MIDD Briefing Paper

BP 53 Infant-Early Child Home Based Mental Health Services

Existing MIDD Program/Strategy Review ☐ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept x (Attach New Concept Form)
Type of category: New Concept

SUMMARY: At its core, this new concept aims to adequately fund home-based Infant and Early Childhood Mental Health (IECMH) services which are best provided in the home of the infant, young child and their caregiver(s). Mental health services for very young children always take place in the context of their primary relationships, so they are at least dyadic in nature. This new concept was modified to propose funding travel costs for home-based IECMH services rather than adding funds to Medicaid managed care case rates. The overarching goal of this new concept is to fund the home based nature of IECMH services recognizing there are additional costs when services are offered in a client's home rather than at a community mental health agency clinic setting.

Collaborators:

Name	Department
Nancy Creighton, Data Analyst	DCHS
Sean Davis, Behavioral Health Contracts Manager	DCHS
Meg Lineweaver, Trauma Informed Care Program Specialist	DCHS

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	Role	Organization
Kathy Crane	Clinical & Quality Management Services Coordinator	DCHS
Katrina Hanawalt	MH Program Manager	Center for Human Services
Sean Davis	Behavioral Health Contracts Manager	DCHS
Jill Klenota	-Infant MH Program Supervisor -Board Member	Navos Washington Association of Infant MH
Dick Crabb	Care Authorizer/MH Contract Monitor	DCHS

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?

This new concept at first proposed adding funds to the current Regional Support Network (RSN) reimbursement rate per enrolled (Medicaid funded) customer to support home based services to infants and toddlers, including a recommended level of clinical supervision and continued expansion of services.

The initial concept was altered in agreement with the proposer[1] after the proposer was informed that there are both federal Medicaid[2] guidelines that disallow implementation of adding funds to actuarially determined Medicaid managed care case rates. At its core, this new concept aims to adequately fund home-based Infant and Early Childhood Mental Health (IECMH) services which are best provided in the home of the infant, young child and their caregiver(s). Mental health services for very young children always take place in the context of their primary relationships, so they are at least dyadic in nature.

This new concept was modified to propose funding travel costs for home-based IECMH services rather than adding funds to Medicaid managed care case rates. The overarching goal of this new concept is to fund the home based nature of IECMH services recognizing there are additional costs when services are offered in a client's home rather than at a community mental health agency clinic setting.

The proposal has two components:

1. An hourly travel rate with the additional possibility of a capitated (maximum) amount of travel time per session allowed for reimbursement; plus
2. The standard mileage rate for miles travelled by staff providing and/or attempting to provide IECMH services in the client's home.

This approach would allow all miles traveled to receive the standard mileage rate and perhaps just a portion of the actual travel time.

Another aspect of this new concept is the assertion that funding transportation costs to support home-based/community-based service delivery would incentivize expansion of service to currently underserved communities (for IECMH), including almost all areas of East King County. Only 10 percent of all children under six years of age, served 10/1/14 through 9/30/15 by King County's Behavioral Health and Recovery Division's contracted mental health providers, lived in East King County zip codes.

IECMH services foci include strengthening and repairing the primary caregiving relationship(s) between parent/caregiver(s) and child; responding to and repairing effects of childhood trauma, parental depression, effects of mental illness and/or substance abuse on the infant/young child; and, teaching the caregiver(s) how to support healthy developmental progress for their infant/young child. For a

[1] 12/17/15 phone call conversation with new concept proposer.

[2] Medicaid is a payer of last resort. Once each state sets its rates, any additional funds to providers of Medicaid eligible services may only substitute for Medicaid funding, not add to it. Additionally, Washington's Medicaid funded mental health services operate under capitated managed care case rates. This means actuaries looking at a variety of factors, have established a comprehensive case rate (cost) for service provision.

variety of reasons, home-based services are especially important for caregivers of infants/young children. The delivery model for IECMH services requires an in-home option.

After consultation with subject matter experts in preparing this briefing paper, the primary drafter of this new concept was advised to revise the concept a second time to incorporate additional relevant information. The resulting new concept thus being proposed in this briefing paper is to provide the option of travel reimbursement to providers for all outpatient mental health services provided to children, youth, families and adults. This concept assumes use of the proposed two part funding:

1. An hourly rate for travel reimbursement that may be capitated; plus
2. Funding the standard mileage rate for round trip miles traveled.

This new concept with its subsequent modification has resulted in highlighting a significant system gap and chronic deficiency in providing mental health services. Where applicable, data focused on IECMH services will be included to honor the original proposal and initial population focus. The applicability of this transportation reimbursement need for other populations will also be included.

This concept aims to at least reduce and perhaps, depending on the amount of money allocated, correct a significant system gap. By definition, those receiving Medicaid funded mental health services are poor. Low income status is often accompanied by lack of reliable automobile transportation and/or sufficient funds to pay for gas and automobile upkeep, thereby requiring reliance on public transportation. Public transportation to provider agencies often means long transportation time for mental health consumers, including multiple bus transfers, delays, waiting time between bus routes, and walking from the bus stops to the agency location providing services.

King County is geographically large, with increasing population density and accompanying longer travel times, regardless of transportation mode. Currently, staff travel-time to provide mental health services in the consumer's home or a community setting convenient to the client, is not reimbursed by the Medicaid managed care case rate. This system gap adds to agencies' costs and also cuts into staff productivity (reportable service hours). This gap and the related circumstances have led to a lack of or significant absence of home or community based outpatient mental health services outside of clinic settings.

The following table provides a snapshot of the service locations for youth served by King County's contracted mental health agencies for October 1, 2012 through September 30, 2015.

Service Location for youth under 6 years old 10/1/2012 – 9/30/2015		**Service Location for youth under 6 years old 10/1/2014 – 9/30/2015**
Location	**Percentage**	**Percentage**
Office-MH Agency	70.8%	65%
School	11.2%	14.9%
Home	10.4%	12.3%
Other Unlisted Facility	7.4%	7.2%

Providing services in the client's home or a community setting is more accessible and convenient for those receiving services, reduces barriers to service from the client's perspective, increases client engagement, improves customer service, increases the ease of collaboration with other service providers, reduces the stigma of receiving mental health services by providing them in an integrative manner in a setting typical for the client, and, in the case of crisis intervention services, reduces the likelihood of more costly services. For infants and young children, a normative location may be the home, a child care, or a pre-school setting. For school age youth, a normative location may be school or after school programs. For youth thirteen and older who may seek mental health services independent of their caregivers, staff coming to a location where the youth is reduces added burdens for the youth by not requiring them to get to the mental health agency to receive services.

As King County is preparing to integrate mental health and substance use disorders services as of April 1, 2016, an idea was explored to consolidate the crisis response portion of services for those enrolled in the public mental health system. One significant concern spurring this concept was the lack of face to face crisis response for enrolled consumers. This contrasts with the availability of face to face mental health crisis response for people in King County's geographical boundaries who are not enrolled in the public mental health system.

While that idea has been tabled, the new concept presented here of providing a travel reimbursement to outpatient mental health providers could include the expectation of face to face crisis response, not just phone based crisis response. The attachment of this type of explicit expectation would be another way of not only improving the provision of outpatient mental health services by increasing home and community based service locations, but also increasing the frequency of face to face crisis response for enrolled consumers.

This new concept relates to MIDD I Strategies 1a, 1b, 1d, 1g, 1h, 2b, 3a, 4b, 4c, 4d, 5a, 6a, 7a, 7b, 8a, 10b, 11b, 12a, 12b, and all four MIDD II Strategy Areas: Prevention and Early Intervention, Crisis Diversion, Recovery and Reentry, and System Improvements.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☒ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

Prevention and Early Intervention: reduced barriers to services; increased access to person-centered, culturally appropriate treatment services by infants, youth, individuals and families; reduced risk factors for substance use and mental health disorders by increasing client engagement; increased access to primary (mental health) services.

System Improvements: reduced barriers to services; increased geographic availability of services; increased accessibility of services and treatment; improved client experience; increased availability of behavioral health services at optimal times and locations; improved quality of care; improved care coordination; use collaborative recovery/strengths based system of care approach.

Crisis Diversion: reduced barriers to services; decreased harm to infant/young child and parenting relationship for those in crisis or at risk for crisis; increased system coordination among all serving clients.

Recovery and Reentry: reduction in detention, jail and emergency room utilization, increased employment and education outcomes, increased housing stability, increased utilization of culturally appropriate recovery services; and reduced barriers to services.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

The lack of travel reimbursement for staff providing mental health services in the home and other non-agency community settings is a huge system gap with many rippling effects, and has been a chronic issue for providers. This gap reduces the effectiveness of service provision and client engagement, in addition to detrimentally affecting agencies' fiscal bottom lines and administrative implementation of best treatment approaches.

Among the reasons mental health managed care was first implemented over twenty years ago in Washington State was to move from a Medical Model[3] focused on how many pre-determined, defined types of service units are provided in a clinic-based setting, to a Rehabilitation Model where the focus is on Washington State's community mental health system's flexibility to provide services to best meet clients' needs. It also was an administrative way of encouraging implementation of recovery research including client driven services; peer services; the fact that recovery is possible; culturally applicable treatment approaches; and strengths based approaches, etc.

The gap created by a lack of funding for staff transportation costs is so significant that it has been mentioned by mental health providers for multiple years in multiple settings[4]. Please see the footnote for more detail.

[3] Medicaid statutes have different sections. The Medical portion of the law is different than the Rehabilitation portion of the federal Medicaid statutes (laws).

[4] The following list is a sample of the significance and frequency of this gap being raised by King County contracted mental health providers: 1) At Mental Health Youth Provider Meetings every time the group talks about a multitude of treatment issues such as assessment of strengths, evaluation of supports and barriers, school based needs and issues, abuse issues, pregnancy issues, diffusing individual and family crises and responding to bullying; 2) At Mental Health Clinical Directors Meetings when a variety of quality management discussions occur; 3) At Mental Health Partnership Meetings of chief executive officers where a variety of operations and policy issues are discussed; 4) Every time there is a discussion of case rates; 5) Every time the topic of agency costs arises; 6) Every time the topic of underfunding of mental health services occurs; 7) Every time there is a discussion of the constraints on service provision; 8) Often when receiving complaints about the crisis response for enrolled consumers; 9) When conversations of customer satisfaction occur; 10) When discussing constraints on implementing evidence based practices; 11) When discussing limits on expanding service provision; 12) When discussing productivity issues, including service hours; and, 13) When discussing staff costs.

There are many reasons why home and/or community-based service provision may be preferred and/or required by clients, families and/or treatment approaches. What follows are some examples. This is not an exhaustive list.

- IECMH services foci include strengthening and repairing the primary caregiving relationship(s) between parent/caregiver(s) and child; responding to and repairing effects of childhood trauma, parental depression, effects of mental illness and/or substance abuse on the infant/young child; teaching the caregiver(s) how to support healthy developmental progress for their infant/young child. For a variety of reasons home-based services are especially important for caregivers of infants/young children. The delivery model for IECMH services requires an in-home option.
- When school age youth are seeking mental health services to deal with abuse by family members, or don't have transportation, or don't want to have to explain where they are beyond school hours, they are best served where they physically are, which is often schools or other community , non-mental health agency settings.
- If youth are having difficulties in school or evidencing behavior problems in school or after school programs, they are often best served in those settings. Treatment might include consulting with the adults in those settings and/or teaching them skills to help the youth successfully participate or matriculate.
- Adults whose management of mental health symptoms means they need assistance navigating a landlord, an employer, neighboring apartment dwellers, or the store owner where they buy groceries may need their service provider to help them in the physical location where the problems are occurring.
- Enrolled consumers in crisis may be best assisted by a face to face crisis response, not only a phone response. In addition to better customer service, a face to face crisis response may also reduce total time spent by all other parts of the mental health crisis response system[5] and/or use of more costly services.
- Assessing client strengths, needs and barriers and providing services in a client's home/living situation can be particularly helpful in increasing accurate diagnosis, developing treatment goals, and selecting most applicable treatment approaches. This is true for infants, young children, school age children, parents, youth ages 18 – 24 often described as 'transition age youth', people with physical disabilities, people with developmental disabilities, adults, and/or older adults seeking mental health services.
- Providing culturally consistent mental health services may include providing services in the cultural community where the person lives and/or belongs and/or assisting the client to successfully participate in community events which by definition occur in the community, not a contracted mental health facility.
- Providing mental health services in normative settings helps reduce the stigma of having a mental illness by integrating services into life.

[5] Other parts of the crisis response system that might experience less work include King County Designated Mental Health Professionals (DMHPs), hospital emergency room staff, Crisis Clinic Hospital Authorization staff, other Regional Support Networks' (RSNs) Hospital Authorization staff needed to approve a voluntary or involuntary hospitalization for someone physically in King County for whom those RSNs have financial and mental health treatment responsibilities, Inpatient and Evaluation and Treatment mental health facilities, hospital/unit staff, and all related billing and administrative personnel attached to these crisis services.

The lack of transportation reimbursement has significant and far reaching effects on how mental health treatment services are provided. Two results are a high frequency of clinic-based services, and less client engagement (which reduces treatment efficacy).

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

Providing a transportation reimbursement option to contracted mental health outpatient providers serving children, youth, families, and adults, including older adults, will increase mental health services being provided in the setting most fitting for the consumer and/or the specific treatment method, not just the most economical setting for the provider. Some types of services such as Infant Early Childhood mental health services are best provided in the home. Many mental health service consumers prefer to receive their services in comfortable and familiar settings.

Evaluating consumer, family, and environmental strengths, needs, challenges and supports as part of the assessment and diagnostic process and as part of the treatment process are often enhanced by conducting these activities where the consumer lives and/or spends their days. Practicing new skills in the environments where the consumer needs to implement them can support skill development, and, where applicable, changes in family, school or work dynamics such as collaborative problem solving, more clear behavioral expectations, and environmentally workable behavioral alternatives and options.

Filling this transportation reimbursement gap would support mental health agencies in choosing the best approach, not just the most economically necessary approach. It would also increase client empowerment, voice, and choice.

Providing services to consumers in the community integrates mental health services into the person's life. Additionally, if King County wishes to integrate trauma-informed approaches into provision of mental health services, it is important to fund this concept, as a client's experience of safety may be enhanced by mental health services being provided in an environment the client experiences as safe.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

Providing the option for a mental health consumer to receive services in their home or a community based setting rather than a mental health agency helps King County implement a recovery and resiliency oriented system.[6] It implements recovery principles[7] including clients' self-directing their recovery path, services being individualized and person-centered; supporting clients' empowerment by providing a range of options for clients to choose among, and respecting people, which includes eliminating discrimination and stigma.

[6] http://www.kingcounty.gov/healthservices/MentalHealth/Recovery.aspx
[7] http://www.kingcounty.gov/healthservices/MentalHealth/Recovery/10FundCompRecovery.aspx

There is still significant stigma[8] for individuals admitting they have a mental health disorder, for individuals and families admitting they need mental health services, and for communities admitting that addressing behavioral health issues is of primary concern in maintaining and increasing the health of their people. Reducing the stigma associated with mental illness has been a key focus of SAMHSA federal grants,[9] including Washington State's five year Mental Health Transformation Grant[10], 2005-2010.

Funding transportation costs is such a significant system gap that it comes up as an issue in every significant meeting and conversation in which contracted mental health providers have the opportunity to express concerns, make recommendations, and identify barriers and challenges. To review a partial list, please see footnote number five of this document.

Providers value using and implementing treatment approaches that work to improve and increase individuals', families' and communities' mental health. This includes but is not limited to evidence based, research based, and promising practices. When treatment approaches recommend or require home or community based settings, outside of an agency setting, the lack of staff transportation reimbursement impairs treatment implementation.

King County has just completed a five year Trauma-Informed Care (TIC) grant funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative mental health and substance use disorder services [11]. SAMHSA's concept paper on trauma and trauma-informed approaches includes relevant evidence for this new concept. It identifies six key principles:

1) Safety;
2) Trustworthiness and transparency;
3) Peer support;
4) Collaboration and mutuality;
5) Empowerment, voice, and choice; and
6) Cultural, historical, and gender issues.

There are ten Trauma Informed Approach Implementation Domains. Included below are those domains relevant to this transportation reimbursement concept.

> **Policy Domain**: How do the agencies written policies and procedures include a focus on trauma and issues of safe and confidentiality? How do the agency's written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery? How do the agency's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed?

[8] http://www.cdc.gov/mentalhealth/data_stats/mental-illness.htm, and http://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/ART-20046477
[9] http://www.samhsa.gov/gains-center/grants-grantees/mental-health-transformation-grant
[10] http://www.prnewswire.com/news-releases/washington-among-seven-states-awarded-925-million-for-mental-health-transformation-state-incentive-grants-55423007.html
[11] http://www.samhsa.gov/

Physical Environment Domain: How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this?

Engagement and Involvement Domain: How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services? What strategies are used to reduce the sense of power differentials among staff and clients? How do staff members help people to identify strategies that contribute to feeling comforted and empowered?

Financing Domain: How does the budget support provision of a safe physical environment?

Screening, Assessment, Treatment Services: Is an individual's own definition of emotional safety included in treatment plans? Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? How are…trauma-specific practices incorporated into the organization's ongoing operations?

It is not uncommon for businesses, whether they are public or private, to use financial bottom line concerns as significant drivers to what services they offer and how they deliver services. King County contracted mental health providers in multiple meetings and discussions have repeatedly stated this system gap is extremely significant and impactful to how they are able to provide services.

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Evidence-Based Practice. Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

This new concept implements a trauma-informed, person-centered, culturally consistent approach to mental health services provision[12]. These have been shown to be critical components of a recovery oriented service system. A trauma-informed, person-centered, culturally consistent approach increases client engagement and empowerment in treatment services, and addresses significant correlative and causative factors to a person manifesting symptoms of a mental health disorder and experiencing the effects and limitations that result from suffering and living with a mental illness.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

Data submitted by mental health providers would be able to track: 1) an increase in face to face crisis response service hours for enrolled consumers; 2) an increase in service location percentages for home and community based locations, outside of a mental health clinic; 3) an increase in client service hours due to increased client engagement correlated with service location data; 4) an increase in evidence based practice (EBP) implementation where a home or community based service location option is key to accurate and successful EBP service provision.

C. Populations, Geography, and Collaborations & Partnerships

[12] SAMHSA, Ibid.

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☒ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☒ **Children 0-5**	☒ **Black/African-American**
☒ **Children 6-12**	☒ **Hispanic/Latino**
☒ **Teens 13-18**	☒ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☒ **First Nations/American Indian/Native American**
☒ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☒ **Veteran/US Military**
☒ **Families**	☒ **Homeless**
☒ **Anyone**	☒ **GLBT**
☒ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**
☐ **Other – Please Specify:**	

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

This new concept is being proposed to support increased treatment location alternatives to clinic/agency based services for all consumers of Medicaid funded outpatient mental health services in King County's Regional Support Network, the King County Behavioral Health Organization as of 4/1/2016.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

This new concept proposes to provide transportation reimbursement to all mental health outpatient providers to increase the geographic location distribution of mental health service provision. For example, the originator of this new concept was particularly concerned that only 10 percent of IECMH are provided to infants and young children living in the East King County zip codes.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

It may be necessary for King County to come to agreement with the provider community on prioritization for the use of the proposed transportation funding, if the concept is partially funded. It will be helpful to consult with those entities providing public transportation services to learn of specific geographic King County areas which they know have inadequate availability of public transportation services. Other public and private entities, such as cities, law enforcement, other first responders, other King County departments, remotely located housing and/or employment locations, disability specialists,

refugee populations, homeless and veterans' services, etc., may have valuable information to offer on the locations of high need for mental health services to come.

Collaborating with the work of Best Starts for Kids, Veteran Levy, Health and Human Transformation Levy and health care reform may further inform the implementation of this new concept.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?

While it might also require some state modifications to Medicaid billing instructions to allow for dual billing of the same treatment time, integration of behavioral health with physical health in 2020 would be assisted by implementing this new concept. This concept allows mental health treatment staff to be more responsive to a consumer's teachers, inpatient mental health and/or substance use disorder treatment staff, physical health care providers, and juvenile and criminal justice partners, to assist with transitions, improved collaboration across service systems, and/or insure successful treatment approaches continue in whatever setting the consumer finds themselves.

There has been a strong federal and state emphasis on the use of evidence based practices (EBPs). Some EBPs are best implemented in the home or community. A lack of staff transportation reimbursement creates an unfunded mandate, which can undermine some EBP provision and reduce options that can enhance assessment, diagnosis, treatment planning, provision and evaluation.

King County BHRD, formerly MHCADSD, does contract with one provider to provide transportation for gang affiliated youth to and from their mental health services appointments, as they are unable to safely travel through their environment or use public transportation, given gang territory and affiliations.

2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?

It is possible MIDD transportation support for increased mental health treatment location options may be a change that requires administrative, supervisory, and/or frontline staff adjustment. For instance, will agencies adjust caseload expectations, need to train staff how to report a data element they currently don't report, need to encourage staff to reconsider the locations they are using for treatment processes, such as assessment, treatment planning, skill development, etc.? Change is always challenging, even when that change is desired.

3. What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?

The unintended consequences which might exist must be weighed in relation to the benefit of improved customer service, removing barriers to treatment and most accurately providing services, i.e. infant and early childhood, in the home; for youth, in school; for adults with significant generally disabling symptoms including active psychosis and for older adults, at home and in a variety of residential settings. The fact that many in need of mental health services are ambivalent about engaging in treatment, in part because of the significant mainstream stigma about suffering from a mental illness,

and the role home-based service could play in overcoming ambivalence should also be taken into consideration.

That said, possible unintended consequences include:

1. Possibility of reduced staff service hours as some staff time will be used to travel to and from appointments, which is not included in service hour calculations;
2. More hours of service for those who will engage if transportation barriers are removed. This could also possibly lead to;
3. An 'overload' of service need on a clinician's caseload for which administrative calculations, not to mention actuarially determined case rates, have not accounted for and/or
4. The data and presumptions upon which the case rates are developed being flawed/inaccurate, leading to another way of demonstrating insufficient funding of public mental health services;
5. A need to revise case rate calculations;
6. A need for agencies to develop staff guidance on utilization of community based treatment settings for service provision, including definitions and related concerns such as clinician and consumer safety issues;
7. Possible need for agencies to review their insurance coverage to insure adequate coverage.

It is not known what the scope of the cost would be to implement this new concept without talking with all mental health provider agencies and requesting specific cost estimates perhaps attached to numbers of consumers or other factors.

4. What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?

If this new concept is not funded, it is possible:

1. There will continue to be significant barriers to clients receiving and/or engaging in treatment services;
2. Some evidence based practices will not be provided in the manner and location for which they are intended;
3. Stigma against people acknowledging they are suffering from a mental illness will continue;
4. Services will be organized for the providers' interests and needs, not the service recipient/consumer;
5. The strengths and resources of partnering systems that mutually serve people seeking mental health services from the public mental health system will not be used in the most beneficial manner possible;
6. There will be less multi-service system collaborations in support of the mental health consumers' needs;
7. The system will be significantly less recovery oriented, due to the scope and way in which consumers are allowed to direct their care is significantly diminished.
8. Other people and systems that may theoretically able to assist in a mental health consumer's recovery, resilience and community integration will not be engaged because the person seeking services won't mention them and the clinician won't know about them; and
9. Assessment , diagnosis and treatment planning will be significantly diminished without clinicians being able to gather firsthand information from all relevant sources.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

The current alternative available is if a mental health provider successfully applies for grant funding or receives private funding that funds staff transportation costs that occur as a part of mental health service provision.

A possible approach to implementing this new concept would be to choose to partially implement it by specifying it apply to a specific age population and/or specific types of services.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

This idea could assist and strengthen all other county initiatives by supporting the removal of a restriction on the location where Medicaid funded community mental health outpatient services are offered. Addressing the lack of staff transportation funding would enable the community mental health system to collaborate more frequently, more strongly and more effectively with other service system programs that mutually serve the same customers. It could also encourage more service innovation and strengthen the ability to interconnect services for clients, and potentially reduce client time and cost spent getting to multiple service providers.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

This concept implements principles of recovery, resiliency and trauma informed care. This was addressed in some detail in previous questions B. 3 and 4.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

This new concept supports the increased possibility of customers of the community mental health system receiving services in their ethnically and/or culturally distinct communities. It also reduces a significant cost for poor people, a significant stress for people with disabilities, for older adults, for disenfranchised youth, and for those most affected by trauma and abuse by providing the client with options, which may enable them to choose a service setting they experience as safer, in addition to being less traumatic. Supporting an increase in home and community based mental health service provision is also one way of addressing institutionalized racism, able-bodyism, classism, ageism, and all other 'isms' and 'obias'. Being mentally healthy is an even greater need for those who experience the consequences of injustice, unjust actions, general disregard from others, and a lack of access to the 'means of production' that enable economic stability and prosperity.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

King County BHRD staff time to a) convene providers for cost estimates; b) receive provider input on priorities, if partial implementation of this new concept is approved; c) decide if further contract requirements to this funding will be implemented, such as a requirement to provide face to face crisis intervention in certain defined circumstances, or to provide IECMH services and/or increase provision of IECMH services if already providing them; or to insure some specific percentage of services to school age youth be provided in school settings, or that best practices for young adults with physical disabilities or older adults be implemented.

2. **Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.**

It is not possible to estimate the annual cost without requesting specific cost estimates from mental health outpatient providers.

King County BHRD, formerly MHCADSD, currently contracts with one small provider to provide transportation for gang affiliated youth to and from their mental health services appointments as they are unable to safely travel through their environment or use public transportation given gang territory and affiliations. The contracted amount is $50,000/year and does not fully meet the current costs.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

The only other revenue sources that could be used would be grant funds to individual agencies for specific work where transportation reimbursement was part of the grant proposal and approved funding.

4. **TIME to implementation: Less than 6 months from award**
    a. **What are the factors in the time to implementation assessment?**
    b. **What are the steps needed for implementation?**
    c. **Does this need an RFP?**

Implementing this idea will require gathering estimates from contracted providers and determining if any additional contractual requirements will be attached to the transportation reimbursement. Some examples of possible contract requirements are mentioned in F. 1. above. This would not require an RFP.

Another implementation approach would be to require each contracted mental health provider to submit a plan of how they would use and/or prioritize use of an allocated amount of transportation reimbursement. Such an approach could also gather other relevant provider information, including any implementation steps providers would need to undertake, and the time required to complete those steps.

BHRD would then need to determine the most preferable contracting approach and ensure related data reporting requirements were reviewed and revised as needed to support reporting requirements.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

#53

Working Title of Concept: Infant-Early Child Home Based Mental Health Services

Name of Person Submitting Concept: Katrina Hanawalt
Organization(s), if any: Center for Human Services
Phone: 206-631-8813
Email: khanawalt@chs-nw.org
Mailing Address: 14803 15th Ave NE, Shoreline WA 98155

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

King County has been a leader in Washington State around Infant and Early Childhood Mental Health (IECMH) Services. There are two major IECMH programs housed within Community Mental Health Agencies in King County. Both programs employ mental health therapists who are specially trained in working with this unique population. The programs also both support best practices in serving this population, which include providing reflective supervision and home-based services versus services in the traditional clinic setting. While these programs have been immensely successful at developing important community partnerships and accessing a wide range of the low-income infant and toddler populations of both North and South King County, the current reimbursement policies through the Medicaid RSN and Managed Care Organizations are cost prohibitive. With the tiering system through the RSN, when a client is served under the general tier rate, the reimbursement is so low the agency is either just breaking even for covering the cost of the employee's wage, or is actually working at a deficit per client. The higher tier level is extremely difficult to get and requires such a high level of face to face contactper week with the client that although the reiimbursment rate is better, it is still cost prohibitive. The Managed Care Organizations, for those who do not qualify under the RSH Access to Care Standards, pay at an even lower rate than the RSN. This system, which we rely upon to serve this vulnerable population, is not sustainable. MIDD funding to provide a supplementary rate per enrolled client would allow for home based services, the recommended level of clinical supervision, and the continued expansion of services to infants and toddlers.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

This concept would support the ongoing quality mental health services that are currently in jeopardy due to inadequate funding. Supporting home-based mental health services allows for intervention with families at high risk for maternal postpartum depression, attachment issues, the generational passing down of Adverse Childhood Experiences (ACEs) and much more.

3. How would your concept address the need?
Please be specific.

This concept would allow for Community Mental Health Agencies to continue to provide quality home-based Infant-Early Childhood Mental Health Services. It would also incentivize expansion of services to currently unserved communities, including almost all areas of East King County.

4. Who would benefit? Please describe potential program participants.

Families with Infants, toddlers, and preschool aged children would benefit. Pregnant women at risk for or presenting with perinatal mood disorders would benefit. Infants and toddlers in the foster care system would benefit. Other systems which support families with very young children would benefit.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

The currently enrolled infants and toddlers would be able to continue to receive these important services in their homes, which is the best practice, while additional families could be served and additional communities who currently do NOT have IECMH services may gain these important services.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

This concept fits extremely well with the MIDD objective- the primary focus of IECMH is to support the social and emotional development of young children and their attachment to primary caregivers. When we support the youngest children in our communities, we reduce negative outcomes across the lifespan, as evidenced in the ACEs literature. Supporting healthy attachment is one of the best ways to prevent ACEs in the lives of young children because it increases the protective capacity of the parent.

8. What types of organizations and/or partnerships are necessary for this concept to be successful?
Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

It will be critical to work with the RSN and Community Mental Health Providers.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.