Children and Youth Behavioral Health Work Group (CYBHWG) Notes

September 15, 2022

☒	Representative Lisa Callan, Co-Chair	☒	Dr. Robert Hilt	☒	Michele Roberts
☒	Keri Waterland, Co-Chair	☒	Kristin Houser	☒	Joel Ryan
☐	Hannah Adira (alternate)	☒	Avreayl Jacobson	☒	Noah Seidel
☐	Javiera (Javi) Barria-Opitz	☐	Nichole Jensen	☒	Mary Stone-Smith
☐	Dr. Avanti Bergquist	☒	Barb Jones	☒	Representative My-Linh Thai
☒	Representative Michelle Caldier	☒	Kim Justice	☐	Dr. Eric Trupin
☒	Diana Cockrell	☒	Michelle Karnath	☒	Senator Judy Warnick
☒	Lee Collyer	☒	Kaur Preet	☒	Lillian Williamson
☒	Representative Carolyn Eslick	☒	Judy King	☒	Senator Claire Wilson
☒	Dr. Thatcher Felt	☒	Amber Leaders	☒	Dr. Larry Wissow
☐	Tory Gildred	☐	Bridget Lecheile	☒	Jackie Yee
☐	Dorothy Gordor	☒	Laurie Lippold	☐	
☒	Summer Hammons	☒	Cindy Myers	☐	

Washington Maternal Care Model

Beth Tinker, *Health Care Authority (HCA)*

See TVW recording (5:30); see page 4 for slides.

Logic model for high-quality, high-value care that improves perinatal health

Ballmer Group grants

Andi Smith, *Ballmer Group*

See TVW recording (27:40); see page 19 for slides

Behavioral Health Workforce Grants

Resource:

- Ballmer group grant list

Policy recommendations: Cross-agency table on youth with no place to discharge

Kashi Arora & Hugh Ewart, *Seattle Children's*

See TVW recording (1:00); see page 25 for slides

Highlights:

- Interpretation of abandonment law changed, leaving kids "stuck" in the Emergency Department until placement.
- Patients have been "stuck" in hospital for up to 200 to 400 days.
- Working with DDA to understand the service needs.
- Therapeutic educational residential placement and or services might be a topic for strategic plan work.

Update: Strategic Plan

Nathanial Lewis, *Health Care Authority (HCA)*
See TVW recording (1:41)

Stipends for people with lived experience

- Stipends will be available by October 3, 2023, for qualifying attendees with lived experience that are not otherwise being paid by the work group or any other subgroup.

Subgroup draft recommendation report out

Behavioral Health Integration (BHI)

See TVW recording (1:45)

- Select care coordination code(s) to be allowed on HCA fee schedule and appropriate payment levels for the service.
- Funding to continue the PAL program and FAST training taking place.

Workforce & Rates

See TVW recording (1:55)

- Barriers include licensure, administrative issues, compacts in the works, and credentialling for individuals from other countries.
- Would like public funding related to conditional grants and loan repayment for staff retention and recruitment.
- Previous priorities – continue to advance apprenticeship work, cultural care for children and families, related a proviso to make sure providers and doing in a cultural way.
- Certified Community Behavioral Health Center.

Prenatal to age five relational Health (P5RH)

See TVW recording (2:06)

- 2 recommendations, possibly 3 related to historical work.
- #1 Legacy item – complex need funds to increase for ECP and childcare programs. Current funding inadequate to meet the needs.
- #2 Legacy item – infant and mental health consultation. Increase investment in the program.
- #3 Legacy – mental health assessment for young children. Policy and funding to support providers to ensure appropriate services are provided.

School-Based Behavioral Health Suicide Prevention (SBBHSP)

See TVW recording (2:12)

- Survey sent to group to determine the recommendations to move forward with a deadline in 2 weeks.

Youth and Young Adult Continuum of Care (YYACC)

See TVW recording (2:20)

- Respite challenges.
- Youth and Parent Peers.
- Survey sent to the subgroup to determine recommendations to move forward.

Discussion: Over-arching recommendations

See TVW recording (2:27)

Highlights:

- Workforce and rates would like to ask for another rate increase as an over-arching recommendation.
- Important to be clear on a strategy or consistent narrative for rates ask since we asked last year.
- A big driver of the workforce is the rate of pay. Specific to CLIP and Crisis beds to ensure staff available to meet the need and fill to capacity.
- Peer support is an underutilized workforce and could be beneficial for the workforce shortage, elevate all peer requests.
- Expanding school base health centers.
- Funding for start-up grants, funding grants.

Public Comment

See TVW recording (3:02)

Highlights:

- Recalibrate mental health and behavioral health to be robust enough for the future.
- Too many access barriers to lower-level care.
- Are autistic adults being engaged? This may be a powerful lived experience voice.

Open discussion

See TVW recording (3:18)

Highlights:

- Workforce recruitment is a large challenge and would like to see recruitment incentives.
- Believe the peer program will be beneficial.
- Rate increases are needed to be competitive in the behavioral health realm.
- Workforce across the whole continuum of age group with continuity of care is needed.
- Appreciate the cross-system thinking.
- Families are the first and best teachers of our children.
- 10/20/22 Peer 101 overview to give better knowledge and understanding around peers.

Chat:

- UWCTU Project Echo
- Report from the Office of Developmental Disabilities Ombuds – "I Want to go home" Reevaluating DDA's Children's Services to Prevent Hospitalization and Out-of-State Placement
- Report – New WA Watchdog Report calls for systemic change to prevent children with disabilities being sent away
- Report from the Health Care Authority – Tax Equity and Fiscal Responsibility Act (TEFRA) and Katie Beckett waivers
- Report from department of Health – Implementation of RCW 43.70.825: Expanding School-Based Health Centers

Washington Maternal Care Model CYBHWG meeting

September 15, 2022

Beth Tinker, PhD, MPH, RN
Clinical Nurse Consultant

Washington State Health Care Authority

Agenda

- **Overall goal for today - Update the CYBHWG on the maternal care model work we are doing and hear your feedback**
- Context: Why we care and related work
- Care model goals and identified levers and VBP approach
- Project timeline
- Questions/feedback- what is most important that we hold in mind in terms of priorities for the CYBHWG ?
- Resources/contact info

Context: Why We Care

- The US spends more than any other country on maternity care and yet has some of the worst perinatal and infant health outcomes.
  - Rising maternal mortality nationally – only developed country in the world
  - The c-section rate in WA is 27.9% - way higher than benchmarks and indicating over medicalization of birth
  - Our preterm birth rate of 8.3% is lower than the national average of 9.85%, but significantly higher in BIPOC population
  - Are not adequately addressing behavioral and social needs, limited PP support
- The Washington State Maternal Mortality Review Panel determined that 60% of maternal deaths here are preventable.
  - A significant number are tied to lack of access to behavioral health evaluation, treatment, and support.
  - There is significant disparity in outcomes. For example, Native American/Alaska Native women were nearly ten times as likely to die of a pregnancy-associated cause than white women.
- Medicaid pays for just under half the births in WA St– over 36k in 2020

Context: Building from a host of complimentary work and initiatives

- The Bree Collaborative (a group of WA based providers and advocates) developing/refining a maternity bundle/episode of care.
- Extension of post-partum (PP) Apple Health/Medicaid coverage from two months to twelve months- in June 2022
- Implementation of a maternity episode of care in WA based commercial lines of business.
- HCA/WA participation in a three-year Institute for Medicaid Innovation learning collaborative on increasing access to midwifery led care and focused on equity.
- Investment in IECMH- policy, programs, and dedicated resources.

What is the Bree perinatal bundle?

- An episode-based payment model, or bundled payment, for a defined period of care, with required evidence-based clinical components, reporting metrics and opportunity for gain-sharing.
- Few highlights: prenatal, L&D, postpartum for 12m, infant included for 30days.
- Promoting physiologic birth
- Increased attention to screenings and appropriate tx: CV, BH.
- Improving post partum care, and tailoring
- Elevating patient-centered care, e.g. shared decision-making

Maternal care model goals

- Incentivize high-quality, high-value clinical obstetric care that improves perinatal health outcomes and addresses racial and ethnic disparities
  - Increase utilization of, and improve quality of prenatal and postpartum care
  - Reduce maternal morbidity and mortality
  - Reduce racial and ethnic disparities in perinatal outcomes
  - Improve birth outcomes
  - Increase care coordination between health care providers for birth parent and infant including leverage of the full 12 months of postpartum Medicaid coverage

Logic model

Incentivize high-quality, high-value care that improves perinatal health outcomes and addresses racial and ethnic disparities

Goals

- Increase utilization of and improve quality of prenatal and postpartum care
- Reduce maternal morbidity and mortality
- Reduce racial and ethnic disparities in perinatal outcomes
- Improve birth outcomes
- Increase care coordination between health care providers for birth parent and infant including leverage of the full 12 months of postpartum Medicaid coverage

Examples of Intervention Levers

- PP care defined by more than one comprehensive visit at 6 weeks
- Systematic BH screening, referral as needed and follow-up during pregnancy and the full year post partum
- Increase physiologic birth and patient informed choice (e.g., reduce c-sections, unnecessary interventions, improve satisfaction)
- Expand the appropriate use of midwives and incorporate doulas and other multi-disciplinary care team members
- Appropriately manage chronic conditions across the continuum – from initiation of prenatal care through end of 12mo PP (and transition to ongoing care)
- Increase attention to SDOH, including universal screening, referrals/linkage, support and follow up
- Leverage quality/reporting metrics to drive better, evidence-based care and improved outcomes
- Consider additional interventions that have demonstrated impact in reducing perinatal disparities: group prenatal care, home visiting, medical home models.

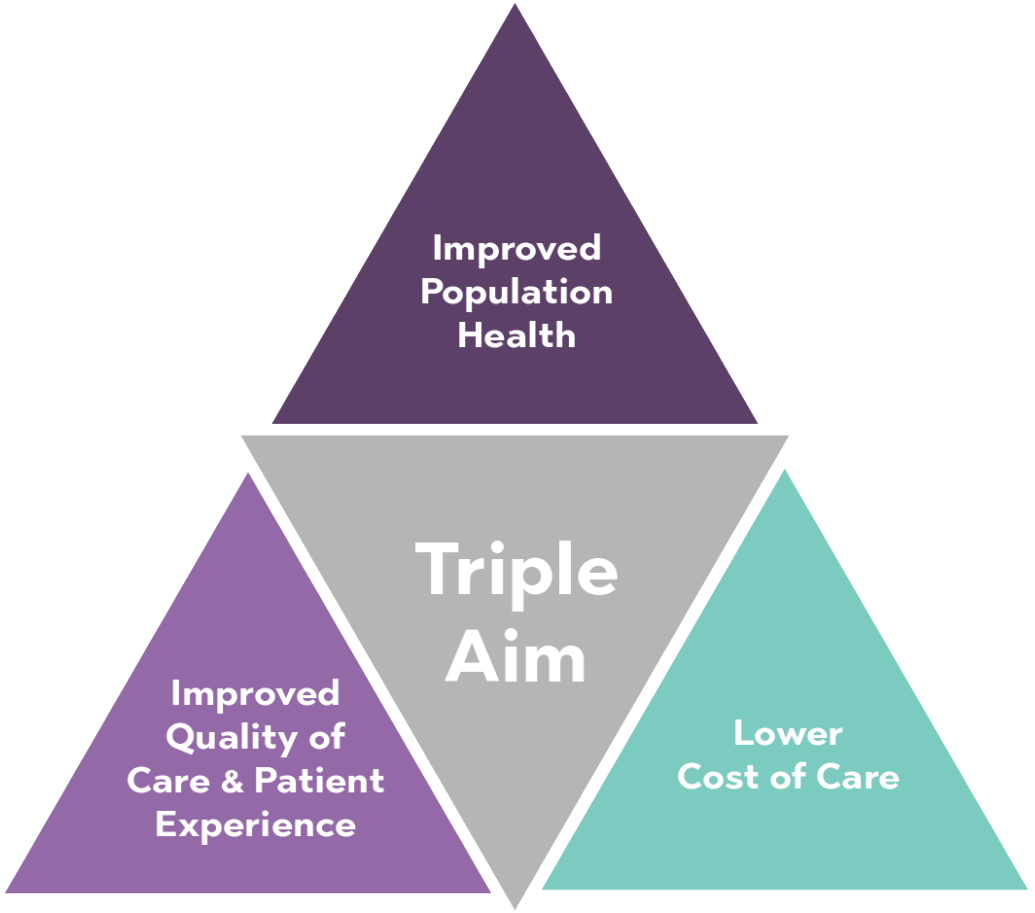
How will HCA pull these levers - VBP

- VBP is value-based purchasing. Sometimes called “pay for performance”. Or, “paying for value” as opposed to “paying for volume”.
- Plan to utilize VBP structure across the prenatal, L&D, and year postpartum. Linking payments to improved performance by health care providers.
- An episode of care structure is planned for the care episode from initiation of prenatal care through 3 months postpartum.

Q: Why VBP?
A: Payment drives transformation

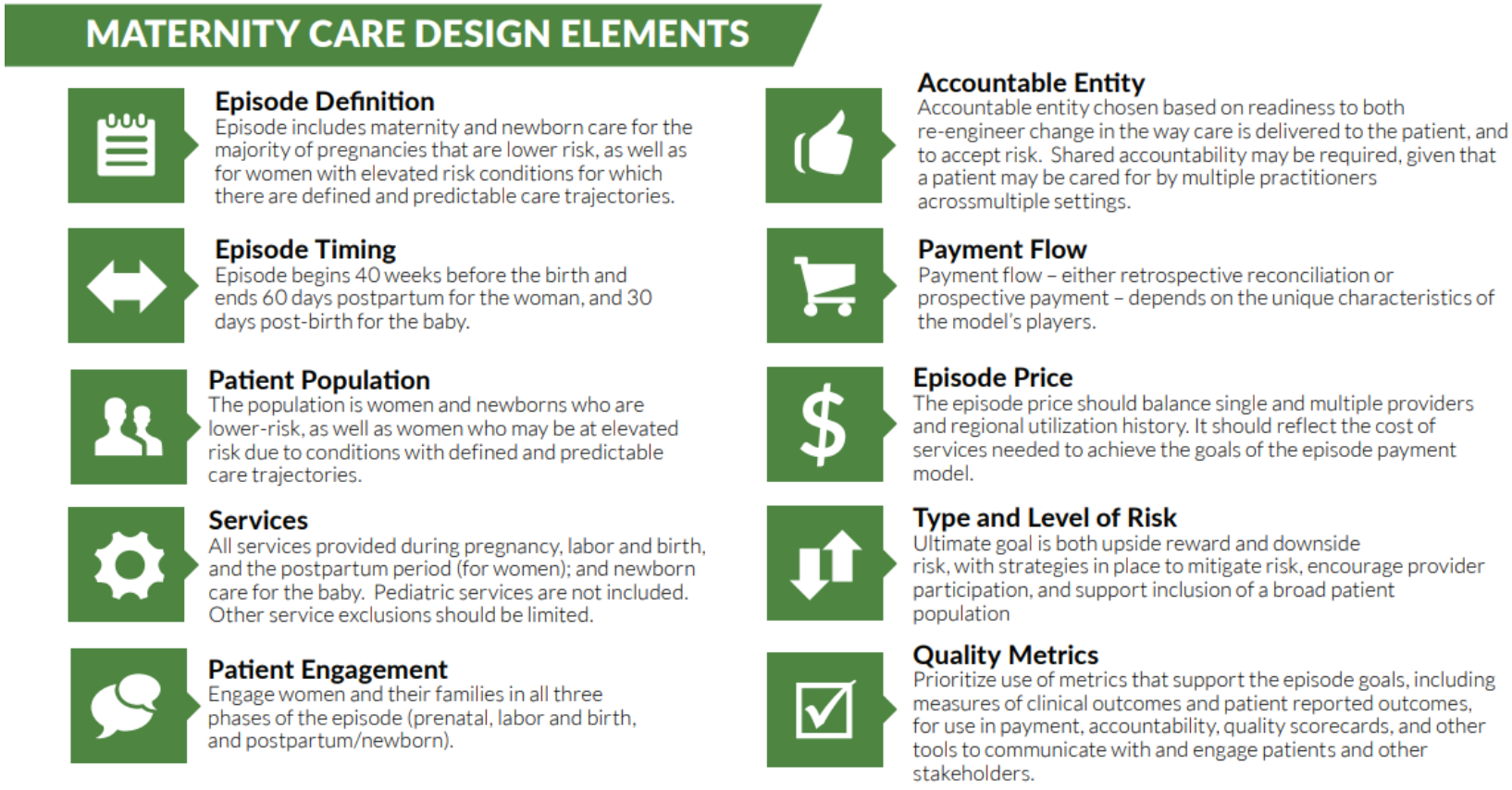
VBP should achieve the triple aim by:

- Reducing unnecessary and low-value health care (lower cost)
- Rewarding preventive and whole-person care (better health)
- Rewarding the delivery of high-quality care (better quality and experience)



Washington State Health Care Authority

Episodes of care are complicated- we are just working on the model design



http://hcp-lan.org/workproducts/maternity-infographic.pdf

Current status

- Contracting with NORC (National Opinion Research Center out of Univ of Chicago) since February of 2022.
- Project team and NORC team foundational work –
  - environmental scan
  - communications and engagement
  - analysis of the current payment structures
  - scoping out policy decisions/options.
- Overall timeline for contract with NORC and developing an episode of care is through the end of the calendar year.

Project timeline

Date	Activity
June – July 2022	Initial engagement sessions, review of the work done in other states
August – September 2022	Draft the model design based on the environmental scan and input shared
October – November 2022	Re-engage with tribes and stakeholder with draft design
December 2022	Finalize model components and create implementation strategies
January – December 2023	Prepare for implementation and, if needed, receive funding
January 2024	Implement Maternity Care Model in Medicaid

Questions and considerations

- Initial feedback on key goals/identified levers of the maternal care model or anything shared today?
- What additional considerations should we address as we design this model?
- Questions?

Resources and contact information

- HCA Maternal Care Model Website - Maternal care model | Washington State Health Care Authority Describes goals of the Maternal Care Model
  - Lists upcoming events
  - Updated regularly as model development and implementation proceeds
  - Upcoming stakeholder listening session 9/27 11am-12pm

- Contact information
  - HCAMaternalCareModel@hca.wa.gov

Questions?
Additional comments?

Feel free to email or call
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Clinical Nurse Consultant, CQCT
elizabeth.tinker@hca.wa.gov
360-972-5506

Behavioral Health Workforce Grant Making Update

Children & Youth Behavioral Health Workgroup

September 15, 2022

Andi Smith

Executive Director, Washington

Behavioral Health Workforce Focus Areas

OVERARCHING GOALS FOR BEHAVIORAL HEALTH WORK IN WASHINGTON :

- *Improve access to high quality behavioral health treatment for low-income Washingtonians*
- *Enhance the supply of behavioral health clinicians practicing in community behavioral health settings, acknowledging that workforce – i.e., the people who deliver behavioral health care – is a primary determinant of access and quality of care*

INCENT
new entrants to the field and mitigate financial barriers to retention for those who practice in community settings

DEVELOP
pathways that create broader access into the field and remove barriers to entry and success

ALIGN
training and supervision to enhance the preparation, knowledge, and skills of the workforce

ADVOCATE
for policy changes and investment in the expansion of the behavioral health workforce

Note: Through both the type of work supported through the slate and within each project, we seek to create greater diversity in the workforce, reflective of the population in need, including those with lived experience

Grants in the WA Behavioral Health Slate

The total investment represented by the grants in this slate is $39,939,450.00

Workforce

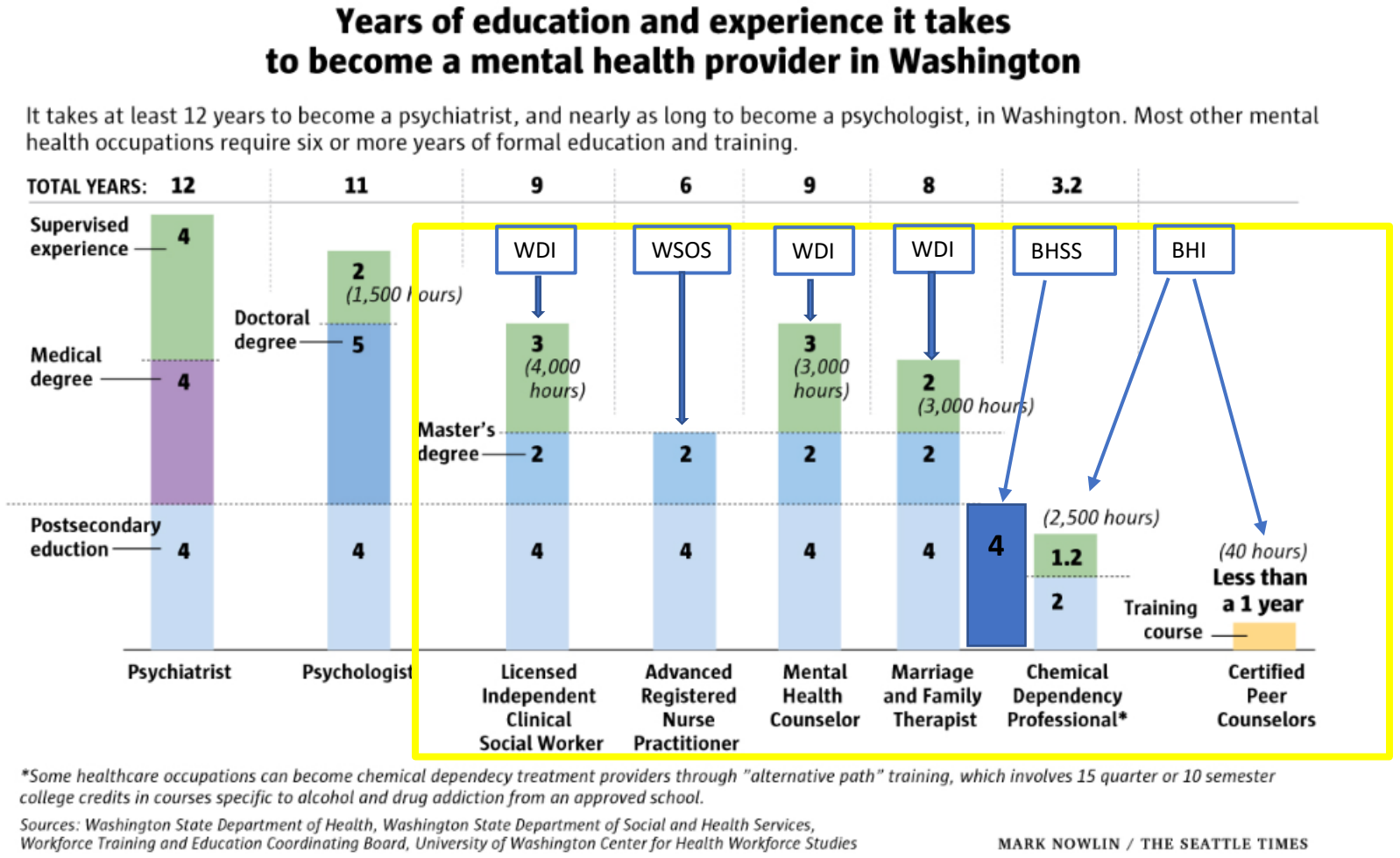
Grant Focus Area	Grantee	Amount	Term
Crisis System Re-Design	UW Behavioral Health Institute	$2,800,000	06/01/2021 - 06/30/2023
Teaching Clinic Model and Rate	WA Council for Behavioral Health	$1,100,000	07/01/2021 - 06/30/2024
Peer Expansion	WA State Health Care Authority	$400,000	06/30/2021 - 06/30/2023
Apprenticeships	Harborview Medical Center - Behavioral Health Institute	$5,500,000	04/05/2021 - 06/30/2024
Master's level Social Workers and Counselors	UW School of Social Work	$24,802,000	04/01/2021 - 06/30/2026
Bachelor's level Behavioral Health Support Specialists	UW Medicine - Dept of Psychiatry	$3,659,450	07/01/2021 - 06/30/2026
Nurse Practitioners	WA State Opportunity Scholarship	$500,000	10/01/2020 - 12/31/2022
Behavioral Health Community Lab	The Seattle Times	$1,178,000	04/01/2021 - 08/31/2023
Bachelor's level - Ballmer Institute for Children's BH	*University of Oregon*	*$425,000,000*	*03/01/2022 – 12/31/2027*

BH Slate Workforce Grant Summaries

Snapshot	Grant Summary
UW Medicine – Department of Psychiatry	• UW Medicine is a health system serving the people of the Puget Sound region in Washington state and is connected with UW School of Medicine and Research Centers and Institutes. Our grant expands Washington state's behavioral workforce over five years through an innovative training program for Behavioral Health Support Specialists for undergraduate students in colleges around the state in partnership with the UW Medicine Department of Psychiatry and Behavioral Sciences.
Harborview Medical Center - Behavioral Health Institute	• Our grant supports University of Washington's Behavioral Health Institute at Harborview Medical Center to collaborate with community partners to create apprenticeship programs in behavioral health to help build a qualified, diverse workforce to meet the demand for care in the region.
University of Washington School of Social Work	• Our grant supports a broad, collaborative response to Washington's behavioral health crisis by expanding the diversity and numbers of well-prepared, debt-relieved students graduating from master's programs in social work and mental health counseling who go on to work
Washington State Opportunity Scholarship	• Washington State Opportunity Scholarship connects the state's leading industries with top Washington talent by reducing barriers to education and training and facilitating entry into high-demand careers for Washington students. Our grant for the Advanced Healthcare Graduate Scholarship supports 96 Doctorate of Nursing Practice students and aims to increase the number of health care providers in Washington's medically underserved areas.
WA Council for Behavioral Health*	• Washington Council for Behavioral Health advocates for and supports its members in strengthening communities and improving the lives of individuals and families across Washington state impacted by mental illness and addictions. Our grant supports the establishment of a pilot project to identify and implement a "teaching rate" for those preparing our next generation of behavioral health practitioners. The work will eventually help ensure those teachers and mentors are effectively compensated.
WA State Health Care Authority*	• Washington State Health Care Authority is the largest health care purchaser in the state and leads the effort to transform health care and help Washington residents have access to better health and better care at a lower cost. Our grant helps drive the uptake of behavioral health peers - meaning those with lived experience and expertise in mental and behavioral health - into the Medicaid and commercial systems to provide encouragement and assistance needed for long-term recovery.

A Different View: Grants in the WA Behavioral Health Slate by Role

Grants in the slate add capacity to each of the occupational types in the behavioral health workforce (in yellow highlight) and adds the Bachelors Level Support Specialist role



Philanthropy and State/Local Government

TAKE AWAY #1: Our investments will be both in formal and informal behavioral health systems

- This slate marked expansion into a new area for Ballmer Group but it's not the destination
- Grantmaking is possible to support school-based health, out of school time, and for lay people in communities.

TAKE AWAY #2: Alignment with public sector priorities is intentional and explicit

- Significant public sector attention and investment in the 2021 and 2022 Legislative Sessions (over $200MM invested in BH in 2022)
- Many of the projects have longer term/future case-making and advocacy components such as demonstrating the impact of investment and refining understanding of challenges through data collection and analysis

TAKE AWAY #3: Think of philanthropic funding as 'risk capital'

- Funding outside of government is flexible, can be fast, and can try things that have a decent chance of not working.
- Funding is also meant to overlap with other Ballmer Group investment areas / social determinants of health

Solutions for Abandoned Patients

9.15.2022

Kashi Arora on behalf of Seattle Children's

Work co-lead by Hugh Ewart

With immense gratitude to collaborators at multiple agencies, hospitals, and organizations as well as to families who have shared their lived experiences.

Seattle Children's

Agenda

1. Problem description
2. Overview of previous and current state
3. Description of process to get to recommendations
4. Overview of recommendations
5. Questions and discussion

Seattle Children's

Problem Description

As articulated by Seattle Children's

Children are not getting the services they need in the places they need them. There is a population of youth who "fall through the cracks" in our behavioral health system.

Their caregivers often feel failed by systems designed to support them and many are no longer willing to accept their child back into their home, which can lead to lengthy unnecessary hospital stays.

There are very few services available in the community to meet the child or family's needs, especially ones that are responsive to the child's developmental level or disability.

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Previous State

As articulated by Seattle Children's

If a child presented to the emergency department (ED) or inpatient unit and did not require hospitalization (or continued hospitalization) and their parent/caregiver was unwilling to take them home although they were ready for discharge:

1. We made every effort to resolve the situation with their families
2. If parent/caregiver was still unwilling to take them home, we followed the process legally called "abandonment"
3. Law enforcement placed the child in protective custody, DCYF accepted them into dependency because they met the definition of "abandoned"

Seattle Children's

Current State

As articulated by Seattle Children's

If a child presents to the emergency department (ED) or inpatient unit and does not require hospitalization (or continued hospitalization) and their parent/caregiver is unwilling to take them home although they are ready for discharge:

1. We make every effort to resolve the situation with their families
2. We reach out to DCYF to initiate abandonment but are informed that patients who are in hospital settings no longer meet the definition of "abandoned" and they do not take them into dependency any longer.
3. Many of these patients stay in the hospital until an appropriate out-of-home placement or other service can be located – for some children this means they are in the hospital for months even though they do not need to be admitted.

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Process

Convened a series of meeting with:

- State agency partners including: DCYF, DDA, HCA, and OSPI
- Children's hospitals including: Seattle Children's, Mary Bridge, and Sacred Heart
- Washington State Hospital Association (WSHA)

Goal: identify policy solutions that would address this issue and support children, youth, and families in this vulnerable position.

Seattle Children's

Summary of Work-to-Date

As articulated by Seattle Children's

1. Scoped the population and defined the problem
2. Outlined services that would support this population
    i. Services we don't have in WA that exist in other states
    ii. Services we have in WA that lack adequate capacity to meet the demand
    iii. Services we have in WA that have so many "rule-out" criteria that they're effectively inaccessible by these youth and their families
3. Identified priority services that would be most impactful/meaningful, and/or would be relatively quick to stand up.
4. Discussed which of those priorities already have work moving forward or services/programs funded
5. Aligned on services we'd prioritize for policy funding

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Services

There are additional services or expanded capacity necessary to meet the needs of children/youth in this population.

Approach

There needs to be a new way that all service providers/agencies come together to support these children and their families.

1. Expand capacity in DDA in-home and out-of-home services
2. Expand capacity and capability of WISe to serve high-needs youth
3. Therapeutic educational residential placements and/or services
4. Increasing access to ABA in-home supports

Seattle Children's

Policy Priorities – Services

Alignment from multi-agency workgroup, Washington's 3 Children's Hospitals, and WSHA

1. Expand capacity in DDA in-home and out-of-home services – **still working with DDA to identify policy avenues**
2. Expand capacity and capability of WISe to serve high-needs youth – **HCA shared promising pilots including:**
    i. **Exploring how to concurrently offer ABA and WISe**
    ii. **Piloting a Wraparound with Intensive Behavioral Supports (WIBS) model**
    iii. **Continuing educational opportunities such as RUBI and the ECHO for WISe teams**
3. Therapeutic educational residential placements and/or services – **this is a long-term item that could have a first step in the 2023 session**
4. Increasing access to ABA in-home supports – **unclear re: policy avenue**

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Services

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4. Increasing access to ABA in-home supports

Policy modeled after legislation in Nevada that codifies an accountable agency and requires a multi-system collaborative plan for supporting the child and family.

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Policy Priority – Approach

Alignment from Washington's 3 Children's Hospitals and WSHA

This has not been discussed in-depth with agency partners

Legislation modeled after Nevada that codifies:

1. A requirement for state agencies to convene when a hospital identifies a youth at risk of abandonment
2. Names a state agency (DCYF) accountable for developing a plan to provide services [and placement] to the child and family
3. Outlines a clear timeline for plan development and service initiation

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Summary

Requesting support for expanding services for this population

AND support for a policy that codifies a new approach to supporting these vulnerable children and their families

Seattle Children's

Questions? Thank you!

& immense gratitude to those who collaborated on and informed this complex work.

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