Progress Report to the Legislature

Children's Mental Health

As Required by 2SHB 1088, Sec 4(3) & 5(1)-(2)

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Department of Social and Health Services
Health & Recovery Services Administration
Division of Behavioral Health & Recovery, Division of Health Care Services &
Office of the Assistant Secretary
PO Box 45502
Olympia, WA 98504-5502
(360) 902-0818
Fax: (360) 902-7651

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APPENDICIES

Appendix A, Hilt, R. (2010, February). *Primary Care Principles for Child Mental Health* Retrieved from http://www.palforkids.org/docs/Care_Principles_20102502.pdf

Appendix B, Hilt, R. & Myers, J. (September 2009). *The Partnership Access Line Establishing an empirically based child psychiatry consultation program for Washington State: Background, Program Description, and Measures* paper presented as deliverable for Primary Care provider Program contract with the Department of Social and Health Services. Seattle, WA.

Appendix C-1, Varley, C. K. (January 2009). *Summary Report Effect of Second Opinion Review on Attention Deficit Hyperactivity Disorder (ADHD) Medication Prescribing in a Medicaid Insured Population* paper presented as deliverable for Children's Mental Health Medication Review contract with the Department of Social and Health Services. Seattle, WA.

Appendix C-2, Varley, C. K. (May 20, 2009). *Summary Report Effect of Second Opinion Review on ADHD Prescribing in a Medicaid Insured Population* Children's Mental Health Medication Review paper presented as deliverable for Children's Mental Health Medication Review contract with the Department of Social and Health Services. Seattle, WA.

Appendix D, Children's Mental Health Access & Services in Washington State: Stakeholder Input & Recommendations (December 2008). Draft report prepared for the Department of Social and Health Services Health and Recovery Services Administration, Mental Health Division by the Washington Institute for Mental Health Research & Training, University of Washington, Division of Public Behavioral Health & Justice Seattle, WA

Attachment to Appendix D

Appendix E, Knowlton, S. *Letter* Re: Projected Cost of House Bill 1088 – Revised (July 24, 2009).

Improving Children's Mental Health Services

Executive Summary

The Washington State Legislature passed landmark legislation (2SHB 1088) in 2007, which set out a series of goals to improve mental health care for children. Sections 4 and 5 of the legislation, codified in RCW 74.09.490, tasks the Department of Social and Health Services (Department) with:

- Developing recommendations for increasing access to and improving the quality of children's mental health services.
- Developing and implementing policies that improve care coordination and medication management in the treatment of behavioral and emotional disorders in children.

Access to Care Standards and the Children's Mental Health Services Benefits Package

Increasing access to Regional Support Network (RSN) services can be done by raising the CGAS scores called out in the Access to Care Standards which would allow higher functioning children to enter into services. It is expected that increasing the CGAS will result in a new cohort of clients gaining access to the system and some additional costs of providing these services. The Department contracted with Milliman to provide estimates on the increased costs of the program if the Access to Care Standards are increased by 5 to 10 points. Milliman provided optimistic and pessimistic scenarios from a cost perspective ranging between $6.6 million to $24.6 million.

The Department also contracted with Milliman to project the cost of increasing the use of evidence based high-intensity programs (wraparound services, multidimensional foster care services (MTFC), multi-systemic therapy (MST)), and to provide for subacute residential crisis respite services. Milliman was unable to provide cost projections stating "the factors that make specialized programs feasible for certain populations are not uniform across the State."

In addition to these activities, a variety of stakeholder work was conducted by the Department, facilitated by the Washington Institute for Mental Health, Research and Training. This work provided a variety of recommendations from stakeholders for making improvements to children's mental health in the areas of access, service and support, and system design.

Care Coordination

The Department began its effort to improve the coordination of mental health care for children by forming advisory committees and working extensively with community providers, associations and the Evidence-based Practice Institute. As a result, a set of clinical guidelines that provide clinical care management pathways and treatment recommendations, including diagnostic tools for children with emotional or behavioral disturbances and medication management were established and published in "Primary Care Principles for Child Mental Health" (care guide) updated February 2010 (Appendix A). Since its publication, the care guide has been well received. Through August 2009 1,500 printed copies of the have been distributed to providers, while 3,000 have been downloaded from the PAL website: http://palforkids.org/resources/

The care guide is integral to the Partnership Access Line (PAL) program, which offers telephone consultation and outreach training services to community providers. PAL was first implemented March 2008 in Region 6 (western Washington) and expanded to Region 1 (Spokane, Washington) in November 2008. Since inception of the program, 450 providers have received peer consultations regarding children and adolescents with emotional or behavioral disturbances.

In addition, PAL consultants have made 22 outreach presentations throughout Regions 1 and 6. A report describing the PAL program from inception through the evaluation plan is found in Appendix B.

Medication Management

Beginning with the class of drugs used to treat attention deficit hyperactivity disorder (ADHD), the Department implemented a medication management program, which requires a second opinion review by a board certified child and adolescent psychiatrist when children are prescribed mental health medications that exceed age and dose thresholds or when more than one medication is used to treat a mental health condition.

A review of activity and outcomes completed January 2009 (Appendix C-1) concludes second opinions have resulted in safer and more effective care for Medicaid insured children with ADHD who are treated with medication.

On February 1, 2009, the Department expanded medication management by requiring a second opinion review for prescriptions that exceed age and does limitations for antipsychotic drugs. A summary review of both ADHS and AAP outcomes completed May 20, 2009 (Appendix C-2) describes the significant safety concerns being addressed buy this phase of the second opinion review process.

Introduction

This report, including appendices, details the Department's progress toward improving access to care, the Children's Mental Health Benefits Package, care coordination and medication management of children with emotional or behavioral disturbances as required in Sections 4 and 5 of 2SHB 1088. These sections have multiple parts and subparts which address many aspects of improving access, services, care coordination and medication management. Accordingly, each subsection and its respective parts, is reiterated below followed by a description of progress the Department has made in each area.

Progress Report

Section 4(3) Directs the Department to make recommendations for revisions to the children's Access to Care Standards and the Children's Mental Health Services Benefits Package.

Access to Care Standards

Current Access to Care Standards for Regional Support Network (RSN) mental health services stipulate that children can gain access to RSN services under two levels. In order to qualify for Brief Intervention, children must score 60 or below on a CGAS evaluation. To qualify for Community Support, which authorizes a longer period of treatment and the full range of State Plan modalities, they must score 50 or below on the CGAS score. Children age 0-5 are not required to meet the CGAS criteria to be eligible for care.

Increasing access to RSN services can be done by raising the CGAS scores called out in the Access to Care Standards which would allow higher functioning children to enter into services. It is expected that increasing the CGAS will result in a new cohort of clients gaining access to the system and some additional costs of providing these services.

The Department contracted with Milliman to provide estimates on the increased costs of the program if the Access to Care Standards are increased by 5 to 10 points. Milliman provided optimistic and pessimistic scenarios from a cost perspective as follows:

- Increasing Access to Care Standards by 5 points would result in increased costs ranging between $6.6 million to $17.6 million. These projections estimate that approximately 5,000 to 11,000 additional children will be served by the RSNs.
- Increasing Access to Care Standards by 10 points would result in increased costs ranging between $9.9 million to $26.4 million. These projections estimate that approximately 8,000 to 18,000 additional children will be served by the RSNs.

A detailed description of the methodology and analysis is provided in Appendix E.

Children's Mental Health Services Benefits Package

2SHB 1088 directed the Department to make recommendations for changes to the benefits package available to children emphasizing "developmentally appropriate evidence-based and research-based practices, family-based interventions, the use of natural and peer supports, and community support services." The Department conducted activities to try to project the costs of implementing new services in the Children's Mental Health Services Benefits Package. In addition, the Department conducted a variety of stakeholder activities to develop

recommendations for improving children's mental health services. Following is a summary of these activities.

Cost Projections
The Department contracted with Milliman to project the cost of implementing several modalities which would meet the goals of 2SHB 1088, namely: increasing the use of certain high-intensity programs (wraparound services, multidimensional foster care services (MTFC), multi-systemic therapy (MST)), and to provide for subacute residential crisis respite services. Milliman reviewed the work of TriWest Group which previously provided rough cost estimates for the first three of these evidence based practices in a report submitted in 2007. Milliman raise some questions regarding the TriWest Group cost projections and recommended the use of pilot programs and surveys for providing more accurate cost estimates. According to Milliman, "the factors that make specialized programs feasible for certain populations are not uniform across the State, making local staff the more suitable stakeholders for estimation of program costs." A detailed description of the methodology and analysis is provided in Appendix E.

Stakeholder Work
In September 2007, the Department contracted with the Washington Institute for Mental Health Research and Training (WIMHRT) at the University of Washington to facilitate stakeholder input into the process of developing recommendations related to access to care and services and supports. WIMHRT gathered input through a variety of methods including:

- Two Community Forums which included a combined 350 people
- Interviews and questionnaires completed by Regional Support Network (RSN) representatives
- Input from Assistant Secretaries and Administrators of the Department
- One statewide Children's Mental Health Survey; and
- Two Tribal Roundtables

Following is a summary of the recommendations from the WIMHRT report:

- Support provider organizations to increase youth and family access to, and engagement in, service.
- Shift RSN utilization management away from front-end restrictions across all enrollees to proactive care management for the most intensive and costly services.
- Address limits to access to services posed by current Access to Care Standards (ACS) - recommended increasing the CGAS score to 70 and expansion of diagnostic categories covered under ACS. Increase access to child psychiatrists by expanding the current Partnership Access Line (PAL).
- More actively promote Family Advocacy, Peer-to-Peer Support, and Youth Support.
- Further, expand current technical assistance and other supports to Family Support and Advocacy Organizations

- Implement evidence-based practices (EBPs) for youth at risk of out-of-home placement or transitioning home from out-of-home placement settings including Multidimensional Treatment Foster Care (MTFC), Functional Family Therapy (FFT), Multi-systemic Therapy (MST), and Family Integrated Transitions (FIT).
- Implement EBPs for youth exposed to past trauma including Trauma Focused Cognitive Behavioral Therapy (TF-CBT).
- Implement EBPs for youth with co-occurring mental health and substance abuse disorders.
- Implement evidence based models that target early signs of behavioral problems and assist parents in working with oppositional and defiant behaviors including Parent-Child Interaction Therapy (PCIT) and The Incredible Years.
- Implement prevention and early intervention programs with evidence for effectiveness that align with stakeholder priorities including Nurse-Family Partnership, Positive Parenting Program (Triple-P), Good Behavior Game, and School Development Project (Seattle Social Development Project).
- Increase availability of Wraparound care coordination statewide.
- Build infrastructure to support implementation of prioritized EBPs using such models as Partnerships for Success, Communities that Care, and Getting to Outcomes.
- Increase leadership roles of families and youth in system design and accountability monitoring by promoting and supporting cross-system community collaborative teams.
- Increase leadership roles of families and youth in system design and accountability monitoring by building greater capacity at the Department level to use cross-system teams with youth and family leadership.

Additional detail on this report can be found in Appendix D.

Section 5(1) (a) Directs the department to make improvements by developing and implementing policies in four areas: 1) Improve prescribing practices; 2) Increase the use of evidence-based and research-based practices; 2) Improve communication and care coordination; and, 4) Prioritize care in the family home.

Improve prescribing practices
The department formed advisory committees, worked with community providers, associations, and the Evidence-based Practice Institute to develop and implement the mental health treatment guidelines, which offer guidance on the seven most common mental health diagnoses in children. In addition to offering credible assessment tools, these treatment guidelines emphasize behavioral interventions before medication options for each diagnosis based on best practices.

Increase the use of evidence-based and research-based practices
The mental health treatment guidelines, titled "Primary Care Principles for Child Mental Health" (Appendix A), promote the use of evidence-based and research-based practices and reduce variation in practice patterns in order to improve the quality of children's mental health therapy. The treatment guidelines, commonly referred to as the PAL guidelines, are a core work product of the PAL program. They were originally intended for primary care physicians and practitioners;

however, the audience has been expanded to include specialists. Endorsed by the Washington State Chapter of the American Academy of Child and Adolescent Psychiatry, the guidelines have been well received by providers. A total of 1,500 printed copies of the care guides have been distributed; three thousand copies have been downloaded from the website www.palforkids.org.

Improve communication and care coordination
The department has made improvements in communication and care coordination between primary care and mental health providers through case consultations and outreach events. PAL consultants have trained providers to use general and disorder specific mental health rating scales in their practices through individual case consultations and lecture based presentations. General symptom rating scales are used to screen for the likelihood of an emotional or behavioral disturbance being present. Disorder specific rating scales are useful for diagnosing and monitoring particular child mental health problems. Providers report they value and use these tools in their practices.

Prioritize care in the family home
A report prepared for the Mental Health Division titled "Children's Mental Health Access & Services in Washington State: Stakeholder Input & Recommendations" (Appendix D) recommends implementing evidence-based practices (EBPs) for youth who are at risk of out-of-home placement or who transition home from out-of-home placement settings. Ten counties (Benton, Clark, Franklin, King, Mason, Skagit, Snohomish, Thurston, Whatcom, and Yakima) are identified as having implemented EBPs that address the service needs of this population.

Section 5(1) (b) Instructs the department to identify those children with emotional or behavioral disturbances who may be at high risk due to:

- off-label use of prescription medication
- use of multiple medications
- high medication dosage
- lack of coordination among multiple prescribing providers

The Department is further directed to establish one or more mechanisms including obtaining second opinions from experts in child psychiatry to evaluate the appropriateness of the medication(s) these children are using.

To comply with the objectives outlined above, on March 1, 2008, the Department entered into a contract with the Seattle Children's Hospital to institute a pilot program to review the appropriateness of mental health medications prescribed for children. The Department began requiring prior authorization and a second opinion for the use of ADHD medication in:

- all children between the ages of 0-4,
- children age five to seventeen for doses exceeding established limits; and,
- children receiving multiple medications.

On February 1, 2009, the department implemented second opinion reviews of atypical antipsychotic (AAP) prescriptions when established maximum daily doses of AAPs, stratified by age, were exceeded.

ADHD and AAP prescriptions that exceed thresholds are identified by edits in the pharmacy point of sale claim system. If a prescription exceeds thresholds, department staff request a second opinion from a contracted child and adolescent psychiatrist who conducts a medical record review and evaluates appropriateness of the treatment regimen, including:

- Assessing Prescriber's use of established tools, e.g., those in the "Primary Care Principles for Child Mental Health" guide, to make or confirm clinically appropriate diagnoses;
- Reviewing and determining whether appropriate intervention efforts, e.g., behavior modifications, have been tried and failed;
- Reviewing previous efforts with medication(s) and documentation of failure to respond;
- Assessing and determining appropriateness of Prescriber's clinical rationale for the treatment regimen, including assessment of documented qualitative/quantitative behavior responses;
- Facilitating Prescriber's assessment of benefit versus harm with proposed new medication treatment; and
- Contacting Prescribers within three business days of receiving the referral and medical records to schedule a Reviewer-to-Prescriber discussion, when appropriate.

Section 5(1) (c) Requires a review of the psychotropic medications of all children under five and one or more mechanisms be established to evaluate the appropriateness of the medication these children are using, including but not limited to obtaining second opinions from experts in child psychiatry.

The Department's efforts to improve antipsychotic prescribing practices for treatment of emotional/behavioral disturbances in children are informed by data collected and analyzed while participating in the Kids Getting Anti-psychotics Project. Washington Medicaid joined with 20 other Medicaid states to look at AAP use in children. This review found that most AAP use is off label and issues related to prescribing too many or too much mental health medication to the too young may be significant.

Atypical antipsychotic use data for Washington State Medicaid fee-for-service children are summarized below:

- **Total Users of Anti-psychotics (AAP):** 4,978 (1.4%) of kids
- **Growth trends:** AAP users grew 25% and unit costs grew 38% comparing 2004 to 2007
- **AAP use in the very young:** 187 AAPs users are less than 5 years old
- **High Dose:** 499 (10%) of users are prescribed high doses of AAPs
- **High User Types:** Foster care (5.8%) and aged/blind/disabled clients (8.6%) had the highest AAP use rates
- **Multiple AAP use:** 896 (19%) of users had two or more AAP prescriptions
- **Multiple Mental Health Drug use:** 621 (2.3%) of kids are prescribed 5 or more mental health drugs
- **Poly-prescribers:** 7,176 (37%) of kids had two or more prescribers (~1,000 had 4 or more prescribers) for all mental health drugs given to children
- **Adherence:** 1,588 (39%) had a gap in AAP use of greater than 20 days

- **Provider Types**: 45% of AAPs were prescribed by Psychiatrists, 34% PCP and 21% ARNP
- **Regional Variation:** Prescription patterns in western Washington are different than southeastern Washington. There were higher rates of poly-pharmacy (multiple prescriptions) and higher dosing observed in eastern Washington.

Section 5(1) (d) Instructs the Department to track prescriptive practices with respect to psychotropic medications with the goal of reducing the use of medication.

An analysis of Medicaid data (Appendix C-1) found requiring a second opinion reduced outlier ADHD medication practices and overall worked well with the community. The program highlighted some aberrant practices and stopped potential over dosing.

From May 2006 to April 2008, 5.35% of ADHD prescriptions exceeded safety thresholds, resulting in 1,032 situations where a second opinion was indicated. Of those, 576 (56%) resulted in a prescription adjustment.

When the pre and post periods were compared, the requirement for a second opinion reduced ADHD medication utilization in children less than five years old (23%), use of high dose (53%) and use of combinations (44%).

Similar measures as those applied to the ADHD second opinion program will be used to track and analyze antipsychotic prescriptive practices.

Section 5(1) (e) Directs the Department to encourage the use of cognitive behavioral therapies and other treatments which are empirically supported or evidence-based, in addition to or in the place of prescription medication where appropriate.

The PAL treatment guidelines are organized by diagnoses and promote appropriate behavioral therapy prior to starting medication to manage a child's condition. The child and adolescent psychiatrists in the PAL program hold their advice to a high evidence based standard.

The PAL program is an empirically based child psychiatry consultation program. A report describing what it is, how it was established and how it will be measured is included in Appendix B.

Section 5(2) Instructs the Department to convene a representative group of providers who contract with the Department under RCW 74.09.522--Agreements with managed health care systems to do the following.

Section 5(2) (a) Establish mechanisms and develop contract language that ensures increased coordination of and access to Medicaid mental health benefits available to children and their families, including ensuring access to services that are identified as a result of a developmental screen administered through early periodic screening, diagnosis and treatment.

Following discussions between the Department, providers and contractors held in 2008, concerns arose about managed care organizations' identification of children (and adults) with special needs,

particularly mental health needs. The Department responded by increasing requirements related to coordination of care in an amendment to the Healthy Options contract effective January 1, 2009.

Section 5(2) (b) Define managed health care system and regional support network contractual performance standards that track access to and utilization of services.

The contract between the Department and Healthy Options requires managed care organizations to meet quality-of-care standards, in accord with federal protocols. A requirement that quality standards address behavioral health was added to the Healthy Options contract effective January 1, 2009.

Section 5(2) (c) Set standards for reducing the number of children that are prescribed antipsychotic drugs and receive no outpatient mental health services with their medication.

The PAL treatment guidelines serve as a clinical standard and emphasize behavioral interventions before medication options. Each disorder-specific guideline is based on best practices. A common theme typically emerges in both clinical experience and in the results of formal research trials, that a combination of medical treatment and social/behavioral care often ensures the best of outcomes.

The Department implemented age and dose limitations for antipsychotic medication prescribed to children beginning February 2009. Prescriptions exceeding dosing limitations for age require a second opinion. Treatment recommendations made by reviewers include getting the child into therapy where appropriate.

In July 2008, the Department implemented legislation aimed at increasing access to outpatient mental health services by expanding the number of visits and the type of providers eligible to accept mental health referrals for children age 18 and younger who receive medical benefits from the Department (and are Medicaid eligible).

The expansion increased access to mental health services for children and youth who do not meet the Regional Service Network (RSN) Access to Care Standards. As of February 2009, the Department issued provider numbers to 537 new mental health providers. Between July and December 2008, some combination of licensed Psychologists, Psychiatric Advanced Registered Nurse Practitioners, Independent Clinical Social Workers, Advanced Social Workers, Marriage and Family Therapists and Mental Health Counselors provided 4,758 treatment sessions to 1,835 children and youth.