Washington State Health Care Authority

Report to the Legislature

Access to behavioral health services for children and youth

Engrossed Second Substitute Senate Bill 5432; Section 4002(1); Chapter 325; Laws of 2019

RCW 74.09.495

December 1, 2022

Acknowledgements

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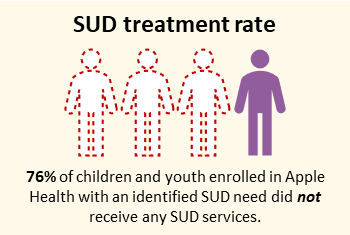
Executive summary

In accordance with RCW 74.09.495, Health Care Authority has reported on several metrics regarding access to behavioral health services for children and youth enrolled in Apple Health (Medicaid) in 2021.

Mental Health Services: approximately 1 in 3 children and youth enrolled in Apple Health who needed mental health services did not receive them, with young children less likely receive needed services. Even after a visit to the emergency department for mental health needs, 35 percent of these children and youth did not receive follow up care within seven days and 23 percent did not receive care within 30 days.



Substance Use Disorder Services: approximately 3 in 4 youth who needed Substance Use Disorder services did not receive them. Even after an SUD-related emergency department visit, 84 percent of youth did not receive follow-up services within seven days of their visit, and 77 percent did not receive care within 30 days.

Provider Availability: Data regarding the availability of providers was limited; however, reports from a variety of sources suggest that the availability of providers continues to be a key challenge in access to care. Data about the languages spoken by behavioral health providers serving children and youth was also limited, but the available data suggests that, in some settings, approximately 17 percent of clinical staff speak a language other than English, with the most commonly spoken language being Spanish.

Eating Disorders: Data regarding eating disorder diagnoses found that 6,331 children and youth (less than 1 percent of the total population) were diagnosed with an eating disorder. Data regarding eating disorders treatment settings and available providers was limited.

Differences across race and ethnicity: A number of differences across different racial and ethnic groups were seen in the different metrics included in this report. Many differences were small, and the significance of these differences is unknown, but understanding and addressing these differences is a critical component of HCA's commitment to health equity.

Looking forward: Health Care Authority is currently involved in several efforts to address barriers to access noted in this report and improve the system of care. In addition, HCA and partners are actively working on several projects that may result in more comprehensive data in future reports. Lastly, while the information included in this report included only a subset of the Washington state population (children and youth enrolled in Apple Health), the Children and Youth Behavioral Health Work Group's work to develop a strategic plan requires collection of data statewide regarding all aspects of the behavioral health system of care, from promotion to prevention, treatment, and recovery, and for all children, youth, young adults, and families. This data will provide a roadmap for developing longer term, system-wide strategies to ensure access to high-quality equitable care and supports.

Introduction

Background

Early and accurate recognition of behavioral health issues, coupled with appropriate and timely intervention, enhances health outcomes while minimizing overall expenditures. However, within the current system of care, families face barriers to receiving a full range of services for children experiencing behavioral health problems. Disparities also exist in the diagnosis and initiation of treatment services for children of color, with studies demonstrating that children of color are diagnosed and begin receiving early interventions at a later age.

To address these concerns, the legislature passed ESHB 2489 in 2016, which established the Children & Youth Behavioral Health Workgroup, to identify barriers to accessing behavioral health services for children and families, and to advise the legislature on statewide behavioral health services for this population.

In addition, the bill created a requirement for the state Medicaid agency to report annually on the status of access to behavioral health services for children (birth through age 17) enrolled in Apple Health (Medicaid), as Apple Health covers approximately half of all children within Washington[1]. At a minimum, this report must include the following components, which must also be broken down by age, gender, and race/ethnicity:

a) The percentage of discharges for patients ages 6 through 17 who had a visit to the emergency room with a primary diagnosis of mental health or substance use disorder during the measuring year, and who had a 30-day follow-up visit with any provider with the same primary diagnosis.
b) The percentage of children and youth with an identified behavioral health need who received behavioral health services during the reporting period.
c) The percentage of children and youth who received behavioral health services, including the types of services provided.
d) The number of children and youth behavioral health providers available in the previous year, the languages spoken by those providers, and the overall percentage of children's behavioral health providers who were actively accepting new patients.
e) Data related to mental health and medical services for eating disorder treatment in children and youth, including the number of: eating disorder diagnoses; patients treated in outpatient, residential, emergency, and inpatient care settings; and contracted providers specializing in eating disorder treatment and the overall percentage of those providers who were actively accepting new patients during the reporting period.

[1] Calculation created from the Office of Financial Management's population data and the Apple Health Client eligibility dashboard.

Organization of results

In accordance with this statute, Health Care Authority has provided the following report. Results are provided in four sections.

Section 1. Behavioral health services provided to children and youth

- the percentage of children and youth who received behavioral health services and the types of services provided

Section 2. Unmet need for behavioral health care for children and youth

- the percentage of children and youth with an identified behavioral health need who received behavioral health services during the reporting period
- the percentage of children and youth who received follow-up care after a visit to the emergency room for behavioral health needs

Section 3. Behavioral health provider workforce serving children and youth

- the number of children and youth mental health providers available; and the percentage of theses providers who were actively accepting new patients†
- the languages spoken by those providers†

Section 4. Eating disorder diagnosis, treatment, and workforce for children and youth

- the number of children and youth diagnosed with an eating disorder
- the percentage of children and youth with an eating disorder who received mental health and medical services in outpatient, residential, emergency, and inpatient care settings*
- the number of providers specializing in eating disorder treatment; and the percentage of theses providers who were actively accepting new patients*

Efforts to address access challenges: The results within this report highlight many challenges regarding access to behavioral health services for children and youth. Following the results, current and recent efforts to address these challenges are described.

Understanding this data

Data in this report comes from ProviderOne, Behavioral Health Data System (BHDS), the Integrated Client Database (ICDB), the Behavioral Health Provider Survey (BHPS), and Network Adequacy Reports submitted by managed care organizations. Due to the differences in data sources over time, data in this report may not be comparable to data reported in previous years. For all metrics, race/ethnicity data is reported inclusively, which means that children and youth may be identified in multiple racial/ethnic categories. For more information, please see Appendix A: Data Collection & Definitions.

†There are several limitations to the data provided in Section 3. Data about the percentage of providers accepting new clients is available only for providers contracted with managed care organizations, and the amount of variation in the data between managed care organizations suggests concerns with data quality. In addition, data about the languages spoken by providers is available only from a survey of behavioral health agencies, which had a response rate of approximately 35%.

*There are several limitations to the data provided in Section 4. Data about the settings in which children and youth with eating disorders receive care was not available, and there was very limited data about the number and availability of providers who specialize in eating disorder treatments.

Results

Section 1. Behavioral health services provided to children and youth

Background: In October 2021, the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), and the Children's Hospital Association (CHA) jointly declared a national emergency in child and adolescent mental health. Although comprehensive information about the prevalence of mental health conditions for children and youth is limited, a review of national behavioral health data by the Center for Disease Control and Prevention (CDC) suggested that as many as 1 in 5 children and youth may experience a mental health disorder every year (Bitsko et al., 2022), and data from the National Survey of Children's Health suggests that there have been significant increases in rates of mental health disorders for children and youth in recent years, especially following the onset of the COVID pandemic (Lebrun-Harris et al., 2022). Children and youth of color, LQBTQIA+ children and youth, children living in rural areas, and children and youth with intellectual and/or developmental disabilities may be at increased risk of mental health concerns due to systemic racism, sexism, homophobia, and other types of oppression and marginalization (see the U.S. Surgeon General's 2021 Advisory on the Youth Mental Health Crisis), and nearly 70 percent of youth in the juvenile justice system have a diagnosable behavioral health disorder (Vincent et al., 2008). Lastly, while attention to the mental health needs of infants, toddlers, and preschoolers has been more limited, recent research has shown that the prevalence of mental health concerns in young children is comparable to school-age children (Dougherty et al., 2018), and intervention at this stage may be especially effective, both in terms of health outcomes and cost (Oppenheim & Bartlett, 2022).

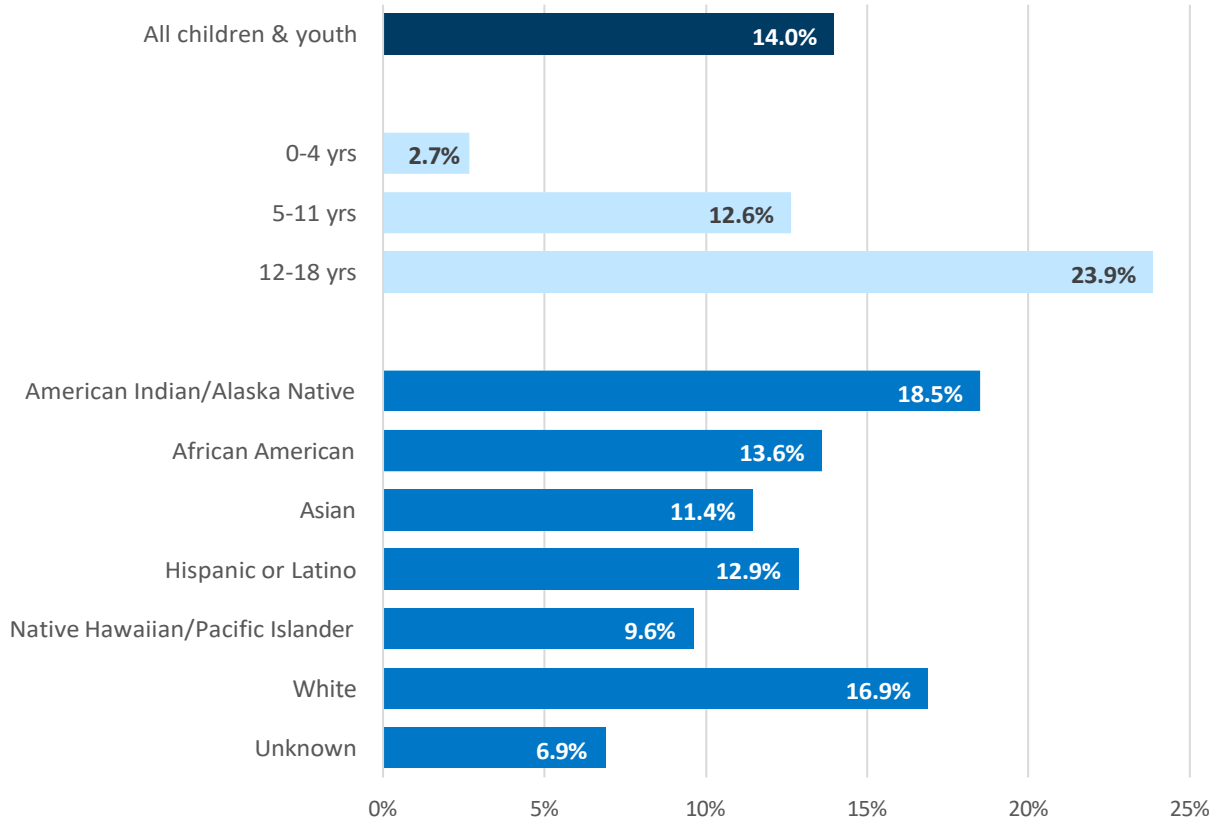
Washington is not exempt from this crisis of child and youth mental health; on March 26, 2021, Governor Jay Inslee issued an emergency proclamation regarding the Child and Youth Mental Health Crisis in Washington state, and in 2022, Mental Health America ranked Washington 40th in the nation for youth mental health. However, early diagnosis and appropriate services for children and their families can make a difference in the lives of children with mental disorders, especially when those services are family and youth driven, community-based, and culturally and linguistically appropriate (see the Systems of Care values).

Key results: In 2021, approximately 14 percent of children and youth (0 – 18 years) enrolled in Apple Health received any mental health and about 1 percent of youth (11-18 years) received Substance Use Disorder (SUD) services. In looking at demographic differences, a smaller proportion of young children (0-4 years) received mental health services than older children and youth. In addition, there was variation across racial/ethnic groups in the proportion of children and youth who received mental health services and SUD services.

Mental health services

In 2021, approximately 14 percent (n=126, 286) of children and youth (0-18 years) enrolled in Apple Health received mental health services. A smaller proportion of young children (0-4 years) received mental health services, while a greater proportion of youth (12-18 years) received services (see Figure 1). There was also variation across racial/ethnic groups in the proportion of children and youth who received mental health services (see Figure 1).

Figure 1. Percent of Medicaid Title XIX or CHIP eligible children and youth (0-18 years) who received any mental health treatment services in 2021, by age and race/ethnicity[2]



*Race/ethnicity data is reported inclusively: children and youth may be included in multiple racial/ethnic categories. A review of differences across racial/ethnic groups for all metrics in this report is available in Section 5.

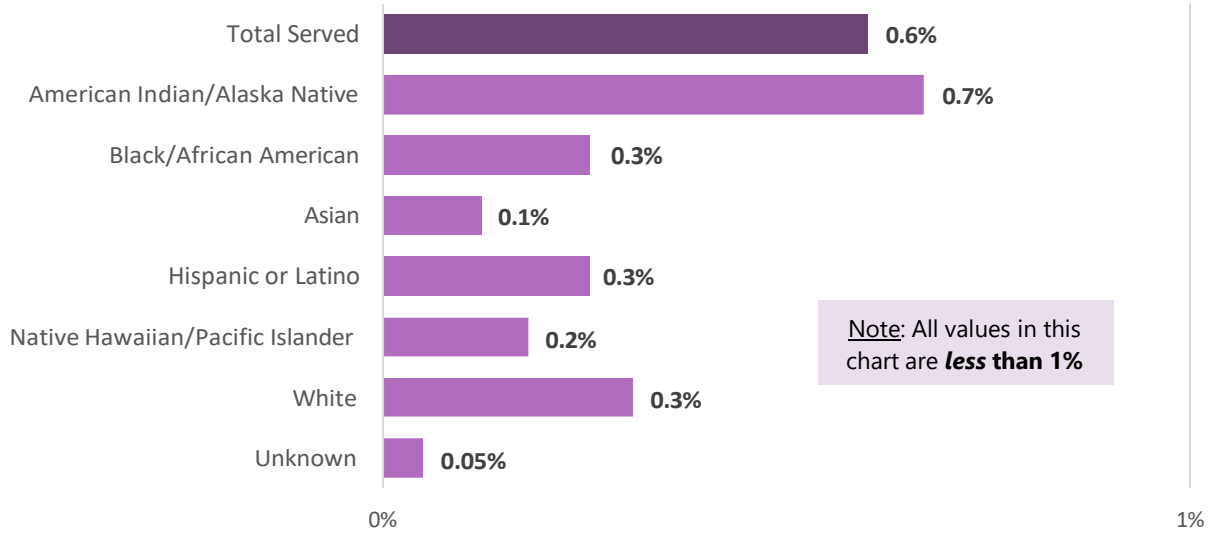
More information: More information about mental health services received by children and youth, including full demographic data and more information about the types of services received (outpatient, crisis, and/or inpatient services), is available in Appendix B: Additional Data Tables.

[2] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Substance use disorder (SUD) services

In 2021, fewer than 1 percent (n=2,183) of youth (11-18 years) enrolled in Apple Health received SUD services. There was some variation across racial/ethnic groups in the proportion of children and youth who received SUD services (see Figure 2).

Figure 2. Percent of Medicaid Title XIX or CHIP eligible youth (11-18 years) who received any SUD treatment services in 2021, by race/ethnicity[3]



*Race/ethnicity data is reported inclusively: children and youth may be included in multiple racial/ethnic categories. A review of differences across racial/ethnic groups for all metrics in this report is available in Section 5.

More information: More information about SUD services received by youth, including full demographic data and more information about the types of services received (outpatient, crisis, and/or inpatient services), is available in Appendix B: Additional Data Tables.

[3] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Section 2. Unmet need for behavioral health care for children and youth

Background: Nationally, about half of all children do not receive needed mental health services (Whitney & Peterson, 2019). While data regarding SUD treatment among youth specifically is more limited, a recent study of Medicaid-enrolled youth found even higher rates of unmet need among youth with substance use disorders, ranging from 82 percent to 91 percent (Clemens-Cope et al., 2021), potentially given the lack of coordination and knowledge of developmentally appropriate practices with SUD system of care (Sterling et al., 2010). In addition, children and youth of color are more likely to have unmet mental health needs (see the American Psychological Association's Guide for Practitioners on Addressing the Mental Health Needs of Racial and Ethnic Minority Youth), and young children are also more likely to have unmet mental health needs than older children and youth (Ghandour et al., 2020).

In the absence of a robust community behavioral health system, the emergency department (ED) can become the de facto provider of mental health services, particularly for youths in crisis. Nationally, the number of mental health related ED visits is on the rise (Kalb et al, 2019) and emergency departments around Washington have reported record high numbers of pediatric patients presenting in mental health crisis (see Seattle Children's Hospital 2022 Community Health Assessment). When youth do present in the ER for behavioral health concerns, timely follow-up care is critical to ensuring their health and safety; attendance at a follow-up mental health appointment within one week of discharge is associated with half the risk for suicide (Fontanella et al., 2020). However, national data suggests that about 60 percent of youth do not receive follow-up care within one week (see Medicaid's State Health System Performance dashboard), and follow-up rates may be even lower for youth with substance-use disorders (Huginin et al., 2022).

Key results: There were several areas with notable gaps with access to behavioral care for children and youth enrolled in Apple Health (Medicaid). Approximately a third of all children and youth (0-17 years) with an identified mental health need did not receive any mental health services, with young children (0-4 years) less likely to receive needed services; there were similar rates for follow-up care after a mental health-related ED visit. In addition, most youth (13-17 years) with identified SUD treatment need did not receive ***any*** SUD services, even after an SUD-related emergency department visit.

Understanding this data: In this report, identified needs are defined through health record information[4]. There may be many children and youth with a need for care that has not been documented by a health care provider. In addition, while this data highlights the percentage of children and youth who received no services, even children and youth who received services may *not* have received the appropriate intensity or quality of services[5].

[4] Specifically, the information in this report comes from claims data. Claims data is a type of health care data that comes from when providers and/or insurance companies submit information about services they have provided, in order to receive or substantiate payment. Claims data usually includes information about the service provided, as well as the health issue being addressed, in addition to other demographic data about the client and provider.

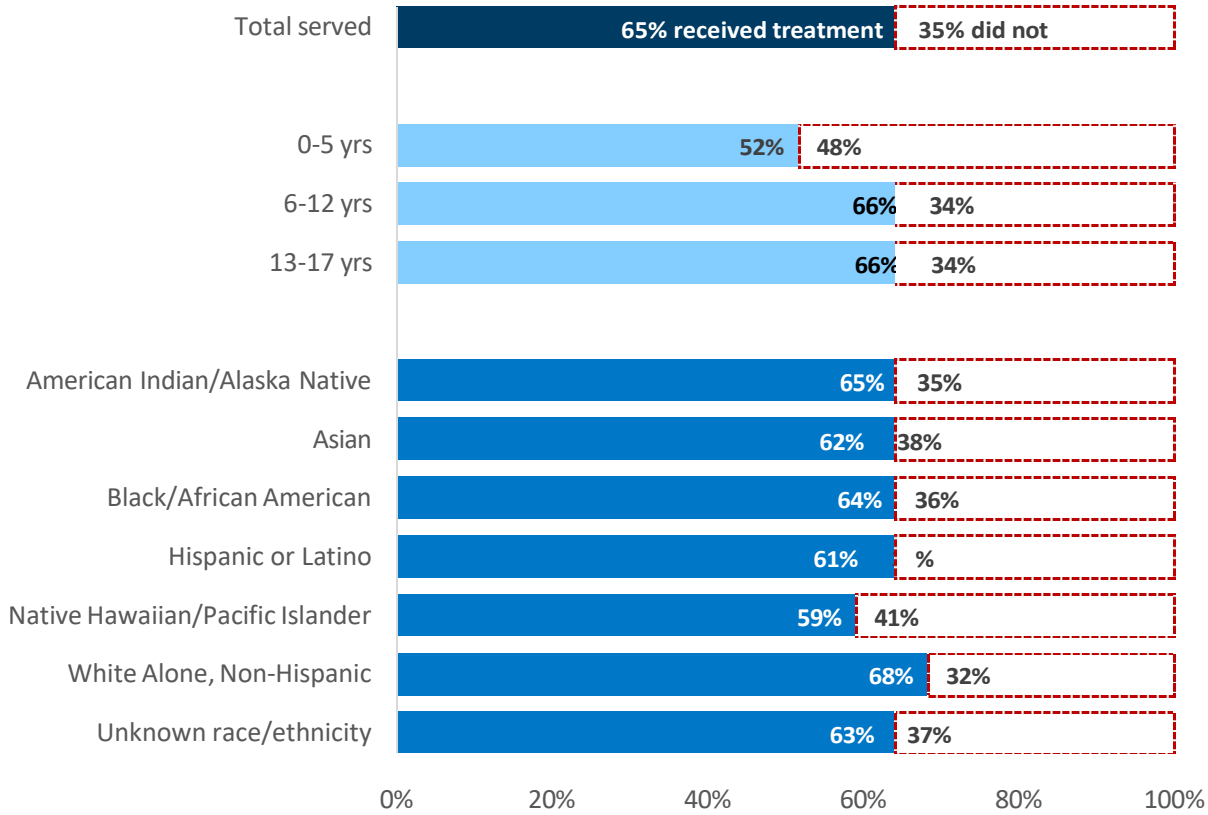
[5] For example, Mental Health America's The State of Mental Health in America in 2023 report found that while 42% of youth in Washington with Major Depressive Disorder received some sort of mental health treatment, only 31% received *consistent* treatment (defined as seven or more visits per year).

Unmet need for mental health care

During calendar years 2020 and 2021, 131,053 children and youth (0-17 years) enrolled in Apple Health (Medicaid) were identified as having a mental health treatment need, but 35 percent (n=45,955) did not receive any mental health services in 2021. In other words, approximately **1 in 3 children and youth** with an identified mental health need did not receive needed care.

Young children (0-5 years) were less likely to receive needed mental health care than older children and youth (6-17 years) (see Figure X). There was also some variation across racial/ethnic groups in the percentage of children and youth who did not receive needed mental health care (see Figure 3).

Figure 3. Mental health treatment rate for Apple Health enrolled children and youth (0-17 years) in CY 2021, by age and race/ethnicity[6]



*Race/ethnicity data is reported inclusively: children and youth may be included in multiple racial/ethnic categories. A review of differences across racial/ethnic groups for all metrics in this report is available in Section 5.

More information: More information about unmet need for mental health care among children and youth, including full demographic data, is available in Appendix B: Additional Data Tables.

[6] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Unmet need for timely mental health care after an emergency department visit

As noted above, ensuring that children and youth have access to needed mental health care after an emergency department (ED) visit is critical to their health, safety, and wellbeing. In 2021, 1,877 children and youth (6-17 years) enrolled in Apple Health (Medicaid) were seen within an emergency department setting for mental health disorder symptoms. **35 percent** of these children and youth did not receive follow up care within one week, and **23 percent** did not receive care within 30 days. Similarly to rates of unmet need for any mental health care, there was variation in rates of follow-up care across racial/ethnic groups (see Figure 4).

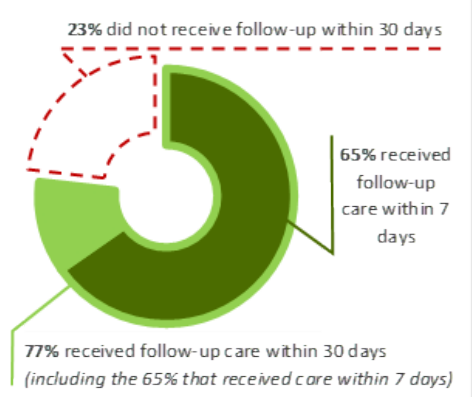
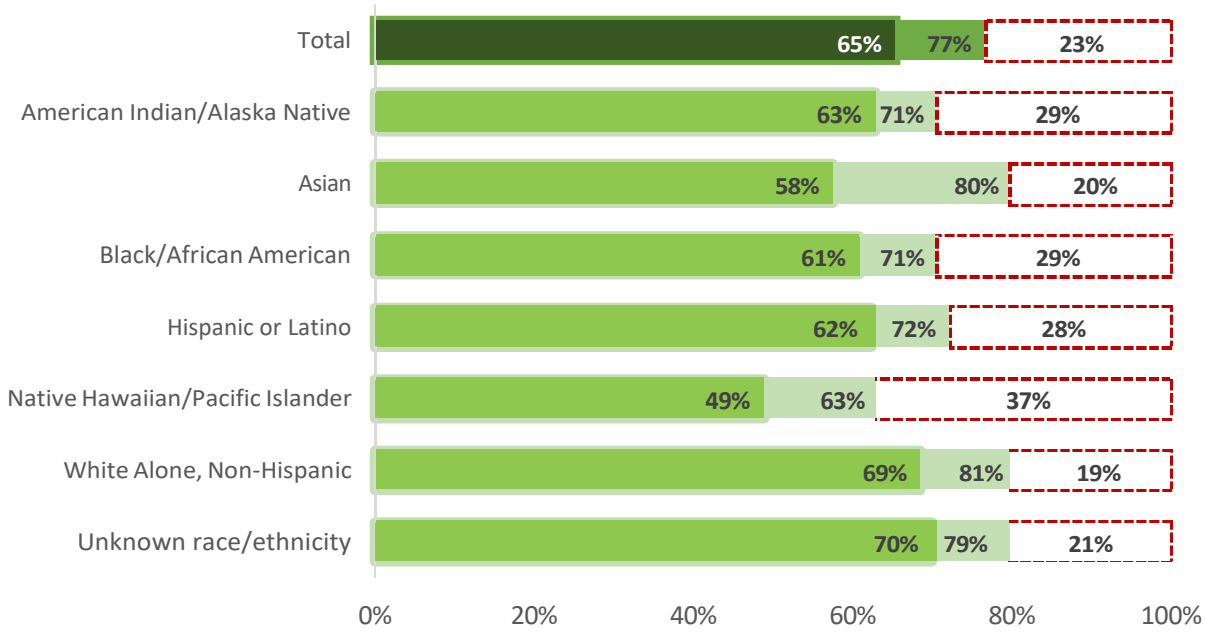


Figure 4. Mental Health emergency department follow-up rates within 7 days and 30 days for Apple Health enrolled children and youth (6-17 years) in CY 2021, by race/ethnicity[7]



*Race/ethnicity data is reported inclusively, which means that children and youth may be identified in multiple racial/ethnic categories.

More information: More information about unmet need for mental health care among children and youth, including full demographic data, is available in Appendix B: Additional Data Tables.

[7] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Unmet need for Substance Use Disorder (SUD) care

During 2020 and 2021, 5,041 youth (13-17 years) enrolled in Apple Health (Medicaid) were identified as having a Substance Use Disorder (SUD) health treatment need, but **76 percent** (n=1,213) did not receive any SUD services; in other words, approximately **3 in 4 youth** who were identified as having a SUD care need did not receive care. There was some variation across racial/ethnic groups in the percentage of youth who did not receive needed SUD care (see Figure 5).

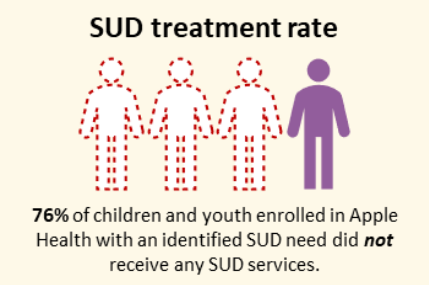
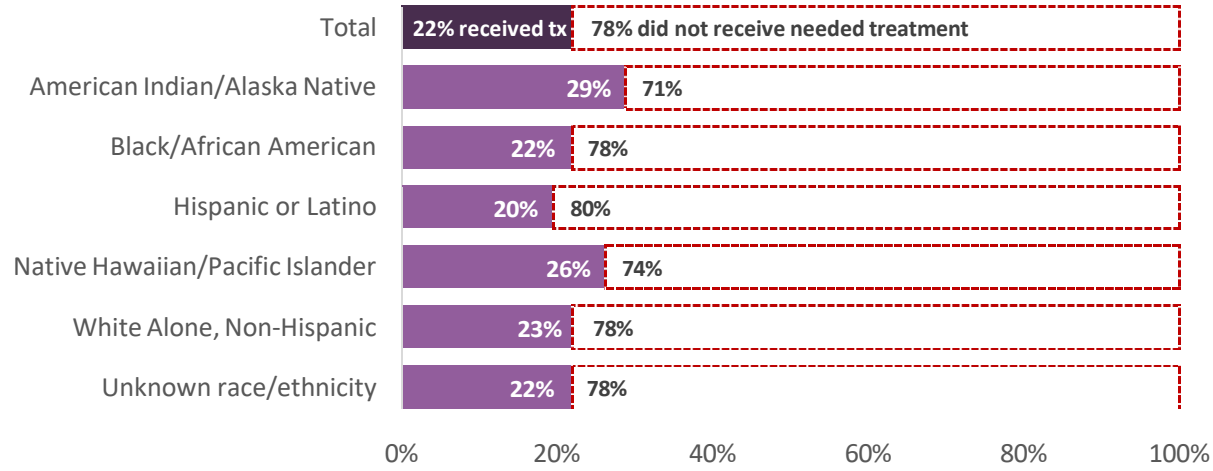


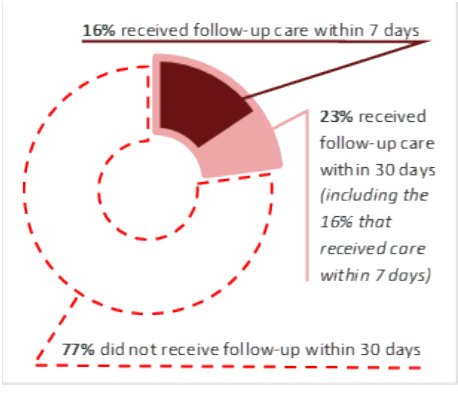
Figure 5. Substance use disorder treatment rates for Apple Health enrolled youth (13-17 years) in CY 2021, by race/ethnicity[8]



*Race/ethnicity data is reported inclusively: children and youth may be included in multiple racial/ethnic categories. Data for Asian youth are not available for this metric due to suppression requirements for small numbers. A review of differences across racial/ethnic groups for all metrics in this report is available in Section 5.

Unmet need for timely SUD care after an emergency department visit

In 2021, 353 youth (13-17 years) enrolled in Apple Health (Medicaid) were seen within an emergency department setting due to SUD symptoms**. 84 percent** of these youth did not receive follow-up services within one week of their ED visit, and **77 percent** did not receive care within 30 days. Because of the small numbers of youth who had SUD-related ED visits, it is difficult to compare rates of timely follow-up care across racial/ethnic groups.



More information: More information about unmet need for SUD care among youth, including full demographic data, is available in Appendix B: Additional Data Tables.

[8] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Section 3. Behavioral health provider workforce serving children and youth

Background: As noted above, there are considerable gaps in access to needed care for children and youth behavioral health needs, and the availability of the behavioral health workforce is one of the key factors in addressing access to care. Data from the Health Resources and Services Administration (HRSA) shows that over a third of Washingtonians live in areas with a shortage of mental health providers, and a survey by the Washington Council for Behavioral Health of licensed behavioral health agencies in Washington state found that, in 2021, over half of all agencies had to close or limit outpatient services due to workforce shortages.

Finding providers who can serve children and youth may be especially challenging: Washington state is categorized as facing a "severe shortage" of child and adolescent psychiatrists, and less than 1 percent of children in Washington attend school districts that meet the recommended ratio of students to school psychologists and counselors (see the National Center for Educational Statistics). A report from the Joint Legislative Audit and Review Committee (JLARC) found that the Mental Health Referral Service Line, a phone line staffed by Seattle Children's Hospital with a database of over 4,000 child- and youth- serving behavioral health providers, needed over three weeks on average to find an available provider for a family. Anecdotal reports from youth mental health providers in Washington indicate that providers are closing, not accepting new clients, or running with months-long waitlists (see Seattle Children's Hospital 2022 Community Health Assessment), and interviews with youth and families reveal that shortages of providers in specialty areas such as youth substance use disorder and infant-early childhood mental health services exacerbate already existing inequities in accessing care.

A shortage of providers who can deliver culturally and linguistically appropriate services is a key concern to improving access to care, especially given the rising percentage of Washingtonians who speak a language other than English; the most recent census data shows that approximately 20 percent of children in Washington speak a language other than English, with about 10 percent speaking Spanish. Individuals who speak English less than very well are more likely to experience delays in treatment, inadequate care, and misdiagnosis (Ohtani et al., 2015). While recent national data suggests that most mental health facilities do provide services in languages other than English, about half of those facilities use interpreters, rather than bi- or multi-lingual clinical staff (Loho & Rosenheck, 2021). Although interpretation services can support families in accessing care[9], linguistic match between providers and clients further improves access to and also increases the effectiveness of behavioral health services (Marquine & Jimenez, 2021, Griner & Smith, 2006).

Key results: Data regarding the availability of behavioral health providers who serve youth and children was limited. The data about the languages spoken by behavioral health providers serving children and youth suggests that, in some settings, approximately 17 percent of clinical staff speak a language other than English, with the most spoken language being Spanish. HCA continues to work with managed care organizations (MCOs) to monitor and understand what data they collect from behavioral health providers. This information may be used to update future network adequacy reporting standards and result in more complete data in future years.

[9] In line with 42 C.F.R. § 438.10(c)(4)), Apple Health (Medicaid) providers are required to make available interpreter services and translated written materials for clients with a primary language other than English. Learn more on HCA's Interpreter Services webpage.

Availability of behavioral health providers

Understanding this data: HCA collects information about the availability of child- and youth- serving individual mental health providers and Substance Use Disorder (SUD) agencies/facilities contracted with managed care organizations (MCOs).

This data is reported prospectively by providers to the managed care organizations, who then share this information with HCA on a quarterly basis. The variation in the number and availability of providers, mental health providers specifically, reported by the different MCOs and in different quarters suggests inconsistencies in data collection, validation, and reporting. HCA and MCOs are actively engaged in efforts regarding data quality improvement for these metrics, and reports in future years may include more reliable information.

HCA does not collect this level of information from providers who are contracted to provide services to children and youth enrolled in Apple Health without a managed care plan (sometimes known as fee-for-service)[10]. The information provided below only includes mental health providers contracted through managed care.

Mental health disorder providers

In 2021, data from managed care organizations (MCOs) regarding the number and availability of contracted individual child- and youth- serving mental health providers demonstrated strong variability, which suggests inaccuracies and/or inconsistencies in how this data was collected and validated. Due to these concerns, HCA is not including this data in this report. HCA and MCOs are actively engaged in efforts regarding data quality improvement for this metric, and reports in future years should include more reliable information.

Substance Use Disorder (SUD) providers

In 2021, managed care organizations (MCOs) reported that they contracted with varying numbers of youth-serving substance use disorder (SUD) agencies/facilities across quarters (see Table 1 on the following page). Most MCOs reported contracting with around 65-125 different youth-serving SUD agencies/facilities each quarter, with some variation across MCOs and quarters.

[10] While 95% of all children and youth enrolled in Apple Health are enrolled in managed care, almost half of all children enrolled in Apple Health without managed care are American Indian/Alaska Native and over a third are Latine/Hispanic (see the Apple Health Client Eligibility Dashboard); understanding access to care for the fee-for-service population is a critical component of HCA's commitment to health equity.

Table 1. Range of number of contracted individual child- and youth- serving SUD agencies/facilities across quarters by Managed Care Plan (MCO), in 2021[11]

Managed Care Organization	Number of agencies/facilities
Amerigroup Washington	83 – 89
Coordinated Care of Washington	99 – 124
Coordinated Care of Washington – Integrated Foster Care	99 – 124
Community Health Plan of Washington	106 - 117
Molina Healthcare of Washington	82 – 95
UnitedHealthcare Community Plan	66 – 68

MCOs reported extremely high rates of new client acceptance for these facilities, with almost all MCOs reporting that 100 percent of youth-serving facilities were accepting new clients every quarter (see Table 2). As noted in the previous section, given the many sources reporting difficulty in finding child- and youth-serving providers, the accuracy of this data is unclear.

Table 2. Range of percentage of contracted individual child- and youth- serving SUD agencies/facilities who were accepting new clients across quarters by Managed Care Plan (MCO), in 2021[12]

Managed Care Organization	Percentage of agencies/facilities
Amerigroup Washington	98% – 100%
Coordinated Care of Washington	100%
Coordinated Care of Washington – Integrated Foster Care	100%
Community Health Plan of Washington	100%
Molina Healthcare of Washington	100%
UnitedHealthcare Community Plan	100%

More information: More detail about the availability of SUD facilities who serve youth is available in Appendix B: Additional Data Tables.

[11] See above

[12] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Language(s) spoken by behavioral health providers serving children and youth

Understanding this data: Systematic information about the languages spoken by behavioral health care providers serving children and youth is not collected by HCA. However, some information about the languages spoken by behavioral health providers is collected through the Behavioral Health Provider Survey (BHPS), which is sent to all publicly funded behavioral health agencies licensed through Washington's Department of Health. The 2020/2021 survey had a response rate of only 35%, which means that most behavioral health agencies are ***not*** represented in the data below. Behavioral health agencies reported on the languages spoken by all staff, and so while the results provided below are specific to agencies who serve children and youth, they are not necessarily representative of the individual providers who serve children and youth.

In addition, because this survey is only sent to behavioral health agencies, this section does not include information about the languages spoken by behavioral health providers who practice outside of licensed behavioral health agencies (i.e., in private practice, primary care settings, etc.).[13]

HCA continues to work with managed care organizations (MCOs) to understand what data they collect from behavioral health providers regarding linguistic diversity. This information may be used to update future network adequacy reporting standards and result in more complete data in future years.

In 2021, behavioral health agencies who served children and youth reported that approximately **17 percent** of their clinical staff were bilingual or multi-lingual and able to provide services in a non-English language[14].

17 percent of clinical staff were reported to be bi- or multi-lingual.

Spanish was the most common language spoken by clinical staff at these agencies, representing 10 percent of staff. Other commonly spoken languages among staff were Chinese (1.4%), Korean (0.6%), Vietnamese (0.6%), American Sign Language (0.4%), and Tagalog (0.4%).

More information: Additional information about the number and percent of staff who spoke languages other than English is available in the full report: Languages spoken at behavioral health agencies serving children and youth in Washington state.

[13] An HCA analysis found that, in 2019, almost twice as many children received behavioral health services within primary care settings (7%) than in behavioral health agency settings (4%), with some variation across regions, age, and racial/ethnic groups. Understanding culturally and linguistically appropriate mental health services in all service settings is a critical component of HCA's commitment to integrated care.

[14] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Section 4. Eating disorder diagnosis, treatment, and providers

Background: With a mortality rate higher than any mental illness other than the substance use disorders, eating disorders are a significant public health problem (Derenne & Lock, 2016). The average age of onset for eating disorders is 12- to 13-years-old, with eating disorder specialists reporting an increase in the diagnosis of children, some as young as five or six (Mental Health America). While information on the prevalence of eating disorders is limited, data from National Comorbidity Survey Adolescent Supplement (NCS-A), suggests that the prevalence among U.S. adolescents aged 13 to 18 years is roughly 3 percent (Merikangas et al., 2010). Although previously mischaracterized as diseases of non-Hispanic white, affluent adolescent girls, eating disorder behaviors are increasingly recognized across all racial and ethnic groups, in lower socioeconomic classes, preadolescent children, males, and LGBTQIA+ youth. However, diagnosis and care may be delayed for certain groups due to the misperceptions still held by some health care providers (Hornberger et al., 2021).

The treatment of eating disorders is multidisciplinary, often long-term, and may require expensive, high-level care, such as inpatient stabilization or residential or partial hospitalization programs. In addition, many outpatient providers may not have the expertise needed to provide quality treatment (Hornberger et al., 2021). However, there is strong evidence to suggest the efficacy of family-focused, developmentally appropriate and multidisciplinary approach to care for children and youth with eating disorders (Mairs & Nichols, 2016), and when treatment is provided, youth have greater success in recovery from eating disorders than their adult counterparts, with overall recovery rates of approximately 70 percent (Hornberger et al., 2021.

Key results: During 2020 and 2021, 6,331 children and youth (0-20 years) enrolled in Apple Health (Medicaid) were diagnosed with an eating disorder. Female children and youth, White children and youth, and older youth and young adults (13-20 years) had higher rates of eating disorder diagnoses.

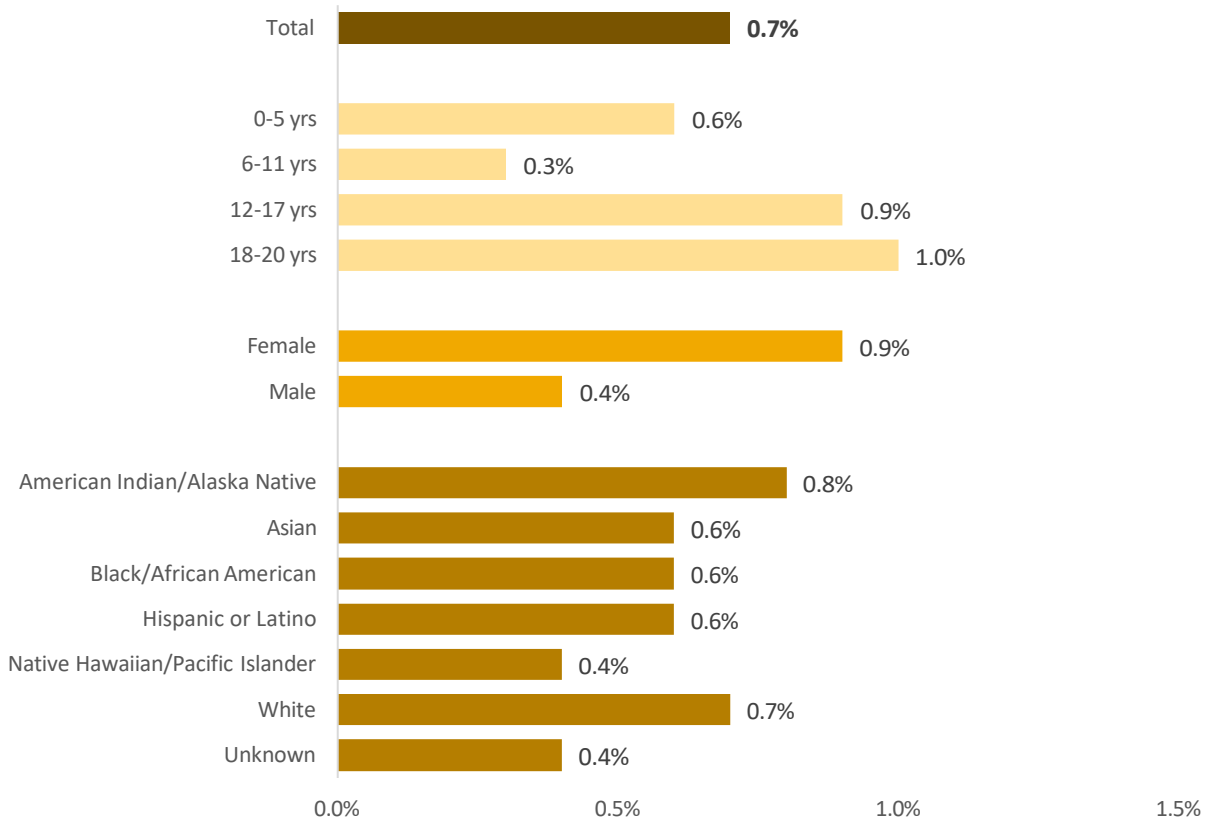
Other information about eating disorder treatment settings and specialized providers was limited. However, HCA is currently partnering with the Research and Data Analysis (RDA) team at Department of Social and Health Services (DSHS) to conduct a descriptive study of youth enrolled in Apple Health with eating disorders, which may provide additional information on this topic in future years.

Eating disorder diagnoses

During 2020 and 2021, 6,331 children and youth (0-20 years) enrolled in Apple Health (Medicaid) were diagnosed with an eating disorder[15], representing less than 1 percent (0.7%) of all Apple Health children and youth. A higher proportion of female children and youth, as well as youth and young adults (12- 20 years) were diagnosed with an eating disorder (see Figure 6). In addition, there was some variation across racial/ethnic groups in the percentage of children and youth who were diagnosed with an eating disorder (see Figure 6).

[15] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Figure 6. Prevalence of eating disorder diagnoses among Apple Health enrolled children and youth (0-20 years) in CY 2020-2021 by age, gender, and race/ethnicity[16]



*Race/ethnicity data is reported inclusively: children and youth may be included in multiple racial/ethnic categories. A review of differences across racial/ethnic groups for all metrics in this report is available in Section 5.

Eating disorder treatment services

Children and youth with eating disorder diagnoses may receive a mixture of emergency, inpatient, and outpatient services, and may receive these services in both behavioral health and physical health settings; the complexity of the mixture of care makes analysis of this data challenging. At this time, HCA cannot report on the number of Apple Health children and youth who receive eating disorder treatment by care setting. However, HCA is currently partnering with the Research and Data Analysis (RDA) team at Department of Social and Health Services (DSHS) to conduct a descriptive research study regarding Apple Health (Medicaid) youth with eating disorders. The study will include an overview of demographic characteristics of these youth, as well as their utilization of different services, which may result in the availability of additional information on this topic future years.

[16] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Providers specializing in eating disorder treatment

Eating disorder treatment is provided by a variety of provider types across behavioral and physical health care, including behavioral health specialists, inpatient hospital, and primary care providers. Nationally, there is no specific taxonomy or provider type that captures eating disorder treatment specialty, and HCA does not collect additional systemic data across all provider types to capture this. HCA does actively monitor cases in which children and youth enrolled in Apple Health need access to eating disorder treatment services, and information gathered through this monitoring process suggests that there are some specialty providers in Washington state who can provide inpatient, outpatient and/or residential eating disorder care to children and youth enrolled in Apple Health. At this time, however, HCA cannot report on these providers' availability to accept new patients. The research study noted above may provide additional information on this topic in future years.

More information: Further information regarding eating disorder diagnoses by age, gender, and race is available in Appendix B: Additional Data Tables.

Section 5. Differences across race/ethnicity in access to behavioral health care

Almost half of all children in Washington state are children of color, and this proportion is growing. Studies have shown that prevalence of and access to care for behavioral health conditions varies across racial and ethnic groups. Due to the overarching and complicated impacts of racism and systemic oppression, the types of disparities observed vary by service type, setting, data set, and how race and ethnicity are categorized (Alegria et al., 2011; Marrast et al., 2016; Rogers et al., 2021). For example, compared with White youth, Black and African American youth are less likely to use any type of mental health service, but African American youth are more likely to visit emergency departments for behavioral health related needs than White youth (Lu et al., 2021). In another example, Asian American youth are less likely be referred to or use school-based behavioral health services than Black and Latine/Hispanic youth, and among Asian American subgroups, Cambodian youth were particularly less likely to receive school-based mental health services (Lu et al., 2021). These are just a few examples of the disparate effects of systemic racism on access to behavioral health care among children and youth.

Given the importance of understanding racial equity issues in access to behavioral health care, this report included racial-ethnic breakdowns of all key metrics. Race and ethnicity were reported inclusively, which means that children and youth could be categorized in multiple racial/ethnic groups. Like existing research, this report found varying patterns of access to care across racial and ethnic groups. Results across all metrics in this report are summarized below:

- **American Indian/Alaska Native children and youth** had higher rates of mental health and Substance Use Disorder (SUD) service usage and lower rates of unmet need for SUD care. American Indian/Alaska Native children and youth also had higher rates of eating disorder diagnosis.
- **Asian children and youth** had higher rates of unmet need for follow-up care 7 days after a mental health-related emergency department (ED) visit but had lower rates of unmet need 30 days after the visit. Asian youth also had lower rates of SUD service usage.
- **Black/African American children and youth** were relatively close to the average for most metrics.
- **Native Hawaiian and Pacific Islander children and youth** had higher rates of unmet need for mental health care in general and after ED visits, but they had lower rates of unmet need for SUD care. Native Hawaiian and Pacific Islander children and youth also had lower rates of eating disorder diagnosis.
- **White children and youth** had higher rates of mental health service usage and lower rates of unmet need for mental health care in general and after ED visits. White children and youth also had higher rates of eating disorder diagnosis.
- **Children and youth for whom no race or ethnicity data was available** had lower rates of both mental health and SUD service usage. These children and youth also had lower rates of eating disorder diagnosis.

While this information paints a complicated picture, it is important to remember that many of the differences between racial/ethnic groups were small, and the significance of these differences is unknown.

Efforts to improve access to behavioral health care

As noted throughout the report, there are striking gaps in access to behavioral health care for children and youth enrolled in Apple Health, with disparities particularly around Substance Use Disorder (SUD) care for youth, and mental health care for young children. Health Care Authority has been involved in several efforts to address these gaps and improve access. Many of these initiatives were created through the advocacy of the Children & Youth Behavioral Health Workgroup, and several are funded through the Systems of Care initiative[17] and/or the Substance Abuse Block Grant. Several of these initiatives are guided by involvement and leadership from the community, and center the importance of diversity, equity, and inclusion in their approach and outcomes, with a goal of addressing disparities in access.

Improving access to behavioral health care for youth in crisis

As noted in the report, over 2,000 children and youth enrolled in Apple Health visited the emergency department (ED) for behavioral health needs in 2021, but many of those youth did not receive critical follow-up care. Importantly, research has shown the effectiveness of youth mobile crisis teams in reducing the number of behavioral health related ED visits among youth (Fendrich et al., 2019). In 2021, Washington state legislature passed E2SHB 1477 to establish call center hubs for those calling 988 and form a Crisis Response Improvement Strategy Committee (CRIS) to assess the current crisis system and make recommendations moving forward. In 2022, only 4 out of 10 regions had youth mobile crisis response teams. HCA is working to establish at least one youth crisis team in each region, with the goal that all youth have access to Mobile Response and Stabilization (MRSS) services, regardless of insurance coverage, and can receive crisis services for up to eight weeks. By implementing this model, teams can identify youth in need early, divert families from the emergency department and law enforcement, connect families to service providers through warm handoffs, and keep kids safe in their home, school, and community. For more information, watch this recorded presentation or contact Sherry Wylie, Mobile Crisis Team Administrator for Youth, Young Adults and Families.

Improving access to mental health care for young children and families

As noted in the report, young children (0-5 years) have higher rates of unmet mental health needs than older children and youth. Following legislation passed in 2021 [2SHB 1325], HCA has implemented a set of policies designed to support developmentally appropriate mental health assessments for these children, as assessment is a key step in the process of accessing care. These policies, collectively referred to as Mental Health Assessments for Young Children (MHAYC), included changes to reimbursement that allow providers to better serve infants and young children, as well as funding for professional development opportunities that will build the workforce's capacity to provide these specialized services. Through the work of the Infant-Early Childhood Mental Health Workforce Collaborative (IECMH-WC), over 275 mental health clinicians have received training in the DC:0-5™, a diagnostic system for mental health conditions in children younger than six. Additional trainings and supports are planned for 2023, with a special focus on including culturally and linguistically appropriate services. The IECMH-WC has also hosted a Training of Trainers to create a more racially and linguistically diverse trainer pool. For more information, please visit the Infant-Early Childhood Mental Health webpage or contact Kiki Fabian.

[17] Systems of Care projects are funded by a Substance Abuse and Mental Health (SAMHSA) grant (SM063581)

Improving access to Substance Use Disorder (SUD) services for youth

As noted in the report, the majority of youth with an identified SUD need did not receive any services, even after an SUD-related emergency department visit. Three key efforts are helping to create a stronger system of supports for these youth.

SUD family education

Advocacy and stakeholdering efforts by the Washington Recovery Alliance resulted in support for work and partnership through Health Care Authority, Washington State Community Connectors (WSCC), En Route, and other partners to develop the SUD Family Navigator training, with the goal of educating families about Substance Use Disorders (SUD) and related treatment options across the state. Trainers with lived experience partner with individuals with clinical expertise to deliver the content, which covers up-to-date information around SUD, addiction and its effects on the adolescent brain, skills for families navigating their relationship with someone with SUD, and systems navigation. For more information, please visit the WSCC's webpage or contact Amy Dura, Youth & Young Adult Co-occurring Treatment Program Manager.

SUD family navigator program

In addition, HCA supports SUD Family Navigator Programs in six sites across the state, including Peer Washington, Multicultural Child and Family Hope Center, and Clark County Recovery Café. SUD Family Navigators support parents, partners, and other adult family members of individuals experiencing SUD related challenges through assistance with navigating the system of care, supporting their loved one, and managing their own health and wellbeing. SUD Family Navigators serve families and individuals in a culturally responsive and person-centered manner, building relationships with traditionally underserved communities/populations while addressing Diversity, Equity, and Inclusion (DEI) as it pertains to each individual. Navigators are certified as peers, trained to offer one-to-one peer coaching, socialization, peer group support, educational groups, employment support, supportive housing, resource linkage, referrals to community supports, and other activities within their scope and expertise. For more information, please contact Amy Dura, Youth & Young Adult Co-occurring Treatment Program Manager.

Reimagining Access

During the summer of 2022, Health Care Authority (HCA) partnered with Do Big Good, a human-centered design consulting firm, for the Reimaging Access project. This effort was a co-design project with youth, young adults (YYA) and community partners to identify barriers and challenges related to accessing Substance Use Disorder (SUD) treatment for young people and their families. Do Big Good produced a report that outlines the co-design process, outcomes and recommendations from the young people who were part of the project. It's more important than ever that system partners listen to YYA with lived experience from diverse cultural backgrounds to reimagine access to care that is easily accessible, looks like help to young people and meets their needs. HCA hopes to continue this co-design project, to inform policy for services and supports and to transform care for young people and families. For more information, please read the report or contact Amanda Lewis.

Other efforts to improve access to behavioral health services for children, youth, and families

As noted in the report, there are several areas with notable gaps with access to behavioral care for children and youth enrolled in Apple Health (Medicaid), across both mental health and Substance Use Disorder (SUD) services, impacting children and youth of all ages, genders, and racial/ethnic identities. HCA and its partners are currently involved in several efforts to create a system of care that can more fully meet the needs of children, youth, and their families.

Regional youth behavioral health navigators

Behavioral health needs come in many forms, and most do not fit neatly into a categorical service box. No single entity or system owns full responsibility for all behavioral health needs and a single entity or system is not, on its own, sufficiently leveraged to address the multi-factored complexities necessary for a healthy system. The Regional Youth Behavioral Health Navigators project is an initiative to stand up community-wide teams that convene to support the children youth and families in their regions, to build an access portal for individuals concerned about a child or youth to reach out and request support, and to convene multi-system and multi-disciplinary teams, pulling partners from the regional teams who have potential assets that can support the child and family in accessing what they are seeking, and/or to develop a plan of stability while the resource options get worked out. Health Care Authority (HCA) is currently partnering with Kids' Mental Health Pierce County and the Department of Developmental Administration (DDA) to stand up three regions per year for the next three years, with work currently underway in the Greater Columbia, Salish, and Southwest regions. For more information, please contact Diana Cockrell.

Mental Health Referral Service Line (MHRS)

While network adequacy data from managed care organizations suggests that provider availability for children and youth behavioral health services is high, additional reports and sources demonstrate that connecting children and youth to available providers remains a challenge (see Background in Section 2 of this report). Washington's Mental Health Referral Service for Children and Teens (MHRS), administered by Seattle Children's Hospital, connects children, youth, and families with evidence-supported outpatient mental health services in their community. Through a telephone-based referral service, families are supported in accessing mental health services for their children and youth through individualized navigation support. Information on the families' needs, location, and insurance plan are used to identify providers in their community who are currently accepting new patients and paneled with the family's insurance. The MHRS team is also working specifically to add black, indigenous, and people of color (BIPOC) providers, as well as providers who speak languages other than English to their database, in order to connect families to culturally appropriate care. During State Fiscal Year 2022 (SFY22), MHRS received 3,544 requests, with 1,230 calls from families with Apple Health (Medicaid) coverage. For more information, please review the 2022 legislative report, visit their webpage or contact Christine Cole.

New Journeys: Coordinated specialty care for first episode psychosis (FEP)

Among the many youth noted in this report with an identified need for mental health care, it is estimated that at least 2,000 will experience first episode psychosis (FEP). Research indicates that models like New Journeys, a coordinated specialty care model developed in partnership with the University of Washington (UW) and Washington State University (WSU), offer hope and real help to young people and their families during one of the most vulnerable times of their life. Following legislation passed in 2019 [2SSB 5903], Health Care Authority has implemented a comprehensive Apple Health (Medicaid) funding structure for New Journeys, which became effective in July 2022. So far, seventeen New Journeys teams have been established in nine regions of the state, with ongoing work to expand the number of teams available. Lastly, the New Journeys network is partnering with others to develop models specifically for rural and American Indian/Alaska Native communities, with the goal of increasing equitable access care. For more information, please review the 2022 legislative report, visit their website, or contact Becky Daughtry.

Managed Care performance improvement project

As noted in the report, managed care organizations (MCOs) play an important role in supporting children and youth's access to behavioral health care. HCA has prioritized increasing behavioral health access for children and youth in Washington state and has been working with the (MCOs) through performance improvement projects (PIP) to decrease the care gap, especially for children and youth from Black, Indigenous and People of Color (BIPOC) communities. The multi-MCO collaborative PIP is partnering with primary care providers to identify BIPOC children and youth who may have an unmet need and to coordinate on-going resources and care. In addition, the MCO collaborative is engaging behavioral health providers in a survey to continue to learn more about care barriers and access issues to formulate future interventions. For more information, please contact the HCA Managed Care Programs mailbox.

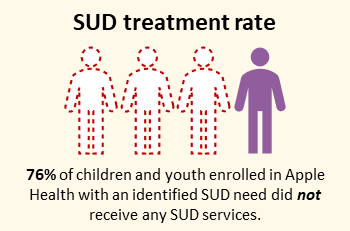
Managed Care performance oversight

HCA has been increasing collaboration with and across MCOs as well as oversight of MCOs to ensure strong coordination of access to behavioral health services. MCOs actively partner with each other and the HCA to support improved cohesiveness across the Apple Health system in messaging and expectations for the provider network in order to better support continuity of care for clients. HCA requires MCOs to provide information on outreach and engagement activities for care coordination, service initiation, and appointment follow ups, such as through the quarterly Children's Mental Health Report and Multi-System Clinical Rounds. HCA continues with a Difficult to Discharge process in which the MCOs report efforts to assist individuals with discharge from inpatient settings and connection to services. Additionally, HCA has developed system partner connections with agencies to facilitate connection to MCO care coordination for MCO assistance in accessing behavioral health services. Examples include linkage with Developmental Disabilities Administration (DDA), Department of Children, Youth and Families (DCYF), Home and Community Services (HCS), and the Children and Youth with Special Health Care Needs (CYSHCN) network. For more information, please contact the HCA Managed Care Programs mailbox.

Conclusion

In accordance with RCW 74.09.495, Health Care Authority has reported on several metrics regarding access to behavioral health services for children and youth enrolled in Apple Health (Medicaid) in 2021.

Mental Health Services: approximately 1 in 3 children and youth enrolled in Apple Health who needed mental health services did not receive them, with young children less likely receive needed services. Even after a visit to the emergency department for mental health needs, 35 percent of these children and youth did not receive follow up care within seven days and 23 percent did not receive care within 30 days.



Substance Use Disorder Services: approximately 3 in 4 youth who needed Substance Use Disorder services did not receive them. Even after an SUD-related emergency department visit, 84 percent of youth did not receive follow-up services within seven days of their visit, and 77 percent did not receive care within 30 days.

Provider Availability: Data regarding the availability of providers was limited; however, reports from a variety of sources suggest that the availability of providers continues to be a key challenge in access to care. Data about the languages spoken by behavioral health providers serving children and youth was also limited, but the available data suggests that, in some settings, approximately 17 percent of clinical staff speak a language other than English, with the most commonly spoken language being Spanish.

Eating Disorders: Data regarding eating disorder diagnoses found that 6,331 children and youth (less than 1 percent of the total population) were diagnosed with an eating disorder. Data regarding eating disorders treatment settings and available providers was limited.

Differences across race and ethnicity: A number of differences across different racial and ethnic groups were seen in the different metrics included in this report. Many differences were small, and the significance of these differences is unknown, but understanding and addressing these differences is a critical component of HCA's commitment to health equity.

Looking forward: Health Care Authority is currently involved in several efforts to address barriers to access noted in this report and improve the system of care. In addition, HCA and partners are actively working on several projects that may result in more comprehensive data in future reports. Lastly, while the information included in this report included only a subset of the Washington state population (children and youth enrolled in Apple Health), the Children and Youth Behavioral Health Work Group's work to develop a strategic plan requires collection of data statewide regarding all aspects of the behavioral health system of care, from promotion to prevention, treatment, and recovery, and for all children, youth, young adults, and families. This data will provide a roadmap for developing longer term, system-wide strategies to ensure access to high-quality equitable care and supports.

Appendix A – Data collection and definitions

Appendix A provides information about the data collection and analysis process, including definitions of metrics used in this report.

Section 1: Behavioral health services provided to children and youth

Data source: Data source: Data were retrieved from the Department of Social and Health Services (DSHS) Integrated Client Databases (ICDB), which contain administrative data from several state data systems, including the ProviderOne Medicaid data system and the Behavioral Health Data System (BHDS).

Population: all youth (0-18 years) who were Title 19 Medicaid or CHIP eligible for at least one month during the reporting period (calendar year 2021). Children and youth who were enrolled in state-funded Apple Health (and not eligible for Title 19 Medicaid or CHIP) were not included in the population for this report.

Definition of mental health services: Mental health services include crisis, inpatient, medication management, peer support, family treatment, case management and psychoeducation.

Definition of SUD Services: SUD services provided to this population include detoxification, residential treatment, case management, medication assisted treatment, and outpatient treatment.

Section 2: Unmet need for behavioral health care for children and youth

Data source: Data source: Data were retrieved from the Department of Social and Health Services (DSHS) Integrated Client Databases (ICDB), which contain administrative data from several state data systems, including the ProviderOne Medicaid data system and the Behavioral Health Data System (BHDS).

Population: all children and youth (0-17 years) who were enrolled in Apple health for at least 11 months during calendar year 2021.

Definition of unmet need for mental health care: This item is tracked using the HEDIS measure SUPPL-MH-B Mental Health treatment penetration-broadly defined. Mental health treatment rate is the number of children and youth who received mental health services in calendar year 2021 out of the number who were identified as having a mental health need in calendar years 2020 -2021. Children and youth identified as having a mental health need had a diagnosis of mental illness, receipt of psychotropic medication, and/or a mental health service in 2020 or 2021. Children and youth that received mental health service during the measurement year received at least one treatment service or were identified as receiving management of a mental health condition within a primary care setting during 2021.

Definition of unmet need for substance use disorder care: This item is tracked using the RDA-defined measure - SUPPL-SUD: Substance Use Disorder Treatment Rate. Substance use disorder treatment rate is the number of youth who received SUD services out of the number who were identified as having an SUD need. Youth identified as having a SUD need includes youth with at least one substance-related diagnosis, procedure, prescription, treatment, or arrest in CY 2020 or CY 2021. Youth that received SUD service during the measurement year receiving substance use disorder services, outpatient mental health disorder services, or both in CY 2021. Substance use disorder services include inpatient services, outpatient services, opiate substitution, and case management.

Definition of unmet need for timely follow-up care after an emergency department visit: The definitions for these metrics come from four HEDIS (Healthcare Effectiveness Data and Information Set) measures that track coordination of care after a child or youth is seen in the ED for a SUD or mental health disorder symptom presentation. More information about the definition of these measures is available at the links from the National Committee for Quality Assurance (NCQA) below:

- Follow-up after emergency department visit for alcohol and other drug dependence - within 7 days and 30 days of emergency department visit (HEDIS-FUA-7D and HEDIS-FUA-30D).
- Follow up after emergency department visit for mental illness - within 7 days and 30 days of emergency department visit (HEDIS-FUM-7D and HEDIS-FUM-30D).

Section 3: Behavioral health provider workforce serving children and youth

Available Providers

Data source: Data was provided by Managed Care Organizations to the HCA on a prospective, quarterly basis. MCOs receive this data from providers. Providing this data is a component of contractually required network adequacy analyses.

Population: Individual mental health providers and substance disorder treatment agencies/facilities contracted with each managed care organization during each quarter were included in this analysis. Providers with the same National Provider Identifier (NPI) were identified as duplicates and were removed. Providers contracted to serve children and youth enrolled in Apple Health without a managed care plan (also known as fee-for-service) were not included in the population for this report.

Definition of mental health provider: mental health providers include individually licensed practitioners of the following types: Physician, Osteopathic Physician, Nurse Practitioner, Social Worker Advance License, Marriage and Family Therapist, Mental Health Counselor, and Psychologist. Agency affiliated counselors and peers are not considered "mental health providers" for this analysis.

Definition of child- and youth- serving mental health provider: Within the network adequacy data, MCOs report on whether each provider/facility serves youth, reporting either Yes or No.

Definition of youth-serving substance use disorder facility: Within the network adequacy data, MCOs report on whether each facility provides any of the following services, reporting either Yes or No: Youth Outpatient, Youth Intensive Outpatient, Youth Residential, and Youth Recovery House.

Definition of accepting new clients: Within the network adequacy data, MCOs report on whether each provider and/or facility anticipates being able to accept new clients in the coming quarter, reporting either Yes or No.

Languages Spoken by Providers

Data source: These data are a result of the Behavioral Health Provider Survey (BHPS), and online survey that was conducted from December 2021 through April 2022. The online survey was conducted from December 2021 through April 2022. The target population for the survey consists of Department of Health licensed, community-based mental health (MH) and Substance Use Disorder (SUD) treatment agencies providing publicly funded services in Washington state.

Population: Originally, the sample included 754 agencies with each location considered as a distinct entity. However, agencies with multiple sites were given the option to consolidate them into one survey . Accounting for survey consolidation and agency closures, the adjusted population size is 662 agencies. Responses were received from 231 agencies resulting in a response rate of 34.9%. Overall, 126 agencies indicated they provide BH services to children and youth representing 54.5 percent of the agencies responding to the survey. These 126 agencies were the population of focus for this report.

Definition of bi- and multi-lingual providers: Respondents were asked "How many of your behavioral health clinical staff are bilingual or multilingual and are able to provide BH services in a non -English language?" That question was followed up with "How many of your behavioral health clinical staff speak a language other than English?" The survey listed 46 different languages plus an 'Other' category.

Section 4: Eating disorder diagnosis, treatment, and providers

Data source: Data source: Data were retrieved from the Department of Social and Health Services (DSHS) Integrated Client Databases (ICDB), which contain administrative data from several state data systems, including the ProviderOne Medicaid data system and the Behavioral Health Data System (BHDS).

Population: all youth (0-20 years) who were Title 19 Medicaid or CHIP eligible for at least one month during the reporting period (calendar year 2021). Children and youth who were enrolled in state-funded Apple Health (and not eligible for Title 19 Medicaid or CHIP) were not included in the population for this report.

Definition of eating disorder: The following ICD-9 and ICD-10 codes were used to define a diagnosis of an eating disorder.

ICD 9	
Code	**Long Code Description**
307.1	Anorexia nervosa
307.5	Other & Unspecified disorders of eating
307.50	Eating disorder, unspecified
307.51	Bulimia nervosa
307.52	Pica
307.53	Rumination disorder
307.54	Psychogenic vomiting
307.59	Other disorders of eating

ICD 10	
Code	**Long Code Description**
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F50.8	Other eating disorders
F50.81	Binge eating disorder
F50.82	Avoidant/restrictive food intake disorder
F50.89	Other specified eating disorder
F50.9	Eating disorder, unspecified
F98.21	Rumination disorder of infancy
F98.29	Other feeding disorders of infancy and early childhood
F98.3	Pica of infancy and childhood

Appendix B – Additional data tables

Appendix B is a collection of additional detailed data tables from all sections of this report. Because of the size of this collection, it is available as a separate document.