NACBH NEWS

National Association *for* Children's Behavioral Health

SEPTEMBER 2018

TABLE OF CONTENTS

UPCOMING CONFERENCE

ARE YOU REGISTERED FOR NACBH'S EMERGING BEST PRACTICE CONFERENCE?

Building Staff Capacity Through Effective Leadership

October 17-19, 2018
Hotel Contessa, San Antonio, Texas

Hotel Room Blocks Close Sept. 17!

REGISTER HERE

NACBH PUBLIC POLICY COMMITTEE

Denis McCarville, AK Child & Family, Anchorage, Chair
Libby Nealis, Advocacy and Communications Associate, NACBH

Standing Monthly Conference Call: 4th Friday of each month, 2:00 – 3:00 (Eastern)
(866) 906-0123, participant code 6405051

Continuing the conversation around ESSA and Community-School Mental Health Partnerships

If you were unable to join our June webinar on "Opportunities to Build School-Community Mental Health Partnerships," we encourage you to listen to the webinar recording at your leisure, posted on the committee page in Members Only at www.nacbh.org.

We have begun to compile a toolkit of resources to assist NACBH members in identifying partners, getting involved in local conversations, and articulating what your organization can offer in coordinated programs and services to better address the mental health needs of our youth. First up: Take a look at the Coalition for Community Schools' online guidance to gauge where you might be in the partnership-building process.

Nine Elements of Effective School Community Partnerships to Address Student Mental Health, Physical Health, and Overall Wellness

1. A leadership team comprised of school and community stakeholders.
2. Assets and needs assessment to address student health and wellness, and a framework for results.
3. A designated person located at the school to lead the coordination of school–community partnerships.
4. Clear expectations and shared accountability for the school and community partners.
5. High-quality health and wellness services that leverage school and community resources.
6. Ongoing comprehensive professional development for all school leaders, staff, and community partners.
7. A detailed plan for long-term sustainability.
8. Regular evaluation of effectiveness through a variety of measures.
9. Communication plan to share progress and challenges.

Your State's ESSA Plan

States have now submitted plans to the U.S. Department of Education detailing how they will comply with the federal Every Student Succeeds Act (ESSA), and begun moving forward on plans to spend the federal dollars that could be directed toward school-community mental health programs and partnerships. ***Given the above vision of an effective school community partnership, what role can your organization play? Where is your state in the process of planning the use of new education funding streams that support children's mental health?***

The American Institutes of Research (AIR) has compiled ESSA resources on numerous relevant topics, such as School Climate and Safety, School Discipline, Students with Disabilities, and Supporting At-Risk Students. Dig in to find even more great information on Families, Communities, and Social Systems and Trauma-informed Care in Service Systems. You can also view plans by state, see what your and other states are doing, and what partners may already be involved.

Stay tuned for additional information on news and reports of interest, and join the next Public Policy Committee call on Friday, September 28 @ 1:00 p.m. Eastern. A reminder and agenda will be emailed the week before. Don't forget to like us on Facebook and Twitter!

NACBH BEST PRACTICES COMMITTEE

Jan Carson, Catholic Charities, Timonium, Maryland, Co-Chair

Chrissy Lynch, Devereux Advanced Behavioral Healthcare, Villanova, Pennsylvania, Co-Chair

Standing Monthly Conference Call: 3rd Tuesday of each month, 1:00 – 2:00 p.m. (Eastern)
(866) 906-0123, participant code 6405051

All members are welcome to participate in the Best Practices Committee (formerly 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 to volunteer a presentation, add an agenda item or join the committee. The roster is posted on the Members page of the NACBH website.

The July 17 call included some follow-up on June's discussion of violent intruder protocols, a brief report from Jan on how the new Joint Commission Behavioral Health Advisory Committee is organizing its work, and a new discussion item: how NACBH member agencies asks questions about gender and how they document the information. The committee will invite experts to present on this topic during a future monthly conference call, from the Institute for Innovation & Implementation at the University of Maryland School of Social Work. (See Workshop No. 4, *Do Ask, Don't Tell*, on page 17 of the Training Institutes' 2018 program.)

During the August 21 call, we heard from several members about their recent Joint Commission surveys, and Jan Carson provided the following update on the Joint Commission's new Behavioral Health Advisory Council:

The Joint Commission's newly reorganized Behavioral Health Advisory Council met on August 13 – 14, 2018. The Council is comprised of fifteen members from organizations across the country representing large and small Joint Commission accredited organizations including substance use services, payers, and advocacy organizations. This was the first opportunity for all of the newly-formed Advisory Councils to come together for face-to-face meetings. Joint Commission President and CEO Mark Chassin, MD, FACP, MPP, MPH, gave an inspiring presentation on using high reliability processes to achieve zero harm in health care. Dr. Chassin discusses the initiative in several videos available online.

The Behavioral Health Care Advisory Council discussed the following topics pertinent to the behavioral health field:

- The revised requirement for Behavioral Health Care Measurement (CTS 03.01.09) to promote the use of measurement-based care with a focus on the following:
- Instrument selection
- Using the data to monitor and modify treatment
- Aggregating the data to evaluate outcomes
- Expectations in upcoming surveys
- Telehealth Services – evaluating the quality and safety
- Expansion of telehealth services including telehealth reimbursement
- Technology-based service settings – using existing infrastructure; totally provided in the community; provided through contracted services

- Evaluating Telehealth Services – applying the existing Joint Commission requirements to telehealth services

The next meeting of the Behavioral Health Advisory Council is scheduled for October 2018.

Please join the next Best Practices Committee call on Tuesday, September 18 @ 1:00 p.m. Eastern. A reminder and agenda will be emailed the week before.

FFPSA: HOUSE WAYS & MEANS COMMITTEE HOLDS "HEARING ON THE OPIOID CRISIS: IMPLEMENTATION OF THE FAMILY FIRST PREVENTION SERVICES ACT"

On July 24, the Ways & Means Committee held a hearing to review the Administration for Children and Families' (ACF) progress in implementing the Family First Act.

Jerry Milner, Associate Commissioner, The Children's Bureau, ACF, was the sole witness. He described an implementation approach that will allow states as much flexibility as FFPSA allows, saying that regulations will not define "key concepts" more specifically than what is in the law, such as "candidate," "imminent risk of foster care entry," and "risk of sex trafficking." He said that states and tribes will be allowed maximum flexibility in claiming funding for prevention services, in the "promising" practices category, in particular.

In outlining ACF's outreach and engagement efforts to hear and respond to implementation concerns, Mr. Milner listed a variety of constituents, forums, and formats, but did not mention any related to the provision of or payment for health care services for foster children. He also outlined key implementation challenges, again not mentioning anything related to health care. The omission is not surprising, since Ways & Means has jurisdiction over child welfare, but not Medicaid. But it is also a bit discouraging, in terms of maintaining silence on the unmentionable Medicaid IMD exclusion.

Mr. Milner identified the following "important" implementation challenges:

- Start-up costs are a potential barrier for states
- Availability of an adequate array of placement options for children in foster care
- 12-month availability of prevention services is too short for many families' needs
- Labor-intensive review of all studies and prevention programs and services as part of the clearinghouse
- Limited current availability of well-supported prevention programs and services
- Difficulty determining which kinship navigator programs would meet statutory criteria
- Limited number of qualified residential treatment programs (QRTPs) meeting the statutory criteria
- Limited availability of qualified individuals to assess placements in QRTPs

That's a hefty list, and more complicated than its description in testimony. Mr. Milner attributed the last bullet point to national workforce shortages, but the real challenge is in the statutory definition of "qualified individuals," who must be "a trained professional or licensed clinician who is not a state employee or affiliated with any placement setting in the state."

His description of a potential shortage of QRTPs refers specifically to the requirements for national accreditation, a trauma-informed model, and aftercare services for 6 months post-discharge. Then this oblique sentence: "There are additional requirements, such as court approval, for children placed in these programs that may reduce or eliminate federal participation for children placed there." We're not clear on how a court decision would reduce or eliminate federal participation, but we can think of an "additional requirement" that surely could: the Medicaid IMD exclusion.

FFPSA: ACF REQUESTS COMMENTS ON MODEL FAMILY FOSTER HOME LICENSING STANDARDS

Comments are due October 1 to the Administration for Children and Families (ACF) on proposed model licensing standards for foster family homes, as required by the Family First Act. By April 1, 2019, states will have to provide specific information to ACF on whether their foster family home licensing standards are consistent with the model standards and, if not, the reason; and whether the state is exercising the option to waive non-safety licensing standards for relative foster family homes.

ACF is proposing one set of standards for comment to apply to relatives and non-relatives, as well as state and tribal child welfare agencies. After reviewing standards, guidelines and recommendations from multiple national experts, ACF based its proposed model most closely on the standards published by the National Association for Regulatory Standards.

The proposed standards are organized into eight categories covering the essential components of licensing a foster family and the physical home, such as foster home capacity, sleeping arrangements, emergency preparedness plans, living space and condition of home, physical and mental health of foster family, background checks, and training. They do not address related policies and procedures which ACF deemed outside the scope of the FFPSA's requirements (e.g., foster home licensing and re-licensing procedures, emergency placement procedures, procedures for pre-service training, care of children after placement in a licensed foster home, post-licensing requirements such as foster parent record keeping and reporting).

NACBH members are encouraged to review the Request for Comments, share it with your state associations and colleagues, and consider responding before the October 1 deadline.

HOW STATES ADDRESS SOCIAL DETERMINANTS OF HEALTH IN MEDICAID CONTRACTS AND CONTRACT GUIDANCE

Through managed care and value-based contracting, states are increasingly turning their attention to addressing social determinants of health (SDoH) to improve population health. The National Academy for State Health Policy (NASHP) convenes a state accountable health workgroup for members that emphasize population health in their purchasing models. A recent workgroup project charts the characteristics of 11 state Medicaid plans, identifying:

- Which determinants states prioritized in their contracts
- How they incorporated SDoH into contractor requirements, and
- How states monitor and pay for these activities

The results are not broken out for special populations, but provide a good general view of where the ground is being laid and where more work is needed, particularly in evaluating the effect on population health, and experimenting with provider reimbursement.

NACBH members are encouraged to download the report for reference as policies in your state evolve.

LOOKING FOR SOME POSITIVE NEWS ABOUT MEDICAID?

Research helps advocates for Medicaid expansion refute a false narrative.

A frequent argument against Medicaid expansion is “there aren't enough doctors accepting Medicaid” patients to go around. Opponents of the Affordable Care Act contend the law exacerbated that problem by expanding Medicaid. The *Washington Post* disputed this in 2017, **writing there wasn't sufficient evidence** to support this statement. Using claims data from primary care physicians nationwide, after comparing 2013 to 2015, when states began expanding Medicaid, there was actually a slight uptick in doctors' patient population on the government program. In the states that chose to expand (then 30, plus Washington, D.C.), the average share of a doctor's patients on Medicaid went from 10.2% in 2013 to 13.6% in 2015. In non-expansion states, there was no notable difference either way, according to the study.

Another way to measure Medicaid effectiveness and patients' access to doctors is how often they actually get care. According to a 2016 Medicaid and CHIP Payment and Access Commission (MACPAC) report, Medicaid recipients were "as likely to have seen a doctor in the past year as those with private insurance." And unsurprisingly, "Medicaid enrollees were considerably more likely to have seen a doctor in the past year." As for children needing vaccines, regular care and sick visits, much less treatment for health conditions, the data overwhelmingly illustrate that when adults have coverage, their children do as well.

Pay now or pay later.

Kaiser Health News reports that the Medicaid expansion can help patients manage their health and reduce unnecessary spending. Analysis by CDC demonstrates how, in the case of diabetes, Medicaid access results in more consistent preventive care, leading to a substantive reduction in health care costs due to fewer hospital admissions. The same has been found in other studies of major public health issues, like opioid abuse. The Journal of Health Economics found admission to opioid treatment facilities increased 18 percent in expansion states, largely due to a 113% increase in admissions of Medicaid beneficiaries. As noted by Kaiser Family Foundation regarding community health centers' role in treating opioid addiction, evidence like this will influence the debate, particularly as we consider the children affected by these public health issues, and the costs that are shifted into other systems as a result of untreated health conditions.

Medicaid expansion costs the feds less than subsidizing ACA coverage.

Modern Healthcare recently crunched the latest numbers from the Congressional Budget Office (CBO), including an estimated $4,900 federal Medicaid cost per beneficiary in 2018 versus $6,300 per subsidized enrollee in private coverage. CBO projected that the gap will widen by 2028, the end of its 10-year window, when the federal cost to underwrite coverage on the insurance exchanges will be 57% higher than its cost for Medicaid coverage. We look forward to seeing the math on how much Medicaid provider reimbursement could be improved while still saving money systemwide, under a more expansive single-payer scenario.

UPCOMING WEBINAR: AMP+ SKILLS ENHANCEMENT TRAINING FOR YOUTH PEER SUPPORT PROVIDERS

Research on peer support in mental health consistently cites a lack of clarity around the role and its essential skill set as a barrier to high-quality implementation. This webinar will report on a study testing the AMP+ skills-enhancement intervention for peer support providers working with youth and young adults. AMP+ provides web-based training and video coaching specific to the peer role. Peers reported high

satisfaction, improved their skills, and reported reduced work-related anxiety.

September 18, 2018, 1:00 – 2:00 p.m. Eastern

REGISTER FOR WEBINAR

More information about AMP+ is available online at the Pathways Research and Training Center (RTC) at Portland State University.

ARCHIVED WEBINAR: TIPS AND TRICKS TO STARTING A YOUNG ADULT COUNCIL

The Transitions to Adulthood Center for Research at the University of Massachusetts has posted this recent webinar, discussing the value of young adult councils along with in-depth instructions on how to organize one within any organization that serves young adult clients.