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Introduction

Good morning Chairman Gray and members of the Committee on Health. My name is Beth Kurtz. I am a Supervising Attorney at Children's Law Center[1] and a resident of the District. I am testifying today on behalf of Children's Law Center, which fights so every DC child can grow up with a loving family, good health and a quality education. With over 100 staff and hundreds of pro bono lawyers, Children's Law Center reaches 1 out of every 9 children in DC's poorest neighborhoods—more than 5,000 children and families each year.

I appreciate this opportunity to testify regarding the performance of the Department of Behavioral Health (DBH) over this past year. Approximately 99,000 children and youth under 21 years of age are enrolled in the District's Medicaid program.[2] DBH notes that as many as 20% of children and adolescents may have a mental health disorder that can be identified and require treatment.[3] This means that nearly 20,000 of the children on Medicaid in DC likely have a mental health disorder that can be identified and requires treatment,[4] but in FY 2017, only about 12,000, or about 12%, of publicly insured children received mental health services.[5] That is a reduction from FY16, in which about 16% of publicly-insured children received mental health services.[6]

A decrease in utilization is particularly concerning because at Children's Law Center, many of the children we work with—children in the foster care system or

receiving special education services—only need our help because their mental health needs have gone unaddressed. Many have been faced with multiple adverse childhood experiences and resulting complex trauma and need access to high-quality services to achieve stability. But even our well-trained lawyers have difficulty connecting children to appropriate mental health services and cite the lack of timely, quality and appropriate mental health services as one of the greatest barriers to success for our children. Appointment delays, disorganization, and high staff turnover rates plague many of the Core Service Agencies (CSAs) that provide needed mental health services to many Medicaid-eligible children. In general, despite some progress over the past several years, gaps in the system of care still leave families, teachers, social workers, probation officers, lawyers and judges scrambling to meet the mental health needs of at-risk children in the District. I will now discuss a few strengths and challenges.

DC Social, Emotional and Early Development Program

DBH has recently staffed and begun implementing the DC Social, Emotional and Early Development (DC SEED) Project after having been awarded a federal grant to expand the system of care for early childhood mental health care. Through DC SEED, three provider agencies selected by DBH last year as sub-grantees[7] will increase their capacity to serve young children (ages 0-6) through implementation of evidence-based practices (Parent-Child Interaction Therapy (PCIT), Child-Parent Psychotherapy for Family Violence (CPP-FV), and Strengthening Family Coping Resources (SFCR)) and

certified family peer specialists. It will be important for the DC SEED staff and partner organizations to work closely with the networks designed to support early childhood development in the District, including child care centers, the State Early Childhood Developmental Coordinating Committee (SECDCC), the Department of Health (DOH), the Office of the State Superintendent of Education (OSSE) and District of Columbia Public Schools (DCPS). We look forward to the impact that this funding stream might have on the availability and quality of services for young children.

High-Fidelity Wraparound

In FY 2017, high-needs youth in the District experienced a significant gap in the availability of one of the key services that DBH has touted for this population: High-Fidelity Wraparound. The High-Fidelity Wraparound model is an established care coordination and family support model that seeks to mobilize all supports and services to maintain children with emotional or behavioral difficulties safely in their communities.[8] In the winter of 2017, the sole provider of this service, DC Choices, indicated its intent to end its contract with the District, prompting an approximately seven month period in which the service was unavailable. Fortunately, DBH has selected a new provider of this service, MBI Health Services, LLC,[9] which began accepting referrals in the fall of 2017.

The program is designed to provide individualized and child- and family-driven planning, monitoring and coordination of services, and linkage to non-Medicaid

reimbursable services, supports or interventions through flexible funding. With that said, we note that there are fewer local dollars made available for the new High-Fidelity Wraparound Contract with MBI Health Services, and as a result, there is lower capacity and a decrease in the available flexible funding per youth.[10] We look forward to partnering with DBH to increase utilization of the High-Fidelity Wraparound contract, and look forward to receiving future data on the impact of this iteration of the service as a mechanism for PRTF diversion.

District of Columbia Mental Health Access in Pediatrics (DC-MAP)

We are pleased with the progress in implementing the Mental Health Access in Pediatrics (DC-MAP) project over the course of the past two years, following the enactment of the *Behavioral Health System of Care Act of 2014*.[11] DC MAP began providing psychiatric and care coordination consultation services to a pilot group of pediatricians in May 2015 and became available to all DC pediatricians and their staff in September 2015.[12] The program is staffed collaboratively by Children's National Health System and MedStar Georgetown University Hospital.[13] There are now 213 pediatric primary care practices or providers enrolled,[14] and as of the first quarter of FY18, there have been over 1,000 total calls to the DC MAP consultation line.[15] We note, however, that over 75% of all calls to the consultation line have been for community referrals or care coordination needs, rather than for diagnostic, medication, or treatment consultations.[16] This breakdown is perhaps a symptom of our challenging mental

health system for children, which I will discuss shortly. Regardless, we are heartened by increases in utilization of this innovative project and look forward to continued growth.

Provider Sustainability

As the Committee is aware, the past year saw the closure of several important providers in the Mental Health Rehabilitative Services (MHRS) network.[17] Many of the court-involved children that Children's Law Center represents received services from DC Choices, Youth Villages, Family Matters of Greater Washington, and First Home Care. Although we understand that these provider closures and changes may have happened for a variety of reasons, we are left with concerns about the viability of the MHRS provider network. In particular, provider sustainability challenges may threaten our clients' ability to access the Evidence-Based Practices that have been highlighted in our system as part of the Families First project since 2011.[18] For example, our court-involved teens with complex family challenges have not been able to access Multi-Systemic Therapy (MST) since the closure of Youth Villages.[19] The impact of a closure is always exacerbated when the provider closing its operation was the *sole* provider of an Evidence-Based practice or specialty service.

We are pleased regarding the outcomes of DBH's recent rate study,[20] and appreciate DBH's commitment to reviewing its billing structure and referral pathways, not simply rate levels, in addressing whether systemic barriers may have contributed to

the financial instability of certain now-closed providers.[21] We also encourage DBH to consider diversifying the providers of each Evidence-Based Practice so that the closure of one provider does not deny all children enrolled in Medicaid in the District the opportunity to benefit from that practice. We are heartened that in FY17, DBH lifted its moratorium on new provider certifications for new CSAs as well as for certifications in providing certain Evidence-Based Practices, to include MST and Functional Family Therapy among others.[22] But we note that the process of certifying new providers has been a slow one, and we encourage DBH to continue examining barriers to attracting qualified providers.

A Fragmented System

Although each of DBH's certified MHRS providers is a private entity entitled to its own "business decisions," as DBH notes in its oversight responses,[23] it is the Department of Behavioral Health itself that must ultimately take responsibility and exercise leadership when it comes to the ability of children in the District to access needed services.

It is encouraging that over the course of the past year, DBH has undergone an organizational restructuring process designed to increase collaboration and effectiveness, and limit the silos that have created past challenges. We welcome to the thoughtful integration of all clinical and community services—child-focused and adult-focused, substance use disorder services and mental health services.[24] We also applaud

the recent move to shift oversight of Free-Standing Mental Health Clinics[25] from the Department of Healthcare Finance (DHCF) to DBH, which we hope will create more consistent oversight for providers in the District.

But major systemic challenges remain due to the fragmentation of our public mental health system. Neither DBH nor any other agency reports about and monitors all children receiving mental health services through DC Medicaid. DBH does report on and monitor the children being served through its MHRS system and a few other programs which it runs, including the Early Childhood Mental Health Consultation Program – Healthy Futures, the Parent-Infant Early Childhood Enhancement (PIECE) Program, the existing School Mental Health Program (SMHP), and the High-Fidelity Wraparound Program. However, DBH does not review or monitor services received through Medicaid managed care organizations (MCOs), which serve the overwhelming majority of children in DC. We know from DHCF that in FY17 over 7,000 children received some mental health service through their MCO.[26] DBH has reported efforts to collaborate with the MCOs regarding ways to improve collaboration and care coordination for children and youth, but we are unaware of the outcomes of these efforts. We continue to urge more steps towards an integrated system and collaboration across agencies and with the community.

Poor Coordination Between Inpatient Services and Community-Based Services

Additional coordination and monitoring challenges exist due to barriers in collaboration between inpatient psychiatric units that service children in hospital settings and community-based service providers. The kind of coordination necessary is exemplified in DBH's Continuity of Care policy.[27] The policy requires that an acute care facility notify DBH of the admission of a Medicaid enrollee, and DBH must inform the acute care facility of the enrollee's Core Services Agency (CSA). The policy further requires the CSA provider to have face-to-face contact with the youth in the hospital and participate in discharge planning. But time and again, such care coordination efforts are not realized for the children we represent. In FY15, when DBH was receiving psychiatric unit discharge data from both Children's National Health System (CNHS) and the Psychiatric Institute of Washington (PIW), only 61% of youth discharged from an inpatient stay received a community-based service within a week.[28]

That was unacceptable in FY15. But two years later, not only are there no signs of improvement, but DBH has also reported that it no longer receives and maintains this data reliably because CNHS no longer provides it and because PIW provides it inconsistently.[29] Of the 68 discharges that PIW reported to DBH in FY17, only 15% of those children received a community-based service within seven days. DBH has recognized these unacceptably low numbers, but has not implemented any policy, practice changes, or additional funding to increase this percentage. Without sufficient community-based care and coordination with hospitals, children with acute psychiatric

needs are at a high risk for reoccurring hospitalization or placement in a Psychiatric Residential Treatment Facility (PRTF). We encourage DBH to take affirmative steps to bring together the hospitals, DOH, DHCF, and any other necessary stakeholders, not only to develop appropriate data-sharing protocols, but also to collaborate regarding how best to serve this highly vulnerable consumer population in the community.

Quality and Timeliness of Services in General

In addition to coordination and access, a successful system needs to provide timely offered, high-quality care for those who receive services. This continues to be a significant problem. We regularly see high turnover among practitioners, practitioners who do not have the skill to engage children or their caregivers, and a lack of communication among professionals involved with the families.

DBH's own data reflects the experience of my colleagues. It has been two years since DBH released a Child and Youth Community Service Review (CSR), and unfortunately DBH has reported that its FY17 Community Service Review will not be available until the end of FY18.[30] But relying on the last known data, in only 67% of cases did reviewers find that the children's mental health system performed "in the acceptable range,"[31] and 12% of cases received the lowest possible scores.[32] The FY16 Provider Scorecards, released in September 2017, show that none of the 15 providers that serve children received the top scores of five or four stars, and 8 of the 15 received between 0 and 2 stars, which are low scores that may require corrective action by

DBH.[33] Simply getting a service is not enough. The reality is that the poor quality of care means that mental health problems persist or exacerbate.

Mental health treatment must also be timely in order to be effective. We regularly work with children who have waited months to receive services. MHRS regulations require that CSAs provide consumers with an appointment within seven (7) business days of referral.[34] But DBH reports that it takes, on average, 26 days for a newly referred consumer to receive a Diagnostic Assessment.[35] Then, following a recommendation for treatment in the Diagnostic Assessment and the subsequent development of a treatment plan, there are often delays in implementing services. We are particularly concerned about the breakdown of average wait time in days before the implementation of treatment services as listed in DBH's response to Question 20 in this year's oversight questions. For example, Community-Based Intervention (CBI) is touted as the most intensive and effective home- and community-based service for children who routinely experience mental health crises and have highly acute needs. The applicable DBH policy requires CBI providers to engage consumers within 48 hours of authorization of referral.[36] But DBH is now reporting that there is an average of 42 *days* before the service is billed.[37] We need more data to understand these delays, but more importantly, we need DBH's leadership in developing and sustaining a provider workforce so that children can actually access mental health services when they need them.

As discussed previously, available FY17 data from DHCF shows a decline in utilization of mental health services for children and youth. DBH's data mirrors this—only 4,807 children received MHRS services in FY17 compared to 5,512—about a 13% reduction.[38] There is no evidence that the need for such services has reduced, and we are left with concerns that challenges with provider consistency, quality and timeliness as detailed above may adversely affect these numbers. At bottom, FY17 has not shown major improvements in the lives of children with mental health needs in the District.

Conclusion

In conclusion, while there are some promising efforts on the part of DBH to improve aspects of the children's mental health system, serious challenges remain. Without major structural reform, the existing system may continue to fail the children who need it most. DBH should continue and increase its efforts to increase collaboration and care coordination across systems that serve youth with mental health concerns. Only then will at-risk children in the District get the mental health services they need.

Thank you again for the opportunity to testify. I am happy to answer any questions.

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[1] Children's Law Center fights so every child in DC can grow up with a loving family, good health and a quality education. Judges, pediatricians and families turn to us to advocate for children who are abused or neglected, who aren't learning in school, or who have health problems that can't be solved by medicine alone. With more than 100 staff and hundreds of pro bono lawyers, we reach 1 out of every 9 children in DC's poorest neighborhoods – more than 5,000 children and families each year. And, we multiply this impact by advocating for city-wide solutions that benefit all children.

[2] DHCF FY17 Performance Oversight Responses, Q40.
[3] Department of Behavioral Health website states: "It is estimated that as many as one in five children and adolescents may have a mental health disorder that can be identified and require treatment." http://dbh.dc.gov/service/children-youth-and-family-services
[4] 20% of the 98,929 children and youth who receive public health insurance is 19,786.
[5] DHCF FY17 Performance Oversight Responses, Q40.
[6] DHCF FY16 Performance Oversight Responses, Q39.
[7] DBH FY17 Performance Oversight Responses, Q110.
[8] See DBH Policy: High Fidelity Wraparound Care Planning Process, *available at* http://dbh.dc.gov/node/876552.
[9] DBH FY17 Performance Oversight Responses, Q76.
[10] DBH FY17 Performance Oversight Responses, Q76.
[11] See D.C. Code § 7-1142.01, *et seq.* (2012 Repl.).
[12] DBH FY17 Performance Oversight Responses, Q109.
[13] *See* http://www.dcmap.org/
[14] DBH FY17 Performance Oversight Responses, Q109.
[15] Data provided at the DC Collaborative for Mental Health in Pediatric Primary Care Community Advisory Board Meeting, Jan. 26, 2018.
[16] Data provided at the DC Collaborative for Mental Health in Pediatric Primary Care Community Advisory Board Meeting, Jan. 26, 2018.
[17] *See* DBH FY17 Performance Oversight Responses, Q74, 77, 78.
[18] *See* http://www.evidencebasedassociates.com/district-of-columbia.
[19] *See* DBH FY17 Performance Oversight Responses, Q101.
[20] *See* DBH FY17 Performance Oversight Responses, Q81.
[21] *See* DBH FY17 Performance Oversight Responses, Q77.
[22] See Department of Behavioral Health Extends Period to Submit Certification Applications for Mental Health and Substance Use Disorder Services, July 26, 2017, *available at* https://dbh.dc.gov/release/department-behavioral-health-extends-period-submit-certification-applications-mental-health.
[23] *See* DBH FY17 Performance Oversight Responses, Q77.
[24] *See* Department of Behavioral Health Realigns to Support Integrated Mental Health and Substance Use Disorder Treatment and Track Outcomes, Oct. 1, 2017, *available at* https://dbh.dc.gov/release/department-behavioral-health-realigns-support-integrated-mental-health-and-substance-use.
[25] *See* Public Meeting: DBH and DHCF Oversight of Free Standing Mental Health Clinics, Dec. 20, 2017, *available at* https://dhcf.dc.gov/release/public-meeting-dbh-and-dhcf-oversight-free-standing-mental-health-clinics-fsmhcs.
[26] DHCF FY17 Performance Oversight Responses, Q40.
[27] *See* DBH Policy: Continuity of Care Practice Guidelines for Children and Youth, *available at* http://dbh.dc.gov/node/242892.
[28] DBH FY15 Performance Oversight Responses, Q48.
[29] *See* DBH FY17 Performance Oversight Responses, Q113.
[30] DBH FY15 Performance Oversight Responses, Q98. This is the most recent CSR for children's services that is currently available. *See* DBH FY17 Performance Oversight Responses Q39.
[31] DBH FY15 Performance Oversight Responses, Q98 Attachment.
[32] DBH FY15 Performance Oversight Responses, Q98 Attachment.
[33] DBH FY17 Performance Oversight Responses, Q38, Q38 Attachment.
[34] §22-A D.C.M.R. § 3411.5 (f).
[35] DHCF FY17 Performance Oversight Responses, Q20.

[36] *Available at* https://dbh.dc.gov/node/243222.
[37] DHCF FY17 Performance Oversight Responses, Q20.
[38] DHCF FY17 Performance Oversight Responses, Q100.