NACBH NEWS

National Association *for* Children's Behavioral Health

SEPTEMBER 2017 | VOL 1 NO 4

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National Association for Children's Behavioral Health
1025 Connecticut Ave, NW, Suite 1012 | Washington, DC 20036

EXECUTIVE DIRECTOR NOTES

Pat Johnston, Executive Director

Dear NACBH Colleagues,

Back to school! My favorite time of year and, yes, I was that kid.

For Congress, it's back to work and a To Do list that had quite a growth spurt over the August recess. The urgent need to provide emergency funding for Hurricane Harvey recovery, along with replenishing FEMA's coffers and reauthorizing the National Flood Insurance Program are now at the top of the list. Returning to the list, as Denis McCarville notes in his Public Policy Committee column, is ACA repeal, replace and/or repair, joining CHIP, debt ceiling, budget and appropriations actions. And reauthorization of the Federal Aviation Administration.

With only 12 legislative days where both the House and Senate will be in session in this month of critical deadlines, there is no time for intraparty battles or interparty brinksmanship. Let's hope the pressure forces some efficiency in moving the must-pass legislation with a minimum of drama.

In the real world, I have been reminded in recent days that NACBH members are prepared to respond to actual threats in your communities, and steadily continue serving children through the worst that comes. Your colleagues at Devereux Advanced Behavioral Health evacuated clients and staff from their Victoria and League City, Texas, programs as Hurricane Harvey approached. It's hard for me to imagine the scope of planning and execution for just this one kind of emergency, but what is really humbling is the care that is taken to reduce trauma for the kids in such a stressful situation and maintain communication with their families. When things return to normal there, we'll invite Devereux to tell us about the experience (their third evacuation in recent years) on a Standards Committee call, including how their emergency plans are refined as a result. In the meantime, I know you join me in keeping a good thought for the Devereux, Texas, team and their families.

Back in Washington, there has been progress on two behavioral health provisions in the 21st Century Cures Act, passed last December:

New Assistant Secretary for Mental Health and Substance Use, U.S. Department of Health and Human Services – The Cures Act created this position to both replace the Administrator of the Substance Abuse and Mental Health Services Administration and to coordinate mental health and substance use programs at other federal agencies. In early August, the Senate confirmed Elinor McCance-Katz, M.D., Ph.D., for the post, which includes an ambitious portfolio of planning, evaluation, surveillance and policy development activities. Dr. McCance-Katz is board certified in general psychiatry and addiction psychiatry, with an extensive

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UPCOMING CONFERENCE

Technical Meeting:
Value-Based Purchasing
November 30-December 1, 2017
St. Pete Beach, Florida

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focus on co-occurring disorders, clinical pharmacology, medications development for substance use disorders, drug-drug interactions, addiction psychiatry and treatment of HIV infection in drug users. Previously, she served as SAMHSA's first chief medical officer, from 2013 – 2015, before returning to clinical practice, academia and research.

New Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) – The Cures Act established this committee to improve federal coordination of efforts "to address the pressing needs of adults with serious mental illness and children and youth with serious emotional disturbance." It includes senior leaders of 10 federal agencies including HHS, the Departments of Justice, Labor, Veterans Affairs, Defense, Housing and Urban Development, Education, Labor and the Social Security Administration, along with 14 non-federal public members. The non-federal members, appointed last month for three-year terms, are mental health researchers, providers, patients, family members, judges, law enforcement officers and other professionals. The ISMICC's first meeting is taking place as this is being written, and we'll report further as we see how their discussions evolve. The broad charge is for them to report on advances in research and outcomes, and recommend federal actions to better coordinate services.

HHS Secretary Tom Price has identified serious mental illness as one of the department's top three clinical priorities. His opening remarks at the August 31 ISMICC meeting reinforced NACBH's earlier perception that the committee would focus more on adults than children, and more on serious mental illness than mental health. But we will track opportunities to weigh in on their issues and agenda, and keep you informed so that you can add your views. Won't it be nice to advocate for something constructive in the policy space versus responding to negative developments on Capitol Hill? Stay tuned! ☐

REDESIGNED NREPP LEARNING CENTER LAUNCHED

The Substance Abuse and Mental Health Services Administration has launched a new Learning Center for the National Registry of Evidence-Based Programs and Practices (NREPP). The latest in a multi-year update of NREPP, the Learning Center offers resources in five thematic areas:

1. **Emerging Evidence in Culture-Based Practices**
2. **Developing an Evidence-Based Practice or Program**
3. **Implementing a Program**
4. **Sustaining a Program**
5. **Topics in Behavioral Health**

From NREPP's home page, users can access a searchable registry of more than 350 mental health and substance use disorder interventions, learn more about the registry and the requirements for inclusion, provide suggestions on additions to the Learning Center, and join a listserv to receive NREPP updates including notice of open submission periods. The next open submission period will be later this year or early 2018. ☐

PUBLIC POLICY COMMITTEE REPORT

Denis McCarville, AK Child & Family, Anchorage, Alaska, Chair

Standing Monthly Conference Call: Fourth Friday of each month, 2:00 – 3:00 p.m. (Eastern)

Just when you thought the Senate was going to move on to tax reform, repeal and replace of the ACA is back again. At the time of this writing, two separate actions by the Senate are in the works. Those of us who care about accessible behavioral health for children and their families – and accessible health care in general – should be back on alert.

The first action is a plan proposed by Republican Senators Bill Cassidy (LA) and Lindsey Graham (SC), which would drastically decrease funding for health coverage by the federal government to all states and take away coverage from millions of Americans. In a recent report, Judith Solomon, Vice President for Health Policy at the Center on Budget and Policy Priorities (CBPP) stated, "No one should be fooled. The Cassidy-Graham plan is just another ACA repeal bill and would have the same harmful effects as the other failed repeal bills, including costing millions of people their health coverage."

Much like earlier versions of repeal and replace, this plan would eliminate both the ACA's marketplace subsidies and the ACA enhanced matching rate for the Medicaid expansion. These would be replaced with an inadequate block grant whose funding would shrink further over time and then disappear altogether after 2026. The plan would allow states to waive ACA provisions that prohibit insurance companies from placing annual or lifetime limits on coverage, and would allow insurers to make what are now essential benefits optional, such as mental health and substance use treatment services, among others. Not surprisingly, the Cassidy – Graham plan would convert Medicaid's current federal-state financial partnership to a per capita cap on federal reimbursement, which would limit and ultimately reduce services for young people needing behavioral health treatment, in my opinion.

However, the other action underway – at least on the face of it – looks more promising. A bipartisan effort in the Senate through the Health, Education, Labor and Pensions (HELP) Committee is on the move, with hearings before the 23-member committee beginning just after Labor Day. While Senators Cassidy and Graham are reportedly working with the White House to block this bipartisan approach, Senator Lisa Murkowski (R-AK) has been adamant that a bipartisan bill is the only road forward for health care in our country. In a statement to the Alaska Dispatch News, she reported that the committee will hold its first hearing with five state insurance commissioners on September 6 and a hearing with panel of governors the following day. HELP Committee Chair Lamar Alexander (R-TN) then announced two additional hearings the following week, with health care providers, insurers, advocacy groups and policy experts briefing the committee.

While there is no bill at this point, committee members are talking about authorizing cost-sharing subsidies to insurance companies in the individual marketplace to be paid over a one- to two-year period. This would remove the subsidy payment from the month-to-month decision making at the White House, and give insurers confidence that the support will continue. A more controversial discussion point is whether to allow additional flexibilities to states under the ACA's 1332 waiver program.

This is a dynamic process and can change at any time. We certainly cannot afford to let our guard down and let the Cassidy-Graham bill find its way to the President's desk. On the other hand, if cooler heads can prevail, hearings are productive in the Senate HELP Committee, and the House agrees to incremental improvements, we may begin to fix our country's broken health care system and protect the accessibility of behavioral health treatment services. Either way, this is a subject that doesn't seem to be going away and something that we will need to monitor and be ready to advocate with our Members of Congress. □

STANDARDS COMMITTEE REPORT

Jan Carson, Catholic Charities, Timonium, Maryland, Co-Chair
Laurie Beaulieu, Wingspan Care Group, Shaker Heights, Ohio, Co-Chair

Standing Monthly Conference Call: Third Tuesday of each month, 1:00 – 2:00 p.m. (Eastern)

All members are welcome to participate in the Standards Committee discussions of accreditation standards and surveys, compliance issues, peer consultation on timely hot topics, and presentations by NACBH members on program and performance improvement initiatives. Please email the co-chairs or Pat Johnston to volunteer a presentation, add an agenda item or join the committee. The roster is posted on the Members page of the NACBH website.

Report from the August 15 call:

Use of Chemical Restraints: The committee continued its discussion of the use of chemical restraints. Most of the members are not using chemical restraints. Discussed the precautions used by some members to include a physician and a nurse when medications are used that are not regularly prescribed medications. In some cases, a physician is required to examine the child before the use of a prn or an emergency medication. Some of the members are not using any prn or emergency medications. These members rely on the crisis prevention model and the treatment philosophy to avoid the use of prn and emergency medications.

Joint Commission Standard CTS 03.01.09: This standard requires the use of outcome measurement for behavioral health. Members have questions on how outcome measurements can apply to the diverse populations served. Members are also looking at standardized assessments that are already in use in their organizations. Scott Williams, PsyD., Director, Department Health Services Research at The Joint Commission, has been invited to join the next Standards Committee Call.

Evidence of Standards Compliance (ESC) Process: The committee noted the recent changes in the ESC process. The Joint Commission provided greater clarity in the response required in the ESC process. Details are available on TJC website.

New Name for the Standards Committee: The committee discussed several ideas for a new name for the committee that better captures the scope of the committee's work. There was agreement that the term "best practices" seems to be a good fit going forward. The suggestions will be taken into consideration and the new name announced in the upcoming Standards Committee call on September 19.

Agenda for September 19:

- A report from a member on a recent Joint Commission survey
- Scott Williams, PsyD., Director, Department Health Services Research, at the Joint Commission joins the call for a discussion of the requirement for behavioral health outcome measurement
- Follow-up on the name of the Standards Committee □

NACBH MEMBER SPOTLIGHT:

SHOW ME THE NUMBERS: INDIANA'S OUTCOME MEASURES PROJECT PROVIDES INVALUABLE DATA

Countless child care agencies in every corner of the nation can tell great stories. Seemingly every professional in the field can recount heartwarming tales of success, and heartbreaking tales where things have gone poorly. But when you're appealing to government authorities seeking fiscal support, they invariably want numbers.

An innovative project in Indiana is providing those numbers – lots and lots of them – and showing the success stories that come along with them. Two decades ago, the Indiana Association of Resources and Child Advocacy (IARCA) developed the Outcome Measures Project, which was designed to continually assess the strengths and limitations of their programs.

After 20 years of collecting, analyzing and presenting data, the project's directors say they have come a long way.

"We started with paper – lots of boxes and crates of paper," said IARCA Executive Director Cathy Graham, MSW, LCSW. The project collects data from 53 of the state's 89 agencies. "We have gone through development where now it's all done via a secure web portal and all the data are on a web application. And we have two Ph.D.-level external evaluators who review the data and report the findings."

When Graham and other IARCA staff and members meet with Indiana state legislators or venture to Capitol Hill to meet with the Hoosier State's congressional delegation, they go armed with data. Recent numbers show that at discharge 79 percent of children studied have a positive outcome, 61 percent achieve their permanency plan and at six months follow-up, 85 percent have not been involved with the court for new offenses, and 98 percent have not suffered new abuse or neglect, either with themselves or within their family members.

While a few other states do research on their programs and crunch numbers, the Indiana project takes pride in its sheer size and scope of data.

"At the aggregate level, this project is very long-running and very large. We don't know of another project of its kind that even approaches the size of this," said Mark Hess, MSW, the Outcome Project Coordinator.

"Some research will be based on studying 100 children or fewer. We collected data from around 6,300 children last year. So when our external evaluators go look for anything to research, we know we have enough data that the results are going to be credible."

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That credibility, and the numbers to back it up, were the keys to establishing the project back in the days of collecting reams of paper. Graham, who worked in state government at the time, acknowledges that the stories told by agencies are compelling, but legislators as a rule are "numbers people" and are more swayed by data when determining funding levels.

"Many state associations have a collection of stories about the children they're serving, but there are very few that actually have that level of concrete data," she said. "Legislators always want to know if the efforts are doing any good and what we can do for abused and neglected kids and kids who are in trouble with the court. We can use these data to show that we are making significant progress for these troubled children. It is important to educate legislators on how the money is used and why this is an investment in children and families."

Not just for legislators, the data are used by individual agencies to see how their individual provider performance compares to statewide averages. Agencies in turn use the reports for writing grants, for fundraising, for their board of directors' reports, for accreditation and other uses. The organizers admit that despite all of the success they have had collecting, analyzing and presenting data over the past two decades, there are myriad opportunities to do more and serve more people using Indiana as a model.

"We want to make sure we keep the project current and ahead of the curve," Hess said. "We're also interested in expansion. We're looked at as an Indiana project, but there's no reason it can't be regional or even national. We're interested in expanding into other states because we think we have a strong history. The founding mothers and fathers really set this up right."

For more information on the IARCA Outcome Measures Project, please visit their website at http://iarca.org/index.php/outcomes-eon. ☐

UPDATED: MEDICAID AND CHIP REIMBURSEMENT FOR LANGUAGE INTERPRETATION SERVICES

The National Health Law Program (NHeLP) has updated its 2009 issue brief on Medicaid and CHIP coverage of language interpretation services, summarizing existing state mechanisms for directly reimbursing health care providers who arrange for the services. Since then, Hawaii and Virginia have stopped paying for the services, and Connecticut, New York and Texas have started.

The updated brief provides detailed information on the reimbursement process, interpreter training and certification requirements and some rate, expenditure and encounter information for the District of Columbia and 14 states that cover the services: Connecticut, Iowa, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, New York, Texas (sign language interpreters only), Utah, Vermont, Washington and Wyoming.

Please see NHeLP's How States Can Get Federal Funds to Pay for Language Services for Medicaid and CHIP Enrollees for general information on the subject. This may be a good time to think about how this reimbursement supports or could support your treatment services, and incorporate that into your advocacy messaging. ☐