

Recommendations to Transform the Public Behavioral Health System for Children and Families

In 2021, *A Path Forward—Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia* was published, creating a blueprint for developing an optimal public behavioral health system through the implementation of 94 recommendations across six issue domains. The coalition of organizations involved in developing the initial report has conducted a review to produce a list of priority recommendations for policymakers to focus on over the next two years. The priority list does not supplant or minimize the other recommendations; instead, it directs policymakers' efforts in changing a large and complex system. A full report on the 5-year review process of *A Path Forward* will be published in the coming months.

We invite interested policy makers to contact Sharra E. Greer at Children's Law Center to learn more about implementing these recommendations.

Leadership and Governance

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

Implementing Bodies: DBH, DHCF, CFSA, DC Health, DHS, MCOs

Timeline to Implementation: Short Term

As much as possible, decision-making about the behavioral health system for children should formally involve youth and family representatives. It is important to note that the community must be integrated into the decision-making process and not be siloed into separate advisory or working groups. Processes such as updating DBH's Children's Plan or proposing changes to the School-Based Behavioral Health program have not included community collaboration, leading to stalled efforts and detrimental changes to programming. Youth and families should be in the room with government, providers, advocates, and other stakeholders to provide input that is equally considered when making decisions that affect them.

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

Implementing Bodies: DBH, DHCF, CFSA, DC Health, DHS, MCOs

Timeline to Implementation: Short Term

Such a system is necessary to make informed policy decisions, evaluate system functioning, and increase accountability. Interagency collaboration to design and develop a behavioral health surveillance system should be prioritized. Leaders should identify a sustainable source of financing, support the required capacity building, and establish data-sharing agreements to support a behavioral health surveillance system.

Financing

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

Implementing Bodies: DHCF, DBH, MCOs, CSAs

Timeline to Implementation: Short to Medium Term

- Establish a pathway for creation and payment of certified community behavioral health clinics (CCBHCs).
- Develop value-based and alternative payment models that prioritize children's social and emotional health.
- Implement value-based payment (VBP) arrangements that adjust for social risk when linking quality measures to payment incentives, using methods such as reporting quality-improvement data stratified by social risk level or adding bonuses for reducing disparity rates.
- Conduct operational readiness assessments across government agencies, providers, and MCOs to prepare for behavioral health managed care carve-in, specifically examining VBP readiness. That should include an assessment of whether provider organizations have the necessary technological tools to track and measure performance.

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

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

Implementing Bodies: DBH, DHCF

Timeline to Implementation: Short to Medium Term

Newly established rates must be inflation-indexed, and a formal mechanism for regularly examining and updating rates, rate structures, and rate-setting methods should be established. As a matter of parity, behavioral health services should be adjusted or rebased as frequently as comparable medical and surgical services.

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

Implementing Bodies: DBH, OSSE/DCPS

Timeline to Implementation: Short to Medium Term

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

- **Continue to partner with Community Based Organizations (CBOs) to provide services within schools.**
 - In October 2025, the Department of Behavioral Health proposed a plan to move the SBBH program fully in-house, ending all relationships with CBOs by School Year 2028-2029. Significant concerns were raised across all stakeholders regarding this decision – with consensus that it was not developed in partnership with schools, based on their needs and school readiness for SBBH programming and ultimately would take away from workforce, capacity to serve all schools, and the public health approach to SBBH cultivated over the last 10 years through the engagement with CBOs.

- **Maintain a minimum grant about of \$120,000 for CBO grants.**
 - In School Year 2025-2026, the DC Council raised the grants from \$80,000 to \$120,000, during this school year we saw increase retention and higher recruitment. Grant amounts should not be changed until the current rate can be evaluated.
- **Improve measures/benchmarks set by DBH for school behavioral health organization and clinician accountability.**
 - The current benchmarks prescribed by DBH do not collectively measure whether organization-level and clinician-level performance are as desired for SBBH. There is a need for measures that can be tracked consistently across the SBBH program, including DBH clinicians, and reported universally on a school-by-school basis.
- **Accurately landscape and collect data on available SBBH resources in schools, ensuring that existing data resources are leveraged.**
 - DBH undertook an environmental scan of resources – which raised numerous concerns including its methodology, accurateness, and ability to be a living document. While we agree there is a need to clearly understand schools current resources, it must be done in partnership with school leaders and in correlation with school readiness assessments. This must be a collaborative process between OSSE, DCPS, and DBH to leverage existing data resources (e.g. the Healthy Schools Act) to ensure collection is not burdensome and is accurate to truly inform resource allocation to schools.
- **Continue investment in evaluation on a yearly basis.**
 - DBH completed a multi-year evaluation but there was no mention of it in the 2025 Comprehensive Plan on how it informed the plan. Additionally, ongoing evaluation should be implemented to ensure the District is informed on the successes and the struggles of SBBH implementation.
- **Create additional workforce capacity in schools to improve coordination of SBBH programming.**
 - OSSE and DCPS should provide dedicated funding to cover the cost of the additional staff capacity needed to effectively provide program communication and coordination, as well as support to the clinician. That could include funding for the school behavioral health coordinator position, which is critical to supporting the clinician's work.

- **Invest in building and sustaining a pipeline for SBBH workforce.**
 - Having a strong behavioral health workforce is foundational to the long-term success of the SBBH expansion. DC should invest in workforce development strategies that can address its current limited behavioral health workforce.
- **Expand Mental Health Consultation into Applicable Schools to support not only student but also adult well-being.**
 - The utilization of a consultation model (like their already deployed Healthy Futures) could be very appropriate for some schools, and we urge DBH to further discuss how it may leverage consultation to support adult well-being in schools. There are other models outside of Early Childhood Mental Health Consultation (ECMHC) that use consultation to support behavioral health in the school setting – like MedStar Wise and TeacherWise. Adult mental health and behavioral patterns directly influence a child's behavioral health. As such, it is crucial that DC's SBBH program not only addresses children and youth behavioral health, but also that of adults in schools. DBH could work to identify where consultation could be more appropriate than a clinician or in addition to a clinician – depending on the need.
- **Continue to invest in the implementation of DC Law L25-0279, Child Behavioral Health Services Dashboard Act of 2024.**
 - The legislation requires the creation of a directory on LinkU including a list of providers offering child and youth behavioral health screening services, behavioral health assessment services, behavioral health prevention and early intervention services, and behavioral health treatment services in the District, including the provider's contact information and a link to their website; and Behavioral health resources available through DBH's school-based behavioral health programs established by the Early Childhood and School-based Behavioral Health Infrastructure Act of 2012. The goal is to create a more centralized effective communications tools explaining what services are available and how those services can help students, families, and teachers should be developed and disseminated to all schools, along with guidance and technical support for effective distribution to all members of the school community. Communications materials should be customizable to allow schools to add school-specific information regarding the clinician and the

referral process, with easy self-referral directly to clinicians by students or their parents.

Service Delivery

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

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

Timeline to Implementation: Long Term

We recommend the District work toward establishing a full continuum of services for children less than 18 years old in need of acute or crisis stabilizing psychiatric care that is accessible to children who are uninsured or on public health insurance. Examples of services that can meet the acute needs of children include:

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

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

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

Timeline to Implementation: Long Term

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

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

- Standardize screening tools for SUD (ensuring that the tools are culturally competent and evidence-based or at least evidence-informed) and implement them universally at PCPs, in the school system, in the child welfare system, and in the juvenile justice system.
- Substance use outpatient services should be integrated or co-located together with mental health services to decrease stigma and provide easier access for adolescents and their families.
- Explore the implementation of other adolescent substance use evidence-based treatments besides ACRA.
- Improve communication and understanding of available SUD services for youth among PCPs and other clinical and nonclinical providers.
- Increase evidence-based prevention programs for youth that target the most frequently used substances, particularly marijuana.
- DC should explore opportunities for expansion of DC MAP services to include SUD.

3. Improve family-centered care.

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

Involving families in the behavioral health care of children through family-centered practices can improve the behavioral health outcomes of children and their communities. Further, taking into account the caregiving needs of parents and other caregivers of children and youth with behavioral disorders can help empower them to better care for themselves and their children.

Workforce

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

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

Providers who have similar backgrounds to youth receiving care are more likely to form a strong therapeutic bond with clients and achieve better recovery outcomes as a result.

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

- Develop training and summer programs that target minority transitional-age youth, while promoting and providing incentives for work in the behavioral health field. Career ladders should be highlighted in such efforts.
- Develop formal recruitment strategies that extend to culturally and ethnically diverse organizations to foster diversification of the provider workforce.
- Recruit community members, paraprofessionals, and peer mentors to increase the number of staff trained to deliver direct care to clients. Use scholarships and loan repayments for underrepresented students to recruit and retain a diverse workforce.
- Consider offering certification and licensing test preparation at free or reduced cost to District natives, particularly those who represent minority communities. Use pathway or pipeline programs, in which potential candidates for professional training are identified throughout the grade school and college years and introduced to the field at an early age.
- Area Health Education Centers (AHECs) located in the District should be leveraged to introduce diverse student populations to health care professions.
- Consider incentivizing recruitment and retention of minority behavioral health professionals by enhancing reimbursement rates proportional to the extent that providers recruit and retain staff who effectively meet the diversity, inclusion, and equity needs of their clients.

2. Implement strategies to minimize workforce turnover.

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

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

- **Ease administrative burden**—Minimize and simplify the extensive, perhaps excessive, documentation required from behavioral health professionals who provide services to those with public health insurance. That may be accomplished through reviewing administrative requirements issued by DC Medicaid and eliminating duplicative processes or mandating and/or incentivizing plans to reduce prior authorization requirements for providers who meet specific performance and compliance targets.
- **Implement provider incentives**—Ensure that there are career ladders, supervision, career development, team-based work, continuing education, community amenities, experience-based step pay increases, and merit pay. Research has indicated that immediate, meaningful cash incentives have a greater effect on retention in comparison to longer-term benefits such as retirement contributions. However, nonfinancial incentives, such as employee awards, are also recommended in reducing burnout and turnover.
- **Offer sufficient compensation and fair scheduling**—Conditions for behavioral health professions in the public system should be examined to ensure there are living wages and fair scheduling practices, paid sick time, as well as paid family and medical leave. Additionally, it is critical that value-based payment arrangements accurately calculate costs and sufficiently reimburse nonclinical care positions, including care coordinators, discharge planners, and CHWs. Use of independent contractors should be evaluated to determine whether there are recruitment, retention, or quality differences compared with regular employees, and rates should be structured to allow the best mix of independent contractors, employees, or both on a service-level basis.
- **Improve training for behavioral health workers**—To enhance incentives for retention, consider supporting advanced training for bachelor's-level behavioral health workers and fellowship opportunities for graduate-level staff. Further, given high levels of burnout experienced by behavioral health providers, behavioral health organizations should offer resilience training that may help reduce burnout symptoms. It is important to note that while those training opportunities are important, they cannot replace structural and operational changes that will directly help to reduce burnout. The DC government should provide support to behavioral health organizations that are making structural changes to support workforce retention.

- Create nonsupervisory expert tracks so people can stay in care delivery and receive adequate compensation for it—Establishing a tiered payment mechanism that reimburses according to experience and education may further incentivize workforce retention.
- Improve supervision for behavioral health workers—Ensure behavioral health workforce is supported through adequate supervision. It also remains critical that organizations establish their own supervisor-to-staff ratios and supervision times that work for their context. Additionally, research has noted that supervisors' feedback should be based on live observation of actual practice and client feedback/outcomes in community mental health services, and supervision of therapists should incorporate evidence-based practices, such as modeling and role-play. Supervisors whose teams include peer specialists should receive special training and support to know how to help peers be successful in the behavioral health workforce.

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

Implementing Bodies: DHCF, DBH, CSAs, MCOs

Timeline to Implementation: Short to Medium Term

Advance the next-generation behavioral health workforce by robustly incorporating non-licensed workforce extenders, including paraprofessionals, peers, navigators, and CHWs into primary care, specialty behavioral health care, early learning, and other community-based settings. Peer-operated centers, family-run organizations, and other natural and informal supports must be recognized for the vital contributions they already make to the lives of District residents with behavioral health conditions and turned to as the necessary complement that they already are to the behavioral health workforce continuum. This type of integration requires adequate reimbursement, compensation, and training/education for this workforce. Integration bolsters accessibility through a team-based approach that includes the individuals whom many community members contact first and trust the most.

More specific examples of integration strategies are:

- Provide ongoing training and refreshers to clinicians and supervisors on the role of paraprofessionals (peers, CHWs, etc.) on the team to help bridge the gap between clinicians and nonclinicians. Provide cross-trainings with both clinicians and paraprofessionals. It is important to build trust and relationships between team

members and address stigma regarding staff with lived experience. Such training should promote the sharing of client information between peer and nonpeer staff, as well as cooperative service planning.

- Work with peer specialists to develop clearly defined roles and scope of work on the team that allows them to incorporate their lived and cultural experiences, such as peer specialists providing training to nonpeer team members on issues of recovery, trauma-informed care, advocacy, wellness promotion, etc.
- Ensure strong training opportunities are available for individuals interested in becoming peer specialists, as well as ongoing professional development and training opportunities for current peer specialists. While the role of a peer specialist will differ across settings and teams, a District-wide set of minimum-identified competencies may be beneficial for peer specialists. It is important for such competencies to balance the preservation of peers' unique strengths and technical proficiency.
- Introduce billable mechanisms and funding that is integrated into department budgets to promote the availability and use of natural supports for children who are experiencing acute or chronic behavioral health issues, as well as behavioral health crises.
- Allow sufficient Medicaid billing for the wide range of peer support services. As the government continues to explore avenues for compensating peer specialists, we emphasize the need for Medicaid reimbursable mechanisms.

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

Implementing Bodies: DHCF

Timeline to Implementation: Short Term

To make it easier for child-serving providers to join MCO networks, DHCF should require uniform credentialing requirements for all MCOs. As part of that requirement, all MCOs should be required to accept DBH certification as meeting MCO standards and credential DBH-certified behavioral health provider organizations and FQHCs at the organizational level (rather than at the individual staff level). There needs to be a consistent process for determining which organizations are paneled and credentialed through group practice standards and facility standards. Whether or not MCOs are required to credential at the organization or individual level, DHCF should require

electronic exchange of provider organization staff records using standardized processes, forms, and formats to be adopted by all MCOs.

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

Information and Communication

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

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

DHCF, DBH, the HIE Policy Board, CRISP DC, different provider types (including behavioral health providers), and MCOs should work together to develop clear regulations and guidance on patient data (including behavioral health data) that can or cannot be shared, the level/types of data each can have access to, and how the data can be used.

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

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

DHCF should require MCOs to adopt uniform standards for data requests and provide a standard format and process of data collection to be used by all MCOs and providers. Public reporting about collected metrics should be frequent enough—perhaps quarterly—for DHCF, MCOs, provider organizations, and members of the public to call for a change of course if performance appears to be falling short.

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

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

An annual children's behavioral health campaign can address gaps in public awareness regarding the availability of behavioral health services for children in the District, including a variety of nongovernmental messengers with the appropriate training and sustained resources to share this information and how to access these services. Such a campaign can also aim to increase behavioral health literacy, especially around behavioral health problems and their treatments, among parents/caregivers and youth.

Technology

1. Develop and improve CRISP functionalities to meet the needs of behavioral health providers and relevant government agencies.

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

- Privacy and data sharing: HIE policies must be continuously updated in accordance with federal regulatory guidance. Technical assistance should be given to providers to update their electronic systems, workflows, and privacy notifications as changes occur. A public awareness campaign explaining changes, including how they impact consumers; what they need to know; as well as when, how, and what consent is obtained, should also complement any changes.
- Care coordination, social determinants of health, social services, and other organizations/public agencies: Develop the capability of the CRISP system to integrate CBO and social service organizations' data to facilitate care coordination and decrease duplicative reporting.
- Population health data analytics: For providers and government agencies, it is important for CRISP to facilitate aggregated data collection, analysis, and publication to facilitate system-level learning. Part of the steps to achieve that involves cost (e.g., developing or buying and implementing the necessary technology tools, hiring, training, and retaining staff), as well as having the workforce and policies in place to respond to the data analytics and group-level data.

- Ensure timely access to discharge summaries: To increase timely access to follow-up care and facilitate effective transition planning and care coordination, hospitals need to reduce the amount of time it takes to send a patient discharge summary from hospital EHRs to the CRISP system for next-care providers to access.

The HIE Policy Board OCE Subcommittee suggested the following transition of care data elements should be prioritized for exchange in the District Designated HIE to facilitate an effective transition of care at the time of discharge: discharge diagnosis, discharge medications, reason for visit, and medication allergies. Hospital organizations should ensure at a minimum that those data elements are made available within 48 hours of discharge, in alignment with federal guidance that requires patients to have access to their electronic health information within 48 hours of discharge.

2. Expedite District licensing requirements to meet the demand for telebehavioral health.

Implementing Bodies: DC Health Professional Licensing Boards

Timeline to Implementation: Short Term

To address the limitations created by current licensure requirements, particularly those related to service delivery via telehealth, the DC health professional licensing boards could take several approaches.

The District should allow licensed professionals outside of the District to serve District residents via telehealth as long as they are in good standing in their home state.

Second, DC health professional licensing boards should also consider adopting the model of expedited endorsement. That would require the licensing boards to set criteria that would allow those who qualify to receive a license to practice in the District at an accelerated rate.

While the DC health professional licensing boards are reviewing licenses of individuals who hold one in another jurisdiction, by default those awaiting review should be allowed a provisional right to practice for 120 days while waiting for District license application approval or denial.