Washington State Health Care Authority

Children and Youth Behavioral Health Work Group (CYBHWG)

From Governor's emergency proclamation:

I also hereby direct our Health Care Authority and Department of Health to immediately begin work on recommendations on how to support the behavioral health needs of our children and youth over the next 6 to 12 months and to address and triage the full spectrum of rising pediatric behavioral health needs.

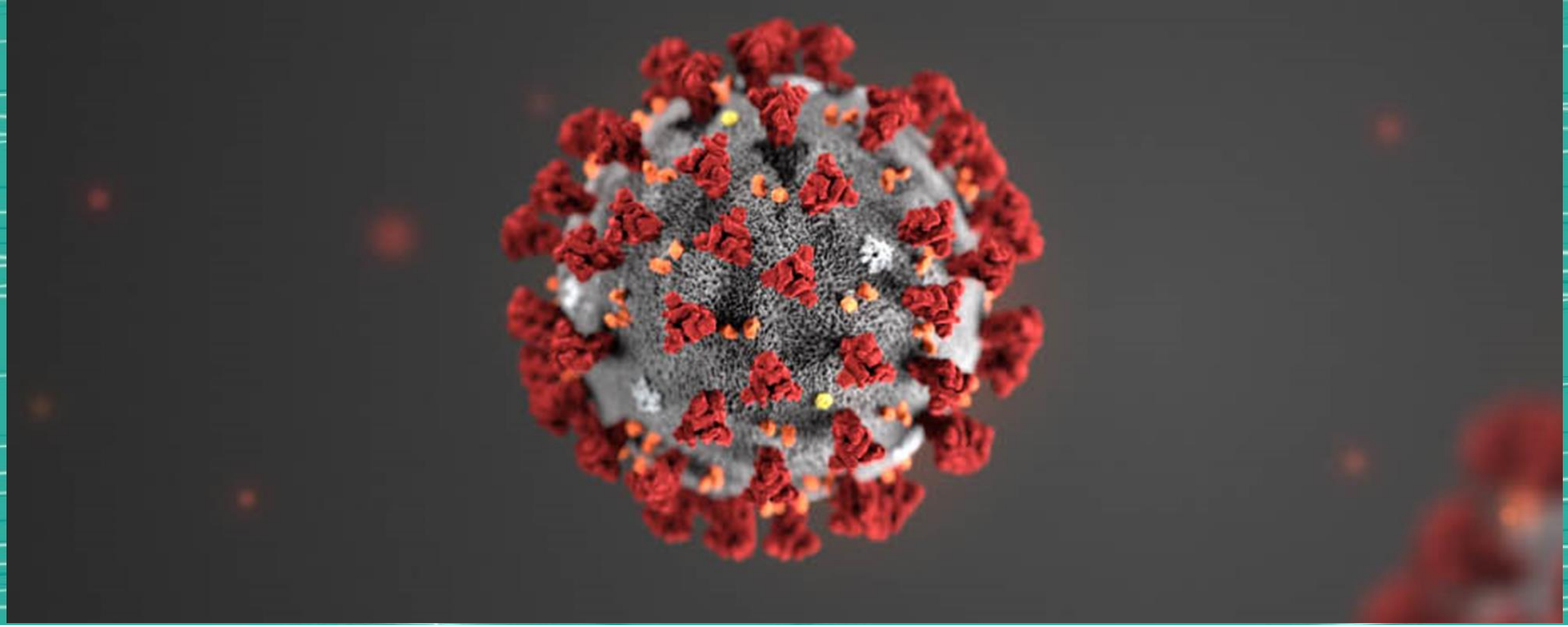
Tuesday, March 23
10:00 am – Noon

Attendees					
☒	Representative Lisa Callan, Co-Chair	☒	Dr. Robert Hilt	☒	Michele Roberts
☒	MaryAnne Lindeblad, Co-Chair	☒	Kristin Houser	☐	Joel Ryan
☒	Dr. Avanti Bergquist	☒	Avreayl Jacobson	☒	Noah Seidel
☐	Tony Bowie	☐	Kim Justice	☒	Mary Stone-Smith
☒	Representative Michelle Caldier	☒	Nichole Jensen (non-voting)	☐	Representative My-Linh Thai
☐	Senator Jeannie Darneille	☒	Andrew Joseph, Jr.	☒	Jim Theofelis
☒	Jamie Elzea	☒	Michelle Karnath	☐	Dr. Eric Trupin
☒	Representative Carolyn Eslick	☒	Judy King	☐	Senator Judy Warnick
☒	Dr. Thatcher Felt	☐	Sarah Kwiatkowski	☒	Mandy Weeks-Green
☒	Tory Gildred	☒	Amber Leaders	☒	Lillian Williamson
☒	Camille Goldy	☒	Laurie Lippold	☒	Dr. Larry Wissow
☒	Dorothy Gordor	☐	Lauren Magee	☒	Jackie Yee
☒	Summer Hammons	☒	Cindy Myers		

#	Agenda Items	Lead
1.	Update: Behavioral health forecast Dr. Kira Mauseth, Co-lead – DOH Behavioral Health Strike Team	*See page 4 and TVW recording (starts at 00:05:20).*
2.	Pediatric behavioral health work group report Dr. Tona McGuire, Co-lead – DOH Behavioral Health Strike Team; Member, Pediatric Disaster Workgroup, Disaster Clinical Advisory Committee Dr. Vicki Sakata, Senior Medical Advisor – Northwest Healthcare Response Network	*See page 13 and TVW recording (starts at 00:19:09).*
3.	Governor's emergency proclamation Amber Leaders (Governor's Office)	*See TVW recording (starts at 00:46:00).* Highlights: • Governor issued executive order regarding return to in-person learning. • Catalyst: Behavioral health crisis for children and youth. • Directed Health Care Authority and Department of Health to make recommendations on how to build up and support behavioral health system. • CYBHWG brings together expertise and background in these issues; uniquely situated to bring recommendations forward.
4.	Today's work/Preliminary ideas	*See TVW recording (starts at 00:48:42) and page 30 for Preliminary ideas list.* • Developing a list of recommendations (K-12 and prenatal-5). • Criteria: can be implemented quickly to meet immediate needs; equitable, scalable statewide.

		• Preliminary list: Ideas solicited from subgroup leads, legislators, champions, and others; a beginning list, to be expanded upon by work group. • Tying DOH's disaster response work with CYBHWG members' perspective and experience. • Organized, structured approach to provide relief, crosswalking all of the systems.
5.	Public comment	*See TVW recording (starts at 1:00:10).* • **Karen Kelly:** Workforce development most important; center diversity and equity. • **Rep. Carolyn Eslick:** HopeSparks – amazing, collaborative work with UW to reach youth when they see their primary care doctor. 80% are accepting offer. Need workforce to duplicate statewide. • **Rep. Eslick and Jim Theofelis:** Shelters for homeless youth – critical need for behavioral health supports and training for shelter staff. Embedding a staffperson in shelters. • **Michelle Karnath:** When thinking about workforce, consider peers – underutilized – ready to provide support to youth and families. • **Kristin Wiggins:** Keep in mind needs of whole family, parents as well as children; as older children go back to school, it affects the whole family, including younger children.
6.	Review priority lists and discuss on top priorities	*See: TVW recording (starts at 1:11:40).* *Page 34 for breakout group notes.* *Page 37 for synthesis of ideas and recommendations.* **Workforce and Rates** (Laurie Lippold) • Existing workforce and rates recommendations. • Care coordinators/navigators for primary care priorities. • Incentivize providers to extend hours and days they provide services. • Behavioral health training for BH providers. • Flexible funding adequate to be able to build capacity. **Youth and Young Adult Continuum of Care** (Rep. Carolyn Eslick) • Workforce – including equity/diversity/inclusion; including supporting those who cannot afford the education. Consider not requiring a master's; provide supports to BIPOC and natural community leaders who don't have that level of education. **School-based Behavioral Health & Suicide Prevention** (Camille Goldy) *Did not have time to talk about school-based supports; most discussion was around coordinated care.* • Increased resources for care coordination in an integrated model – with supports in the schools. • Universal screening – that includes students with autism and disabilities. • Expanding PAL for Schools. • Equitable services means all kids tget the services they need, regardless of insurance. **Prenatal through Five Relational Health** (Jamie Elzea) • Investments in complex needs funds for ECEAP and child care. • Development of best practices for telehealth 0-25. • Supporting families and caregivers. • Care coordination. • Early ECEAP to do upstream work. • Supports for children who need more intensive development services – ESIT providers for longer than birth to 3.

		Behavioral Health Integration (Sarah Rafton) • Coordination/navigation in primary care. • Bolster Child • Supporting primary care providers in crisis management. • Supporting parents and caregivers: Through care coordinators and navigators, tele-opportunities to support parents in real time. • Rapid access to telehealth for behavioral health services including groups. • Raise rates for behavioral health screening in primary care (from $2 to $10).
7.	Next steps/Closing thoughts MaryAnne Lindeblad & Rep. Lisa Callan	*See TVW recording (starts at 1:24:43).* *See page 40 for edited Chat log.* **Next steps:** • School-based Behavioral Health & Suicide Prevention will focus on school-based supports to add to these recommendations at their April 2 meeting. • HCA will take these recommendations and use them as a baseline to work with OSPI and DOH. • Co-chairs will convene the CYBHWG again to float recommendations that agencies develop.



Washington State Department of Health

BEHAVIORAL HEALTH IMPACTS OF COVID-19

March 23, 2021 special update

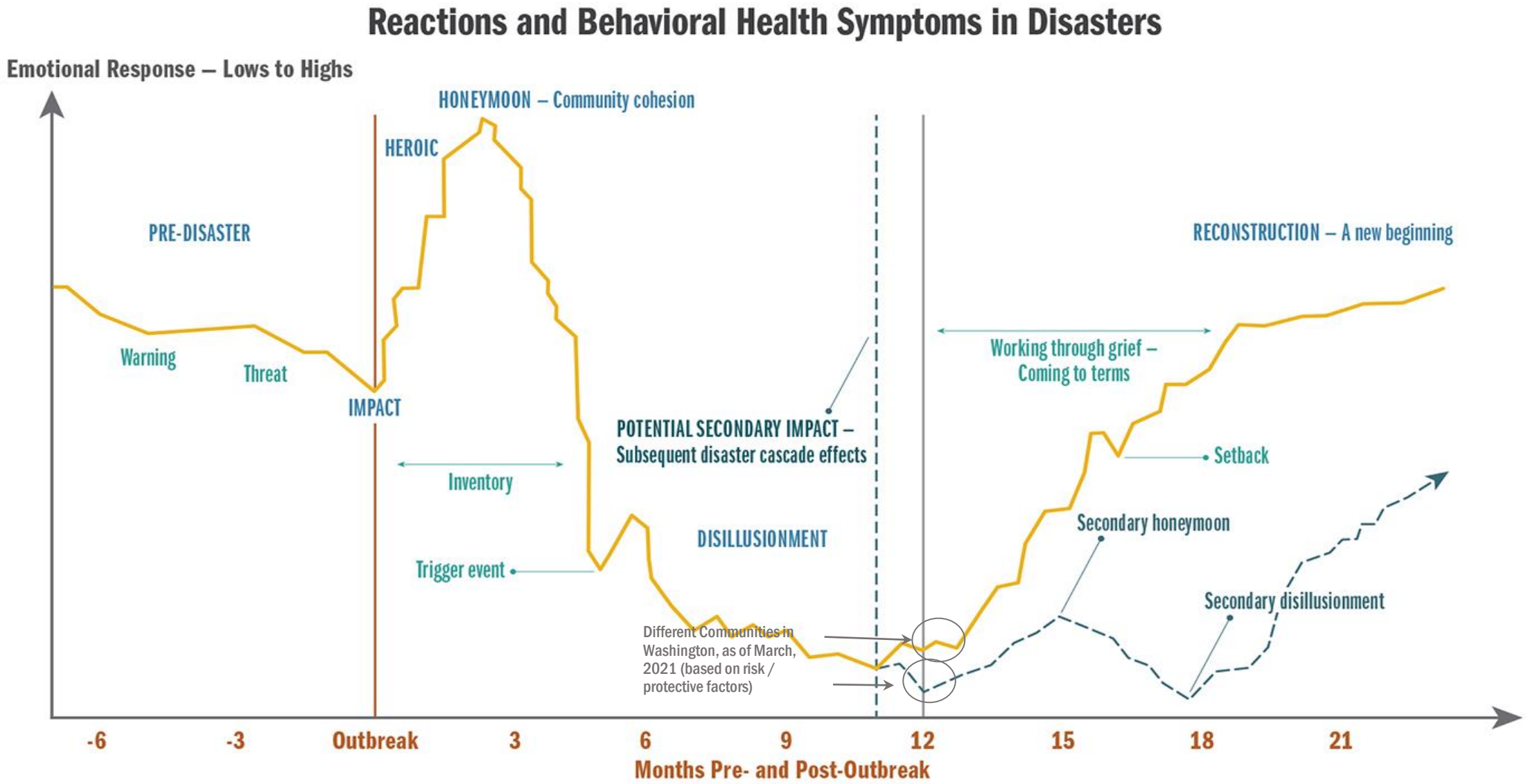
Brief Overview: Development and Further Reading

Background:

- Developed by combining academic literature, a wide variety of data sources, and the expertise of the DOH Behavioral Health Strike Team
- Highly subject to future waves, government actions, societal trends, social and economic impacts
- Continually informed by new research and data sources

Further reading:

- Statewide Impact Forecast *(updated monthly)*
- Behavioral Health Situational Report *(updated weekly)*


Reactions and Behavioral Health Symptoms in Disasters
Emotional Response – Lows to Highs
HONEYMOON – Community cohesion
HEROIC
PRE-DISASTER
RECONSTRUCTION – A new beginning
Warning
Threat
IMPACT
Working through grief –
Coming to terms
POTENTIAL SECONDARY IMPACT –
Subsequent disaster cascade effects
Setback
Inventory
Secondary honeymoon
DISILLUSIONMENT
Trigger event
Secondary disillusionment
Different Communities in Washington, as of March, 2021 (based on risk / protective factors)
-6
-3
Outbreak
3
6
9
12
15
18
21
Months Pre- and Post-Outbreak

Key Things to Know

Upwards of **three to four million** Washingtonians are or will likely experience *clinically significant* behavioral health symptoms within the next several months- this includes children, youth and young adults.

- Depression, anxiety, and acute stress will likely be the most common
- COVID-19 Unique Impacts: New diagnosis; Post-COVID-19 Psychosis
  - Some adults over 65 seem to have increases in diagnoses of dementia 14-90 days after the initial COVID-19 diagnosis
- Symptoms for most people continue to be strongly influenced by the pandemic and associated consequences
- Many people are **beginning** to move out of the Disillusionment phase of the disaster response cycle and into the Reconstruction and Recovery phase.
  - **This speed and experience of this process will vary significantly among communities and demographic groups.**

Key Things to Know

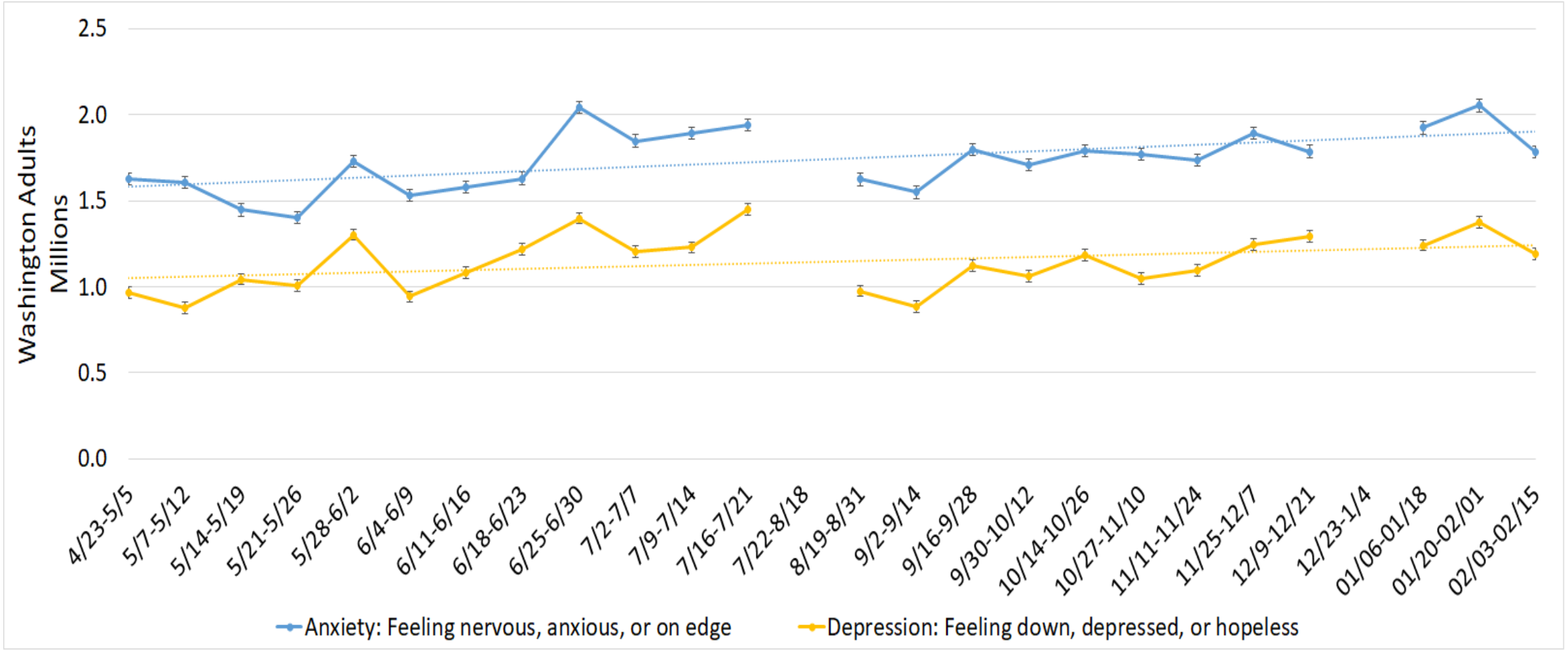
- **One year "Anniversary" reactions to the pandemic will likely be widespread and varied on both an individual and community basis.**

- **Unemployment:** The concept of functional unemployment (those who want full time work but who are unable to get it, or those working full time below the poverty line - 20k / year) has been included in the forecast to create a more nuanced picture of how economic factors may be influencing behavioral health symptoms for the general public.

General fatigue, exhaustion, and feeling overwhelmed are common experiences:

- Sleep problems, diminished cognitive and high-level thinking, memory challenges, and increased impacts of existing behavioral health symptoms such as depression, anxiety, or trauma
- Pandemic Apathy informs "acting out": Denial/ignoring consequences, and "acting in": Extreme hopelessness/not engaging
- For youth, teens, and young adults we anticipate an **increase in risk-oriented behaviors in the spring and summer** due to the degree of psychological impact those groups have experienced.

Anxiety, Depression WA Adults (Census Bureau)



Vaccines, Hope, and Patience

Vaccines bring hope, potential start to the end of the pandemic

- Hope is a positive and powerful tool for resilience and recovery
- They will protect loved ones, those most vulnerable, and ourselves
- Likely an increasing desire to move towards normal, or a "new normal"

Patience will be essential – and very difficult moving into spring and summer months

- More than year has passed, societal and personal impacts, strong desire for "normal life" again
  - Emotional regulation for many people is diminished
- Flurry of information, concerns around the vaccine itself, tiering/phases, etc
- Additional spikes in disease within communities, concerns about additional strains
- Frustration around vaccine rollout and expectations

Resources:

DOH - Forecast and situational reports, guidance and resources:

https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020COVID19/HealthcareProviders/BehavioralHealthResources

WA State – General mental health resources:
https://coronavirus.wa.gov/information-for/you-and-your-family/mental-and-emotional-well-being

Looking for support?
Call Washington Listens at
1-833-681-0211

WA Listens
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Washington State Department of Health

ADDRESSING THE EMERGENCY OF BEHAVIORAL HEALTH CARE IN YOUTH

DOH Behavioral Health Strike Team
Northwest Healthcare Response Network

Pediatric Inpatient Behavioral Health Workgroup

NWHRN/DOH

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NWHRN/DOH

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Today's Objectives

- Characterize the challenge and level of need
- Emphasize the need for a "disaster response" posture
- Introduce the Pediatric Inpatient and Outpatient Workgroups convened by the Northwest Healthcare Response Network (NWHRN)
- Share recommendations from both workgroups
- Share disaster perspective on prioritizing options

Goals

- Find urgent stopgap measure for pediatric mental and behavioral health surge (both outpatient and inpatient)
- Develop methods for coordinated triage from the initial contact with pediatrician or other primary care provider and school resources through referral for behavioral health outpatient care, crisis care, and inpatient or residential care
- Facilitate regular communication among all stakeholders
- Gather data and metrics to inform and guide the uptake and success of interventions
- Coordinate for long term-success, leveraging current stakeholder engagement
- Explore funding options to help address this issue
- Remain cognizant of healthcare inequities

Address Current Barriers to Pediatric Outpatient Access

BOTTOM LINE IS THAT WE DON'T HAVE ENOUGH BEHAVIORAL HEALTH PROVIDERS FOR YOUTH PRE-COVID, AND NOW WE HAVE A LARGE SURGE ON TOP OF SCARCITY OF RESOURCES, LEADING US TO A LEVEL OF EMERGENCY FOR YOUTH BH

- Recruit and mobilize volunteers to free up capacity e.g. Newly retired behavioral health providers, other licensed professionals willing to be trained in evidence-based behavioral health methods, such as trauma-focused cognitive behavioral therapy (TF-CBT), and able to provide 4 – 6 pro bono sessions
- Create structure for access to training for licensed and in-training behavioral health professionals who could help with surge
- Outreach to pediatricians and other primary care providers who might be willing and interested in training on TF-CBT and other skills based interventions, and providing interim sessions
  - Outreach to universities with graduate departments and training for psychologists and psychiatrists, social workers, child and family counselors to help mobilize and coordinate volunteers to include supervised students in training (UW, SPU, SU)
  - Create coordination structure to connect patient with provider

Consider a Broad School Based Screening and Intervention "Sonoma Model"

- Based on current SAMHSA grant in CA, but will be funded in the future by US Dept of Ed. Aimed at children in communities impacted by disaster(including COVID) and some ACEs screening
- Outreach to all parents of students Third Grade and up, offering screening/triage via modified PsySTART triage and PTSD screener, and intervention if care is indicated
- Utilizing current school staff and hiring additional masters level clinicians to provide triage/screening and intervention via Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Grant pays for staff training
- Children at risk are offered 4 sessions of skills module from TF-CBT, re-screened and if not improved are offered an additional 8-10 sessions to include all modules of TF-CBT
- To date, 1000 children screened in 9 school districts with 200 identified as at risk and offered intervention at no cost, delivered by school staff

Additional School Based Resources

- Creating an urgent consultation service for school staff who have concerns about students. This could be modeled after the already established PALS consultation service or an extension of this service.
- Provision of weekly case consultation to school staff by Behavioral Health providers from multiple sources such as from private clinics, Universities, DOH resources and PALS Psychologists
- Establishment of additional school based health services, which could include BH care

Address Transition through Continuum of Care

- **Engage in expansion of ED extension services** to include assistance with some services within EDs
  - Standards for boarding, triage to inpatient or outpatient care
- **Train up staff at general EDs to assist with surge at peds hospitals for behavioral health emergencies**
  - Consider train-the-trainer model to increase capacity for this training
  - Consider expanding the training to school staff, other behavioral health providers, and parents
- **Develop additional crisis resources**
  - Small, localized crisis stabilization services, based on Seattle Children's model of Crisis Consultation Clinics to assist with short-term stabilization, safety planning, parent coaching, and skills for youth
  - Consider a model of training up non-BH providers who would be "care connectors" for patients during the interim between ED and care. These CC would keep in touch via text to offer support and reminders about getting into care. Program based on UCLA and Duke models
- **Hire and train Behavioral Healthcare Navigators** who can assist with coordination of access to care on an outpatient basis, inpatient admission, and discharge planning
- **Consider additional staffing for referral resources such as Referral Assist to allow faster connection to potential resources for families**

Address Current Barriers to Pediatric Inpatient Care

- Develop Multidisciplinary Triage Teams, comprised of individuals from organizations, care providers, navigators, and others who can triage complex cases to appropriate care, and who are in a position to make decisions. Based on Kids Mental Health Pierce County model.
- Consider a statewide or regional (at minimum) inpatient coordinating system to better understand bed availability, potentially utilizing current systems in place
- Add data on available beds, as well as information on the queue for admission and level of severity and priority
- Facilitate situational awareness and communication to all inpatient and residential care facilities

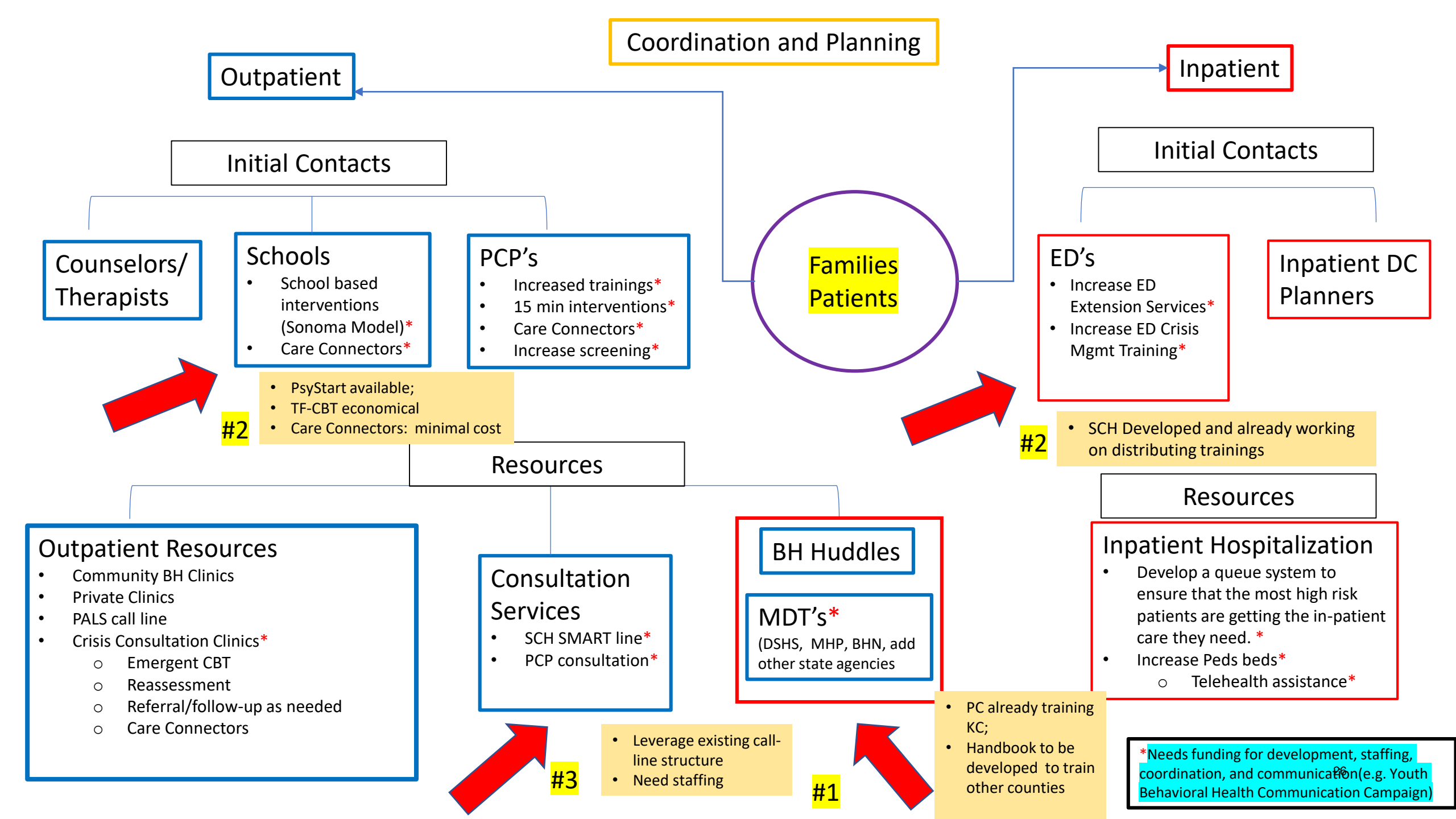
Facilitate Access to Inpatient Care

- Provide inpatient and residential care facilities medical or pediatric mental health assistance so they can potentially expand peds inpatient capability, such as consultation from pediatric hospitalists and peds BH subject matter experts
- Explore and assist with regulatory issues which may be impeding access, e.g. bed type and licensure
- Work with commercial and state insurance to assist with streamlining access to care and assure parity

Gather Metrics and Data

- ED coding for mental health visits (numbers and trends)
- Primary care provider coding for mental and behavioral health visits (numbers and trends)
- Number of peds related crisis calls
- Number of peds mental and behavioral health boarders in the ED
- Rates of Pediatric ICU care for suicidal behavior (tracked over time)
- Rates of medical ward admissions for BH reasons (tracked over time)

Overview
Emergency Response Perspective


Coordination and Planning
Outpatient
Initial Contacts
Counselors/ Therapists
Schools
School based interventions (Sonoma Model)*
Care Connectors*
PCP's
Increased trainings*
15 min interventions*
Care Connectors*
Increase screening*
Families Patients
#2
PsyStart available;
TF-CBT economical
Care Connectors: minimal cost
Resources
Outpatient Resources
Community BH Clinics
Private Clinics
PALS call line
Crisis Consultation Clinics*
Emergent CBT
Reassessment
Referral/follow-up as needed
Care Connectors
Consultation Services
SCH SMART line*
PCP consultation*
#3
Leverage existing call-line structure
Need staffing
BH Huddles
MDT's*
(DSHS, MHP, BHN, add other state agencies
#1
PC already training KC;
Handbook to be developed to train other counties
Inpatient
Initial Contacts
ED's
Increase ED Extension Services*
Increase ED Crisis Mgmt Training*
Inpatient DC Planners
#2
SCH Developed and already working on distributing trainings
Resources
Inpatient Hospitalization
Develop a queue system to ensure that the most high risk patients are getting the in-patient care they need. *
Increase Peds beds*
Telehealth assistance*
*Needs funding for development, staffing, coordination, and communication(e.g. Youth Behavioral Health Communication Campaign)

Summary

- Data supports urgent need
- Significant alignment on goals
- Priorities: (Top 3)
  - Huddles/MDT's
  - Schools: identify at risk
  - Workforce Extenders: ED Extension; Care Connectors
- Other Priorities
  - Reimbursements
  - In-patent capacity
- Emergency Response Posture
  - Situational Awareness
  - Command, Control, Coordination/Communication

Questions?

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Preliminary Ideas

Supporting children, youth and families in the current behavioral health crisis

We are looking for proposals and recommendations to support the behavioral health needs of children and youth over the next 6 to 12 months that:

- Address and triage the full spectrum of rising pediatric behavioral health needs,
- Are equitable (regardless of what kind of insurance a student has),
- Are scalable statewide.
- Can be implemented quickly to meet immediate needs.

The ideas listed below represent a start. Many of you may have ideas to add to this list.

Within OSPI, ESDs, and schools

Tier 1

Current recommendations and existing programs

Recommendation/Idea	**Impact horizon**
OSPI's Decision Package Building Staffing Capacity to Support Student Well-being requests resources increasing staffing ratios related to the safety and social emotional needs of students. ✹ *Partial funding in Governor's budget.*	2022-2023 biennium
OSPI's Decision Package Supporting Students Through Multi-tiered Systems of Support requests resources that provide training and technical assistance on evidence-based approaches to supporting students' academic, social, emotional, and behavioral needs. ✹ *Partial funding in Governor's budget.*	2022-2023 biennium

Expansion of current recommendations and existing programs

Recommendation/Idea	**Impact horizon**
UW Bothell BH online course expansion for K-12 school district staff *FY 2022: $200,000 GFS; FY 2023: $200,000 GFS* ✹ *Budget proviso submitted.*	2022-2023 biennium
Provide additional $ for existing services and supports provided through OSPI.	Next 12 months
Outdoor education expansion ✹ *Proviso submitted.*	2022-2023 biennium
Increase number of regional behavioral health navigators (currently only 1 per region)	Next 12 months

New ideas

Recommendation/Idea	**Impact horizon**
Contracts for classified, certificated, or administrative staff who will provide tiered academic and social-emotional supports to students most impacted by the disruption of in-person learning, including locating and reengaging students who have disengaged from school, one-on-one and small-group instruction, and other intensive learning supports.	Next 12 months
Universal Assessment for social emotional needs, including training for staff and SEB screening tools, *and (next page)*	Next 12 months

Recommendation/Idea	Impact horizon
Invest in real time assessment, triage, and evidence-based supports for schools a. The "Sonoma Model" is a promising approach to population-based screening and rapid access to evidence-based therapeutic interventions via telehealth. We recognize that taking this to scale would be a significant undertaking but are excited by the prospects of their approach. b. School personnel need triage guidance – what they are seeing and where to turn – including knowing that primary care can be a resource in absence of timely counseling access. c. Dr. Hilt's psychologists at the PAL team have had success providing case-based support to school counselors weekly; expansion of this resource could support school personnel. d. Dr. Hilt has ideas for "Fast Track" Referral Assist for schools to provide real-time information about counseling access by region.	Next 12 months
Implementation resources for SEL, including training for staff on use of tools	Next 12 months
Professional learning for educators focused on learning recovery and acceleration, including assessing student learning and social-emotional needs and mental health literacy for all staff.	Next 12 months
Allocate funds to ESDs/school districts/schools to assess what they need to address students' behavioral health needs (at Tiers 1, 2, and 3) – training on SEL training signs of trauma (i.e., how will trauma be showing up in the behavior of children/youth), MH First Aid, etc. *FY 2022: $250,000 GFS; FY 2023: $250,000 GFS for technical assistance* ✹ *Proviso submitted for OSPI to provide technical assistance to school districts.*	2022-2023 biennium and future years
OSPI grant program for school districts to purchase SEL curricula *FY 2022: $500,000 GFS; FY 2023: $500,000 GFS for SEL curricula* ✹ *Proviso submitted for OSPI to administer a grants program for school districts SEL curricula submitted.*	2022-2023 biennium and future years

Tier 2

New ideas

Recommendation/Idea	Impact horizon
Student education groups and intervention groups (Student Assistance Program)	Next 12 months

Tier 3

New ideas

Recommendation/Idea	Impact horizon
Funding (to schools or CBOs) for service encounters that does not rely on insurance reimbursement (Medicaid or private insurance) and: • Pays a higher rate to BH providers to incentivize working with children and youth.	Next 12 months
MCO base rate for ESDs	Next 12 months
Seed money for ESDs to become licensed behavioral health agencies.	Next 12 months and future years
Seed money to increase the number of school-based health centers	Next 12 months and future years
Increase resources in the region that foster collaboration between the Accountable Communities of Health, ESDs, and School Districts, including resources for care coordination.	Next 12 months and future years

Recommendation/Idea	Impact horizon
Expand the PAL for Schools consultation line statewide. • Tier 1: mental health promotion for all staff • Tier 2: Telehealth consultation with school staff • Tier 3: individual student and family telemedicine appoints and crisis management	Next 12 months
Fund and Incentivize care coordination - aligned to work group recommendation of "Identify and remove barriers to using existing funding sources."	Next 12 months

Beyond Schools

Current recommendations or existing programs

Recommendation/Idea	Impact horizon
Teaching clinic enhancement rate: This would be used to develop a recommended enhancement rate for behavioral health training and supervision of students and others seeking their certification or license. ✹ *Included in Governor's budget; provisos submitted in House and Senate.*	Future years
Expand student loan repayment program to increase the number of behavioral health professionals. ✹ *Budget provisos submitted in House and Senate.*	Future years
Respite care for youth with behavioral health challenges: Direct the HCA to explore Medicaid waiver options for respite care without adversely impacting the DDA and DCYF respite waivers - $150,000. ✹ *Budget provisos submitted in House and Senate.*	Future years
Development of standards for use of telehealth with the 0-25 population: Provide one-time funds to the Behavioral Health Institute to work collaboratively with the Evidence Based Practices Institute and others to develop standards. *$410,000*	Future years
Respite care for youth with behavioral health challenges and their families	Next 12 months

Expansion of current recommendations or existing programs

Recommendation/Idea	Impact horizon
Additional capacity for Children and Youth Referral Assistance (PAL): Temporarily expand capacity of the PAL referral assist line to address the tremendous need that has arisen due to COVID. *Estimated cost: $185,000 (or is it $280,000) for 2 specialists for 1 year.*	Next 12 months
Infant and early childhood mental health (IECMH) expansion *FY 2022: $1,200,000 GFS; FY 2023: $1,200,000 GFS* ✹ *Budget proviso submitted.*	2022-2023 biennium
Additional funding for Office of Homeless Youth grant for behavioral health services in shelters.	Next 12 months

New ideas

Recommendation/Idea	**Impact horizon**
Since referrals to counseling can take weeks, increase resources to primary care so they can support families until they can work with a behavioral health provider, including: • Clinic-based navigation for families so they can maintain connection to health care and be successful in getting into behavioral health care, in addition to bolstering PAL's Referral Assist Line. • Support for PCPs in crisis management. • Support parents in strategies to support their children. • Rapid access to evidence-behavioral health care via telehealth whenever possible.	Next 12 months
Rising Strong: Funding to develop a master plan to establish Rising Strong, a program geared towards keeping families involved with SUD together and children out of foster care in Western WA (modeled after Rising Strong in Spokane). The plan would go to the capital budget committee in 2022. *Estimated cost: $150,000*	Future years
Training: In addition to educators/school employees, caseworkers in child welfare, health care professions, and others who work with children/youth would benefit from training around the impact of the pandemic on the BH of children, youth, and families. As previously stated, how will trauma show up in the behavior of individuals?	Next 12 months and future years
Grants to providers: Issue grants to BH providers to do group interventions/therapies/support, generally not reimbursed by insurance or readily available.	Next 12 months
Mobile support: Purchase vans (or other vehicles that could be outfitted as service sites) that could provide services such as navigation, support, information/referral/connections with warm hand-offs, transportation to appointments, short term case-management, whatever the individual needs.	Next 12 months and future years
Wrap-around services for youth covered by private insurance	Future years
Bed expansion for inpatient youth care – how to provide surge capacity.	Next 12 months
Fund concrete goods and services to meet families' immediate crisis needs, such as housing.	Next 12 months
Are there other pilots – in schools or beyond – that could be launched quickly?	Next 12 months and learning for future years
Provide workforce supports for children and youth behavioral health to help providers who serve adults transition to meeting children and youth crisis needs	Next 12 months
Supports for hospitals and emergency departments in addressing children and youth in crisis.	Next 12 months
Funding for family navigators.	Next 12 months

Reports from breakout groups

Workforce and Rates

Top need: Workforce development!

Continue to prioritize the priorities the WF and R subcommittee advanced previously.

Then:

1. Care coordinators/Navigators in PCP sites
2. Incentivize clinicians to extend their hours, days they provide services
3. More training for PCPs to be able to address BH issues they are seeing in their practices

$s MUST be flexible and need to be adequate to be able to get the workforce in place.

School-based Behavioral Health & Suicide Prevention

- Increased resources for care coordination within an integrated BH Model
- Universal Screening and referral to a robust system that can respond
- Increase staff embedded in schools that connect with the healthcare system
- PAL for Schools
- Increased staff for referral assist

Prenatal through Five Relational Health

- Investments in complex needs fund (ECEAP and child care). Included in Fair Start for Kids Act.
- Telehealth recs for 0-25 behavioral health.
- Supports for parents, families, caregivers.

Additional detail

Development of standards for use of telehealth with the 0-25 population: Provide one-time funds to the Behavioral Health Institute to work collaboratively with the Evidence Based Practices Institute and others to develop standards. $410,000 (operating)

ECEAP Complex Needs Fund: Provide behavioral health supports to state preschool (Early Childhood Education and Assistance Program, or ECEAP) by investing $4.5M in one-time federal funds to the ECEAP complex needs fund. $4.5 million in supplemental; $2 million in operating

Child Care Complex Needs Fund: Provide behavioral health supports to childcare providers. This needs to be established. Suggest mimicking ECEAP complex needs fund startup of $2 million (operating budget)

Note: The ECEAP Complex Needs Fund and the Child Care Complex Needs Fund are both included in the Fair Start for Kids Act. In the House version it would go into statute right away. In the Senate version it is subject to available funds.

Option - Early ECEAP: Increase birth to three ECEAP (aka Early ECEAP) pilot by 150 slots. This program serves at-risk infants and toddlers with comprehensive early learning and family support modeled after the federal Early Head Start program and the state ECEAP program. $3 million (operating budget)

Youth and Young Adult Continuum of Care

Top need: **Workforce Development!**

- Lack of in person appointments – what can providers do to open for in person engagement? – Telehealth not working for many families as it is difficult to engage, there are challenges with internet/bandwidth, not comfortable on camera, distractions during telehealth time.
- HopeSparks – built integrated pediatric care facility, using collaborative care model from UW and has implemented it to fidelity – rolled out in the beginning of COVID pandemic which was interesting, well child visits often turned into a behavioral health conversation, finding 80% of parents say "yes" and are not having to go home and make numerous calls – 1.2 days from offering into enrollment, numbers of enrollment are skyrocketing – striving to catch kids early, before they are needing an outpatient footprint – building an entire new step of care and are seeing results – they do believe they can scale it - need to discuss B-5 – the team is 3 people, ARNP, PCP, and BHCM – Question from group - is it insurance agnostic? YES, it's been successful because they had a runway to get it rolling before getting codes set for pay – Rep Eslick is sad to know insurance issues haven't been addressed as of yet, would like to see that happen
- ECEAP Association – one of their big challenges in both hiring mental health specialists and referring, it is difficult to find specialists of color, could we think about this in terms of laying down an infrastructure (scholarships, cohort models, recruitment model) in mid university to see if they want to consider – one time money, how can we use it in the best way for long term success – Rep Eslick agrees and suggests working on ways to support interested people in getting needed education – Tona McGuire loves the collaborative care model and hears primary care are more and more doing mental health, offering training in CBT is a bonus for primary care providers and that gives training, oversight, and other benefits – Rep Eslick reminds that with collaborative care we still need the work force, we can start now and begin to build it
- If we treat this as a disaster, it gives us the mandate and permission to do it differently, programs and policies don't change lives, people change lives. Some atta boys he wants to touch on, can we get some messaging out now to let young people know that it is okay to not be okay? How can we arm the entire state with Pub Health messaging that adults need to be more aware and support both PTA's and common folks. More direct interventions – capacity and access are the two big issues we have discusses, young POC want to be certified and can't afford it – do people need that Masters to be helpful, are we making room for Peer Counselors? How can we support these Natural Leaders? We need community level interactions and support to be preventive from youth moving

into more intense services. Peer work is great in this aspect. Jim has been serving kids for 40 years and see young people out of foster care, queer youth not yet accepted by family, how can we provide support for those serving these youth? We have the youngest professionals, least trained, and least paid working in these shelters and supporting these youth. They don't have the skillset or capacity to know the difference between psychosis and trauma acting out. We need BH resources directly into these shelters. Young people have been avoiding these shelters due to COVID and insufficient staffing. He states there has been a number of OD's - Karen Kelly WA State Community Connectors strongly agrees!

Behavioral Health Integration

- Clinic-based navigation and coordination in primary care for families so they can maintain connection to health care and be successful in getting into behavioral health care, in addition to bolstering PAL Referral Assist Line.
- Support for PCPs in crisis management, including training, case-based support, and increased reimbursement for PCP support for BH crisis.
- Support parents in strategies to support their children.
- Rapid access to evidence-behavioral health care via telehealth whenever possible.
- Increased funding for BH screens in primary care.

CYBHWG: Synthesis of recommendations – 3/23/2021 meeting

I. Summary

* YYACC – Youth & Young Adult Continuum of Care NWHRN – Northwest Healthcare Response Network **Recommendations**	**Workforce & Rates**	**School-based BH**	**YYACC***	**Prenatal thru 5**	**BH Integration**	**NWHRN***
Cross-system						
Increased resources for care coordination within an integrated behavioral health model		✓				
Supports for parents, families, caregivers.				✓	✓	
Preventive - Public health messaging statewide for adults and for youth; community efforts.			✓			
Create coordination structure to connect patient with provider						✓
Work with commercial and state insurance to assist with streamlining access to care and assure parity.						✓
School System – ***More to come in next week's subgroup meeting***						
Universal screening and referral to a robust system that can respond / NWHRN: "Sonoma Model" – outreach to all parents re screening/triage/intervention model; current school staff and additional clinicians providing 4-14 sessions of Trauma Focused CBT for children and youth screened at high risk.		✓				✓
Increase staff embedded in schools that connect with the healthcare system		✓				
Urgent consultation service for school staff (could be PAL, or extension of PAL)						✓
Provision of weekly case consultation to school staff by BH providers (private clinics, universities, DOH resources, PAL clinicians)						✓
Establish additional school-based health services, including BH						✓
PAL for Schools		✓				
Outpatient behavioral health						
Increased staff for Children and Teens Mental Health Referral Assist		✓			✓	✓
Support providers in returning to in-person engagement/ appointments.			✓			
Incentivize clinicians to extend their hours and days providing services.	✓					
Telehealth recommendations for 0-25 behavioral health/ Rapid access to evidence-based behavioral health care				✓	✓	
More training/supports for PCPs to be able to address BH issues they are seeing in their practices./ Support for PCPs in crisis management, including training, case-based support, and increased reimbursement for PCP support for BH crisis.	✓				✓	
Clinic-based navigation and coordination in primary care for families					✓	
Increased funding for behavioral health screens in primary care.					✓	

	Workforce & Rates	School-based BH	YYACC	Prenatal thru 5	BH Integratio	NWHRN
Primary care						
Outreach to pediatricians and other primary care providers who might be willing and interested in training on Triple P and other skills based interventions, and providing interim sessions						
Integrated behavioral health in pediatric care (HopeSparks)			✓			
Care coordinators/navigators in PCP sites	✓					
Hospital/ED system						
Engage in expansion of ED extension services – standards for boarding, triage to IP or OP care						✓
Train up staff at general EDs to assist with surge at peds hospitals for BH emergencies						✓
Develop additional crisis resources – small localized crisis stabilization services, based on Children's model of Crisis Consultation Clinics – short-term stabilization, safety planning, parent coaching, skills for youth. Consider non-BH provider care connectors (UCLA and Duke models).						✓
Hire and train BH navigators.						✓
Develop multi-disciplinary triage teams (based on Kids Mental Health Pierce County Model).						✓
Inpatient care						
Consider statewide or regional IP coordinating system to better understand bed availability.						✓
Add data on available beds and queue for admission and level of severity and priority.						✓
Facilitate situational awareness and communication to all IP and residential care facilities.						✓
Provide inpatient and residential care facilities medical and BH assistance, such as consultation services, so they can potentially expand beds.						✓
Explore and assist with regulatory issues, e.g. bed type and licensure.						✓
Workforce						
Recruit and mobilize volunteers (BH professionals) willing to be trained in evidence-based behavioral health methods and able to provide 4 – 6 pro bono sessions						✓
Outreach to universities with graduate departments and training for psychologists and psychiatrists, social workers, and child and family counselors to help mobilize and coordinate volunteers to include supervised students in training (UW, SPU, SU)						✓
Create structure for access to training for licensed and in-training behavioral health professionals who could help with surge						✓
Workforce development: Develop workforce infrastructure – for capacity and diversity (more POC) – scholarships, cohort models, recruitment models – higher ed – supporting people in getting needed education. 2021 Workforce & rates recs.	✓		✓			

	Workforce & Rates	School-based BH	YYACC	Prenatal thru 5	BH Integratio	NWHRN
Early childhood system						
Investments in complex needs fund (ECEAP and childcare) *Included in the Fair Start for Kids Act*				✓		
Other systems						
Behavioral health resources/supports in shelters.			✓			

II. Priorities - Northwest Healthcare Response Network – Youth Behavioral Health Workgroup

1. Implement huddles/multi-disciplinary teams to address those with immediate, complex needs.
2. Schools: Identify at-risk students and provide supports, including care connectors.
3. Provide behavioral health supports to emergency department staff: training, workforce extenders, care connectors

III. Existing programs which could potentially be scaled up or used as models

Direct support to youth and families

- *Children and Youth Referral Assistance*

Supports in schools

- *Behavioral Health Navigators*
- *PAL in Schools pilot*
- *"Sonoma Model" in schools*

Crisis services

- *Crisis Consultation Clinics (Seattle Children's Hospital)*
- *Multidisciplinary Triage Teams (Kids Mental Health Pierce County)*

Supports through pediatric primary care providers

- *UCLA and Duke models for training and care connectors programs*
- *Triple P training for primary care practices*

CYBHWG Chat log - 3-23-2021 (edited)

- When we say school based that's k-12, right? What is the thinking around childcare and pre-k?
- Are we looking at peer navigators (parent navigators)?
- We need to think about a similar model for early learning.
- Education Staff Associate Certificated School Social Workers, Psychologists, Counselors and Nurses could be explicitly stated in the "schools" box. School-employees who serve and support behavioral health needs of students. School Social Workers are specifically trained as mental health professional who specialize in the school setting and coordination of care.
- The Care Connectors for the Text Back program can leverage peer navigators, yes.
- Seattle School District is partnering with the UW SMART center in their Research Intervention Project training all School Social Workers in TF-CBT
- The Governor did not identify a level of funding in his executive order.
- Are children who are in foster care being factored into the discussion? Also, young adults that are aging out of the system.
- Workforce!!
- If not in one of the other recommendations, would want to ask for expedited examination of the results of the IOP/PHP pilot that HCA is implementing so that, if appropriate, it can be expanded.
- Navigation or coordination can help improve racial/ethnic congruence if done right.
- The apprenticeship work is underway; that was a strong support item from the CYBHWG and is a very effective way to increase diversity of the workforce.
- Care navigators available to pediatricians who identify families in need, particularly pregnant mom's through parents of age 3. Could set up MDTs of key biopsychosocial agencies with goal of linking families to resource versus asking them to navigate and find their way through this complex system alone.
- Mental health curriculum at school for all children, models offered a key transitional academic transition points K-->1; 5/6-->7th;8/9th-->10th. Resilience, coping, identification of internal and peer warning signs, when/how to get adult support…etc. We have health and sed-ed modules at school. We need a mental health curriculum for our youth.
- Prenatal through 5 - Upstream and preparatory work is incredibly important. Supporting all caregivers – parents, providers, teachers.
- I wonder about including the Parent to Parent program to support parents – some of them had amazing experiences and could share information and ideas with other parents. Might this be a way to get more support for parents – to include P2P in PCP offices? Or have a referral process from PCP offices to P2P?
- P2P would be good support for parents…
- Could make on-line parenting groups very widely available.
- P2P is doing this – has been very successful at getting parents involved in supports via zoom!
- Let's remember that we must have long term beds for our youth!
- I totally support parent groups via Zoom. This could be very helpful for the families I take care of with all the degrees of mental health challenges.
- Have we thought about mobilizing Community Networks that began as part of the ACEs work in