## Agency Recommendation Summary

Bringing a population approach to behavioral health has never been so critical as it is now in the face of the COVID-19 pandemic. With increased economic insecurity, a life-threatening pandemic and clinical resources at capacity, the behavioral health of individuals, families and communities is at risk. People who were struggling before are struggling more. Hope for recovery lies in giving people most impacted equal space to define solutions. This package invests in community-driven supports and resources aligned with the efforts to dismantle poverty in Washington State and supports critical disaster preparedness and response infrastructure to sustain the behavioral health capabilities and functionality established during the pandemic.

## Fiscal Summary

| Fiscal Summary<br>*Dollars in Thousands* | Fiscal Years | | Biennial | Fiscal Years | | Biennial |
|---|---|---|---|---|---|---|
| | 2022 | 2023 | 2021-23 | 2024 | 2025 | 2023-25 |
| **Staffing** | | | | | | |
| FTEs | 1.2 | 9.7 | **5.45** | 9.6 | 9.6 | **9.6** |
| **Operating Expenditures** | | | | | | |
| Fund 704 - H | $142 | $3,738 | **$3,880** | $3,635 | $3,635 | **$7,270** |
| Total Expenditures | **$142** | **$3,738** | **$3,880** | **$3,635** | **$3,635** | **$7,270** |

## Decision Package Description

Bringing a population approach to behavioral health has never been so critical as it is now in the face of the COVID-19 pandemic. The health care system alone cannot meet behavioral health needs, especially for already marginalized populations. A key role of public health is to support community-driven, resiliency-oriented solutions that enhance safety nets and community-based resources for children and families. With our clinical systems at a breaking point to respond to acute and ongoing health needs of Washingtonians, particularly behavioral health needs, investment in community-based and community-led resiliency-building and safety net supports is critical.

The COVID-19 pandemic has disproportionately impacted different communities, including communities of color where existing health disparities drive increased risk of health issues and decreased likelihood of receiving quality care or support. To address widening health disparities and increasing rates of behavioral health issues, the department proposes a two-fold strategy of (1) investing in community-based safety net supports and public health initiatives that address existing inequity in care for people experiencing behavioral health challenges and (2) developing a sustainable behavioral health disaster recovery and response infrastructure that can quickly and effectively identify and address the equity and behavioral health needs of future disasters.

**Health Equity Zone Investment**

In the 2021 session, Senate Bill 5052 *Concerning the Creation of Health Equity Zones* tasked the department with supporting community-driven solutions to health disparities experienced at a local level. As the lead agency, the Department of Health (department), in partnership with community leaders, and coordinating with the Governor's Interagency Council on Health Disparities, local health jurisdictions, and accountable communities of health, will build 2-3 health equity zones in Washington State. Through partnership with community, health equity zones will allow for resources and support that meet the unique needs of each zone.

Current Substitute Senate Bill 5092 (biennial operating budget) funding will enable DOH to spend the first 12 months working with partners including community leaders to develop a plan and process for the selection and implementation of the first health equity zones. In the second year, the department plans to establish at least 3 zones, with an emphasis on developing partnerships, infrastructure and community-centered processes which will create a foundation for increasing the number of health equity zones across the state. Substitute Senate Bill 5092 did not include funds for communities to implement projects.

The department requests funds to support the establishment of 3 zones by providing the funding needed for community members to convene, identify their top health priorities, and develop projects to address these priorities. Currently, funding is not available for implementation of community-level health equity projects and this proposal seeks to address this need for resources for participating community partners. The department will continue to support communities in implementation of zone projects and related collaborative activities to reduce identified health

disparities in their zones. This funding allows us to invest in timely solutions to address health inequities, under the direction of community.

**Birth Equity Project Expansion**

The pandemic has worsened psychological distress, especially for pregnant women, for who social isolation is a risk factor for postpartum depression and other poor health outcomes (Ruyak SL, 2021) (Berthelot, 2020). Programs to enhance support during the prenatal period, labor and delivery, and in the postpartum period have been proven to reduce disparities that have persisted for decades, and address more recent impacts of the pandemic on perinatal depression and anxiety.

The Washington state maternal mortality review panel (MMRP) found that 60% of the pregnancy-related deaths were preventable. One of the leading underlying cause of death among *pregnancy-related* deaths were behavioral health conditions. The panel identified a lack of knowledge about perinatal behavioral health conditions, treatments, and resources, as well as stigma/bias related to behavioral health conditions**.** Non-Hispanic (NH) Black/African American and American Indian/Alaska Native population have the highest infant mortality in Washington state. These disparities have been relatively constant over the last two decades in our state.

The Birth Equity Project supports culturally specific, evidence based or informed projects that enhance prenatal care and parent social support for communities experiencing the most extreme perinatal health disparities. Projects have included tribal doula and home visiting programs, and group parenting support classes in both urban and rural settings. Programs reach pregnant people and families from American Indian/Alaska Native communities, African American/Black communities, Pacific Islander communities.

Additional funding will allow the department to train new community health workers serving the American Indian/Alaska Native and Black/African American population, to meet the health needs of those communities. This will help address provider shortages and the absence of providers that reflect the population they serve. Funding will also allow programs to reach more families most at risk of poor health or birth outcomes.

Perinatal behavioral health education and outreach supports

The Washington state maternal mortality review panel (MMRP) identified a lack of knowledge about behavioral health conditions, treatments, and resources, as well as stigma/bias related to behavioral health conditions as a factor in preventable pregnancy-related death. Additionally, a majority of maternal deaths in Washington occur to individuals with Medicaid insurance, and there are higher rates of maternal mortality in American Indian/Alaska Native and Black Non-Hispanic populations. All programs proposed will serve those populations, or providers that serve those populations.

The perinatal behavioral health program funds small community projects that increase knowledge and skill of providers, patients, and families about behavioral health conditions during and after pregnancy, and the treatment and resources that are available for support. This includes training for peer mental health counselors, social media campaigns emphasizing the role mental health plays during the perinatal period, parent support groups for Black/African American and Spanish speaking families, behavioral health training for NICU providers, and linking prenatal care to opioid use disorder treatment programs.

Additional funding will allow more specialized programs to reach communities experiencing disparities in perinatal health outcome as well as greater knowledge and awareness of perinatal mental health throughout the state.

Around the state, providers are eager to integrate behavioral health into perinatal care. However, many perinatal providers lack knowledge about behavioral health resources, and behavioral health providers lack the skill set to address unique needs that arise during the perinatal period. This work is also following statewide efforts to integrate primary physical and behavioral health. Growing interest and readiness make this a prime period to launch public health campaigns and provider trainings to ensure more people utilize behavioral health resources during the perinatal period.

**Quitline**

Tobacco use remains the number one cause of preventable death in Washington, more than alcohol, suicide, illegal drugs, motor vehicles,

homicide, and AIDS combined. This results in over $2.8 billion in medical costs in our state each year. Individuals with serious mental illness or substance use disorder smoke at disproportionately high rates and represent a significant commercial tobacco[1]related health disparity. Life expectancy for people with severe mental disorders is decreased by 10 to 25 years due to smoking related illness. Treating tobacco use disorder with evidence-based cessation methods and implementing tobacco-free policies can help reduce this disparity.

A 2018 survey found that 31.6% of U.S. adults experiencing serious psychological distress smoked cigarettes, compared to a 13.0% prevalence among those not experiencing serious psychological distress. (National Health Interview Survey, 2018). Evidence shows that treating tobacco dependence improves mental health and recovery from addiction. Specific to opioid recovery, people who smoke have increased withdrawal, increased cravings, and lower detox completion, so addressing tobacco dependence is critical to successful recovery. Tobacco dependence treatment is associated with decreased anxiety, depression, and stress, and improvements in overall mood, regardless of psychiatric diagnosis. Additionally, tobacco dependence treatment during treatment for other substance use disorders increased likelihood of sobriety from alcohol and other drugs by 25% compared to standard care. Research finds that, as with the broader population, the vast majority of people with behavioral health conditions want to quit.

If implemented, this proposal to expand Quitline access will streamline access to, and increase utilization of, evidence-based tobacco cessation services, and significantly reduce health care expenditures. All Washingtonians who use tobacco will have the opportunity to call and speak with a qualified counselor, set up a quit plan, and be shipped [WDT(1)] nicotine replacement therapy (regardless of insurance status) to help curb their physical dependence on nicotine.

DOH seeks funding for Quitline services equivalent to $0.84 per adult smoker in Washington, which would be sufficient to both serve approximately 2,800 additional callers per year and increase the amount of nicotine replacement therapy available to callers. DOH also seeks 1.0 FTE to promote the requisite health systems changes for increasing Quitline reach, including healthcare provider outreach and training activities, as well as Quitline electronic referral program implementation. This position would also help ensure that program efforts are integrated into ongoing health care reform and behavioral health integration activities, including working with health plans to promote comprehensive coverage of tobacco cessation benefits, and overseeing communication strategy development and implementation for Quitline promotion. Last, DOH seeks $336,000 to develop messaging and communication strategies to effectively reach populations that are both disparately affected by commercial tobacco use disorder and less likely to use the Quitline and other quit support services.

Currently, Washington state's capacity for treating nicotine addiction remains among the lowest in the country. Tobacco-related death and disease continue to disproportionately impact underserved communities, including people with behavioral health conditions, people of color, and sexual and gender minorities. This is, in part, due to the ongoing lack of access to evidence-based, treatment-centered, and culturally appropriate resources for tobacco cessation in Washington State . Although there are numerous proven tobacco dependence treatments, there remains a patchwork of non-uniform and unequal insurance coverage for tobacco cessation in Washington. For example, health care providers are generally able to counsel and bill for tobacco cessation counseling for their privately insured patients, as well as to immediately prescribe nicotine dependence treatment medications at no cost to these privately insured patients. Meanwhile, Medicaid clients, who are twice as likely to smoke and who are significantly more likely to be from underserved communities, are typically referred for telephone counseling and they face barriers to accessing some FDA-approved medications. This represents a mismatch of need and intervention.

**Proposed Quitline expansion:**

**Increase in reach;** total reach: estimated 4,833 people accessing Quitline and nicotine replacement therapy

**Increase in NRT length;** Nicotine replacement therapy: up to 8 weeks of NRT

**BRFSS Random Child Module**

The impact of the pandemic on families in Washington will need to be measured to help best guide response and support services. The Behavioral Risk Factor Surveillance System (BRFSS) is a public health data collection tool, used widely for public health assessment and surveillance of chronic and emerging health issues. It depends on partnerships (including fiscal commitments) among DOH, state agencies, local health jurisdictions, and the CDC. While BRFSS is primarily an adult survey, the Random Child Selection module can be added to support collection of information about children in a household. This information allows for understanding the behavioral and physical health of adults,

and risks for their children.

2022 will be a particularly important year to collect the information through the Random Child Selection module. Data collected in conjunction with the module can be analyzed to provide a more robust assessment of the intersection between mental and physical health & well-being and the pandemic experience of families in Washington.

Specific areas of added value from collecting and analyzing information through the

Random Child Selection (RCS) module include:

Social determinants of health collected through a new CDC-funded module combined with the RCS module will open up analysis of the impact of these determinants on the well-being of individuals and their households.

Worker Health can be explored by looking at the health and behavioral health for individuals in households with and without children.

A Caregiver Module and other BRFSS question combined with the RCS will provide information about the "sandwich generation" – those who are caregivers for both children and adults/seniors.

New racial discrimination questions developed through collaboration by several Washington local health jurisdictions will be included on the 2022 BRFSS. Including the RCS module will allow further assessment of racism's multigenerational effects and the differential impact on those with and without children.

Additional focus areas include food insecurity and firearm safety. A firearm safety module implemented with the RCS would be funded by University of Washington/Haborview researchers. Previous analyses of similar data collected through BRFSS using the Random Child Selection module and the firearm safety module have been shared at national conferences and published in *JAMA Pediatrics*.

Because COVID-19 has had such a profound effect on the health of individuals and families across the state, 2022 is a critical year to include the Random Child Selection module add on survey. The physical health disparities and mental health crisis stemming from the pandemic will drive specific analyses, from those addressing the mental health, worker health, and food insecurity issues that have been documented during the pandemic, to the impacts on family caregivers and firearm safety that we are still seeking to better understand. Finding from these analyses can be used to guide policy decision-making and community recovery efforts.

**Behavioral Health Disaster Planning and Preparedness**

In addition to the community-based and community-led resiliency-building and safety net supports identified above, it is critical for behavioral health and equity to be integrated into future disaster response and recovery efforts. This infrastructural investment must occur prior to the next disaster to be effective.

During the COVID-19 pandemic response, we learned that input and subject matter expertise from the Behavioral Health Strike Team is essential for response operations. The team provided expertise for core products, including monthly impact forecast, incident management team situational reports, and behavioral health briefings to the legislature and public Although a strike team may be demobilized during non-response times, the department needs to continuously maintain the capacity and capability so it can quickly and effectively stand back up when needed. This includes resources to recruit, train, and exercise team members as well as resources to activate the team when needed.

Additionally, core coordination and planning work needs to be advanced for future behavioral health responses based on lessons learned from COVID-19. This includes development of DOH and state level plans, identification of partner roles and resources, coalition development, and a multitude of other preparedness and readiness activities. While organizations and staff are dedicated to these functions in the healthcare system, the same is not available for the behavioral health field. This proposal would include developing impact and capacity assessment systems across agencies, triage and referral processes, preparedness and response coalitions, and creation of response plans. An additional 1.0 FTE planner would help adequately resource and advance this work.

Finally, the state needs the ability to conduct statewide disaster behavioral health assessments to inform vulnerability, track capacity, identify

equity gaps, and build resiliency in its behavioral health disaster response functions. The team of 2.0 FTE would meet partner requests by developing Community Resilience Measures (syndromic and other), Regional Impact Situational Reports, Demographic-Focused Situational Reports (e.g., elderly), and Workforce Health Assessments. The core functions of this capability (e.g., (forecast, sitrep, metrics) have been established during the COVID-19 response through extensive internal and external partner engagement and field testing. However, DOH will not be able to use them in future incidents or for preparedness/resilience work without maintaining capacity. These functions are essential for future disaster behavioral health responses.

## Assumptions and Calculations

***Expansion, Reduction, Elimination or Alteration of a current program or service:***

Health Equity Zone investment

This activity is an expansion of the initial investment provided in ESSB 5092, which appropriated $703,000 General Fund State per fiscal year.

Birth Equity project expansion

This activity invests in the expansion of our existing birth equity project, by supporting 4 additional community-driven birth equity projects, with the majority of funding going directly to community-led solutions to disparities in maternal and child health. Current FFY21 budget is $873,578.

Perinatal behavioral health education and outreach supports

This activity supports investment in small community projects that increase the knowledge and skill of providers, patients, and families about behavioral health conditions during and after pregnancy, and the treatment and resources that are available for support. This will be all new work.

Quitline

Expands Quitline access will streamline access to, and increase utilization of, evidence-based tobacco cessation services, and significantly reduce health care expenditures. Current budget is $320,000 per fiscal year.

BRFSS Random Child Module

This temporarily expands the survey scope to learn more about COVID-19 health impacts.

Behavioral Health Disaster Planning and Preparedness

These are new activities.

***Detailed Assumptions and Calculations:***

See attached 2021-23 Q8 Behavioral Health Systems GAP FnCAL

***Workforce Assumptions:***

**Health Equity Zone investment**

$8,739/FY Fiscal Analyst 3 – 0.1 FTE: Salary and benefits. To process contracts and pay invoices to communities.

$609,000: community grants for the 3 zones to equitably address COVID recovery

**Birth Equity project expansion**

$108,552/FY Management Analyst 4 – 1 FTE: Salary and benefits. To lead and coordinate this project expansion.

$69,408/FY Epidemiologist 3 (non-medical) – 0.5 FTE: Salary and benefits. To review data and identify trends to stakeholders.

**Health Equity Zone investment**

$8,739/FY Fiscal Analyst 3 – 0.1 FTE: Salary and benefits. To process contracts and pay invoices to communities.

$609,000: community grants for the 3 zones to equitably address COVID recovery

**Birth Equity project expansion**

$108,552/FY Management Analyst 4 – 1 FTE: Salary and benefits. To lead and coordinate this project expansion.

$69,408/FY Epidemiologist 3 (non-medical) – 0.5 FTE: Salary and benefits. To review data and identify trends to stakeholders.

$9,525/FY Budget Analyst 3 – 0.10 FTE: Salary and benefits. To develop budget, monitoring and day-to-day financial tasks such as payroll, cost allocations, error checking and assisting program staff.

$8,739/FY Fiscal Analyst 3 – 0.1 FTE: Salary and benefits. To process contracts and pay invoices.

$14,530/FY WMS 02 – 0.10 FTE: Salary and benefits. Provide leadership and oversight of project.

$50,000 FY23 Contracts: work with a contractor to transition the Community Health Advisory Committee so that it is more reflective of local solutions and a broader constituency. In addition, to explore the most effective use of this body to inform the departments programs and policies. The department will to do this through a community-driven, inclusive process, in alignment with grant guidance and requirements and utilize a community engagement facilitator to ensure guiding principles are being met.

$800,000/FY Grants: supports culturally specific, evidence based or informed projects that enhance prenatal care and parent social support for communities experiencing the most extreme perinatal health disparities.

**Perinatal health supports**

$4,370/FY Fiscal Analyst 3 – 0.1 FTE: Salary and benefits. To process contracts and pay invoices.

$200,000/FY Grants: funds small community projects that increase knowledge and skill of providers, patients, and families about behavioral health conditions during and after pregnancy, and the treatment and resources that are available for support.

**Quitline**

$99,463/FY Health Services Consultant 3 – 1.0 FTE: Salary and benefits. To promote the requisite health systems changes for increasing Quitline reach, including healthcare provider outreach and training activities, as well as Quitline electronic referral program implementation.

$9,525/FY Budget Analyst 3 – 0.10 FTE: Salary and benefits. To develop budget, monitoring and day-to-day financial tasks such as payroll, cost allocations, error checking and assisting program staff.

$13.109/FY Fiscal Analyst 3 – 0.15 FTE: Salary and benefits. To process contracts and pay invoices.

$976,345/FY Grants: to develop messaging and communication strategies to effectively reach populations that are both disparately affected by commercial tobacco use disorder and less likely to use the Quitline and other quit support services. CDC best practices on recommended funding levels was consulted as a guide to calculate these costs.

**BRFSS**

$32,500 FY23: One-time survey to measure impact of the pandemic on families in Washington to help best guide response and support services.

**Disaster Planning and Preparedness**

$217,104/FY EMERGENCY MANAGEMENT PROGRAM SPECIALIST 3– 2.0 FTE: Salary and benefits. To fund staff who needed to train and exercise a behavioral health strike team as well as funding to activate a strike team prior to the arrival of federal funds that may become available.

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$108,552/FY EMERGENCY MANAGEMENT PROGRAM SPECIALIST 3 – 1.0 FTE: Salary and benefits. To fund staff who will develop: impact and capacity assessment systems across agencies; triage and referral processes; preparedness and response coalitions, and; behavioral health response plans

$108,552/FY EMERGENCY MANAGEMENT PROGRAM SPECIALIST 3 – 1.0 FTE: Salary and benefits. To fund staff who will conduct statewide disaster behavioral health assessments to inform vulnerability, track capacity, identify equity gaps, and build resiliency in its behavioral health disaster response functions

### *How is your proposal impacting equity in the state?*

Reduced health disparities [specific outcomes dependent on community] at local level. May be tracked using Washington Tracking Network Information by Location module

Increase in community resiliency and agency in funded communities.

Improved birth outcomes for Black and American Indian/Alaska Native populations, especially at funded community level.

Improved access to perinatal and postpartum behavioral health resources.

Improved trust between state agencies and local communities.

Improved understanding by local communities about how to access and understand statewide data systems, especially at the community level.

## Strategic and Performance Outcomes

***Strategic Framework:***

This work contributes to Goal 2.1 of the Governor's Results Washington by investing in community recovery and supporting the strategies and recommendations of the Poverty Reduction Workgroup. This work also contributes to Goal 2.2 by integrating behavioral health resources into the social safety net and investing in community solutions to recovery. This work is also aligned with Goal 5 by supporting inclusion and equity in service delivery.

This package strongly aligns with the three cornerstone values of innovation, equity and engagement which support the agency's strategic plan. Many of these strategies are innovative in their approach and are new to Washington State, have an equity focus especially connected to racial and ethnic disparities in health outcomes and require not only community engagement but community leadership.

***Performance Outcomes:***

Reduced health disparities [specific outcomes dependent on community] at local level. May be tracked using Washington Tracking Network Information by Location module

Increase in community resiliency and agency in funded communities.

Improved birth outcomes for Black and American Indian/Alaska Native populations, especially at funded community level.

Improved access to perinatal and postpartum behavioral health resources.

Improved trust between state agencies and local communities.

Improved understanding by local communities about how to access and understand statewide data systems, especially at the community level.

## Other Collateral Connections

***Puget Sound Recovery:***

N/A

***State Workforce Impacts:***

N/A

***Intergovernmental:***

This package aligns with the Governor's Poverty Reduction Workgroup's Blueprint for a Just and Equitable Future. It is part of a collective effort by many state agencies (DSHS, HCA, ESD, Commerce, SBTC and DOH) to invest in state and local strategies to reduce poverty and mitigate its impacts. There are close ties to local public health jurisdictions and Accountable Communities of Health. We are also asking tribal nations about how they would like to be involved in this work. Impacts to other state agencies are collaborative and have been discussed.

University of Washington/Harborview is committed to contributing $6,500 on top of this request for the BRFSS module.

***Legal or Administrative Mandates:***

N/A

***Stakeholder Response:***

We are building on existing efforts, including a widely stakeholder 10 year plan to reduce poverty in Washington State. Because of that, we anticipate broad support by stakeholders.

Accountable Communities of Health – anticipate support

Community based organizations – anticipate support, especially those involved in the Poverty Reduction Workgroup

Washington State Hospital Association [Birth Equity expansion] – anticipate support as this is an expansion on existing efforts.

***Changes from Current Law:***

N/A

***State Facilities Impacts:***

N/A

## IT Addendum

***Does this Decision Package include funding for any IT-related costs, including hardware, software, (including cloud-based services), contracts or IT staff?***

No

## Objects of Expenditure

| Objects of Expenditure<br>*Dollars in Thousands* | Fiscal Years | | Biennial | Fiscal Years | | Biennial |
|---|---|---|---|---|---|---|
| | 2022 | 2023 | 2021-23 | 2024 | 2025 | 2023-25 |
| Obj. A | $92 | $711 | **$803** | $696 | $696 | **$1,392** |
| Obj. B | $33 | $258 | **$291** | $253 | $253 | **$506** |
| Obj. C | $0 | $50 | **$50** | $0 | $0 | **$0** |
| Obj. E | $5 | $56 | **$61** | $57 | $57 | **$114** |
| Obj. J | $4 | $0 | **$4** | $0 | $0 | **$0** |
| Obj. N | $0 | $2,609 | **$2,609** | $2,576 | $2,576 | **$5,152** |
| Obj. T | $8 | $54 | **$62** | $53 | $53 | **$106** |

## Agency Contact Information

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