://www.aap.org/en-us/Documents/ttb_aces_consequences.pdf.

developmental disabilities or delays, and racism. Yet, with a strong public behavioral health care system, risk does not have to equal inevitability, and recovery, within home and community, is possible for all.

Public behavioral health services in the District are delivered through a variety of programs and services: Core Service Agencies, nonprofits, private providers, hospitals, family support organizations, child care providers, and primary care physicians. It is important to recognize that the District's public behavioral health system is spread across multiple child serving agencies. This makes it extremely challenging for families looking to access services due to the lack of coordination between agencies. The District's current public mental health system crosses sectors and is made up of the following child serving agencies:

- Child & Family Services Agency (CFSA)
- Department of Behavioral Health (DBH)
- Department of Healthcare Finance (DHCF)
- Department of Health (DOH)
- Department of Youth Rehabilitation Services (DYRS)
- District of Columbia Public Schools (DCPS)
- Office of the State Superintendent of Education (OSSE)

Each agency plays a vital role in providing services to children and families. This paper will not go into an in-depth review of all services provided by each agency, but will highlight those programs and services that are critical in treating children and youth with behavioral health concerns. The District has made progress in improving the system of care over the last several years through the implementation of federally funded grants, the increase of investment of local dollars towards programs and services that use a public health model approach, and other policy changes. Although progress is evident, reforming the system is needed to ensure that all children have access to high-quality behavioral health services. This paper will not address gaps but instead, provide stakeholders with a common knowledge about how the system is currently designed, the services provided, and the legislation and efforts currently underway that may impact how the system operates and expands over time.

CURRENT SYSTEM & SERVICES

This section provides an overview of the current elements of the public mental health system for children and youth, including entry points, services, financing, service delivery locations, eligibility, and service authorization.

Access & Entry Points to Mental Health Services

There are many ways to access mental health services in the District under the public mental health system. Children and youth most often access services through Department of Health Care Finance (DCHF)-funded services (Medicaid Fee-For-Service or Medicaid Managed Care Organization); the Department of Behavioral Health (DBH); mental health programs located in schools; and crisis or inpatient services at local hospitals.

DC Medicaid Delivery System – Fee-For-Service (FFS) or Managed Care Organizations (MCOs)

Currently, approximately 100,000 children in the District are insured by Medicaid.[6] 90 percent of children with DC Medicaid are insured by one of the four Managed Care Organizations (MCOs): Amerigroup DC, AmeriHealth Caritas of District of Columbia, Health Services for Children with Special Needs (HSCSN)[7], and Trusted Health Plan. Each MCO is responsible for providing office-based mental health services for children.[8] To be reimbursed under DC Medicaid, providers must be credentialed with each of the MCOs. The remaining 10% of children are insured under Medicaid Fee-For-Service (FFS). This includes some children with disabilities not residing in an institution, some children residing in long-term care (LTC) facilities, children linked with Department of Youth Rehabilitation Services (DYRS), and children under the custody of Child & Family Services Agency (CFSA). Under DC Medicaid FFS, providers are paid for the service provided by unit. Beneficiaries enrolled in DC Medicaid FFS have access to any Medicaid-enrolled provider.

The Medicaid program's benefit for children and adolescents is known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). EPSDT provides comprehensive and preventive health services for children under age 21. The goal of EPSDT is to ensure that children and adolescents receive appropriate preventive dental, mental health, developmental, and specialty services at the right time. Through periodicity schedules, states must set guidelines for providers to follow. These periodic schedules must be provided at intervals that meet reasonable standards of medical practice. In DC, EPSDT services are called HealthCheck. The DC Medicaid HealthCheck Periodicity Schedule follows the American Academy of Pediatrics (AAP) guidelines and consultation from the local medical community. For example, the HealthCheck Periodicity Schedule denotes at which well-child visits mental health screening should occur. Additional interperiodic screens (e.g., developmental, mental health) may be necessary to determine whether a child needs further care.

Points of Entry:

- Medicaid MCO:
    - Receipt of direct mental health services from a physician or other provider within an MCO's behavioral health provider network;
    - Referral from a primary care physician or specialist in an MCO after an EPSDT appointment (or well-child visit)
- Medicaid FFS:
    - Mental health services furnished by a provider enrolled with FFS Medicaid;
    - Referral from a primary care physician or specialist after an EPSDT appointment (or well-child visit)[9]

Eligibility Determination: Medicaid benefits are available to District residents from ages 0-20 who meet the income guidelines. The District covers children (0-18) with household incomes up to 319% of the 2014

[6] Department of Health Care Finance response to DC Council Performance Oversight Question 31, FY18.
[7] HSCSN is the managed care organization for Supplemental Security Income-eligible DC youth ages 0-26.
[8] The Department of Health Care Finance has contracts with the Managed Care Organizations, which include specified contractual obligations regarding behavioral health. An outline of the contractual obligations for the MCOs (except for HSCSN) is included in Appendix F. DHCF also released a transmittal in July regarding behavioral health obligations by the MCOs. *See* Transmittal 18-23 Policy and Procedure: MCO Behavioral Health Covered Services, available at https://dhcf.dc.gov/node/1346966.
[9] Wotring, J.R., O'Grady, K.A., Anthony, B.J., Le, L.T., Rabinovitz, L.A., Yoon, I.S., Rotto, K. (2014). Behavioral health for children, youth and families in the District of Columbia: A review of prevalence, service utilization, barriers, and recommendations. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Federal Poverty Level (FPL) as referenced below.[10] The District also covers children (19 and 20) with household incomes up to 216% of the FPL.[11] Please note that in DC, the Children's Health Insurance Program funds are used to expand the Medicaid program. In addition to meeting the income requirements below one must be able to prove DC residency and that you are a U.S. citizen or a lawful permanent resident.

- $3,227.22 for individuals
- $4,375.62 for a family of 2
- $5,524.02 for a family of 3
- $6,672.42 for a family of 4
- $7,820.82 for a family of 5
- $8,969.22 for a family of 6
- $10,117.62 for a family of 7

*Figures compiled using 2018 FPL numbers distributed by the US Department of Health and Human Services. (Source: DC Department of Health Care Finance)

Authorization: Prior authorization is required for certain covered services to document the medical necessity for those services. To determine whether a covered procedure code requires prior authorization for members in the FFS delivery system, see the DC Medicaid Fee Schedule. To determine whether a procedure code requires prior authorization for MCO members, providers must refer to the member enrolled Managed Care Organization. If a health care provider determines that a service is needed, it should be covered and allowed under the federal Medicaid Act and the EPSDT benefit.[12] For example, if a child needs personal care services to ameliorate a behavioral health problem, then EPSDT should cover those services to the extent the child needs them — even if the state places a quantitative limit on personal care services or does not cover them at all for adults.[13]

Services Provided: The following services are covered by each MCO: 1) diagnostic and assessment; 2) medication evaluation and management; 3) counseling/psychotherapy; and 4) crisis services. However, if the child needs more intensive in-home or community based services, the responsibility shifts from the MCO to Mental Health Rehabilitation Services (MHRS) reimbursed by Fee-For-Service. Mental Health Rehabilitation Services are the mental health services provided by the DC Department of Behavioral Health to Medicaid-eligible individuals with serious emotional disturbance or serious mental illness. These Medicaid Rehabilitation Option (MRO) services are an expanded benefit, including services such as community support services, Community Based Interventions (CBI), Assertive Community Treatment (ACT), adult rehabilitation day services, and other activities not supported at lower levels of care, such as

[10] *See* Infants & Children (0-20), https://dhcf.dc.gov/node/892192 (last visited Feb. 4, 2019)
[11] *See* Infants & Children (0-20), https://dhcf.dc.gov/node/892192 (last visited Feb. 4, 2019)
[12] Federal law requires that all Medicaid eligible children under the age of 21 receive Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT). In DC, providers are able to access online trainings and materials on Medicaid's EPSDT benefit on DC HealthCheck, a training and resource center led by DCHF. DC HealthCheck provides information on the areas that must be covered during a well child visit such as comprehensive physical exams, immunizations, labs, and dental, mental health, developmental, hearing, and vision screening.
[13] DC Health Check, Health Check Data Requirements, available at https://www.dchealthcheck.net/trainings/documentation/epsdt/index.html (last visited Feb 4, 2019)

Free-Standing Mental Health Clinics or the mental health outpatient services now often offered by Federally Qualified Health Centers.

Children under Fee-For-Service receive their office-based and in-home mental health services directly through MHRS.

Service Delivery:

- Free-Standing Mental Health Clinics (FSMHCs)[14]
    - FSMHCs offer outpatient care for individuals not enrolled in Mental Health Rehabilitation Services (MHRS). Historically, these services provided to Medicaid enrollees are reimbursed directly by Medicaid and are not routed through DBH. These reimbursable services include individual psychotherapy, medication management prescription visits, family therapy, family conferences, psychological testing, and group therapy.[15]
    - If a beneficiary has to transition to MHRS due to illness severity or acuity, they then have to go through a more structured process of evaluation and monitoring (e.g., 3 hour assessment to start services and then provide periodic updates for service continuation).
    - DBH and DHCF have been working collaboratively to transition oversight of Free- Standing Mental Health Clinics from DHCF to DBH effective October 2019.
- Hospital-Based Clinics: A hospital-based clinic refers to services provided in hospital outpatients departments that are clinically integrated into a hospital.
- MHRS Providers, including Core Service Agencies (CSAs), sub-specialty and specialty providers[16]
    - MHRS providers, including CSAs, are DBH certified community-based MHRS providers reimbursed by Medicaid. CSAs are able to offer a range of core MHRS, and other MHRS providers may be sub or subspecialty providers, only offering, e.g., Community Based Interventions (CBI), Assertive Community Treatment (ACT), or day rehabilitation day services.
- Federally Qualified Health Centers (FQHCs)[17]
    - FQHCs are community-based health care providers that provide services typically offered in an outpatient clinic. FQHCs include community health centers, migrant health centers, healthcare for the homeless, and health centers for residents of public housing. They are paid based on FQHC Prospective Payment System (PPS) for medically necessary primary health services and qualified preventive health services furnished by an FQHC practitioner.[18]

Payment/Financing: DHCF finances services through contracts with MCOs and directly through individual providers on a FFS basis. DHCF pays capitation rates to the four contracted MCOs to finance the delivery of services accessed by MCO-enrolled beneficiaries within the managed care network. The MCO is responsible for paying and credentialing a provider network that offers traditional mental health

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[14] *See* 29 D.C.M.R. § 800 *et seq.*

[15] Acosta, J, Blanchard, J.C., Pollack, C.E., Benjamin-Johnson, R., Adamson, D.M., Gresenz, C.R., Saloner, B.. (2010). Working Paper: Guide to the Behavioral Health Care System in the District of Columbia. Washington, DC: RAND Health.

[16] *See* 22-A D.C.M.R. § 3400 *et seq*.

[17] *See* 42 U.S.C. § 254b; *see also* 29 D.C.M.R. § 4500 *et seq*.

[18] Centers for Medicare and Medicaid Services, Medicare Learning Network Booklet, Federally Qualified Health Center. (2018), *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf.

outpatient services (e.g., diagnostic assessment, psychotherapy, and psychiatric evaluation and medication management services). Mental Health Rehabilitation Services delivered through non-MCO arrangements are paid on a FFS basis, even when delivered to MCO-enrolled Medicaid beneficiaries. MCO enrollees are eligible to receive home and community-based MHRS, such as community support and community-based interventions (CBI), through the DBH provider network at no financial cost to the MCO if they meet the eligibility requirements determined by DBH.[19]

The Department of Behavioral Health

DBH certifies and contracts with MHRS providers, including CSAs, sub and specialty providers, to deliver services under MHRS for children and youth diagnosed with a severe emotional disturbance and adolescents with substance use disorders. CSAs are nonprofit and for-profit community-based providers that serve as the clinical home for enrolled consumers. To be certified as a CSA, a provider must offer the four core MHRS services:[20]

- Diagnostic/Assessment Services
- Medication/Somatic treatment
- Counseling
- Community support

However, providers that only offer a subset of MHRS services are able to be certified as specialty providers. *See* 22-A D.C.M.R. § 3412 Specialty services include Assertive Community Treatment (ACT), *see* 22-A D.C.M.R. § 3423, Community Based Intervention (CBI), s*ee* 22-A D.C.M.R. § 3422, and Day/Rehabilitation Services, *see* 22-A D.C.M.R. § 3420. To access any services offered in MHRS, the consumer must be enrolled at a community-based service provider. This can take place in person (face to face) at any certified CSA and/or by calling the Access HelpLine at 1-888-793-4357. The purpose of the Access HelpLine is to provide enrollment, service authorization, and guide individuals through the intake process at the community service provider of their choice, provided the community service provider is open for intake at that point in time. The Access HelpLine also triages crisis calls and operates a suicide line. Please note that several CSAs offer weekly walk-in hours for new enrollees (see Appendix C for list of community-based service providers). However, the intake process varies by agency as some providers require new patients to come in during walk-in hours. If an individual seeking care, or the parent of a child seeking care, knows they want to work with a particular CSA, they should contact the CSA directly. If they do not know which CSA they prefer, or do not know which CSAs are available, they should reach out to the Access HelpLine.

Youth should be able to get help with substance use disorders directly through any of three Adolescent Substance Abuse Treatment Expansion Program (ASTEP) treatment providers in the District of Columbia (see Appendix D). ASTEP offers help for adolescents with co-occurring mental health and substance use disorders. ASTEP providers implement the Adolescent Community Reinforcement Approach (A-CRA). A-CRA is a behavioral health intervention that seeks to replace environmental contingencies that have supported alcohol or drug use with prosocial activities and behaviors that support recovery. The A-CRA

[19] Wotring, J.R., O'Grady, K.A., Anthony, B.J., Le, L.T., Rabinovitz, L.A., Yoon, I.S., Rotto, K. (2014). Behavioral health for children, youth and families in the District of Columbia: A review of prevalence, service utilization, barriers, and recommendations. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[20] *See* 22-A D.C.M.R. § 3411

model also incorporates caregivers and community participation in sessions.[21] DBH also has two Substance Use Disorder (SUD) grants: 1) State Youth Treatment (SYT) and 2) District of Columbia's Changing and Improving Treatment for our Youth (DC-CITY). The goal of these programs is to improve access and quality of treatment for adolescents and transitional aged youth with substance disorders and co-occurring disorders.

Points of Entry:

- Access HelpLine (AHL): The Access HelpLine is an entry point to the public behavioral health system for all District residents. The AHL is open 24 hours per day, seven days per week and is staffed by DBH professionals who can refer the caller to immediate help or ongoing care. There are several reasons why an individual may use the AHL, such as getting emergency psychiatric care, finding out what services are available, suicide hotline and obtaining authorization for specialty services. Service authorization requests are submitted to care coordinators who can make those determinations. Care coordinators in the Access HelpLine authorize and re-authorize MHRS services for the consumers in the DBH system that is funded by local dollars or Medicaid, as well as involuntary psychiatric admissions in the District regardless of funding source.[22] DBH recommends individuals in need of behavioral health services use the Access HelpLine (AHL) to get enrolled to a community-based service provider (e.g., CSA). However, AHL is not a single point of entry to the system for consumers.
- Contacting a CSA directly;
- Provider- or self-referral to MHRS from Medicaid MCO or Medicaid FFS provider;
- Referral from hospital staff, DYRS, CFSA, DBH-certified MHRS providers; or Child and Adolescent Mobile Psychiatric Service (ChAMPS), an emergency response service for children and adolescents who are having a mental health or behavioral health crisis;
- Referral from parents, District of Columbia Public Schools (DCPS), or public charter schools to the School Mental Health Program (SMHP) operated by DBH.[23]

Eligibility Determination: Any child or youth aged 0-20 with severe emotional disturbance (SED) diagnosis which requires intensive mental health needs is eligible for MHRS services. *See* 22-A D.C.M.R. § 3403.

Authorization: DBH reimburses MHRS claims for the provision of medically necessary services to eligible consumers. All MHRS require an authorization number for claims submission.

Services Provided:

- **Evidence-Based Treatment Practices:** The Families First Program was established by DBH in 2011 to accomplish the following goals: 1) Increase the number and quality of evidence-based programs in the District of Columbia public mental health system and to expand the array of

[21] DC Department of Behavioral Health Services, Children & Youth Services Division, presentation by Patrina Anderson.

[22] Wotring, J.R., O'Grady, K.A., Anthony, B.J., Le, L.T., Rabinovitz, L.A., Yoon, I.S., Rotto, K. (2014). Behavioral health for children, youth and families in the District of Columbia: A review of prevalence, service utilization, barriers, and recommendations. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[23] Wotring, J.R., O'Grady, K.A., Anthony, B.J., Le, L.T., Rabinovitz, L.A., Yoon, I.S., Rotto, K. (2014). Behavioral health for children, youth and families in the District of Columbia: A review of prevalence, service utilization, barriers, and recommendations. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

services along the continuum of care, available to children and their families; 2) Ensure provider agency and community readiness; 3) Ensure clinical expertise to deliver proven practices; and 4) Increase community awareness and support for evidence-based programs. Originally, nine evidence-based practices were implemented under Families First. Two of those evidence-based practices, Multisystemic Therapy-PSB (for problem sexual behavior) and Multisystemic Therapy-EA (for emerging adults) ended when the providers of those services closed. The District currently offers seven evidence-based programs for children, youth and young adults ages 0-29. DBH partners with Evidence Based Associates (EBA) to contract with MHRS providers to provide these services. EBA also helps oversee the implementation of these evidence based programs and provides oversight management for local providers. Below is the list of the following evidence-based treatments (See Appendix B for an in-depth description of evidence-based treatments):

- Child-Parent Psychotherapy – Family Violence (CPP)
- Parent Child Interaction Therapy (PCIT)
- Trauma Systems Therapy (TST)
- Trauma-Focused Cognitive Behavior Therapy (TF-CBT)
- Functional Family Therapy (FFT)
- Transition to Independence (TIP)
- Multisystemic Therapy (MST)

- **Early Childhood Mental Health**
  - *DC SEED:* The District strategically prioritized investing in expanding early childhood mental health programs through their System of Care (SOC) grant award in fall 2016 – The DC Social Emotional and Early Development Project (DC SEED). DC SEED is a four year Substance Abuse and Mental Health Services Administration (SAMHSA) System of Care grant focused on increasing early childhood provider capacity, implementing early childhood-specific interventions, establishing a centralized referral hub, and evaluating outcomes from interventions. DBH is piloting one core component – expanding early childhood evidence-based practices and increasing provider capacity – at Mary's Center, Community Connections and Parent Infant Early Childhood Enhancement (PIECE) Program before expanding to other agencies. The DC SEED project also aims to infuse early childhood specialty content into community-based interventions (CBI), high fidelity wraparound, and family-peer specialist curricula. One of the other major goals of this grant is to ensure child development centers have access to individualized early childhood mental health phone consultation services. DC SEED plans to implement this goal by partnering with members and organizations in the early childhood sector (i.e. District of Columbia Department of Health (DC Health) Home Visiting, Child Development Centers, Early Stages, Primary Care Physicians (PCPs), and other early learning programs).
  - *PIECE Program*: In FY09, DBH launched the PIECE Program to provide early childhood mental health interventions and treatment to children ages birth to seven years of age, and their families, who present with challenging social, emotional and disruptive behaviors that cause impaired functioning at home, school, and in the community. In addition, the PIECE Program provides services to mothers who are pregnant and post pregnancy, who have been identified as experiencing mental health challenges that impact early attachment and parenting of their infant child. The PIECE Program seeks to provide comprehensive services to children and families that enhances early cognition, language development, emerging motor and adaptive skills, social, emotional and behavioral functioning, which supports school readiness. The program utilizes a number of treatment modalities to strengthen the parent child dyad, as well as two evidence based practices. The program services include individual, family, art therapy, play

therapy, and the parents' psychoeducational group. The two evidence-based practices are Child Parent Psychotherapy (CPP) focusing on families with young children exposed to violence and other forms of trauma, and Parent Child Interaction Therapy (PCIT) which focuses on teaching parents and caregivers skills and techniques to improve disruptive behaviors.

- *Healthy Futures*: Healthy Futures is based on the Early Childhood Mental Health Consultation (ECMHC) model. ECMHC is an evidence-based model for supporting young children's social-emotional development and addressing challenging behaviors in early learning environments. ECMHC aims to build the capacity and improve the ability of staff, families, programs, and systems in early care and learning to prevent, identify, treat and reduce the impact of mental health problems among children from birth to age 6 and their families. The DC Department of Behavioral Health currently provides ECMHC through their Healthy Futures program, which is located in 61 child development centers (center and home-based) throughout DC. The Healthy Futures program helps to build capacity in child care providers in order to promote social-emotional development, prevent escalation of challenging behaviors, decrease, with the goal of eliminating, early childhood expulsion, and increase appropriate referrals for additional assessments and service. An expansion of this program was passed by the DC City Council in 2018 (Birth to Three for All DC Act), but has not yet been funded.
- *Primary Project:* The primary project is an early intervention and prevention program that provides service to pre-kindergarten through third grade children in select public and charter schools, and child development centers that are identified with mild school adjustment issues. Primary Project uses trained associates to work with students who are acting out, display mild aggression, are anxious or withdrawn, or have learning problems that interfere with progress in school. The program uses early screening tools with all children to identify those in need of additional supports. Currently, the Office of the State Superintendent of Education (OSSE) provides additional funding to DBH for the Primary Project and Healthy Futures programs.

- **High Fidelity Wraparound**
  - DBH also offers high fidelity wraparound 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.[24] The high fidelity wraparound model provides care coordination and family support by creating individualized plans to help families develop goals, prioritize needs, and implement a transition plan. This program is currently funded through the District's local dollars. In early 2017, the former provider of this service, DC Choices, terminated their contract with the District. This led to a shortage of a provider for high fidelity wraparound for over six months. In July 2017, DBH selected MBI Health Services LLC to replace DC Choices as the sole provider. MBI Health Services, LLC continues to serve as the only provider of high fidelity wraparound and their contract has been renewed through July 9, 2019. Per their contract, they shall provide high fidelity wrap around services for up to 94 youths that are referred through the community to address behavioral and socio-emotional needs.
- **Peer Support**
  - Peer support services are delivered by individuals with shared lived experiences with the people they are serving. The Office of Consumer and Family Affairs within DBH manages

[24] Department of Behavioral Health, Coordinating Council on School Mental Health, available on https://dbh.dc.gov/service/children-youth-and-family-services (last visited Feb. 4, 2019).

the Certified Peer Specialist program, which provides training and support to those eligible individuals to become certified to provide support to individuals currently in a behavioral health setting. After completing the three-week training program and 80 hour field practicum, individuals will be eligible to qualify for certified peer specialist jobs within the community behavioral health provider network. Peer support services delivered by a peer hired by a CSA are billable under MHRS community support.

Service Delivery Locations:

- MHRS Providers, including CSAs
- Specialty Providers/Sub-specialty providers
- Child Development Centers
- Schools

Payment/Financing: DBH providers are reimbursed on a FFS basis by Medicaid for MHRS and by DBH for locally funded services. 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.[25]

Crisis Services

The District of Columbia relies primarily on crisis emergency services/mobile crisis as its first line of support for individuals needing mental health care who are not connected with community-based services or are experiencing an acute crisis. Services include assessment for voluntary or involuntary hospitalization, crisis counseling and intervention, medication, and linkage to other services, such as referrals to community-based providers. DBH along with other organizations such as Catholic Charities and CFSA, provide crisis and emergency services for those youth who are in need of crisis services but do not require hospitalization. DBH contracts with Catholic Charities to provide Children and Adolescent Mobile Psychiatric Service (ChAMPS), the primary mobile crisis team for youth in the District. The following services are available for children and adolescents in need of immediate, emergency services:

Points of Entry: Any parent or provider in any setting can initiate crisis emergency services for crisis situations.

Eligibility Determination: Anyone is able to access crisis services. However, a clinician on the ChAMPS team will determine the level of acuity, de-escalate the crisis, provide the crisis intervention and make necessary referrals.

Authorization: Crisis services typically do not require prior authorization by DBH or MCO.

Services Provided:

- **Access HelpLine:** A 24-hour, 7 days per week telephone line staffed by behavioral health professionals who can refer a caller to immediate help or ongoing care. The Access HelpLine can activate mobile crisis teams to respond to children and adults who are experiencing a psychiatric or emotional crisis and are unable or unwilling to travel.

[25] Wotring, J.R., O'Grady, K.A., Anthony, B.J., Le, L.T., Rabinovitz, L.A., Yoon, I.S., Rotto, K. (2014). Behavioral health for children, youth and families in the District of Columbia: A review of prevalence, service utilization, barriers, and recommendations. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

- **ChAMPS:** A 24-hour mobile team that provides services to assess whether a child's behavior poses a danger, requiring possible psychiatric inpatient hospitalization, and to assist with immediate crisis stabilization.
- **The Comprehensive Psychiatric Emergency Program:** A 24-hour, 7 days a week service that provides emergency psychiatric services, mobile crisis services and extended observation for youth 18 years of age and older.
- **Mobile Crisis Stabilization (MCS):** A 24-hour service line for children linked with CFSA. CFSA refers independently to MCS.
- **Inpatient:** There are two major providers for inpatient services for acute, short-term stabilization in the District that serve children and adolescents from ages 2-17, Children's National Health System (Children's National) and Psychiatric Institute of Washington (PIW). Below is a brief description of the services provided:
    - Children's National: Provides inpatient psychiatric care for children and adolescents with illnesses including anorexia, bulimia, ADHD, bipolar disorder, major depression, schizophrenia and obsessive-compulsive disorder under the age of 18. Care provided by a multidisciplinary team of pediatric psychiatrists, nurses, social workers, academic counselors, psychologists, and expressive art therapists.
    - Psychiatric Institute of Washington: Provides inpatient services for youth and adolescents 10-17. For adolescents, services are available to address issues such as major psychiatric disorders, self-destructive, defiant or anti-social behavior and mental health crises such as anxiety, depression or suicide. They recently just added a trauma unit for adolescents, ages 13-17.

Service Delivery: Children's National, PIW, ChAMPS/Catholic Charities

Payment/Financing: Insurance is billed when applicable.

School-Based Services

District of Columbia Public Schools: School Based Health Centers & Early Childhood Direct Services

In addition to the School Mental Health Program, summarized below, The District of Columbia Public Schools also provides students with access to mental health support through their School Based Health Centers (SBHC) and Direct Services Team. A SBHC provides primary care services in a school year round, including medical, oral, and mental health services. Currently, there are eight SBHCs in the District of Columbia with the DC Department of Health overseeing seven. The DCPS Direct Services team provides therapy to early childhood education families. The goal of this program is to provide evidence based therapy, create individual case plans to families in 14 schools, and increase parent engagement. While these services are not available to every school in the District, the schools identified with the most need are typically selected by internal resources (i.e school administrator, ECE staff, DCPS central office).

School Mental Health Program

The Department of Behavioral Health operates a school-based mental health program in 63 public and public charter schools located in the District that offers prevention, early intervention and clinical services to children, youth and their families. In 2017, the District released the School-Based Behavioral Health Comprehensive Plan, a plan to expand the behavioral health services and supports to all students in all DCPS and public charter schools, as required by the *South Capitol Street Memorial Amendment Act of 2012*. *See* D.C. Code § 2-1517.32.

The Task Force on School Mental Health was established in the Fiscal Year 2018 Budget Support Act (L22-0033) to offer suggested improvements and specific recommendations to the comprehensive plan to expand school-based behavioral health programs and services. The Task Force membership was appointed by the Mayor and the Chairs of the Council Committee on Health and Committee on Education. Membership included a parent of a public school student, a parent of a public charter school student, school mental health providers, community-based providers, government representatives and other stakeholders. The final report was submitted to the Mayor and Council of District of Columbia on March 26, 2018.[26]

The plan, as amended with recommendations from the SBMH Task Force, was approved by the DC Council in 2018 for implementation in the 2018-2019 school year, prioritizing SMHP capacity expansion in the top 25 percent of highest risk schools. The plan addresses the following areas: 1) the role of the DBH Clinicians and the timing and factors to consider before changing the role of the DBH Clinician; 2) provider capacity, and what is needed to grow the pool of available community-based partners, including the need to identify additional funding sources to enable providers to deliver school-based services; and 3) the governance structure to guide implementation.[27] A Coordinating Council on School Mental Health was established in spring 2018 to guide the implementation of the plan utilizing community-based providers in addition to current resources, which includes members of the former Interagency Behavioral Health Working Group and the former Task Force on School Mental Health,[28] plus other stakeholders identified by that combined group, e.g., principals, DCPS and DC Charter parents, DC Behavioral Health Association, etc.

Points of Entry: Any Public or Charter school that is in the top 25% of those considered most at risk operates a SBMH program (DBH or grants with CBO).

Eligibility Determination: School Referral; Parent Referral; Self-referral.

Authorization: Based on level of need and source of payment. Pre-diagnostic and diagnostic services are available for any student. Early intervention or time limited services (Tier 2) generally available for appropriate students. Diagnostic (Tier 3) available to all appropriate students; insurance billing will determine authorization and prior authorization requirements.

Services Provided: Prevention (e.g., screening); Early Intervention and Treatment Services; Evidence-Based Practices (varies by school).

Service Delivery:

- DBH and DCPS or DC Public Charter behavioral health clinicians in public schools
- Staff, including clinicians, from CBOs

Payment/Financing: Students do not directly pay for services. If the student has insurance, then the insurance will be billed as applicable. A DBH grant has been awarded to supplement community-based

[26] *Available at* https://dmhhs.dc.gov/sites/default/files/dc/sites/dmhhs/page_content/attachments/Task%20Force%20on%20School%20Mental%20Health%20Report%20%28Final%20Submitted%29%203%2026%2018.pdf

[27] *See* Task Force on School Mental Health Report 2018 Executive Summary *available at* https://dmhhs.dc.gov/service/task-force-school-mental-health.

[28] Department of Behavioral Health Coordinating Council on School Mental Health, available at https://dbh.dc.gov/service/children-youth-and-family-services (last visited Feb. 4, 2019).

organizations to engage in practices that support effective delivery of treatment but are not reimbursable (i.e. participating in team meetings, consultation with teachers, parent/family engagement, prevention activities, etc.) The DC School Mental Health Program is primarily funded by local dollars and federal grants.

Behavioral Health Services for Youth in the Juvenile Justice System or Foster Care System

There are also two agencies that serve youth in the juvenile justice system and foster care system that assist in linking youth with behavioral health treatment, the Department of Youth Rehabilitation Services (DYRS) and Child and Family Services Agency (CFSA). DYRS is responsible for youth involved with the juvenile justice system. Currently, The Youth Service Center is the short term juvenile detention center for youth in the District. Children placed in the custody of the Youth Service Center are able to receive medical and psychiatric care directly at the facility. However, if children have acute mental health emergencies they are sent to Children's National or PIW. Children in child protective services, supportive family services, and foster care are under the supervision of CFSA. When a child enters into the CFSA system they are unenrolled from their Medicaid MCO and moved to Medicaid FFS. Under the Medicaid FFS program, mental health services are provided through DBH's MHRS program. CFSA has also started a small mental health program within CFSA to provide services to children newly removed from their homes and placed into foster care. Youth who are victims of crime may also be eligible for Crime Victim's Compensation. Crime Victim's Compensation pays for mental health services needed as a result of victimization. However, they are a secondary payor (only if the insurance denies the payment). Further, a police investigation is required, so involvement of multiple agencies is required. Additional relevant, discrete programs include:

- **Parent Adolescent Support Services (PASS)**
    - The Parent Adolescent Support Services (PASS) program is a voluntary, early intervention/prevention program for youth aged 17 and under committing status offenses (truancy, running away, curfew violations, and/or extreme disobedience). 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. Youth may be referred to PASS by city agencies, schools, service providers, and concerned family members. Families are not eligible for PAS if they have an open case with the Child and Family Services Agency (CFSA) or if the youth has an active case with CSS or the Department of Youth Rehabilitation Services (DYRS).
- **Alternatives to Court Experience (ACE)**
    - The Alternatives to Court Experience (ACE) is an inter-agency initiative housed at the Department of Human Services (DHS) and operated in collaboration with the Department of Behavioral Health, the juvenile justice entities, and community-based service providers. This is the only program in the District for pre-petition status offenders diverted by the Office of the Attorney General (OAG), pre-arrest delinquency offenders diverted by the Metropolitan Police Department (MPD), and post-arrest delinquency offenders diverted by Court Social Services (CSS). The overall goal of the initiative is to reduce the number of Court-involved youth by linking them with clinically appropriate behavioral health services and community supports in place of prosecution.
- **Teen Parent Assessment Program (TPAP)**
    - TPAP is the Teen Parent Assessment Program. It is a volunteer program that provides case management services for teen parents ages 14-17 years old. Teen parents under the age of 18 participate in a living arrangement assessment. A pregnant minor under the

age of 18 who is expected to deliver within the next four months, or a teen parent under the age of 18 must reside in his or her parents' home or the home of another adult relative or responsible adult. To be eligible for TPAP services you must be TANF eligible, a TANF recipient, or a teen parent under the age of 18 in need of supportive services. Teen parents who are receiving TANF or who are TANF eligible should call the Family Assessment and Resource Center to schedule an appointment to attend a TANF Orientation and complete the Work Readiness Assessment and Individual Responsibility Plan process.

- **Strengthening Teens Enriching Parents (STEP)**
    - Every year, hundreds of youth are reported missing to the Metropolitan Police Department (MPD). A significant number of these youth have multiple missing person's reports and leave home due to: Family conflict; Peer influence; Unaddressed mental health issues; Sex trafficking; Trauma, and other reasons. Dealing with this stark reality, the District's child-serving government agencies and community partners came together and responded with a unified voice: One missing youth is one too many. STEP and partner agencies provide immediate outreach to assess why the youth is leaving home and, together with the family, implement services to reduce the likelihood of future missing person reports and increases family stability.

GROUPS, TASKFORCES, & COALITIONS

This section provides an outline of governmental and member groups, taskforces, and coalitions in the District that focus on behavioral health initiatives in the District.

Children's Roundtable: The Children's Roundtable is a forum to discuss issues that affect District children and youth with behavioral and mental health needs. This group is led by The Department of Behavioral Health, Community Services Administration. There is representation from numerous community based organizations, family run organizations, providers, legal services, and government agencies. The Children's Roundtable meets on a monthly basis for the purposes of information sharing and learning about new initiatives within the System of Care.

DBH Behavioral Health Planning Council: The Behavioral Health Planning Council advises the Director of the Department of Behavioral Health in the planning and implementation of person-centered behavioral health services. The membership of the Partnership Council should be representative of the interests and perspectives held by adults and children, youth, and their families. At least one person from each ward of the District and two representatives from labor unions for departmental workers should be represented in this membership body. Also, at least 51% of the members of the Planning Council shall be consumers or their family members.[29]

DC Behavioral Health Collaborative: The Behavioral Health Collaborative is a body made up of several different member organizations focused on improving the behavioral health care system in the District and identifying a common agenda for behavioral health treatment providers. Below is a list of organizations currently active within the Behavioral Health Collaborative:

- DC Behavioral Health Association
- DC Primary Care Association

[29] *See* D.C. Code § 7–1131.10.

- DC Hospital Association
- AmeriHealth Caritas DC

The DC Behavioral Health Collaborative priorities include: 1) Building Capacity and Ensuring Safety; 2) Operational and Regulatory Improvements; 3) System Redesign and Care Coordination; and 4) Learning Collaboratives, Establishing Best Practices and Information Sharing.

Medical Care Advisory Committee's (MCAC) Subcommittee on Health Systems Redesign: Based out of DHCF, this subcommittee is focused on the following:

To develop recommendations for the MCAC on strategies to achieve the following five State Health Innovation Plan (SHIP) goals: 1) 100% of Medicaid beneficiaries with a qualifying chronic health condition will have access to a care coordination entity; 2) 15% reduction in non-emergent ED visits for all Medicaid beneficiaries; 3) 15% reduction in preventable hospitalizations; 4) Reinvest savings achieved through system redesign to promote prevention and health equity and 5) 85% of Medicaid payments will be linked to quality; and 50% will be tied to an alternative payment model (APM). While this is not specific to behavioral health solely, it includes behavioral health.

These recommendations would be informed by input from beneficiaries and their families, providers and other stakeholders and, guided by data and strategies outlined in the SHIP, Healthy People 2020, and District of Columbia Community Health Needs Assessment. Output from the committee will address what specific changes are needed in the Medicaid program to help integrate community health, social services, behavioral health and medical care; strategies to engage beneficiaries and their families in care decisions, and approaches to leverage resources and collaboration across private sector, government, and non-government entities.

Coordinating Council on School Mental Health: The Comprehensive Plan to Expand Early Childhood and School-Based Behavioral Health Services developed by the former Interagency Behavioral Health Working Group and School Based Mental Health Task Force established a coordinating council to guide implementation of the plan. The Coordinating Council on School Mental Health (CC) includes and is not limited to members of the former Interagency Behavioral Health Working Group and the former Task Force on School Mental Health. The CC will continue and move forward the work of the Task Force on School Mental Health, and the Behavioral Health Working Group before it. The mission of the CC is to hold agencies and participating stakeholders accountable for timely implementation of the expanded School-based Behavioral Health System.

District of Columbia Healthy Communities Collaborative Mental Health Subcommittee: The District of Columbia Healthy Communities Collaborative (DCHCC) was established in 2012 as a coalition of hospitals and Federally Qualified Health Centers (FQHCs) that combine efforts and resources to assess and address community needs. This work is undertaken in partnership, is data-driven, and engages the community. DCHCC members include five hospitals (Children's National, Howard University Hospital, HSC Health Care System, Providence Health System, Sibley Memorial Hospital), four community health centers (Community of Hope, Mary's Center, Unity Health Care, and Bread for the City), the DC Hospital Association and DC Primary Care Association. DCHCC completes a Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) every three years, a federal government requirement not-for-profit hospitals. The 2016 DCHCC CHNA, identified four top priority areas and Care Coordination, Health Literacy, Place-Based Care, and Mental Health. In 2017, the DCHCC Mental Health Subcommittee formed to take action on the mental health priorities. The CHIP goals and strategies aim upstream to make policy, systems, and environmental change. Through this framework, DCHCC's work

goes beyond the clinical interaction, aiming to modify the social conditions of the community, and make healthy choices practical for and available to all community members.

State Early Childhood Development Coordinating Council (SECDCC): SECDCC was created to improve the collaboration and coordination between entities carrying out federally funded and District funded Pre-K and other early childhood programs. The SECDCC supports policies and practices that advance early childhood education for infants, toddlers, and young children. SECDCC's vision is that all children from birth to age 8 will receive the necessary supports and services they need to be ready to learn and develop successfully. This council is comprised of several different committees focused on a variety of areas such as program quality, data, needs assessment and insights, early intervention and family support, finance and policy, health and well-being, and public-private partnerships. These committees work to advance the overall vision of the SECDCC as well as inform the council on their findings and next steps.

ZERO TO THREE Infant and Early Childhood Mental Health Technical Assistance Collaborative: DC was invited by ZERO TO THREE to participate in an Infant and Early Childhood Mental Health (IECMH) Technical Assistance Collaborative to advance the integration and promotion of infant and early childhood mental health services across child-serving systems and to improve children's social-emotional development. Through this work, DC aims to maximize cross-sector understanding and utilization of current policies in DC that support the financing of IECMH, as well as develop an IECMH Services Coverage and Funding Streams Primer to inform the development of policy and programmatic options and potential recommendations for additional IECMH services.

CURRENT EFFORTS

This section provides an overview of the efforts taken through legislation, budget updates, regulations, groups, taskforces, coalitions, and other relevant items under review that are linked to improvements in mental health services.

Legislation & Local Budget

The Behavioral Health Parity Act of 2017 (B22-0597): As introduced, this bill requires all health benefit plans by an insurance carrier to submit an annual report on or before October 1 of every calendar year to demonstrate that each offered product or plan meets the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. This bill also requires DC Medicaid to demonstrate that the Medicaid plan and DC managed care plans also meet the requirements of the federal parity law. This bill was enacted into law on January 16, 2019 and may be cited as the "Behavioral Health Parity Act of 2018". It was transmitted to Congress on January 29, 2019 and its projected law date is March 26, 2019.

Birth to Three for All DC Act (B22-203): This bill focuses on early childhood (0-3) initiatives and system changes in health and early learning. The Birth to Three for All DC Act includes key provisions to improve mental health services in the District of Columbia, including:

- Expansion of HealthySteps[30] to additional health clinics in Wards 5, 7 and 8

[30] For more information on HealthySteps, please see https://www.healthysteps.org/ and www.ecin.org

- Expansion of early childhood mental health consultation (ECMHC) to more child care centers serving low-income children
- Improvements to access and quality of early learning

In June 2018, The DC City Council passed the Birth to Three for All DC Act. This legislation secured partial funding in the FY 19 budget, with $1.3 million allocated for key initiatives. These include additional home visiting services, expansion of HealthySteps pediatric model, onsite classes for teachers earning higher degrees, and the development of the salary scale for early educators. While additional funding is needed to fully implement this legislation over a multi-year strategy, securing partial funding is an accomplishment that should not be overlooked. In Table 1, you will find the breakdown of funding for Fiscal Year 2019 for "Birth to Three All DC".

Fiscal Year 2019 Funding for Key Provisions of "Birth to Three For All DC"

	Dollars
Home visiting programs	$710,566
HealthySteps	$300,000
Onsite Classes for teachers earning higher degrees	$185,335
Salary scale and other studies	$100,183
Total	**$1,296,084**

Source: Fiscal Year 2019 Budget

Note: Reprinted from "DC Fiscal Policy Institute Celebrates the Adoption of "Birth to Three For All DC"" by Wallace, M.

Maternal Mental Health Task Force Act (B22-0172): This bill establishes a Maternal Mental Health Task Force, funded by the Department of Behavioral Health, to study and provide comprehensive policy recommendations to address maternal mental health needs in the District. This legislation went into effect on July 17, 2018 subject to appropriations.

Regulations

Free-Standing Mental Health Clinics: The oversight for this outpatient benefit for Medicaid for behavioral health services is in the process of moving to DBH from DHCF. The draft proposed regulations change eligibility requirements to allow services to be made available to any District resident with a mental health condition, with the expectation for DBH local dollars to pay for care for individuals not eligible for Medicaid, e.g., some categories of immigrants or United States Veterans seeking care not covered under US Department of Veterans Affairs benefits.

On The Radar

- DCBHA Policy Agenda for Fiscal Year 2019 includes the recommendation of creating an Interagency Council on Behavioral Health
- Class Action Lawsuit Against The District of Columbia (Mayor's Office, AG, DBH, DHCF)
    - On August 14, 2018, The Washington Post reported[31]: "Attorneys at several disability rights organizations have filed a class-action lawsuit against the D.C. government, alleging that District officials have failed to provide adequate mental-health services for hundreds of severely troubled children."
    - The claim and more information can be found here: http://www.bazelon.org/mj-v-district-of-columbia/

CONCLUSION

The delivery of public behavioral health care services in the District of Columbia is complex, as there are many different factors to take into consideration, such as the financing for behavioral health services and the system infrastructure that provides these services. Through the development of this paper, initial areas of opportunity and growth to strengthen DC's public behavioral health care system emerged. These included: consumer ability to access behavioral health services – the right services at the right time; difficulty obtaining access to services through the Access HelpLine; decline in number of Core Service Agency providers; care coordination; workforce capacity; culturally competent services, inpatient hospitalization capacity; lack of partial hospitalization resources; and more. In coming papers, we intend to provide a more detailed qualitative and quantitative analysis of the current strengths, and gaps, in the system, and further engage with stakeholders to identify and advance solutions.

[31] Jamison, P., Lawsuit Alleges D.C. has failed hundreds of emotionally disturbed children, Washington Post, August 14, 2018.

Appendix A: Compilation of Mental Health Needs Assessments for the District of Columbia

Source: DC Healthy Communities Collaborative Mental Health Subcommittee

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
District of Columbia Health Systems Plan 2017	Department of Health (DOH)		2017	Adults and Children	The Healthy Systems Plan is a tool to strengthen the health and healthcare systems in DC. The goal is to recommend specific strategic action and to facilitate cooperation between DOH and other public and private sector entities. the HSP will be used to: (1) prioritize and promote certain community need- or service-related issues for investment, (2) clarify issues related to community characteristics, community need, barriers to care, existing service gaps, unmet need, and other health-related factors, and (3) guide a more refined, data driven, and objective CON application	Methodology Quantitative data was compiled from existing sources including Healthy People 2020, BRFSS, DC Healthy Communities Collaborative CHNA, U.S. Census Bureau. Qualitative data was gathered through key informant interviews and community forums engaging service providers, health department officials, community stakeholders, and/or community residents (100 people).	Strategic recommendations made on three priority areas that will serve as guidelines for decisions on Certificate of Need applications: healthy system strengthening (by service sector), health systems and structures, and community health improvement		https://dc.gov/release/mayor-bowser-releases-district-health-systems-plan

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
					review process. Findings: Service capacity is not the dominant health system challenge. The assessment identified the following challenges as those most strongly tied to promoting health equity, improving population health, and strengthening the health system: social determinants of health; engagement in appropriate care; care coordination; integration of clinical and non-clinical services; organization collaboration/partnership; implementation of evidence-informed protocols/services to address health disparities; administrative barriers; health literacy/education/prevention				

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
DC Youth Risk Behavior Survey (YRBS)	Office of the State Superintendent of Education (OSSE)		2017	Middle and High School students	The Youth Risk Behavior Survey (YRBS) is a survey of health-risk behaviors conducted in middle and high schools every two years in Washington, DC and around the United States. The YRBS covers six topic areas including: Behaviors that contribute to unintentional injuries and violence; Tobacco use; Alcohol and other drug use; Sexual risk behaviors; Unhealthy dietary behaviors; Physical inactivity. 2015 survey finding: Lesbian, gay, or bisexual high school students were two to three times more likely to feel sad or hopeless and to think seriously about, plan, and attempt to kill themselves. For example, one out of 11 lesbian, gay, or bisexual high school students had to be treated by a doctor or	The CDC developed the Youth Risk Behavior Surveillance System (YRBSS) in 1990 to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. These behaviors, often established during childhood and early adolescence. The biennial YRBS evaluates a representative sample from both District of Columbia Public Schools (DCPS) and public charter schools (PCS) in 2015, compiling data from more than 30,000 District students in	OSSE will use the data collected through the YRBS to target trainings for all District teachers and principals at public and public charter schools and licensed personnel at child development facilities on how to identify and refer students with behavioral health needs. Data also will be used for public awareness campaigns and training parents, family members, teachers, school personnel and peers on how to assist youth facing mental health challenges or crises. OSSE is strategically partnering with various agencies and organizations to address the issues reflected in the report.		https://osse.dc.gov/service/dc-youth-risk-behavior-survey-yrbs

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
					nurse as a result of an attempted suicide.	grades six through 12. YRBS data are compared to results from 2012, the last year the survey was administered, and include data from 2007, the first year OSSE administered the survey, to show trends over time.	It is important to understand these risky behaviors, in order to create appropriate multifaceted programs. OSSE is revamping current programs and initiatives to focus on the whole child to coordinate and systematically address issues that are intersected. By doing this, OSSE will focus on expanding the availability of resources to schools and families to address the issues both at school and at home. OSSE also understand the importance of diversifying professional development offerings and including youth at the table to address some of the risky behaviors identified		

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
Early Childhood and School-Based Behavioral Health Services Comprehensive Plan; Task Force on School Mental Health	DC Department of Behavioral Health, Deputy Mayor for Health and Human Services, and Deputy Mayor for Education	Co-chairs of Task Force: Dr. Olga Acosta Price and Dr. LaQuandra Nesbitt. For questions: Jay Melder, DMHHS Chief of Staff, 202-427-5731.	2016; 2018	Youth and Young Adults	Despite the District's current investment of nearly $50 million overall in school-based behavioral health, there is not currently a strategy to provide prevention and screening services in 100% of the schools or ensure that all students who have behavioral health needs are connected to the appropriate services. Similarly, there is not currently the capacity for 100% of Child Development Centers to have access to individualized early childhood mental health consultation. This plan, which was developed through a collaborative, interagency process, sets out the framework for creating a coordinated and responsive behavioral health system for all students in all public and public	The Interagency Behavioral Health Working Group (BWG) convened with the task of creating a unified vision that would allocate new and existing school-based behavioral health services for all public and public charter school students and expand early childhood mental health consultation in the child development centers. The BWG membership represents a cross-section of District Government agencies and organizations that are recognized for their vision, advocacy and investment of behavioral health resources and services in schools and child development	In addition to school-wide interventions focusing on the mental health and well-being of all children and creating a school environment that promotes and supports student mental wellness and resiliency, the new model will align allocation of clinical services (Tier 2 and Tier 3 services) with the level of need of that school. Using proxy measures, each school will be identified as having low, medium or high need. Schools in the high need category will be recommended to have at least one full-time mental health clinician. Medium and low need schools are recommended to have at least one part-time mental	As a result of this study, the District's Early Childhood and School-Based Behavioral Health Services Plan outlines a model to expand health services to every public school and public charter school in the city: https://dmhhs.dc.gov/sites/default/files/dc/sites/dmhhs/publication/attachments/District%20School-Based%20Behavioral%20Health%20	https://dmhhs.dc.gov/sites/default/files/dc/sites/dmhhs/publication/attachments/District%20Comprehensive%20Plan%20for%20Early%20Childhood%20and%20School-Based%20Mental%20Health%20Services.PDF

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
					charter schools. The Task Force on School Mental Health was formed by the School-Based Behavioral Health Comprehensive Plan Amendment Act of 2017, it was charged with reviewing the District of Columbia's Comprehensive Plan to expand School-Based Behavioral Health Services.	centers. The Task Force examined key aspects of the Comprehensive Plan: the proposed framework; provider interest and capacity; current school behavioral health programs, agencies, and providers operating in public schools, including best practices; timeline for expanding school-based behavioral health services to all District public and public charter schools; any recommendations for changes to the plan to move forward; and budget recommendations for year #1 implementation in school year 2018-2019.	health clinician. The Task Force recommends changes in the role of the DBH Clinicians and the timing and factors to consider before changing the role of the DBH Clinician; provider capacity, and what is needed to grow the pool of available community-based partners, including the need to identify additional funding sources to enable providers to deliver school-based services; and the governance structure to guide implementation.	Services%20Rollout%20Plan.pdf As of May 2017, the DC Council has the delayed the implementation of this plan for the next school year. The Task Force concluded that having a school-based behavioral health professional in each school that has a school-wide perspective, and is responsible for coordinating and helping the school to integrate all three Tiers	

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
								of support is critical, but they expressed concern in the first year of implementation. The Task Force identified two factors necessary to ensure that provider capacity can expand at the rate needed to achieve comprehensive coverage as soon as possible: additional funding sources for community-based providers and establishing guidelines	

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								for schools and providers.	
DC Department of Behavioral Health Adult Community Service Reviews Report FY 2016	DC Department of Behavioral Health		2016	Adults	Case based review process to understand the experiences of adults and families served within DC's behavioral health system	Consumer safety indicators (safety from harm by others, behavioral risk to self, behavioral risk to others); mental health functioning, substance use, recovery action, social network quality, social network recovery support			Document attachment

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
DC Healthy Community Collaborative Community Health Needs Assessment 2016	DC Healthy Communities Collaborative	Chaya Merrill (dchealthmatters@gmail.com)	2016	Adults and families	Qualitative analysis of stakeholder feedback revealed nine pressing community needs: care coordination, food insecurity, bring care to the community, mental health, health literacy, healthy behaviors, health data dissemination, community violence, and cultural competency.	Mental Health by Ward; mental health professional service areas	Health improvement plan addressing the four community needs: mental health, bring care to the community, care coordination, and health literacy.		http://www.dchealthmatters.org/content/sites/washingtondc/2016_DC_CHNA_062416_FINAL.pdf
DC Healthy People 2020 Framework	DC Department of Health	Emily M. Putzer (Healthy People Coordinator)	2016	Adults and families	The DC Healthy People 2020 (DC HP2020) framework sets goals, population-level health outcome objectives, and targets for the year 2020 and recommends evidence-based strategies to improve key health outcomes for District of Columbia residents. Over 30 agencies and organizations were represented in the collaborative process	Mental Health and Mental Disorders Leading Health Indicators (MHMD-I-Policies and procedures around workplace/school bullying; MHMD-II Proportion of adolescents aged 12 to 17 who experience major depressive episodes; MHMD-III: Proportion of primary care physician visits	Implementation plan will be released in August 2017.		https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/FINAL%20DC%20HP2020%20Framework%20Report%205-23-16.pdf

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
					to develop DC HP2020, which was likewise informed by ongoing community input.	where patients are screened for depression)			
The Health of the African American Community in the District of Columbia (GU Report)	Georgetown University School of Nursing & Health Studies	Maurice Jackson	2016	Adults	The HAACDC report serves as a component of a more comprehensive document that magnifies social and economic conditions that impact the city's African American population	Findings generated and synthesized from a variety of secondary data sources (i.e. the American Community Survey, Medical Expenditure Panel Survey, National Health Interview Survey, Behavioral Risk Factor Surveillance System, and the National Cancer Institute, DChealthmatters.org, and District of Columbia Department of Health's 2014	Integrate mental health in primary care and ensure the availability of behavioral health services		https://www.georgetown.edu/sites/www/files/The%20Health%20of%20the%20African%20American%20Community%20in%20the%20District%20of%20Columbia.pdf

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
						Community Health Assessment).			
Urban Institute Report Health Needs for the Washington Metropolitan Area	Urban Institute	Lisa Dubay	2016	Adults and families	Urban Institute Report describes the health and demographic characteristics of each area, identify community health needs and recommendations from extant sources, and provide examples of some potential types of community investments CareFirst could make.	Data were obtained from several sources. The health and demographic characteristics of different areas analyzed by using both the Robert Wood Johnson Foundation's County Health Rankings and the Health Resources and Services Administration's Area Health Resource File	Recommended strategies: • Clear need for expanded mental health services for children School-based Mental Health Services Weist and Murray (2008) argue for an expanded model of school mental health services based on equitable partnerships between schools, communities and families Recommended Strategies		http://www.urban.org/research/publication/health-needs-washington-metropolitan-area-potential-initiatives-investment-carefirst/view/full_report

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
							• Interpersonal psychotherapy for depressed adolescents (IPT-A) • Coping and support training (CAST) • Multi-tiered systems of support • Interconnected systems framework		

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
School Health Needs Assessment	DC Action for Children	Shana Bartley (info@dckids.org)	2016	Youth and Young Adults	The District of Columbia Department of Health—Community Health Administration (DOH) funds and oversees two major school health programs: The School Nursing Program and School-based Health Centers. In order to ensure that these programs are responsive to the needs of students in DC Public and public charter schools, the DOH commissioned this needs assessment. The analysis revealed that students attending DCPS and public charter schools face a variety of chronic conditions in addition to common childhood ailments that can affect their ability to focus in the classroom. While school health plays a critical role in supporting student learning, these	The School Health Needs Assessment uses both quantitative and qualitative data to provide a comprehensive description of how the DOH's current school health programs meet the needs of students. Qualitative data was collected through semi-structured interviews with key informants across District agencies and health providers as well as through focus groups with parents and students. We analyzed quantitative data that came from a variety of sources to understand the health needs and social determinants of health for DC	1.) Establish a shared vision for children's health in the District.; 2.) Improve data collection and systems for school health services; 3.) Create and distribute process documents and training materials that clearly define the roles and responsibilities of school health providers. 4) Form a school health collaborative or advisory body. 5.) Implement a more robust evaluation and quality assurance process. *Ensure we are creating mechanisms to maximize collaboration among health and behavioral health providers*	DOH revamped its School Health Services in 2016 to align with the Whole School, Whole Community, Whole Child Framework. https://doh.dc.gov/service/school-health-services	https://www.dcactionforchildren.org/our-issues/research-resources/school-health-needs-assessment

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
					services fit in a broader system of care and supports necessary for children to thrive. Related finding: Many students also present behavioral health concerns that can affect their learning. Data measuring Adverse Child or Family Experiences (ACEs) suggest that a large share of children and youth in the District have experienced behavioral health risk factors.	children and utilization patterns of the current school health programs.			

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
Child & Adolescent Mental Health Resource Guide	DC Collaborative for Mental Health in Pediatric Primary Care		2014	Families	The DC Collaborative for Mental Health in Pediatric Primary Care aims to improve the integration of mental health in pediatric primary care for children in the District of Columbia. We have a strong commitment to addressing the mental health needs of diverse children, from birth through 20, and their families, through culturally competent, family-focused initiatives. As part of our work, we have compiled the following mental health resource guide for use by pediatric primary care providers in the Washington, DC area. We intend to update this working guide regularly. The main scope is on those providers in the District of Columbia that serve children and families on Medicaid. However,	N/A	Better mechanism to ensure as many providers as possible are included and that the guide reaches all persons who can benefit from it.		https://www.dchealthcheck.net/documents/Mental-Health-Resource-Guide.pdf

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
					some providers in Maryland and Virginia are included, as well as a few providers across the D.C. area that offer services on a sliding fee scale or accept commercial insurance.				

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
The Integration of Mental Health and Pediatric Primary Care: A Mixed Methods Needs Assessment of DC Providers	DC Collaborative for Mental Health in Pediatric Primary Care		2015	Primary Care and Mental Health providers	Purpose: To determine attitudes, beliefs, and practices of pediatric primary care providers (PCPs) and mental health (MH) providers related to behavioral health and primary care pediatrics. Methods: Surveys - Two separate surveys were developed—one for PCPs (e.g., pediatricians, family practitioners, nurse practitioners) and one for MH providers (e.g., psychiatrists, psychologists, clinical social workers). Interviews: Two semi-structured interview guides were developed based on the surveys. The interviews were designed to give providers the opportunity to discuss their thoughts, feelings, and experiences in further detail.	Beliefs and knowledge about behavioral healthcare for children; relationship between PCPs and MH providers; Current obstacles to caring for patients mental health issues			https://childrensnational.org/~/media/cnhs-site/files/about/advocacy/2015cbrsm.ashx?la=en

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
DC Department of Behavioral Health 2014 Adult CSR Report	DC Department of Behavioral Health	Tony White; for information contact: Susan Koehne (susan.koehne@dc.gov)	2014	Adults	Qualitative review of quality services for adults in the community offered through DBH	Person Status Indicators (e.g., Safety from Harm by Others); Progress Indicators (e.g., Reduction of Psychiatric Symptoms); Practice Performance Indicators	Services for addiction recovery and trauma recovery needed development to improve quality system-wide. DBH may need to develop a strategic plan for providing technical assistance to new providers and managing the growth of those agencies over time. May want to examine the content of trainings and technical assistance currently offered to providers.		Document attachment

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers, and Recommendations	DC Department Behavioral Health / Georgetown University National Technical Assistance Center for Children's Mental Health	James R. Wotring (jr59@georgetown.edu; 202-687-5052)	2014	Families	On March 30, 2010, an argument over a missing bracelet led to one of the deadliest mass shootings in the history of the District, leaving four young people dead and six others wounded. This tragedy underscored the strong link between school truancy, behavioral health issues, and potential violence. In response to this incident and urging by family members of the involved youth, the South Capitol Street Memorial Act (Act) was passed on April 10, 2012 by the DC City Council. The overarching goal of the Act is to transform how the District addresses youth behavioral health issues by identifying early signs of unmet behavioral health needs and promoting effective interventions, thus	Prevalence of Behavioral Health Conditions Among Youth and Children; Prevalence Estimates of Mental Health Diagnosis in Youth Receiving MHRS Services; Description of the Child and Youth Delivery System; Unmet Need	Promote adoption of the CAFAS by other agencies to help standardize data collection on care quality and outcomes. Analyze and synthesize individual client-level data. Determine the service array that seems to work best for children/youth. Examine individual-level service utilization data by ward to begin addressing the possible link between unmet behavioral health needs and delinquency and violent behavior later in life. Continue interagency strategizing around how to best codify and share information. Closely monitor the ICAMS rollout to determine its effectiveness.		https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
					preventing future tragedies. This report was prepared for DBH by the Georgetown University National Technical Assistance Center for Children's Mental Health as one of a series of reports and resource guides required by the legislation to enhance the District's ability to address youth behavioral health issues.		Partner with sister agencies to develop and adopt a universal identifier. Estimate unmet need on a regular basis through an unduplicated count of consumers.		

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
DC Healthy Community Collaborative Community Health Needs Assessment 2013	RAND	Anita Chandra (Anita_Chandra@rand.org; 703-413-1100 x5323)	2013	Adults and families	The analysis of this quantitative data is complemented by an analysis of current stakeholder perspectives regarding health needs, as well as health policy and investment priorities. This CHNA demonstrates the persistence of many issues identified in prior CHNAs: asthma, obesity, mental health, and sexual health. Despite high insurance rates, health care services are not evenly distributed by ward, creating significant challenges to access. There is a need to expand these services, as well as improve care coordination between health and social services to help residents navigate the system and obtain the services they need. Our findings focus on the areas of (1)	BRFSS and YRBS health needs and risk behaviors; DC DOH data; National Center for Health Statistics; SAMHSA, local studies	There's a need for expansion of services, as well as greater care coordination between health and social services.		http://www.rand.org/pubs/periodicals/health-quarterly/issues/v3/n3/09.html

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
					general health quality and the use of preventive services, (2) nutrition and obesity, (3) chronic disease, (4) reproductive and sexual health, (5) mental health and substance use, (5) oral health, and (6) injuries.				

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care	DC Department of Mental Health / RAND Corporation	Carole Roan Gresenz (Carole_Gresenz@rand.org; 703-413-1100 x5412)	2010	Adults and families	This report summarizes findings from a study of the public behavioral health care system in the District of Columbia, including the prevalence of mental health disorders and substance use, the organization and financing of public behavioral health services, utilization of public behavioral health services, and priorities for improvement	To estimate the prevalence of mental health disorders and substance use, we primarily use data from four surveys: the Behavioral Risk Factor Surveillance System (BRFSS); the National Survey of Drug Use and Health (NSDUH); the National Survey of Children's Health (NSCH); and the Youth Risk Behavior Survey (YRBS). To evaluate the utilization of behavioral health care services among District residents, we use administrative data from three sources: eCura, which is the D.C. Department of Mental Health (DMH) electronic patient	Work to reduce unmet need for public mental health care. Track and coordinate care of individuals in the public system with mental health diagnoses. Improve the availability and accessibility of substance abuse treatment services. Increase the coordination of care for individuals with comorbid mental health and substance abuse conditions. Fundamentally upgrade the data infrastructure of the public behavioral health care system to allow for improved monitoring of service utilization, quality of care, and patient outcomes.		http://www.rand.org/pubs/technical_reports/TR914.html

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
						management and billing system; Medicaid managed care claims data from managed care organizations operating in the District; and District of Columbia Hospital Association data. For information about the functioning of the behavioral health care system, we rely on stakeholder interviews and focus groups			

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
Guide to the Behavioral Health System in the District of Columbia	DC Department of Mental Health / RAND Corporation	Joie Acosta, jacosta@rand.org	2010	Adults and families	As a result of the tobacco litigation settlement reached in 1998, more than $200 million was made available to the District of Columbia to invest in the health of the city's residents. In 2007, the District contracted with the RAND Corporation to study health and the health care delivery system in the District and provide an informed assessment of policy options for improving the health care delivery system, including through the investment of the tobacco settlement funds. The findings from this work are summarized in two RAND reports	Evaluation of government agencies - DMH, DCHF, APRA, Housing Programs, Criminal Justice System. Types of mental health services (outpatient, inpatient, crisis and emergency, school mental health, programs for homeless individuals with behavioral health needs, housing programs, financing)	The goal of this working paper was to clarify the nature of this complexity and the way the system operates for policymakers and others interested the nature of complexity and way in which system works. A companion report provides an evaluation of the District's public behavioral health system and identifies challenges facing the system and recommendations for high level priorities to address the challenges.	This study was cited as a source for DC legislation: Jacks-Fogle Family Preservation Case Coordination Authorization Act of 2009 and L18-0273 Data-sharing and Information Coordination Amendment act of 2010; RAND published a companion "guide" to the DC health system to guide everyone who onboarded into the agency so	http://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR777.pdf

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								they would understand the larger context of mental health in DC: : https://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR777.pdf	

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
School Mental Health Services for the 21st Century: Lessons from the District of Columbia School Mental Health Program	U.S. Department of Education, HHS & Justice / GWU Center for Health and Health Care in Schools	Olga Acosta Price (oaprice@gwu.edu)	2008	Youth and Young Adults	In January 2007, The Center for Health and Health Care in Schools at the George Washington University School of Public Health and Health Services was commissioned to assess operations of school mental health programs in Washington, D.C. and recommend future directions in practices, policies and systems development. While this guidance is directed primarily at the District of Columbia Department of Mental Health, the goal of this report is to offer guidance for all public and private organizations and individuals that share a commitment to effective mental health programs for children in the District of Columbia. This report is based on a 16-month examination of	Organizational management; program development and evidence-based practices; training/professional development; financing; program evaluation and outcomes research	A school-based mental health model founded on a public health approach that offers a range of interventions and programs reflecting differing levels of care. DMH must be explicit in its commitment to the School Mental Health Program and put in place the infrastructure. DMH should props the creating of a school mental health workgroup within ICSIC to ensure interagency collaboration, communication, and accountability for school-based initiatives.		https://dbh.dc.gov/sites/default/files/dc/sites/dmh/service_content/attachments/DMH%20Report%20final.pdf

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
					school-connected mental health programs here in the District of Columbia and in cities, counties and states around the nation. In the course of the study, the authors conducted an in-depth examination of school mental health programs in DC, reviewed relevant literature, and interviewed 100 local and national experts in children's mental health and school mental health.				

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
Rodham Institute Environmental Scan	Rodham Institute, George Washington University, Ground Game		2014	Adults and Youth	The environmental scan presents information to assist the Rodham Institute in understanding its internal capacity to engage communities East of the Anacostia River (EOTR). In partnering with the local Washington D.C. community, they hoped to achieve health equity by cultivating the next generation of community-oriented health care providers, and training them in innovative strategies to improve health care for all. The project spanned a 6-week period, and the emphasis was on recent activities and perspectives related to the health access and equity of residents EOTR. The biggest threat we [EOTR] have to the health of this community is mental illness. There are	Ground Game used two major sources of information: detail account of the internal capacity of the Rodham Institute (staff meetings, internet search and review of partnerships within GW community while recognizing the legal structure of Rodham Institute) and telephone interviews and face to face dialogue with 10 key informants from the EOTR community	Re-work the collaboration database, form a community advisory board, and raise Rodham Institute's visibility/credibility. Leverage access to faculty/students in behavior health division and partner with Smart from the Start and DC Youth Invest Trust to assist in a comprehensive needs assessment and the creation of program evaluation tool specifically addressing what mental/behavior health interventions are needed. More interventions are needed to address the low number of primary care providers EOTR. Establish relationships with DOES Youth Employment DCPC and DCPCS and expand HELP's reach to extend		Document attachment

Document Name	Sponsor	Lead author (if listed)	Publish Year	Population	Overview	Methodology, Indicators & Data Sources	Recommendations	Outcomes/ Action	Web link
					people walking around this ward - functional alcoholics- not because they are alcoholics per se but because they are self-medicating for their mental health issues. The facilities are so bad that people would rather deal with addiction than treat their real problems.		beyond students of parents affiliated with GWU in some capacity.		

Appendix B: Evidence-Based Mental Health Treatment Practices Provided via DC DBH Provider Network

Source: DC Department of Behavioral Health Evidence-Based Practices Fact Sheet, 2017.

EBP Service**	Description	Providers
Child-Parent Psychotherapy (CPP) *	For children ages 0-6 and their parents that helps restore normal developmental violence and trauma by focusing on safety, affect regulation, improving the child-caregiver relationship, normalization of trauma related response, joint construction of a trauma narrative.	• Community Connections • DBH PIECE • Mary's Center
Parent Child Interaction Therapy (PCIT)	For children ages 2-6 who act out at home and at school. Teaches parents effective ways to manage their child's unruly behavior.	• DBH PIECE • Mary's Center
Multisystemic Therapy (MST)	An intensive family and community-based program that blends cognitive behavioral therapy, behavior management training, and family therapy to address issues and behaviors associated with at-risk youth (ages 10-17).	• MBI Health Services
Trauma Systems Therapy (TST)*	For children ages 6-20 aims to stabilize the child's environment while simultaneously enhancing their ability to regulate emotions and behaviors.	• Adoptions Together Family Works Together • Contemporary Family Services • Hillcrest Children & Family Center MD/DC Family Resource
Trauma-Focused Cognitive Behavior Therapy (TF-CBT)*	For youth ages 3-18 to help address the unique bio-psychosocial needs of children with Post Traumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences.	• Community Connections • Hillcrest Children & Family Center MD/DC Family Resource
Functional Family Therapy (FFT)	For youth ages 11-18 to improve within-family attributions, family communication and supportiveness while decreasing intense negativity and dysfunctional patterns of behavior.	• Hillcrest Children & Family Center • Parent & Adolescent Support Services (PASS)
Transition to Independence (TIP)	For youth ages 14-29 to engage in their own futures planning process.	• Community Connections • Contemporary Family Services • Family Preservation Services • Life Enhancement Services • MBI Health Services • Parent & Adolescent Support Services (PASS) • Total Family Care Coalition

*Trauma Models. **Some evidence-based practices described are also available through other community-based providers that are not part of the DBH provider network.

Appendix C: DC DBH Listing of Community Based Providers Serving Children & Families

Source: DC Department of Behavioral Health website, https://dbh.dc.gov/page/list-community-based-service-providers, accessed February 2019.

Provider*	Address	Phone / Email
Amazing Love	702 15th Street, NE 20002	(202) 388-8500/gwntemi@alhs-health.com
Better Morning	4545 42nd Street NW, Ste 105 20007	(571) 291-9752
Community Connections, Inc.	801 Pennsylvania Avenue, SE 20003	(202) 546-1512/Mharris@CCDC1.org
Community Wellness Ventures	1130 Varney Street, SE 20032	(202) 450-5822/rwilliams@cwellnesssv.com
Family Solutions of Ohio	650 Pennsylvania Avenue SE, Ste 330 20003	(240) 543-0387 (240) 543-2758
Family Wellness	2526 Pennsylvania Avenue SE 20020	(202) 748-5641/scyrus@theFWC.net
Hillcrest Children & Family Center	915 Rhode Island Ave, NW 20009	(202) 232-6100/jprice@hillcrest-dc.org
Inner City Family Services	2307 Martin Luther King Avenue, SE 20020	(202) 525-4855 Skip@innercityfamilyservices.com
Latin American Youth Center	1419 Columbia Road, NW 20009	(202) 319-2225/lori@layc-dc.org
Life Enhancement Services	1818 New York Ave, NE 20002	(202) 269-2401/Ccolvin@lesdc.org
Life Stride	3005 Bladensburg Road, NE 20018	(202) 635-2320/jdrumming@earthlink.net
Mary's Center	2333 Ontario Road, NW 20009	(202) 483-8319/mgomez@marysCenter.org
MBI	4130 Hunt Place, NE 20019	(202) 388-4300/Cavery@mbis.com
MD/DC Family Resource	6192 Oxon Hill Road Oxon Hill, MD 20745 903 Brightseat Road Landover, MD 20785	(301) 567-8311 (301) 333-2980 bcrawford@mfrinconline.com
Mental Health Services Division	35 K Street, NE 20002	(202) 442-4204/nancy.black@dc.gov
PSI	770 M Street, SE 20003	(202) 547-3870/(301) 654-3903 rwallace@psifamilyservices.com

*Providers certified and contracted by DC DBH.

Appendix D: Adolescent Substance Abuse Treatment Expansion Program (ASTEP) Providers

Source: DC Department of Behavioral Health

Name of Provider	Address	Phone Number	Ages Served
Plant the Seed Youth Treatment Services	5212 Astor Place SE Washington, DC 20019	202-621-8340	Ages 12-20
Hillcrest Children and Family Center	3029 Martin Luther King Jr. Ave SE Washington, DC 20032 1244 Taylor St NW Washington, DC 20011	202-779-8565	
Latin American Youth Center (LAYC)	1419 Columbia Road, NW Washington, DC 20009	202-319-2225	
Federal City Recovery Services	601 Raleigh Pl. SE Washington, DC 20032	202-735-5579	
MBI Health Services	4130 Hunt Place, NE Washington, DC 20019	202-388-4300 Ext. 305	

Appendix E: DC Medicaid MCO Contract Overview – Sections Relevant to Behavioral Health Care

Source: DC Department of Health Care Finance (contract language); table compiled by Children's National Health System

Beginning October 1, 2017

This table outlines contracts awarded to: Amerigroup DC, AmeriHealth Caritas DC, Trusted Health Plan (not HSCSN)

Issue/Section	Contract Language
Language Access and Cultural Competency	C.5.8.1.1 Contractor shall respond with sensitivity to the needs and preferences of culturally and linguistically diverse beneficiaries. In order to ensure that all beneficiaries are treated in a culturally and linguistically appropriate manner, Contractor shall develop, maintain and ensure compliance with policies and procedures that: C.5.8.1.1.**2 Address cultural and linguistic differences in a competent manner**; and C.5.8.1.1.3 Foster in its staff behaviors that effectively address interpersonal communication styles that respect beneficiaries' cultural backgrounds (pg 45).
Enrollment, Education and outreach	C.5.12.1 Contractor shall provide Covered Services to the following categories of eligible Medicaid Enrollees: C.5.12.1.5 Immigrant Children under age 21 who are not US citizens; ineligible for Medicaid or CHIP with income at or below 300% of the FPL as determined by ESA (pg 51)
Enrollee Assistance	C.5.19.4.2.4 Enrollee services staff shall: Schedule appointments and **arrange transportation and language access** accommodations for medical appointments if requested and necessary. Contractor shall not unduly restrict Enrollees' access to this service and may not establish requirements that such requests be made more than five (5) calendar days in advance for non-EPSDT appointments and **two (2) days for well-child visits and other Medically Necessary Service** (pg 64)
Children's Health Services	C.5.20.3.2.1 Contractor shall furnish periodic and inter-periodic EPSDT screening services whenever an Enrollee is under twenty-one (21), or the Enrollees parent or caretaker relative on his or her behalf, requests the services, unless Contractor verifies and documents that the most recent age-appropriate screening services due under the periodicity schedule specified have already been provided to the Enrollee (pg 72). C.5.20.3.2.2 Contractor shall ensure that the **periodic and inter-periodic assessments of infant, child, and adolescent health and development, shall be furnished** (pg 72): C.5.20.3.2.2.1 At intervals specified under the District of Columbia Health Check Periodicity Schedule (Attachment J.12) and upon request at times other than regularly scheduled intervals (pg 72): C.5.20.3.2.3 Contractor shall ensure that Network Providers serving children furnish periodic and inter-periodic assessments that shall consist of: **C.5.20.3.2.3.5 Mental health and substance use screenings as required by the District's Periodicity Schedule. The PCP shall use a validated, brief mental health screen. DBH must approve the screening tool used by the Contractor's PCPs (pg 73).**

	C.5.20.3.3 Enrollees who screen positive for referral to mental health services shall **receive timely access, to an appointment for further assessment and treatment by a mental health Provider** (pg 73). C.5.20.3.4 Contractor shall furnish any diagnostic or treatment service specified in § 1905(a) of the Social Security Act, 42 U.S.C. § 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, regardless of whether the service is listed in sections C.5.20 (pg 73). C.5.20.3.8 Contractor shall furnish Medically Necessary Case Management services as defined in 42 U.S.C. §396d(a)(19). (pg 73). C.5.20.3.11 Enrollees shall be seen by an **outpatient provider within the first seven (7) days of discharge to the community from a psychiatric inpatient facility admission or PRTF**. Within those 7 days the provider must assess the individual, provide prescriptions if needed and make arrangements for pick up or delivery of the medication if assistance is needed. A subsequent appointment must occur within the first thirty (30) days of discharge from an acute care admission (pg 73). C.5.20.12 All children/youth admitted to an acute care facility must be screened for eligibility to receive DBH's Community Based Interventions (CBI) (this service is reimbursed to DBH certified providers) by contacting the DBH Child/Youth Care Manager within 48 hours of the admission. Parents/guardians of children/youth found to be eligible shall be offered this service. CBI is an intensive in-home service and the Contractor is responsible for care coordination and case management for Enrollees receiving the service from DBH (pg 74).
Individuals with Disabilities Education Act (IDEA) Covered Services	C.5.20.4.3 Contractor shall cover all transportation to and from Medically Necessary Services, as defined in this section C.5.20 and C.5.22.5 for children under age 21, regardless of whether the medical or health care service in question is also identified as a "Related Service" under a child's education-related treatment plan employees or contractors. C.5.20.4.4 Contractor shall identify all enrolled children of any age who also receive Early Intervention or educational services under the IDEA and shall report to DHCF all coverage denials or exclusions involving such children within three (3) days of denial or exclusion or in compliance with any MOA between DHCF, DCPS and DCPCS, as applicable (pg 74).
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coverage Rules	C.5.20.5.2 Contractor **shall not be responsible** for coverage or payment of screening, diagnostic, and treatment services when **such services are furnished to an Enrollee in a school setting by a school program**. Contractor shall be responsible for those items and services that are not provided in a school setting in accordance with C.5.20.5.2 (pg 74). C.5.20.5.3 Contractor shall inform families and caregivers about EPSDT in accordance with sections C.5.12 and C.5.18 and **shall provide scheduling and transportation services necessary to ensure timely receipt of assessments and timely initiation of treatment** under 42 C.F.R. § 441.56, et seq. Transportation services consist of: C.5.20.5.3.1 Health care related transportation services required by children who also are participating in educational programs, unless transportation is furnished directly by the school system; and C.5.20.5.3.2 Health care related transportation services for Enrollees under age 21 in foster care or out-of-home placements.

Home Visiting Outreach for High Risk Newborns	C.5.20.6.1 Contractor shall ensure that each **High Risk Newborn receives a home visit from a Registered Nurse**, licensed in accordance with the D.C. Health Occupations Regulatory Act and its implementing regulations, **within forty-eight (48) hours of discharge from the birthing hospital** or birthing center. Contractor shall coordinate with DOH's Home Visiting Program to report this information to DHCF on a quarterly basis. C.5.20.6.3.1 Facilitating parent-child attachment, including Newborn attachment; C.5.20.6.3.2 **Ascertaining family resources, supports, and linkages, as well as family and parent risk factors;** C.5.20.6.3.3 Assessing the **diagnostic and treatment needs of the mother as well as the Newborn, including assessment of need for post-partum care and follow-up care related to a physical condition, mental illness or substance abuse condition;** C.5.20.6.3.4 Arrangement, coordination and follow-up health care for both the Newborn and the mother(s) (including protocols for mothers who are under age 21 and/or who **need post-partum care and/or are suspected of having a physical or mental health condition requiring further diagnosis and treatment**); C.5.20.6.3.5 Care Coordination related to Early Intervention through Office of the State Superintendent of Education (OSSE) , Women, Infants and Children (WIC) through Department of Health (DOH), and family support services through the Department of Human Services (DHS), and other services; and C.5.20.6.3.6 Ongoing follow-up throughout the first (1st) year of life (pg 75).
EPSDT Outreach Activities	C.5.20.7.5 Contractor shall offer scheduling and transportation assistance prior to the due date of each Enrollee's periodic examination and shall provide this assistance when requested and necessary (pg 76).
Medicaid Behavioral Health Services	C.5.20.8.2 The Contractor shall ensure access to Behavioral Health services in accordance with the Mental Health Parity and Addiction Equity Act of 2008, which generally **requires that health insurance plans treat mental health and substance use disorder benefits on equal footing as medical and surgical benefits** (pg 76).
ICP (Immigrant Children's Program)	C.5.20.20.1 The ICP is a program designed to provide health coverage to individuals under the age of twenty-one (21) who are not eligible for Medicaid. Services covered under the ICP are identical to the services covered under Medicaid for children under age twenty-one (21). C.5.20.20.2 **Contractor shall provide the same benefit package to the ICP Enrollees as children enrolled in the DCHFP** (pg 86).
Provider Network and Access Requirements	C.5.21.1 Contractor shall develop and **maintain a Provider network which is sufficient to provide timely access to the full range of Covered Services** to Enrollees including physical, behavioral, and other specialty services and all other services required under this Contract (pg 88). C.5.21.19 Contractor shall maintain and monitor a network of appropriate Providers that is sufficient to provide adequate access to all services covered under the contract for all Enrollees**, including those with limited English proficiency or physical or mental disabilities** (pg 89).
Network Composition	C.5.21.2.1 Network Adequacy Requirements

	Contractor shall ensure that its delivery network is sufficient in number, geographic distribution and types of Providers to ensure that all Covered Services, including an appropriate range of preventive, primary care, and specialty services, are accessible to meet the needs of the anticipated number of Enrollees without unreasonable delay (pg 91). **C.521.2.5.1 Contract shall ensure that the Travel Time to general acute care hospitals or mental health Providers shall not exceed thirty (30) minutes Travel Time by public transportation (pg 91)** C.5.21.2.8.6.6 The routine appointment waiting times (i.e., time routinely spent waiting to see the Provider once the Enrollee has arrived) and the time it takes for an Enrollee to schedule an initial and follow-up appointment (pg 93) C.5.21.2.9.5 Contractor shall recruit licensed, Board-certified or Board eligible Providers needed to provide comprehensive, accessible, and Culturally Competent care on an ongoing basis (pg 94)
Primary Care Providers	C.5.21.3.3 Contractor shall ensure that PCPs have adequate capacity as this term is defined by the standard of care, prevailing industry norms and community standards (as defined in section H.11.7), including any CMS or DHCF guidance on this issue. In evaluating the capacity of PCPs, Contractor shall take into consideration both a PCP's existing Contractor Enrollee load, overall Enrollee load, Medicaid patient load, as well as its total patient load and shall assess the overall patient load against community standards for any specialty involved. Contractor shall also consider whether the Provider is in compliance with the Appointment Time standards set forth in section C.5.21.19. In no event shall Contractor assign additional Enrollees to a single PCP if the Contractor believes that the PCP has reached his/her capacity to provide high quality services to Enrollees. Contractor shall provide this information upon DHCF's request (pg 95).
Behavioral Health Providers	C.5.21.8.1 Contractor shall have **a sufficient number of appropriately skilled Providers to provide Covered Mental Health Services to Enrollees**. Contractor's mental health services network shall include the Department of Behavioral Health's Core Service Agencies (CSA) as this term is defined by DBH (unless this requirement is waived, in writing, by DHCF), as well as a **sufficient number of the following to meet the needs of the Contractor's enrolled beneficiaries**: • Psychiatrists, both adult and pediatric; • Specialists in developmental/Behavioral Health medicine; • Psychologists, both adult and pediatric; • Social Workers, including those specializing in treatment of mental health and substance abuse; • Inpatient psychiatric units for adults and pediatric Enrollees; • Residential treatment facilities; • Partial Hospitalization and Intensive Outpatient Programs; • Coordination and Case Management service Providers; (pg 96) C.5.21.8.4 **Contractor shall submit a quarterly report of a GeoAccess or comparable software showing participating mental health Providers by zip code of office locations and shall highlight all Providers with less than eighty percent (80%) panel availability** (pg 97) C.5.21.8.5 Failure to maintain an adequate and sufficient network that ensures Enrollees have access to covered Mental Health services **without unreasonable delays**, and as described in section C.5.21**, can result in corrective action, fines,**

	penalties and/or sanctions imposed by the District, including, but not limited to the amount listed in section C.5.21.2.9. (pg 98). C.5.21.8.6 Contractor shall ensure that services for the assessment and **stabilization of psychiatric crises**, including those experienced with treating children or adolescents, are **available on a twenty-four (24) hour basis, seven (7) days a week**, including weekends and holidays. **Phone based assessment must be provided within fifteen (15) minutes** of request and, when Medically Necessary, intervention or **face- to-face assessment shall be provided within ninety (90) minutes of completion of the phone assessment**. These services shall be provided by practitioners with appropriate expertise in mental health with on- call access to an adult or child and adolescent psychiatrist (pg 86).
Integrated Care Centers	C.5.21.12 Contractor shall demonstrate that its network includes facilities providing integrated care for Enrollees with complex conditions that require multi-disciplinary assessment, diagnosis, and/or treatment. Such facilities may include multi-disciplinary teams practicing at a common location such as specialty outpatient departments, specialty clinics, and developmental centers (pg 99).
IDEA Service Providers	Contractor's network shall include certified Early Intervention Providers for health related IDEA services to children under age three (3). Additionally, Contractor's **network shall include Providers qualified to perform evaluations for IDEA eligibility and provide health related IDEA services for children three (3) years of age and older** unless and until these services are provided by DCPS. Such Providers shall include those who provide rehabilitation services for improvement, maintenance, or restoration of functioning, including respiratory (including home-based), occupational, speech, and physical therapies (pg 99).
Integrated Care Centers	Contractor shall demonstrate that its network includes facilities providing integrated care for Enrollees with complex conditions that require multi-disciplinary assessment, diagnosis, and/or treatment. Such facilities may include multi-disciplinary teams practicing at a common location such as specialty outpatient departments, specialty clinics, and developmental centers (pg 99).
Capacity to Serve Enrollees with Diverse Cultures and Languages	C.5.21.16.1 Contractor shall include Providers in its Network Provider that understand and are respectful of health-related beliefs, cultural values, and communication styles, attitudes and behaviors of the cultures represented in the Enrollee population and provide translation services to those that request instructions in their native language (pg 100).
Appointment Times for Services	C.5.21.19.5 The following routine appointments shall take place within thirty (30) days of the request: …C.5.21.19.11 IDEA multidisciplinary **assessments** for **infants and toddlers at risk of disability** shall be completed within **thirty (30) days of request**, and any needed **treatment shall begin within twenty-five (25) days** upon receipt of the completed and signed Individualized Family Service Plan (IFSP) assessment (pg 104).
Provider Agreements	C.5.21.27.6.1 The Contractor shall ensure that Provider Agreements with PCPs require such Providers to screen all Enrollees under age 21 according to the EPSDT Periodicity Schedule and applicable federal regulations, to use the **Behavioral Health screening tools described in the EPSDT Periodicity Schedule when conducting Behavioral Health**

	screenings, and provide or refer all Enrollees under age 21 for Medically Necessary treatment services in accordance with EPSDT requirements (pg 113).
Provider Training	C.5.21.29.3.13 Contractor shall, at a minimum, provide training on the following topics:…**Manifestations of mental illness and alcohol and drug abuse, use of the DHCF screening tool to identify such problems, and how to make appropriate referrals for treatment services, including training at least annually for all PCPs so that PCPs proactively identify Behavioral Health Service needs at the earliest point in time and offer Enrollees referrals to Behavioral Health Services when clinically appropriate (114)**
Coordination with PCPs	C.5.21.31.5 Contractor shall establish an effective system for PCPs to make referrals to other network services needed by Enrollees and for authorization of services that the PCP cannot authorize him or herself. **Contractor shall monitor timeliness of referrals and access to specialists.**
Care Coordination and Case Management	C.5.23.1.1 **Ensure that each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating those services.** The Contractor must provide information to the Enrollee on how the Enrollee can contact their designated person or entity responsible for coordinating care (pg 127). C.5.23.2.3 Contractor shall develop a Comprehensive Case Management program utilizing Enrollee's physical and Behavioral Health status including cognitive functioning and condition-specific issues; utilization patterns; clinical history; activities of daily living; life planning; evaluation of cultural & linguistic needs, preferences or limitations and caregiver resources and natural community supports (130). C.5.23.2.7 Contractor shall educate all Enrollees, in **self-care strategies, illness prevention and Wellness activities**. C.5.23.2.13 Contractor shall conduct Care Coordination and Case Management program Enrollee and Provider **satisfaction surveys, at least annually**. Results shall be included in the annual program evaluation. Contractors shall provide summaries of customer satisfaction surveys in accordance with the requirements found at 42 C.F.R (130).
Performance Based Incentive Program	C.5.30.1 **Providing incentives to Contractors for high quality performance is an important component of DHCF's overall strategy to improve the quality of care received by Enrollees.** DHCF shall utilize financial performance-based incentives to encourage CQI and, therefore, improvement in quality of care received by Enrollees. DHCF shall, from time to time, modify the type of incentives and the structure of the performance-based incentive program over the course of the contract period. All Contractors shall participate in the Performance-Based Incentive Program. C.5.30.1.1 **DHCF will make incentive payments according to criteria and standards established by DHCF. The criteria shall include measurement of performance in clinical quality of care**. Information regarding this performance based incentive program can be found in Section E.7 and the scoring algorithm for this program is in Attachment J.25. (179)
Value Based Purchasing	C.5.31.1 **Contractor shall utilize payment arrangements with its contracted Provider network to reward performance excellence and performance improvement in targeted priority areas conducive to improved health outcomes and cost savings for DHCF beneficiaries**. VBP arrangements with Providers include both FFS-based bonus arrangements and Alternative Payment Models (APMs) designed to align financial incentives its Network Providers to increase the value of

	care provided and not focus exclusively on the volume of care provided. APMS are defined as shared savings, shared risk, or capitated financial arrangements with Network Providers that specifically include quality performance as a factor in the amount of payment a Provider receives. C.5.31.2 **Value-Based Purchasing Strategies** A VBP model which aligns payment more directly to the quality and efficiency of care provided, by rewarding Providers for their measured performance across the dimensions of quality. **VBP strategies for this initiative may include any combination of the payment model classifications as defined by the Learning Action Network:** □ Category 2 Fee for Service-Link to Quality and Value □ Category 3 APM Built on Fee-For Service Architecture □ Category 4 Population Based Payment
Value Based Adoption Requirements	C.5.31.3.1 The contractor shall incorporate value based purchasing initiatives with Network Providers. **The Contractor shall have thirty five percent (35%) of their total dollar amount spent on the delivery of health care services linked to Alternative Payment Models by the end of Option Year One**. C.5.31.3.2 The Contractor has discretion in designing value-based purchasing models to meet the requirements of this section of this Contract; however, eligible APMs shall be consistent with LAN categories 3 and 4. C.5.31.3.3 To the extent that DHCF has established clinical outcomes objectives that can be supported by value-based Provider agreements, the Contractor shall implement payment reform strategies to support the Department's initiatives C.5.31.3.4 DHCF reserves the right to approve/disapprove all payment reform initiatives submitted by the Contractor. C.5.31.3.5 **Failure to meet the minimum target will result in a CAP and/or sanctions as determined by DCHF.**
VBP Reporting Requirements	C.5.31.4.1 **The Contractor shall submit an annual report of all implemented VBP strategies to DHCF (Categories 2-4).** The report shall include a brief summary of all VBP initiatives for the Provider network serving DHCF beneficiaries, the performance and quality measures used to monitor and evaluate the initiative, the percentage of Provider payments link to quality (categories 2-4) and APMs (categories 3-4) and an estimate of the number of beneficiaries served by the initiative.

Performance Based Incentive Algorithm

Funding the Performance Based Incentive Program	The incentive design is based on a withhold of the Contractor's actuarially sound capitation rates. During the contract year, DHCF will withhold two percent (2%) of the Contractor's approved capitation payment. The Contractor will have an opportunity to receive all withheld capitation payments by achieving established goals on the required performance measures described below.
Priority Areas	In order to receive any portion of the capitation withhold, the Contractor must meet the minimum threshold for improvement of each of the following three (3) performance measures. 1. Low Acuity Non-Emergent (LANE) Emergency Department Utilization 2. Potentially Preventable Admissions (PPA) 3. Plan All-Cause Readmissions (PCR)
Timing of Incentive Payments	DHCF will distribute a quarterly report identifying Contractor's performance during the calendar year. DHCF will distribute earned incentive payments to Contractor by May 30 of the year following the performance/contract year.

Social Determinants of Health

Issue/Section	Contract Language
Quality Assessment and Performance Improvement (QAPI)	C.5.24.1.4.2 **Analyzes data, including social determinants of health**, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to Enrollees; and C.5.24.1.4.3 Develops system interventions to address the underlying factors of disparate utilization, health-related behaviors, and health outcomes, including but not limited to how they relate to high utilization of Emergency Services (pg 135). C.5.24.1.6 Contractor must integrate Behavioral Health into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Beneficiaries. Contractor must collect data, and monitor and evaluate for improvements to physical health outcomes resulting from Behavioral Health integration into the Member's overall care (pg 136).

Performance Measures	C.5.24.6.4 Contractor shall conduct the following three (3) CAHPS surveys per year: Adults; Children; and Children with Chronic Conditions. Contractor shall also conduct the Agency for Healthcare Research and Quality (AHRQ) Experience of Care and Health Outcomes (ECHO) survey. The ECHO accesses the experiences of adults and children who have received mental health or substance abuse services. The contractor shall include in such surveys any additional questions as requested by DHCF and the EQRO (pg 142). C.5.24.6.7 Contractor shall: **identify disparities in health services and health outcomes between subpopulations/groups** (race/ethnicity and language); identify social determinants of health; and identify the causes for health disparities and develop a plan of action and timeline to remediate those social determinants of health and health disparities and through targeted interventions and submit to DHCF as part of the QAPI program and CQI plan. This plan of action shall include a performance measurement and evaluation component, in coordination with section C.5.24.6 (pg 142)

Table B: Medicaid Behavioral Health Services	
Service	**Benefit Limit**
Services Provided by Department of Behavioral Health: Community-Based Interventions Multi-Systemic Therapy (MST) Assertive Community Treatment (ACT) Community Support	Contractor is responsible for Care Coordination and Case Management for Enrollees receiving services through The Department of Behavioral Health
Physician and mid-level visits including: Diagnostic and Assessment Services Individual counseling Group counseling Family counseling FQHC services Medication/Somatic Treatment	Services furnished by the Contractor's network of mental health care Providers.
Crisis Services	Mobile crisis/Emergency Services, including services provided by Department of Behavioral Health, or Core Services Agencies certified by Department of Behavioral Health
Inpatient Hospitalization and Emergency Department Services	Contractor is responsible for inpatient hospitalization and emergency department services.
Day Services and Intensive Day Treatment	Contractor is responsible for Day Services and Intensive Day Treatment as Medically Necessary without limitations

Case Management Services	Case Management services, as described in § 1915(g)(2) of the Social Security Act and 42 USC § 1396(g)(2), for individuals identified by the Department of Mental Health (DMH) as being chronically mentally ill or seriously emotionally disturbed.
Inpatient psychiatric Facility services	Inpatient psychiatric facility services for individuals under age 21 as described in 42 C.F.R. § 440.160.
Pregnancy related services	Pregnancy-related services described in 42 C.F.R. §§ 440.210(a)(2), and (3), including treatment for any mental condition that could complicate the pregnancy.
Patient Psychiatric Residential Treatment Facility	PPRTF Services for individuals less than age 22 years.
Access to Mental Health Services	Education regarding how to access mental health services provided by the Contractor as well as the DBH.
Pediatric Mental Health Services	All mental health services for children that are included in an IEP or IFSP during holidays, school vacations, or sick days from school.
Inpatient detoxification	Contractor covers inpatient detoxification.
Outpatient Alcohol and Drug Abuse Treatment	Contractor is responsible for referrals to the DBH.
Behavioral Health Service to Students in School Settings	Services are covered if the following is 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 Contractor; 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.