PN25 Behavioral Health Strategic Plan Advisory Group Meeting Notes

Thursday, July 6, 2023
2–5 p.m. Pacific Time

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Members

Youth/Young Adults			
☐ Hannah Adira	☐ El Dolane	☐ Sol Rabinovich	☒ Lillian Williamson
☒ Darren Bosman	☒ Tracey Hernandez	☐ Casi Sepulveda	☐
☐ Xana Caillouet	☐ Bree Karger	☒ Amanda Shi	☐
☐ Sierra Camacho	☐ Kaleb Lewis	☐ Chanson Toyama	☐
☒ Sage Dews	☐ Desi Quenzer	☐ Oscar Villagomez	☐

Parents/Caregivers			
☒ Tina Barnes	☒ Amy Fumetti	☐ Niki Lovitt	☒ Sharon Shadwell
☒ Marta Bordeaux	☒ Melia Hughes	☐ Sarah McNew	☐ Lamara Shakur
☒ Melissa Brooks	☐ Rokea Jones	☒ Alexie Orr	☐ Tui Shelton
☐ Christi Cook	☒ Michelle Karnath	☐ April Palmanteer	☐ Kimberly Slattery
☐ Alyssa Cruz	☐ Karen Kelly	☐ Rosemarie Patterson	☒ Danna Summers
☒ Peggy Dolane	☒ Brandi Kingston	☒ Liz Perez	☒ Marcella Taylor
☐ Jamie Elzea	☐ Nicole Latson	☐ Jessica Russell	☐
☐ Heather Fourstar	☐ Starleen Lewis	☒ Janice Schutz	☐

Other Members		
☒ Shelley Bogart (Department of Social and Health Services-Developmental Disabilities Administration)	☒ Hugh Ewart *or* Laurie Lippold (Workforce & Rates subgroup)	☐ Sarah Rafton *or* Kristin Houser (Behavioral Health Integration subgroup)
☒ Kelli Bohanon *or* Kristin Wiggins (Prenatal-5 subgroup)	☒ Steven Grilli, Department of Children, Youth and Families	☒ Michele Roberts (Department of Health)
☒ Lisa Callan, Co-Chair (House of Representatives)	☐ Summer Hammons (Tulalip Tribes)	☒ Delika Steele (Office of the Insurance Commissioner)
☒ Britni Dawson-Giles Suquamish Tribe	☒ Kim Justice (Commerce – Office of Homeless Youth)	☐ Bridget Underdahl (Office of Superintendent of Public Instruction)
☐ Byron Eagle (Developmental Disabilities Administration-Child Study Treatment Center)	☐ Amber Leaders (Governor's Office)	☒ Keri Waterland, Co-Chair (Health Care Authority)
☒ Carolyn Eslick (House of Representatives)	☒ Jeannie Nist (School Based Behavioral Health & Suicide Prevention subgroup)	

Staff		
Erika Boyd (Legislative staff)	Diana Cockrell (HCA)	Cindi Wiek (HCA)
Rachel Burke (HCA)	Nate Lewis (HCA)	

REVIEW FULL VALUE AGREEMENT

See TVW recording (05:15)

- Advisory group members reviewed and approved the full value agreement, revised to include the proposed changes from the May 22nd meeting.
- Edit request approved: "Speak your truth, from your own expertise."

Full Value Agreement

PROJECT UPDATES

See TVW recording (13:30)

- The end of the fiscal year has been an opportunity to reassess where we are in the planning process to determine if we are on track to meet the legislative objectives.

- **As we reassess:**
    - We want to make sure all the investments in Washington State are focused on the full age continuum, Prenatal through 25.
    - There is a need to identify and talk about *all* parts of services, including but not limited to delivery, promotion of well-being, early interventions, complex needs, crisis interventions and responses, recovery, and ongoing supports to ensure well-being for all the children youth, young adults, and families in Washington State.
    - We continue to try to make sure services and supports are culturally responsive, accessible, affordable, available when and where families need them, and that they cover the full continuum of care, which includes well-being.
    - We want to make sure any investment is targeted and comes with understanding of our current behavioral health system, identifying weak points, gaps, and what is needed.
- **Moving forward:**
    - Continue to work on the vision.
    - Determine how to best engage and involve diverse communities and stakeholders across the state.
    - Develop a picture of the current landscape that shows current services and supports.
      Diana Cockrell shared a potential care continuum framework collect and compile current behavioral health services and supports for children, youth, young adults and families.

Care continuum framework

EMERGING STATE PRACTICES REPORT

See TVW recording (53:10)

Emerging State Practices Report

BREAKOUT GROUP EXERCISE: SETTING A VISION

See TVW recording (1:20); complete notes for breakout groups on page 6

- All attendees were invited to participate in small groups to discuss the following questions:
    - What are your goals for the vision?
    - What personal experience makes those goals important to you?

Identified themes in responses:

- Comprehensive
- Person-focused
- Simple to access and navigate
- Well-staffed
- Proactive
- Integrated
- Investment in behavioral health care with other healthcare: for those with traumatic incidents (experience with cancer for family member)
-

PUBLIC COMMENT

See TVW recording (1:52)

- *Jerri* - There was a wonderful list of 5 things that other states have found to be helpful in rethinking their behavioral health system and number 5 was leadership. I think we kind of skipped over that number 5 fast, but I think it's important to circle back and think about to think about leadership.

  My second thought because they tie together, is what I didn't see in the wonderful grid is where they talked about the different age ranges and the different aspects of the system, or anything that's going to circle around tracking outcomes with a lot of thought around what outcomes we will be tracking.

  Are children staying in school and being successful in school? Are they graduating from high school? Are they finding something meaningful to do after high school? Are they maintaining relationships? Are they safe and stably housed? Those are real life outcomes that currently are a disaster, and we know children are not accessing appropriate behavioral health services when and where they need them. So, I want to see more focus on how this strategic plan creates leadership and includes accountability for real life outcomes, tracking and measurements.

- *Kashi* - I just wanted to name some challenges here with the vision concept. Having a vision that's big and bold is so valuable and I'm struggling with how to balance that with some of the reality. Some of these types of care actually are necessary, or that some of these types of care actually don't need to exist because we do such a good job of supporting kids and families before this kind of crisis happens. Even though they may not be ideal in practice. The in a vacuum is what I'm thinking about.

  Often when we think about the behavioral health system, we make that really about the healthcare part of that or the evidence-based practice or this restrictive rigid definition of behavioral health. There's been so much discussion today about how important it is to make sure that we don't do that in this plan, that there is a wide range of experiences, community programs, interventions that are considered and included and elevated through this work. I know for myself that when we take some of those guardrails off, I can go too big too quickly and start thinking about, you know, social determinants of health interventions and other things that really support kids and families and being healthy and well. And so, at some point we may need to have a conversation about where we must draw the line about what's reasonable to have within this strategic plan so that we can implement it and execute on it. And I think

I'm making more questions than answers, but I wanted to just name those challenges and I'm excited about the next steps. Thank you.

- *Avreayl* - I just want to make comment that I did in our small group as well. Which is if we were to think about designing the systems or our responses to thinking about all the circumstances where there are gaps but from the perspective of youth and families. Who are seeking certain kinds of assistance. Many of us who work in the systems, many of us who have tried to access systems. Often run into the space of well I don't fit in this category of how this system defines itself. And if this system says I don't need any more care, or I don't need this level of care, then it's just left for the parents, the family, the youth to figure it out by themselves. So, when we think about system design or that vision plan, even taking different scenarios we know exist and walking through them. How would this vision meet that need or resolve that gap or the gap of just being left to figure it out on your own devices. So, that's just another possible way of looking at whatever gets proposed and seeing if it meets what we're thinking and what we want.

BREAKOUT SESSION GROUP REPORTS

See TVW recording (1:23)

1. WHAT ARE YOUR GOALS FOR THE VISION?

- Proactive
- Family can present their problem and the system has a place for them in a complex grid about how they'll respond.
- Evidence-based
- No wrong scenario – the system will treat you as you are.
- Prepared response for all presentations of a problem, instead of having to fit into a category.
- System invested in my child's mental health as I am.
- I know who can help me identify and access services.
- Consistent and predictable – not forced to switch providers.
- Collaboration with other state systems that work together and become a tight unit across all areas and levels so no matter where folks are they can get the same supports and care.
- Parent-centered, focus on biological, supporting active involvement.
- Services like WISe were available to everyone.
- The strategic plan needs to address all levels of the system.
- There needs to be something between inpatient and community health.
- The system needs to be easy to understand and access.
- Low barrier – easy to qualify – no income or insurance requirement.
- Services need to be readily available.
- There should be help/support for parents.
- No waiting lists.
- Embrace idea that a person can ha e 2 diagnoses that can complicate each other and providers need to know how to deal with this.
- We need to use better language, such as doesn't communicate with words as opposed to being non-verbal.
- There needs to be better collaboration between schools and providers.
- Shouldn't have to be in crisis to get services.
- We need to attend to the well-being of people…. We need to look at poverty/racism and other factors that deeply impact well-being.
- We need to be able to do non-traditional kinds of things and have them paid for without game-playing, etc.
- Have community make referrals to programs like ESIT, not DCYF.
- **Easy to navigate:** Single door entry. Support in navigating from one step to another, from one level of need to another, because we know it is going to happen.
- **Focused on prevention and starts early:** Focus on upstream preventative factors, including minimizing adverse (childhood) events, at both the broad societal level events and at the family/individual level. Prevention work really starts early in development, earlier than 0. Focusing on maternal health/wellness/wellbeing and supporting mothers from experience trauma or mental health issues.
- **Not driven by funding or eligibility:** the biggest disaster in our state is that funding, eligibility, and outcomes drives the program. We work so hard to get the Medicaid match to get the legislature off our back. But if we focus on the Medicaid match, we will always have an underfunded system. At the fork in the road, we can ask for $100 million dollars in state funds, set it up, and then ask Medicaid to come along side.
- **Co-occurring/multi-disciplinary:** Able to engage with people and have knowledge about whether this is also medical, developmental, behavioral, social determinants (e.g., housing) and connect to needed resources.
- **Linguistically and culturally appropriate care**
    - Personal experience: friends are still having problems with doctors don't understand Mongolian spots, worried about being reported to CPS.

- **Relationship-centered**:
    - Example: Harborview early childhood program – engage 14 times in the first few years of life, so there is a relationship.
- **Includes nontraditional services**: non-traditional ways of providing service and developing mental health programs.
- Vision that is long term. Beyond biennial cycles
- Focus on health and wellness. Not waiting for someone to be sick enough. Focus on health instead of sickness
- Inclusive of a range of diagnostic, race, ethnicity, culture etc. - an "intentionally equitable system for all"
- All state agencies speak the same language and have a common framework for this work - agencies. Both on a policy, implementation – common language and grounding compass between all state agencies. For example, terms like behavioral health should mean the same thing to HCA, DCYF, OSPI etc.
- Youth with complex and challenging needs that don't fit clearly into one system…services for these youth not just left to parents. The system needs to be built with acknowledgement of these complex individuals and intentionally be built so no one "fall through the cracks"
- Ensure there is adequate capacity built for this work or it won't work.
- Ease and transparency for families. They don't need education on how to navigate the system, they just make a call and families don't have to worry about insurance or what happens behind the scenes
- Families should not have to think about where to go or what their child needs, it should be easy
- We say things like "no child left behind" or "all children prioritized" but we need to think about what that would actually look like in real life and build the system with that vision in mind
- The system should reflect priorities of communities – should address things that may fall outside of BH but that have a big impact on BH needs
- Services available whenever needed and wherever individuals and families are – not just certain times or places in the state
- Individuals in Washington know they are important, valued and cared for
- Records we have access to and records we don't have access to
- Consistent rules around insurance
- Doctors, schools,
- Not medicalizing kids
- Autism - SITs waiver – disappeared – transformational -life-changing – in-home behavioral supports
- Making sure the family is included, however you define family.
- Mental health parity with physical health. Community as well as the services.
- Should be no wrong door to getting the services you need.
- High needs kid and resource for other parents.
- Elephant in the room of need – when a person presents a danger to himself and others that allows use of safe methods of restricting behaviors. Needs to be built into our system – or homelessness and incarceration take over.
- School system – kids come with diagnoses – IEPs etc. – but there was not sufficient support. Educators not trained on how to work with these kids.
- Much more streamlined process for getting access to care.
- Services that are needed in state.
- Being asked to wait until they fail all other systems before they can get IP care.
- My goal is to have a shared vision for our young adults to live independently (with healthy family support) in the world. i.e., housed, employed, healthy.
- Capacity Building
    - Behavioral health system to do the bare minimum (Prioritize implementation/what can change now)
    - Talking about many things down the road, but need capacity to be expanded
- Cultural Empathy & Representative Leadership
    - Perfect system emphasizes cultural empathy and inclusion of leaders from different backgrounds and experiences
- Optional anonymity – can stay anonymous when seeking treatment offerings
- SUD & Disease of Addiction
    - Narcan availability

    - Effective medical lifesaving treatment research
- Uplift Unique Lived Experiences
    - As someone who has had experiences not receiving proper treatment or feeling fully supported in relation to mental health services, sharing experience can be helpful since it can provide insight into what living in those kinds of situations might be like.
- Integrated care for medical care conditions

2. WHAT PERSONAL EXPERIENCES MAKE THOSE GOALS IMPORTANT TO YOU?

- We're not using the tools (prescriptions, etc.) that are available to us to find out the core needs of the person. Stop with the guessing game and take the time to figure out the person's need.
- I saw a lot of trauma being inflicted on children due to staff turnover in the local Medicaid-based system in Kitsap.
- My daughter has seen probably 5 therapists in a year and the one who ultimately worked said that she couldn't help my daughter because she has autism.
- Access – this involves all insurances.
- Always in crisis response
- Parent-focused and ensuring that parents have a central role
- Families are in crisis, really vulnerable financially and emotionally
- Sister was dropped from the system
- I also wanted to mention that children experience racism with incorrect dx more than others. I see many children misdiagnosed with ODD as opposed to ASD for example. Also, children don't have the same access to Special Ed services. oftentimes a black or brown child will be sent to the principal instead of receiving supports for learning disabilities or behavioral disorders
- Personal experience: Not having the help I need is just as stressful as having a child with serious mental illness.
- Personal experience: In early childhood world, there is confusion about where to go for services – what's developmental, what's behavioral, what's medical. And if you have access in one system, why is it so hard to navigate to another system?
- Personal experience: friends are still having problems with doctors don't understand Mongolian spots, worried about being reported to CPS.
- Example: Harborview early childhood program – engage 14 times in the first few years of life, so there is a relationship.
- Walking around on the Ave – having to carry Narcan and utilize it

COMMENTS IN CHAT

CONTINUUM OF CARE FRAMEWORK

- Surprised not to see "Return to Community" or something post inpatient. This graph is great in many ways but seems to replicate the mistake of the actual system: drop off /nothing post inpatient. also, sorry if I missed it but are we talking both mental health and SUD? thank you, Diana.
- This may have been said but the "age" doesn't always match what is typically developmentally appropriate
- I like what this is aiming to achieve. Want to make sure that partial hospitalization has a home here (maybe with intensive outpatient). Also, where does crisis care appear? Could it be added somewhere along this continuum?
- There's clearly a lot of thought that has gone into developing these graphics, and I appreciate how it better reflects the complexity of the system. On the Layers to consider slide, I'd love to see Early Care and Education included under System delivery along with School settings. This is where I'm seeing a significant need for intensive intervention for many of my B - 6 clients (and where my family needed support as well), and there are many barriers to system provision specific to this setting that need to be addressed.
- I'm interested in 'non-traditional' types of approaches that could potentially be appropriate for individuals of various ages with different levels of need/acuity. Seems like traditional/clinical approaches are not best for all!
- I am unclear on the relationship between the X and Y axis's ("care continuum" vs "age and transition"). In my limited understanding age is disconnected from the type of care needed.
- Thank you for 'Developmental Responsive" but might suggest adding Culturally Responsive as well.
- Diana, is respite care rolled into any of those categories? I have seen a trend among the highest needs kids discharging from CLIP, that respite care is a really needed component of discharge planning, that is almost always inaccessible.
- I'd like to see an open line of communication with the family. This is so important when the person is transitioned back out.
- I would like to see "involuntary and voluntary" listed as aspects of long-term IP, Inpatient, and Intensive outpatient categories. These are explicit aspects of the continuum of care, and they do not cancel out each other--e.g. a voluntary option for care doesn't negate the need for an involuntary option for care and where/how those services are delivered is unique and distinct.
- I would imagine respite would sit across all of the outpatient to and through Long term for the ages it's appropriate...
- Then we can look at the impact of covid for example.
- The biological family is integral to mental health. Studies show that the breakdown of the biological family is a significant contributor to negative childhood mental outcomes. Under the Preventative box, I would love to see more supports for the biological family.
- Also, adding "un-expected" on ramps like TMI.
- I am excited about these axes to give us the ability to articulate which services/programs exist at the various levels of the continuum specific to age ranges. I have struggled in depicting the continuum to capture the geographic differences - I wonder if there's also a way to physically map where these services are based/operating?

- The comment on attachment fits into what Rep Callan was just speaking to. It goes across the life span and impacts all stages of development.
- Thank you for taking that approach - figuring out what the State already knows, what data it has, etc., before spending State $ on a consultant to go over that ground.
- Adoption and divorce are childhood traumas as profound as foster care.
- Are there any studies that show us reasons for divorce especially among families of complex children?
- Defining what recovery looks like --- for children who are "recovering" from in-utero risk factors. Children develop and grow into their fullest self when we don't think about young children in recovery -- unless it is from a traumatic event.
- Growth and resilience might replace recovery as more appropriate words.
- I agree, I think Recovery feels like an antiquated model and not a good fit.
- Recovery is a process not a destination and recovering from or reducing impact of significant symptoms is part of that process.
- Growth, coping skills, resilience, learning, development...all part of a supportive strategy.
- I think the word 'recovery' has a built-in connotation of returning to some former state, when in reality, personal wellness is a journey forward, with many twists and turns, and ups and downs.
- We can speak about resiliency when we have access to resources.
- Recovery also seems to suggest returning or progressing toward a 'normal' state and does not provide room for celebrating neurodiversity.
- Here is an interesting article that answers some of the largest causes. Seems to reference reliable sources (always need to check that): https://www.forbes.com/advisor/legal/divorce/divorce-statistics/
- On the mapping, is this also available for people with the ACP (Address Confidentiality Program)?

EMERGING STATE PRACTICES REPORT

- As someone who regularly participates with the Quality Learning Collaborative around System of Care/MRSS, another critically important Takeaway I took from New Jersey and Connecticut models, is that the family/youth DEFINE THE CRISIS. that is critical because existing systems often require families to explain and validate the crisis, which can imply fault, feel invalidating, and add trauma for families already in crisis.
- The Utah model also has family defined need for 24/7 triage.
- Our State is dipping its toe into Wellness Coaching. I was one of 16 or so people trained by Peggy Swarbrick in SAMSHA's 8 dimensions of Wellness as a trainer.
- I wonder how a wellness coach would work with a family whose child is attending Northwest SOIL.
- I'm hoping as a group, we can do some careful thinking about EBPs and their place in WA's P-25 BH system of care. There are many populations for whom commonly used and heavily incentivized EBPs are not actually beneficial and may even be harmful (and I'm not just referring to ABA). Being honest about this, really listening to the voices of folks with lived experience and building funding into the system for alternatives so that consumers have true choice feels important.
- Wonder what the cost per school in Michigan…
- Is there any thought as to how the ESD would be affected and or a part of something like this? PSESD does similar programs, though it's only for certain schools.
- Concern that a focus on "wellness" creates a culture of blame for families unable to "prevent" an organic brain illness from manifesting and causing significant impact. So imperative that children with significant

symptoms (and their families) are upheld with evidence-based treatment, care, and concern and not cut off from resources that are shared more broadly for those easier to help.

- Replying to "Concern that a focus...", we need a "both and" perspective!
- https://apnews.com/article/betterhelp-ftc-health-data-privacy-befca40bb873661d1f8986bb75d8df07
- Yes, please feel free to send us thoughts to cybhwg@hca.wa.gov!
  We'd love to hear from all in Chat on these questions:
  - What would be helpful to know about that is not currently covered in this report?
  - What would you like to know more about?
- We keep all comments and feedback to inform the plan as it develops.

BREAKOUT GROUPS: VISION

- For everyone: we create a social safety net system that allows all individuals to THRIVE to the best of their ability, regardless of pre-existing access to resources or any other factors that influence a person's lifetime trajectory".
- Statewide EHR to improve coordination in care.
- My goal is to have a shared vision for our young adults to live independently (with healthy family support) in the world. i.e., housed, employed, healthy.
- What is a 25-year-old healthy state? How do we develop our children who are impacted by life events into full participants in society?
- How to create successful transition "systems" into adulthood for our 25–30-year-olds?
- As a parent of a 22- and 24-year-old who have managed to graduate from high school but are still working to get stability in their lives... mostly due to adaptive skills lagging because emotional regulation skills were lagging. What do "we" collectively expect from our children in our schools. What do they graduate to and how do we celebrate those at the bottom of the class?
- *Celebrate= to lift up and ensure they are securely planted into the adult world.
- Want to strongly endorse Jerri's comments about leadership. We have wonderful partnerships with HCA, DOH, etc., but we need more dedicated time to this work IMO. And outcomes are hard to track, but also an extremely important part of this work.
- And schools... especially in an increasingly privatized education system.
- Whole family-health-centered system design.
- I appreciate that idea of walking through the experience of families (and their service providers), Avreayl.
- Real-life outcomes are so important to track and measure because we will get better at what we track. School engagement, graduation rates, finding something meaningful to do following high school, stable housing...are a few key examples.
- It would be great to have more discussion about what leadership would look like…. What are folks thinking?!
  - In other states there is a Department of Mental Health that is responsible for leadership and accountability.

- Seems like we should at least have a director of children & youth BH services, even if not a separate department, that is staffed with people who have expertise in this area.

- COMMENT- How can we get teaching about emotions, emotional regulation. Practicing yoga and/or mediation, etc. into schools?

    - Replying to "COMMENT- How can we ..." I think it should be included in coursework that counts towards credits. Many schools avoid it because it "doesn't count towards grades.

POST-MEETING COMMENTS, SENT TO CYBHWG@HCA.WA.GOV

CONTINUUM OF CARE FRAMEWORK

JERRI CLARK

After last Friday's strategic planning committee meeting, some important news fell in the state that made me realize a key service area is missing from the schematic—forensic mental health services. Our county jails are the largest providers of mental health services for people experiencing psychotic symptoms of severe mental illness. Psychotic illnesses most commonly begin in late adolescence/early adulthood. A young person experiencing a psychotic break is more likely to end up in jail than in a hospital. Their adequate care and diversion from a prison pipeline needs to be included as a very important element of the strategic plan.

Mental health services through the criminal legal system may be in a juvenile detention center/jail/prison, in a state hospital, or outpatient/out of custody. These services are a disaster in WA State.

Here is the article that dropped Friday about the state's $100 million in fines due for failing to provide an **infrastructure** to keep from warehousing mentally ill people in jail: Federal judge fines WA agency $100 million for mental health failures | The Seattle Times

Federal judge fines WA agency $100 million for mental health failures

Washington officials and advocates have been locked in a legal struggle over how to ensure people with mental illnesses aren't being warehoused in jails.

www.seattletimes.com

We need an alternative way to support people with actual mental healthcare services, not just "civics lessons" (what my son got for $1,000/day at Western State Hospital in 2017). People who are incarcerated because of behaviors related to mental illness need mental healthcare, and that's got to be included as an aspect of the strategic plan, just as involuntary services through the civil commitment system must be included. Here's how North Carolina is addressing the problem of "competency restoration": How North Carolina Hopes to Cut the Waits for State Psychiatric Hospital Beds | FRONTLINE (pbs.org)

How North Carolina Hopes to Cut the Waits for State Psychiatric Hospital Beds | FRONTLINE

WFAE has been exploring the crisis brewing in North Carolina's mental health system. That includes a shortage of state hospital beds. Now North Carolina is piloting a program it hopes will alleviate the crisis.

www.pbs.org

Also, while I have your attention, I keep beating the drum about SMI needing a unique position in the healthcare continuum. Schizophrenia spectrum disorders are not preventable. They have always been and will always be part of the human condition. We need robust, humane systems of care to help people and their families live with them. Involuntary inpatient and outpatient options must be planned for because people with SMI so commonly lack insight and the mental ability to self-manage their own care—specifically because of the nature and severity of their disease. There are many people in WA State who deny the honest truth of this, and they will fight to block appropriate services for this population. That's why I will not stop beating this drum. Here's a really new article that provides the science to support this critical need for planning: Schizophrenia Linked to Non-Inherited Genetic Mutations - Neuroscience News

Schizophrenia Linked to Non-Inherited Genetic Mutations - Neuroscience News

Researchers found a link between schizophrenia and somatic copy-number variants, mutations occurring post-inheritance.

neurosciencenews.com

Thank you for continuing to include my comments and insights as part of this work.

EMERGING STATE PRACTICES REPORT

LAURIE LIPPOLD

I'd love to know if there are states that have embraced nontraditional approaches, if they have been successful, how have they been funded, etc. These would include culturally responsive approaches, nonclinical approaches... that kind of thing. Our subcommittee is exploring this and it would be great to know what the consultants found!

CYBHWG\Strategic Plan\Meetings\Advisory Committee\7-6-23

I think it is really important when looking at what other states do to have folks who can identify what we have in our state already that may be comparable.

VISION

SHARON SHADWELL

Vision: System partners are as invested in my child's mental health as I am. I can feel how much they respect and care about us as human beings. Our dignity is recognized and supported. I know who can help me identify and access the services my family needs. The supports and services are available when we need them and for as long as we determine that we need them. Relationships are consistent, predictable, and coordinated: we're not forced to switch providers after we've been vulnerable and built trust, or we can opt out of services with a provider if we feel unable to trust them; and we don't have to update and educate providers about the care being provided by other professionals serving our family.

I also wanted to follow up on Avreayl's comment, which has been made in other conversations as well, recommending that the workgroup essentially walk through the experiences of hypothetical families at different stages of their child/youth's intersection with various elements of the behavioral health system. I wondered whether there's any plan to offer an exercise like that in future meetings. I can imagine it would elicit so much rich feedback based on the lived experiences of parents, youth, and providers. Much of it would probably overlap with the feedback you've gathered through focus groups; but for some people, it might spark additional insights that are harder to access in response to direct questions in a focus group or survey. If at any point you're trying to think of small group conversations for a workgroup agenda, perhaps this could be on your list for consideration.

JERRI CLARK

My goals for the strategic plan vision?
The system cannot turn families away because they have a need that doesn't fit. Any family can enter the system with a plain-speak explanation of their situation and needs, and the system will have an evidence-based, well-structured plan for meeting the needs, regardless of their nature, severity, or complexity. Care is not withheld or denied because of shortages, silos, and provider agencies that are enabled to cherry pick their clientele.

What makes these goals important, based on my personal experience?
My son was denied medically necessary care because he was "too sick" to be a desirable patient. He killed himself. I know many, many families who are turned away BECAUSE their needs are high. In the status quo, families/youth with simpler needs get the best care and the most well-trained providers. This is upside down.

RICHELLE MADIGAN

Thank you for this incredibly important discussion, and for creating space to really flesh it out.

Here are my thoughts on what a "magic wand" system would look like in my opinion...

1) Assumption of best intent built into every program and system. There is no such thing as a bad kid, or a bad parent. There are people getting their needs met, and people who are NOT. People who are NOT may behave in ways that are very far off from who they are when their needs are met. "Bad kid/ bad parent" Biases in response to behavior are unhelpful and a barrier to needs being met.

2) Every program administered should have a feedback loop built in so that unintended harmful consequences to the end users of all our programs can be identified and addressed in a timely way. Currently our quality improvement measures are almost all quantitative in nature, which misses the opportunity to capture feedback from the people those programs failed to meet the needs of (why didn't it work?).

3) The system needs step up and step down (From CLIP) resources. Some kids need lifelong residential support to avoid incarceration/homelessness/death. On the flip side of that coin, some kids coming out of CLIP need a less

restrictive step-down phase of resources before they can be successful back in their homes. Right now, the bottleneck in CLIP is hugely compounded by the fact that we don't have step up and step down for post CLIP, so kids are revolving dooring back into CLIP or into emergency departments. We need resources to meet EVERY LEVEL of need, right in our own state (not shipping high needs kids to other states away from their support systems that are critical to their wellness). Then our existing resources which are currently striving to meet needs outside their intended scope will be less burdened and more accessible for their intended target populations.

4) Emphasis on access to respite. This is a major need that is critical for high needs kids to remain in their homes and keep their family units intact.

5) Understanding and acknowledgment that when someone in the family is in crisis, it impacts EVERYONE. SO, treating families as a unit. The wellness of an individual is critical to the wellness of the family, just as the wellness of the family is critical to the wellness of the individual. We can't advocate for the wellness of one, at the expense of the other. As a part of this point, we have to stop using CPS/encouraged legal abandonment as any part of a treatment process because they are punitive and traumatizing and unhelpful.

6) As unpalatable as many find this topic, it remains a need in our system, for some people, especially in the case of people with co-occurring intellectual disability/brain injury with mental illness-- That our systems include protocols (and tools for providers to use in communities) for restrictive measures when violent behaviors present imminent danger to self or others.

7) Care coordination should have some automated functionality when it comes to complex/high needs. As a parent in crisis, I shouldn't have to email HCA section managers and state reps in order to get the right people at the table who know the boundaries of the services my kid needs to access. If my kid is discharging from CLIP, intensive care coordination should be automatic. Similarly, if a kid has been through multiple outpatient providers and is still not getting needs met, systems need checkpoints that once past, initiate automated high level care coordination.

8) Centrally located resource pool. Finding out what resources exist, who is doing what, and then put it somewhere where anyone with needs can access it, and it is updated regularly as new resources come online/services change. Currently, even the MCO's all have different information about community resources. Nobody in the state has an all-inclusive list of what we have. The state needs to have that and manage it on an ongoing basis. How can we identify what we need when we don't even fully understand what we have?

PEGGY DOLANE

This recent youth-focused BH study from rural MI gives insight on recommendations we also may want to consider in our state: https://www.gtrcf.org/priorities/youth-wellness-initiative.

Prenatal through 25 Behavioral Health Strategic Plan Advisory Group

July 6, 2023

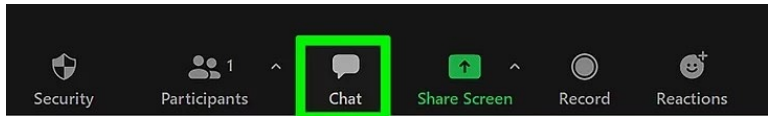
Advisory Group Co-Chairs

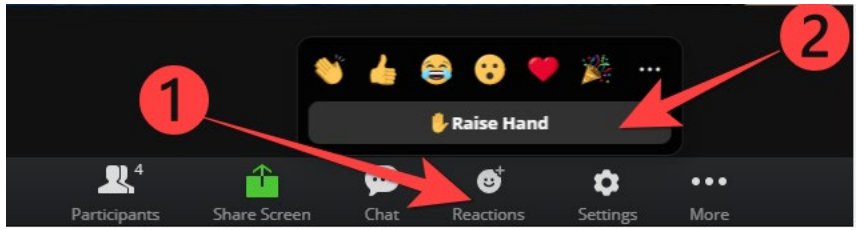
Representative Lisa Callan
Washington State Representative
5th Legislative District

Dr. Keri Waterland
Director for Behavioral Health and Recovery (DBHR)
Health Care Authority

Housekeeping Items

- Meeting is being recorded and will be available on TVW
- You may choose to turn your camera on
- We kindly request that all members place an '-M' after your name (e.g., Name-M)
- All mics have been muted
- Three-hour session
- Questions can be typed into the chat box, or you may select the raised hand icon to be called upon by the facilitator





- There is time for public comment at the end of this session, therefore if you would like to speak, please send us a message in Chat that begins with COMMENT

Agenda review

2:00 – 2:05	Welcome
2:05 – 2:20	Review full value agreement
2:20 – 2:45	Project updates
2:45 – 3:15	Emerging State Practices report
3:15 – 3:25	*BREAK*
3:25 – 3:40	Break out session: setting a vision
3:40 – 4:00	Break out group's reports
4:00 – 4:10	*BREAK*
4:10 – 4:40	Public comment
4:40 – 4:50	Closing
4:50 – 5:00	*Please use this time to complete the short survey about this meeting (see Chat and slide for link).*

Full Value Agreement

- Be respectful of each other
- Speak your truth, from your own experience
- Keep an open mind; listen to understand
- Honor this time as a ~~brave~~ space for you and others to share perspectives across differences without judgement
- Use plain language (explain acronyms, if used)
- Use first names
- Stories stay private, but the lessons may carry forward
- Practice patience with ourselves and each other
- Step up then step back so that everyone has a chance to be heard – one at a time when speaking & give attention to facilitators/speakers
- Be mindful of trauma and recognize the impact of that trauma
- Your experience matters; so does your knowledge and experience
- Encourage grace, compassion and kindness for self

Potential framework for mapping current BH services

Services & supports built for BOTH individual and family/natural supports

Care continuum

- Prevention, promotion, education and wellbeing
- Interventions & education
- Outpatient care options
- Intensive outpatient care options
- Inpatient options
- Long term IP care options

Age & transition ages

Prenatal | Birth | 6 mo. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 13 14 15 | 16 | 17 18 | 19 | 20 | 21 | 22 | 23 24 | 25

Each stage includes:
- Transition/return to stable in lower level of care
- Prevention of escalation of acuity
- Wellness stabilization and recovery supports

Washington State Health Care Authority

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Washington State Health Care Authority

Layers to consider

System delivery

- Individuals with intellectual and developmental disabilities
- Foster, adopted, and dependent youth
- Tribal/American Indian and Alaskan Native
- Juvenile Justice/Juvenile Rehabilitation
- Medical settings
- Regional and Provider pockets of excellence
- Accountable Communities of Health
- School settings
- Behavioral Health Administrative Service Organizations
- Managed Care Organizations (commercial and public)

System specialties

- Applied Behavioral Analysis
- Mental health
- Substance use disorder
- Problem gambling
- Medical/Pharmacology
- Co/Tri/+ occurring

Funding Source Impacts

Developmentally Appropriate Options
Including education, familial/natural support connection, and workforce expertise & development

Trauma informed delivery and supports

Including systemic training, support, incentives, and accountability that measures cultural attunement, developmentally appropriate and person-centered services and supports across systems

Washington State Health Care Authority

Prenatal through 25 BH Strategic Planning

DRAFT Overview of emerging state approaches and practices

June 27, 2023

Executive summary (1/2)

States are pursuing a wide range of efforts focused on BH for children and youth, from system level change to more focused interventions. Across these efforts, several themes emerge:

Cross-sector collaboration, specifically between healthcare and education, is being pursued across many state approaches and initiatives. Many state initiatives identify schools as a primary site of wellness promotion and service delivery; collaboration between healthcare and education (including data sharing) enhances positive outcomes from these efforts and ensure effective utilization of available resources

Digitization is a growing method of BH service delivery. States have invested in tech-enabled services to make it more convenient for youth and families to access care. Examples include developing apps and websites that support access to trained BH professionals, digitally-enabled BH promotion and education resources, and e-consult solutions for providers

Tech enablement to support performance infrastructure may help bring about quality improvement, effective resource allocation, and informed decision-making. Several states have invested in robust tech platforms (e.g., data collection and sharing), which have helped support continuous monitoring of service delivery and improve outcomes

Statewide BH programs are found to be effective when resourced with sustainable funding and dedicated approaches to workforce. States have enhanced funding in a variety of ways, such as creating grant pools earmarked for children and youth and expanding the utilization of Medicaid funding for BH services and supports. For workforce development, states have found success by exposing young people to BH careers, instituting loan repayment programs, enabling attractive career development, among other approaches

While there is no one universal recipe for successful governance models, clear stakeholder roles (including decision-making) and intentional design are important for effective governance. To coordinate actions and meaningfully engage stakeholders (e.g., local community organizations, managed care organizations, parents), state efforts pursue a variety of governance models with different structures, levels of (de)centralization, and key stakeholder roles

Source: Based on discussions with CYBHWG staff in May - June 2023; informed by initiative overviews that follow in this document; sources for each individual initiative are included on profile pages that follow

Executive summary (2/2)

While this document does not provide a comprehensive overview of state-led efforts aimed at improving children and youth behavioral health, the following areas emerge as potential priorities and focus areas for future initiatives, as gleaned from qualitative insights from expert interviews regarding the overall BH landscape:

Goals along continuum of care: Potential opportunity in the overall BH landscape for scaling wraparound services for individuals with complex needs and co-occurring conditions (e.g., intellectual and developmental disabilities, serious mental illness), as well as further enhancing prevention and promotion efforts across age groups and populations

Demographics of focus: While initiatives exist to improve access to BH services for underserved or vulnerable populations – e.g., rural settings, tribal communities, incarcerated and homeless individuals – there remains an opportunity to scale these programs to increase scope of impact and further tailor services to meet unique needs

Age: Potential opportunity in overall BH landscape for services specifically tailored for transitional age youth (TAY), age 19-25 years old, as well as the early childhood period, age 0-5 years old

Cross-cutting goals: Potential opportunity in the overall BH landscape to achieve sustainable funding mechanisms, as opposed to one-time or periodic funding (most commonly for prevention and promotion initiatives)

Source: Based on discussions with CYBHWG staff in May - June 2023; informed by initiative overviews that follow in this document; sources for each individual initiative are included on profile pages that follow

State BH initiatives focused on Prenatal through 25 populations and included in the initial overview

NON-EXHAUSTIVE

AK	Adult Home Care
AZ	Differential Adjusted Payments (DAP)
CA	Behavioral Health Continuum Infrastructure Program (BHCIP)
CA	Behavioral Health Virtual Services Platform
CA	CalHOPE Student Services
CA	Statewide All-Payer Fee Schedule for School-Linked BH Services
CA	Wellness Coach Workforce
CA	Youth drop-in centers
CO	Children and Youth Mental Health Treatment Act
CO	Early Childhood Mental Health support line
CO	I Matter
CT	Mobile Response and Stabilization Services*
GA	Intensive Customized Care Coordination (IC3)
IL	Universal mental health screenings
MA	Community Behavioral Health Centers
MD	Coordinated community supports
MI	Caring for Students (C4S)
MI	Michigan Child Collaborative Care (MC3)
MI	MI Kids Now Loan Repayment Program
MI	TRAILS to Wellness*
MN	School-Linked Behavioral Health Grants
NE	Behavioral Health Education Center
NH	Systemic, Therapeutic, Assessment, Resources & Treatment (START)
NJ	Children's System of Care*
NM	Project ECHO
NY	NYC Well
OH	OhioRISE
OR	Treatment Foster Care Oregon
SC	Center for Excellence in Evidence-Based Intervention
UT	Safe UT

* Deep dive analysis included in final section

Source: Preliminary web search of examples across states, interviews with SMEs identified by HCA conducted in May - June 2023

Overview: Demographics addressed of state BH initiatives reviewed (1/3)

NON-EXHAUSTIVE

✓ Covers 18+ adults, but not transitional age (19-25) specifically

		Age groups					Populations of focus	
		< 0 Prenatal	0-5 Early Childhood	6-12 Childhood	13-18 Adolescent	19-25 TAY[1]		
State	**Program**						**Specific demographics of focus**	**Source[2]**
AK	**Adult Home Care**					✓	Individuals in foster care with severe disabilities (including intellectual disabilities) who are moving into adulthood	Office of Governor, Alaska
AZ	**Differential Adjusted Payments**			✓	✓		Students	Arizona Health Care Cost Containment System (AHCCCS)
CA	**BH Continuum Infrastructure Program**	✓	✓	✓	✓	✓	Vulnerable populations at risk of institutionalization – experiencing incarceration, hospitalization, or homelessness	California Department of Healthcare Services
	BH Virtual Services Platform		✓	✓	✓	✓	Black, Indigenous, People of Color, LGBTQIA+, rural communities, families experiencing homelessness, justice-involved individuals, and foster youth	California Department of Healthcare Services
	CalHOPE Student Services			✓	✓	✓	African American/Black, Asian and Pacific Islanders, Latino/Latinx, LGBTQ+ community, parents/caregivers, veterans, young adults	CalHOPE
	Statewide All-Payer Fee Schedule for School-Linked BH Services		✓	✓	✓	✓	Children and youth aged 0-25	California Department of Healthcare Services
	Wellness Coach Workforce		✓	✓	✓	✓	Children and youth aged 0-25	California Department of Health Care Access and Information
	Youth drop-in centers			✓	✓	✓	Vulnerable and marginalized youth populations including, but not limited to, LGBTQ+, homeless, and Indigenous youth	Mental Health Services Oversight & Accountability Commission
CO	**Children and Youth Mental Health Treatment Act**		✓	✓	✓	✓	Children or youth at risk of out-of-home placement and ineligible for Medicaid	California Behavioral Health Administration
	Early Childhood Mental Health support line		✓				Parents and caregivers	Colorado Department of Human Services

1. TAY = Transitional Age Youth | 2. Demographics of focus as defined in initiative descriptions, specific sources for each initiative included on profile pages that follow
Source: Program and state agency websites (details follow on initiative profile pages), interviews with SMEs identified by HCA conducted in May - June 2023

Overview: Mapping of state BH initiatives reviewed (1/3)

NON-EXHAUSTIVE

State	Program	Goals along continuum of care: Improve promotion, prevention & wellness	Expand capacity of BH treatment	Expand crisis treatment services	Strengthen rehab. and re-integration	Enhance wrap-around services	Cross-cutting goals: Establish new digital access channels	Expand BH workforce / capability for care	Provide equitable access to BH services across settings	Expand eligibility and coverage	Scale evidence-based/informed practices	Enhance funding mechanisms	Funding level	Impact[1]
AK	Adult Home Care	✓	✓		✓				✓	✓			○	
AZ	Differential Adjusted Payments	✓	✓					✓	✓	✓		✓	◔	
CA	BH Continuum Infrastructure Program		✓						✓				●	54 total projects funded, 75% for low-income communities
	BH Virtual Services Platform	✓					✓		✓				●	Implementation in progress
	CalHOPE Student Services	✓						✓	✓		✓		◑	6,000 staff engaged in Community of Practice
	Statewide All-Payer Fee Schedule for School-Linked BH Services[2]	✓								✓		✓	◔	Implementation in progress
	Wellness Coach Workforce	✓						✓	✓				●	Implementation in progress
	Youth drop-in centers	✓	✓						✓				◑	
CO	Children and Youth Mental Health Treatment Act	✓		✓						✓			○	271 children served
	Early Childhood Mental Health support line	✓					✓		✓				◑	

○ Less than $10M funding
◔ Between $10M - $100M funding
● More than $100M funding
○ Funding not available

Source: Interviews with SMEs identified by HCA conducted in May - June 2023; Prioritizing Health: A Prescription for Prosperity | 1. Impact included if publicly available | 2. Funding does not include cost of services to be covered by fee schedule

NJ: Children's System of Care

In 2000, New Jersey redesigned its children's mental health system to ensure services are available regardless of a child's insurance status and without involving the child welfare or juvenile justice systems

Population of focus: Youth under 21

Description

- NJ adopted a "system of care" — a framework that aims to make a wide array of culturally competent services available in a coordinated, easy-to-navigate way
- **Reduces use of institutional-based care** by providing children at risk of out-of-home placements with services in their homes / communities: reserves residential placements for the children who truly needed them
- **Services go beyond medical intervention** – offers peer support groups for kids and parents; access to sports, clubs and other activities that provide opportunities for positive social interactions and mentorship
- PerformCare is the single portal for access to care available 24/7/365
- Investment of over $100 million from 2020-2022

Results to date

Outcomes

70% reduction in number of children living in out-of-home settings between 2006 and 2022 (10,000 to 3,000)

9,700 fewer youth in juvenile detention from 2003 to 2008 (12,000 to 2,300 a year)

297 fewer youth in out-of-state behavioral care from 2007 to 2012

DIVISION OF CHILDREN'S SYSTEM OF CARE

Source: New Jersey Department of Children and Families, WBUR, New Jersey's Children's System of Care

Deep Dive: Children's System of Care (NJ)

Key system elements

Workforce strategies: NJ extends its BH workforce by employing Bachelor's level workers and peer support; roles for non-clinicians include mobile responders, care managers within care management organizations, and behavioral assistance providers. NJ also contracts Rutgers University Behavioral Health Care as a center to provide training, technical assistance, and coaching – 30 courses per month, free of charge

Funding mechanism: Funding for NJ's Children's System of Care (CSOC) is built into Medicaid. Specific funds are earmarked for individuals with IDD – CSOC covers the full array of services for this population segment

Governance and collaboration: PerformCare functions as Administrative Service Organization (ASO) that coordinates services. Care management entities (CMEs) function as independent non-profit organizations to implement high fidelity wraparound in communities – actively engage community stakeholders, such as parents, principals, judges, and Boys & Girls Clubs

Source: Based on expert interview in June 2023, Children's Initiative Concept Paper, CSOC Presentation, Rutgers

Potential takeaways for WA as shared in SME interviews

Cross-applicable principles:

1. Single point of access: Serves as convenient way for parents to access care and navigate services
2. Mobile response and stabilization system: Meets parents' and schools' needs in cases of crisis
3. Intensive care coordination by CMEs: Having entity embedded into the community allows for local accountability
4. Community engagement: Involving parents in the conversation, running support groups, and conducting education sessions for the community facilitates appropriate service design

State-specific considerations:

1. Degree of service decentralization: Differing level of siloes and fragmentation in different states
2. Community organizational infrastructure: Differing level of presence of nonprofits owned by communities to facilitate service delivery

MI: TRAILS to Wellness

Launched in 2013, Transforming Research into Action to Improve the Lives of Students– TRAILS to Wellness – aims to bring proven mental health strategies to the school setting, helping staff provide the support students need

Population of focus: Students in K-12

Description

- TRAILS offers the **training, materials, and implementation support** schools need to provide their students with evidence-based mental health supports that are appropriate for the school setting; **$50M funding** in 2023
- TRAILS offers **3 tiers of programming** that correspond to differing levels of student need:
  - **Tier 1, Universal Education and Awareness:** Social and emotional learning (SEL) for all students to promote resiliency and build self regulation skills; self-care strategies for staff to prevent stress and burnout
  - **Tier 2, Targeted Intervention:** CBT and mindfulness for students with symptoms of depression / anxiety
  - **Tier 3, Suicide Risk Management:** Accurate, timely identification of students at risk of suicide
- Currently operating in Michigan, Colorado, and Massachusetts – goal of expanding to 10 states by 2040

Results to date and initiative goals

Results	Goals
10,000 school staff and mental health professionals have accessed TRAILS trainings and resources	**50%** of Title I designated schools (where at least 40% of students have been identified as low-income) have access to TRAILS resources in at least 10 states by 2040

Source: TRAILS to Wellness, TRAILS Program Overview, Our Impact, University of Michigan

Deep Dive: TRAILS to Wellness (MI)

Key system elements

Equity-focused services: TRAILS engages underserved communities with higher touch implementation support. Recognizing that schools in these areas demonstrate higher workforce turnover, TRAILS focuses on building long-term protocols to ensure continuity of training. TRAILS also develops culturally sensitive materials for its training curriculum designed to be reflective of lived experiences in communities

Funding mechanisms: TRAILS uses combined funding from multiple sources: funding from philanthropies and social impact funds, state appropriated dollars, revenue from direct service contracts; initially partnered with University of Michigan to receive matched Medicaid funding – spun out from University of Michigan in 2022

Community engagement: TRAILS hires teachers to partner with clinical team and design program structure. TRAILS also regularly convenes student groups to gather feedback on curriculum content

Source: Based on expert interview in June 2023, University of Michigan Medicine

Potential takeaways for WA as shared in SME interviews

Cross-applicable principles:

1. Implementation science: Training that goes beyond one-time demonstrations – including collaborative partnership with local districts, on-the-ground champions, and long-term consultation

2. Community engagement: Continuously engaging communities to ensure BH service delivery is tailored to unique cultural needs and reflective of lived experience

State-specific considerations:

TRAILS is actively considering additional states for expansion – looking for several criteria:

1. Funding – States with capacity and willingness to earmark funding from state budget to support BH training efforts (e.g., Michigan allocated $50M in state funding to TRAILS in 2022)

2. Workforce – States with workforce capacity necessary to support TRAILS school-based training program

CA: Statewide All-Payer Fee Schedule for School-Linked BH Services[1]

DHCS and the Department of Managed Health Care (DMHC) will maintain a school-linked statewide all-payer fee schedule to allow students (25 years or younger) to receive outpatient mental health and substance use disorder services at or near school sites starting in 2024

Population of focus: Students aged 0 - 25

Description

- Initiative aims to bring together the healthcare and education sectors to **reimburse for a predefined set of services for all children, regardless of payer status, in a school-linked setting**
- The supporting workgroup is composed of partners representing K-12 education, institutions of higher education, Medi-Cal managed care plans, commercial health plans, county behavioral health departments, behavioral health providers, associations, advocates, youth and parents/caregivers
- Plan to **launch in January of 2024**

Initiative goals

Create a more **approachable billing model for schools** and local educational agencies

Ease burdens related to contracting, rate negotiation, and navigation across delivery systems

Reduce uncertainty around students' coverage

1 Part of the California Children and Youth Behavioral Health Initiative

Source: CYBHI 101, CYBHI January 2023 Progress Report, CYBHI Fee Schedule Working Group Session 3

CA: Wellness Coach Workforce[1]

California Department of Health Care Access and Information (HCAI) is creating a new certified position of Wellness Coach in 2024-2025 to help support the behavioral health needs of California youth in a wide variety of settings

Population of focus: Youth aged 0 - 25

Description

- Wellness Coaches will offer **non-clinical services** that support youth behavioral health, such as wellness promotion and education, screening, care coordination, individual and group support, and crisis referral
- Wellness Coaches will serve youth aged 0 - 25 as part of a care team in a **wide variety of school, health, and community settings**
- Wellness Coaches will earn either a **Wellness Coach I or II certification**, which each require completion of 52 hours of classroom education, 400 hours of on-the-job training, and either an AS or BS degree, respectively
- HCAI received **$338M in funding** to design and build the Wellness Coach workforce
- Training of Wellness Coaches is expected to begin in 2024 with coaches in the field in 2025

Initiative goals

Build a diverse BH workforce with lived experience to serve vulnerable populations

Fill gaps in BH workforce – currently few roles cater to professionals with 1-4 years of education

Ensure the role is both a **desirable occupation** in and of itself and a stepping-stone to more advanced BH roles

1 Part of the California Children and Youth Behavioral Health Initiative

Source: CYBHI January 2023 Progress Report, CYBHI December 2022 Update, HCAI Wellness Coaches Model

CO: I Matter

In 2021, Colorado State Legislature launched the I Matter program to provide access to mental health and substance use disorder services for youth, including addressing needs that may have resulted from the COVID-19 pandemic

Population of focus: Youth ages 0-18 or 21

Description

- Provides up to **six free mental health sessions with a licensed provider** for youth 18 years of age or younger or 21 years of age or younger if receiving special education services
- Partners with Signal BH as a primary provider, which also has a **provider-friendly subcontracting mechanism** for independent providers
- Implements statewide public awareness and outreach campaign that includes **digital ads on social media platforms**, and **on-the-ground outreach to schools and youth organizations**
- Pilot **initial funding of $10M** (catalyzed by federal COVID funding); received **$6M in additional funding** to extend services until at least June 2024

Results to date

Utilization

2,600 Colorado youth have participated in at least one therapy session

7,500 therapy sessions have been completed or are upcoming

Feasibility

$10-50M of funding necessary to implement including extension rounds of support

<2 years to impact and address

Source: I Matter, Colorado Department of Human Services

CO: Children and Youth Mental Health Treatment Act

In 2018, CO passed the Children and Youth Mental Health Treatment Act (CYMHTA) to help families access residential treatment for children with mental illness and avoid out-of-home placement

Population of focus: Low-income families with youth up to age 21

Description

- CYMHTA assists families who are uninsured or underinsured to **pay for residential treatment, community-based treatment, and transitional services for youth up to age 21** with a mental illness
- Under CYMHTA, **families only pay for 7% of the cost** of mental health treatment for their children
- CO's Behavioral Health Administration contracts with four Mental Health Agencies, to operationalize CYMHTA: Signal Behavioral Health Network, Rocky Mountain Health Partners, Beacon Health Options and Beacon Health Options on behalf of Health Colorado, Inc.
- In SFY22, **total funding for CYHMTA was $6.9M**

Results to date

Utilization	Growth	Outcomes
271 children and youth served in SFY22	**10%** growth in children and youth served from SFY21	**83%** of youth discharged had reduced risk of out-of-home placement
97 children served were new to CYMHTA in SFY22		

Source: CYMHTA SFY22 Annual Report

IL: Universal mental health screenings

In 2017, Illinois passed legislation integrating mental health screenings into K-12 school physicals statewide

Population of focus: Students in primary and secondary school

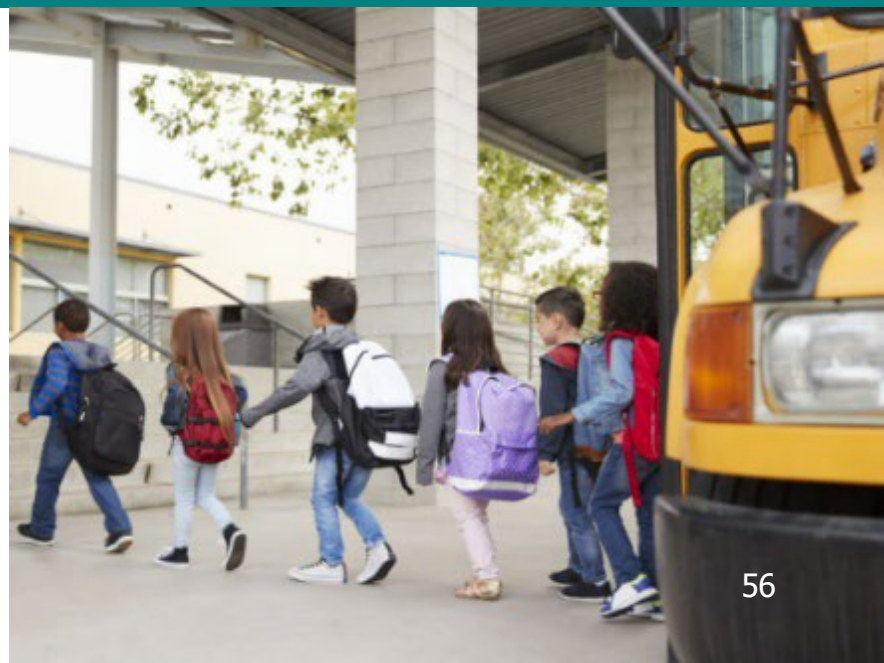
Description

- Requires **social and emotional screenings** for children as part of their school entry examinations
- The standards for the screenings are to be **developed in the Office of Women's Health and Family Services** in consultation with statewide organizations representing school boards, pediatricians, and educators along with mental health experts, state education and healthcare officials, and others
- Aims to cultivate the most up-to-date, evidence-based screening formats to identify potential issues early on and help students receive the support they need
- Currently exploring ways to fund these screenings—including grants legislated this year which provide funding for mental well-being checks

Initiative goals

"[The effort is] aimed at identifying potential mental health problems in school-age children, removing the stigma of mental illness and reducing teen suicide by identifying their needs and providing early intervention"

- Kimberly A. Lightford
Assistant Majority Leader and Vice Chair of the Illinois Senate's Education Committee



Source: The Kennedy Forum, Illinois Department of Human Services

OH: OhioRISE

In 2022, Ohio's Department of Medicaid launched OhioRISE (Resilience through Integrated Systems and Excellence), a specialized managed care program for youth with complex behavioral health and multisystem needs

Population of focus: Children and youth ages 0 - 20

Description

- OhioRISE aims to shift the system of care and keep more kids and families together by creating **new access to in-home and community-based services – e.g., Intensive Home-Based Treatment (IHBT)**
- Primarily designed for children and youth with **significant BH treatment needs**, as measured by the Ohio Child and Adolescent Needs and Strengths (CANS) assessment
- **Aetna Better Health** of Ohio serves as the **single statewide specialized managed care plan**
- Features multi-agency governance to drive towards improving cross-system outcomes
- Serves the most in need and vulnerable families and children to **prevent custody relinquishment**

Results to date

Tech Enablement	Applications	Utilization
2,600+ Ohio assessors registered in CANS IT system	**36,000+** CANS assessments submitted in CANS IT system as of May 2023	**21,000+** total children and youth enrolled in OhioRISE as of May 2023

Source: Ohio Medicaid Managed Care, OhioRISE Launch Report (May 30, 2023)

UT: Safe UT

Youth suicide was the leading cause of death for young people aged 10-24 in Utah. In response, the state commission launched the Safe UT app in early 2016 as a way for youth to access help with any sized problem at any time

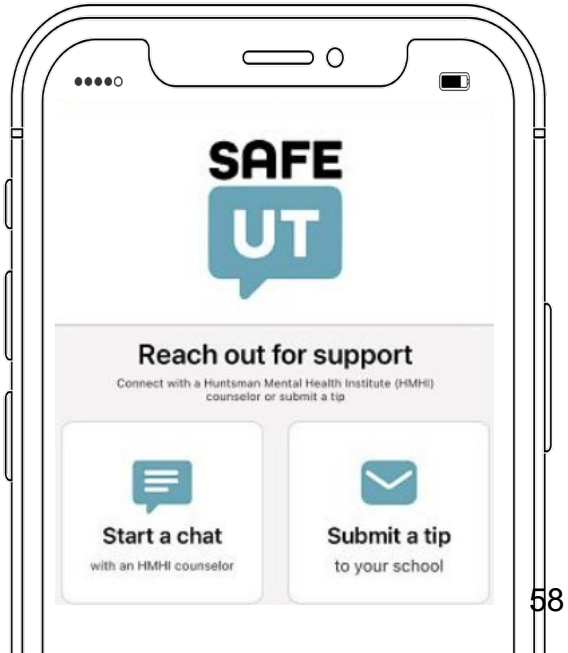
Population of focus: Students K-12 & higher ed

Description

- Safe UT is a mobile app that provides a way for students, parents/guardians, and educators to confidentially connect to a licensed counselor **24/7, 365 days a year**
- Users start a **real-time, two-way messaging exchange** with master's level counselors via chat or call
- **Use is confidential**, and crisis counselors do not inquire about identifying information except in emergencies
- Users can submit a tip on behalf of someone else for concerns regarding bullying, self-harm, and school safety
- **$1.2M of funding** requested in FY 2023
- Commissioned by Safe UT & School Safety Commission, services provided by Huntsman Mental Health Institute

Results to date

Access	Utilization	Outcomes
96% of school districts enrolled	**30,000** unique users	**85%** of administrators agree that mental health stigma has improved since enrolling in Safe UT
882k+ students with access	**12%** projected growth in FY 2023	**349** lifesaving interventions



Source: 2022 Safe UT Annual Report, Safe UT FY23 Funding Letter of Support

AK: Adult Home Care

In 2023, Alaska passed legislation establishing a new alternative for individuals with disabilities in foster care when they age out of the foster care system, allowing them to stay in a familiar surrounding while transitioning to adulthood and receiving care

Population of focus: TAY[1] in foster care system

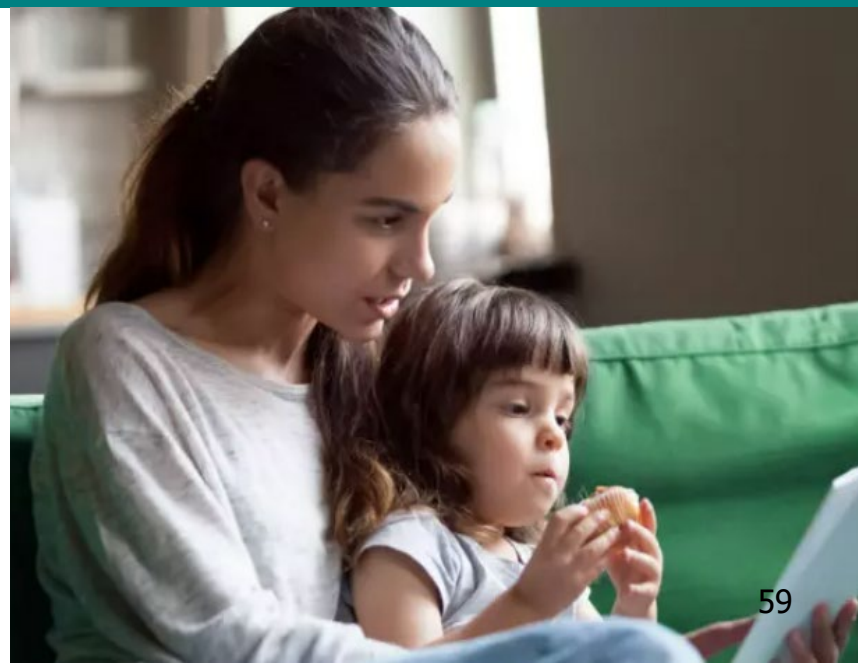
Description

- Part of Alaska's Healthy Families Initiative, HB58 establishes **adult home care as a new service type** and adult care home as a new residential license type
- Enables someone caring for an adult foster child at home to license their **home as an adult daycare**, allowing them to **receive Medicaid payments to cover the cost of care**
- Provides incentives for caregivers to continue to offer support for **individuals in foster care with severe disabilities (including intellectual disabilities) who are moving into adulthood** and would like to continue to **reside in their familiar home setting**
- The new service would be **reimbursed through a 50/50 federal Medicaid match**

Initiative goals

"This legislation [provides] … a new option for home care for … people with disabilities, with fewer administrative burdens than existing options. This legislation will keep families together, provide critical in-home support to Alaskans who need it and simplify the state bureaucracy that helps support all Alaskans through every stage of their life."

- Heidi Hedberg
Commissioner at Alaska Department of Health



1. TAY = Transitional age youth (19-25 yro.)

Source: Office of Governor, Alaska, Alaska House Bill No.58, Alaska Behavioral Health (Image)

OR: Treatment Foster Care Oregon

In 1983, Treatment Foster Care Oregon (TFCO) was developed as an alternative to institutional, residential, and group care placements for children and youth with severe emotional and behavioral disorders

Population of focus: Children ages 7-17

Description

- The two main goals of TFCO are to **create opportunities for youth to successfully live in a family setting** and to simultaneously **help parents provide effective parenting**
- Adolescents are placed in a **family setting for nine months**; community families are recruited, trained, and supported to provide well-supervised placements and treatment
- Youth in TFCO receive weekly support to navigate the program, practice of problem-solving and coping skills along with other skills individualized for their particular needs
- TFCO is currently implemented throughout the United States, Australia, Sweden, Norway, Denmark, The Netherlands, United Kingdom, and New Zealand

Results to date

Outcomes

½ the number of arrests for boy participants

3x less likely to run away from foster care

⅔ fewer days incarcerated for boy participants

$3.15 in benefit for every $1.00 spent on TFCO when considering child welfare and criminal justice involvement

Source: TFCO About, TFCO Evidence, National Gang Center

Emerging State Practices Report

Q&A with McKinsey staff

Discussion

- What would be helpful to know about that is not currently covered in this report?
- What would you like to know more about?

Breakout Groups – Setting a vision

Questions

- What are your goals for the vision?
- What personal experiences make those goals important to you?

How to self-select a breakout room

- Click **Breakout Rooms** in your meeting controls.
- If you hover over the breakout room, you will see an icon that says “Join”
- Click **Join** next to the Breakout Room that best describes you – *Parent, Youth or Young Adult, or System Partner*.
- **If there are too many people already in the room, repeat to join another breakout room** with the same type of participants *or* click **Leave Room** to return to the main session.

Reports from these groups will be included as part of the public record.

Public comment

Now we invite members of the public to share their thoughts and comments

If you would like to speak, please send us a message in Chat that begins with COMMENT - or raise your hand and the facilitator will call on you.

If you prefer, you can share your comments in the Chat box.
Your comments will be saved as part of the record for this meeting; names will be removed.

Closing & Next steps

Next Advisory Group meeting: September 7, 2-5 p.m.

Steering committee members – later this month we will be sending you:

- A survey requesting demographic information as well as information about the types of services you've experienced (school supports, outpatient/counseling, inpatient, crisis services, etc.).
  This will help us all see who is missing; some of this information is also required by the Office of Equity for those receiving stipends.

We encourage everyone to complete the short survey about this meeting

If you are interested in being added to the mailing list, please send an e-mail to cybhwg@hca.wa.gov.

Thank you to everyone who is participating in this process

Prenatal through 25 BH Strategic Planning

DRAFT Overview of emerging state approaches and practices

June 27, 2023

How to use this document

Purpose: This document provides an initial overview of emerging approaches from other states focused on behavioral health (BH) to inform the future state vision of BH for the prenatal through 25 population in the state of Washington. The examples included in this document are not directly transferrable – further analysis is required on relevance and applicability for Washington. Additionally, this document is not a comprehensive list of emerging state BH approaches and efforts – the initiatives included in the initial overview are meant to serve as an illustrative sample.

What is included: This document includes a range of state BH initiatives, from system-level efforts to more focused interventions and initiatives, with differing funding levels; state BH initiatives included in the initial overview were suggested by subject matter experts (SMEs) identified by Children and Youth Behavioral Health Work Group (CYBHWG) staff as well as identified through outside-in initial scan of examples across states. As directed by WA HCA, the document includes three sections: (1) Initial overview mapping of all included initiatives across ages, populations of focus, and goals along the continuum of care, as well as a variety of cross-cutting goals; (2) One-page summary descriptions with information on goals, implementation, and results for each initiative included in the overview; (3) Deep dive analyses on several select initiatives based on interviews with SMEs and initiative leads.

Context: This effort is part of the Prenatal through 25 Behavioral Health Strategic Plan development led by the CYBHWG and staffed by the Health Care Authority (HCA). This document has been created at the request of the CYBHWG. The approaches and considerations included in this document may be further developed based on additional inputs from CYBHWG and Strategic Plan Advisory Group members, staff, and SMEs.

Executive summary (1/2)

States are pursuing a wide range of efforts focused on BH for children and youth, from system level change to more focused interventions. Across these efforts, several themes emerge:

Cross-sector collaboration, specifically between healthcare and education, is being pursued across many state approaches and initiatives. Many state initiatives identify schools as a primary site of wellness promotion and service delivery; collaboration between healthcare and education (including data sharing) enhances positive outcomes from these efforts and ensure effective utilization of available resources

Digitization is a growing method of BH service delivery. States have invested in tech-enabled services to make it more convenient for youth and families to access care. Examples include developing apps and websites that support access to trained BH professionals, digitally-enabled BH promotion and education resources, and e-consult solutions for providers

Tech enablement to support performance infrastructure may help bring about quality improvement, effective resource allocation, and informed decision-making. Several states have invested in robust tech platforms (e.g., data collection and sharing), which have helped support continuous monitoring of service delivery and improve outcomes

Statewide BH programs are found to be effective when resourced with sustainable funding and dedicated approaches to workforce. States have enhanced funding in a variety of ways, such as creating grant pools earmarked for children and youth and expanding the utilization of Medicaid funding for BH services and supports. For workforce development, states have found success by exposing young people to BH careers, instituting loan repayment programs, enabling attractive career development, among other approaches

While there is no one universal recipe for successful governance models, clear stakeholder roles (including decision-making) and intentional design are important for effective governance. To coordinate actions and meaningfully engage stakeholders (e.g., local community organizations, managed care organizations, parents), state efforts pursue a variety of governance models with different structures, levels of (de)centralization, and key stakeholder roles

Source: Based on discussions with CYBHWG staff in May - June 2023; informed by initiative overviews that follow in this document; sources for each individual initiative are included on profile pages that follow

Executive summary (2/2)

While this document does not provide a comprehensive overview of state-led efforts aimed at improving children and youth behavioral health, the following areas emerge as potential priorities and focus areas for future initiatives, as gleaned from qualitative insights from expert interviews regarding the overall BH landscape:

Goals along continuum of care: Potential opportunity in the overall BH landscape for scaling wraparound services for individuals with complex needs and co-occurring conditions (e.g., intellectual and developmental disabilities, serious mental illness), as well as further enhancing prevention and promotion efforts across age groups and populations

Demographics of focus: While initiatives exist to improve access to BH services for underserved or vulnerable populations – e.g., rural settings, tribal communities, incarcerated and homeless individuals – there remains an opportunity to scale these programs to increase scope of impact and further tailor services to meet unique needs

Age: Potential opportunity in overall BH landscape for services specifically tailored for transitional age youth (TAY), age 19-25 years old, as well as the early childhood period, age 0-5 years old

Cross-cutting goals: Potential opportunity in the overall BH landscape to achieve sustainable funding mechanisms, as opposed to one-time or periodic funding (most commonly for prevention and promotion initiatives)

Source: Based on discussions with CYBHWG staff in May - June 2023; informed by initiative overviews that follow in this document; sources for each individual initiative are included on profile pages that follow

Overview of state BH initiatives

1. Overview mapping of initiatives

2. Initiative summaries

3. Initiative deep dives

State BH initiatives focused on Prenatal through 25 populations and included in the initial overview

NON-EXHAUSTIVE

AK	Adult Home Care
AZ	Differential Adjusted Payments (DAP)
CA	Behavioral Health Continuum Infrastructure Program (BHCIP)
CA	Behavioral Health Virtual Services Platform
CA	CalHOPE Student Services
CA	Statewide All-Payer Fee Schedule for School-Linked BH Services
CA	Wellness Coach Workforce
CA	Youth drop-in centers
CO	Children and Youth Mental Health Treatment Act
CO	Early Childhood Mental Health support line
CO	I Matter
CT	Mobile Response and Stabilization Services*
GA	Intensive Customized Care Coordination (IC3)
IL	Universal mental health screenings
MA	Community Behavioral Health Centers
MD	Coordinated community supports
MI	Caring for Students (C4S)
MI	Michigan Child Collaborative Care (MC3)
MI	MI Kids Now Loan Repayment Program
MI	TRAILS to Wellness*
MN	School-Linked Behavioral Health Grants
NE	Behavioral Health Education Center
NH	Systemic, Therapeutic, Assessment, Resources & Treatment (START)
NJ	Children's System of Care*
NM	Project ECHO
NY	NYC Well
OH	OhioRISE
OR	Treatment Foster Care Oregon
SC	Center for Excellence in Evidence-Based Intervention
UT	Safe UT

* Deep dive analysis included in final section

Source: Preliminary web search of examples across states, interviews with SMEs identified by HCA conducted in May - June 2023

Overview: Demographics addressed of state BH initiatives reviewed (1/3)

NON-EXHAUSTIVE

✓ Covers 18+ adults, but not transitional age (19-25) specifically

		Age groups					Populations of focus	
		< 0 Prenatal	0-5 Early Childhood	6-12 Childhood	13-18 Adolescent	19-25 TAY[1]		
State	**Program**						**Specific demographics of focus**	**Source[2]**
AK	**Adult Home Care**					✓	Individuals in foster care with severe disabilities (including intellectual disabilities) who are moving into adulthood	Office of Governor, Alaska
AZ	**Differential Adjusted Payments**			✓	✓		Students	Arizona Health Care Cost Containment System (AHCCCS)
CA	**BH Continuum Infrastructure Program**	✓	✓	✓	✓	✓	Vulnerable populations at risk of institutionalization – experiencing incarceration, hospitalization, or homelessness	California Department of Healthcare Services
	BH Virtual Services Platform		✓	✓	✓	✓	Black, Indigenous, People of Color, LGBTQIA+, rural communities, families experiencing homelessness, justice-involved individuals, and foster youth	California Department of Healthcare Services
	CalHOPE Student Services			✓	✓	✓	African American/Black, Asian and Pacific Islanders, Latino/Latinx, LGBTQ+ community, parents/caregivers, veterans, young adults	CalHOPE
	Statewide All-Payer Fee Schedule for School-Linked BH Services		✓	✓	✓	✓	Children and youth aged 0-25	California Department of Healthcare Services
	Wellness Coach Workforce		✓	✓	✓	✓	Children and youth aged 0-25	California Department of Health Care Access and Information
	Youth drop-in centers			✓	✓	✓	Vulnerable and marginalized youth populations including, but not limited to, LGBTQ+, homeless, and Indigenous youth	Mental Health Services Oversight & Accountability Commission
CO	**Children and Youth Mental Health Treatment Act**		✓	✓	✓	✓	Children or youth at risk of out-of-home placement and ineligible for Medicaid	California Behavioral Health Administration
	Early Childhood Mental Health support line		✓				Parents and caregivers	Colorado Department of Human Services

1. TAY = Transitional Age Youth | 2. Demographics of focus as defined in initiative descriptions, specific sources for each i nitiative included on profile pages that follow
Source: Program and state agency websites (details follow on initiative profile pages), interviews with SMEs identified by HCA conducted in May - June 2023

Overview: Demographics addressed of state BH initiatives reviewed (2/3)

NON-EXHAUSTIVE

✓ Covers 18+ adults, but not transitional age (19-25) specifically

		Age groups					Populations of focus	
		< 0 Prenatal	0-5 Early Childhood	6-12 Childhood	13-18 Adolescent	19-25 TAY		
State	**Program**						**Specific demographics of focus**	**Source[1]**
CO	**I Matter**		✓	✓	✓	✓	All youth, including those receiving special education services	I Matter
CT	**Mobile Response and Stabilization Services**		✓	✓	✓		Available across child welfare, juvenile justice, prevention and behavioral health systems	Connecticut Department of Children and Families
GA	**Intensive Customized Care Coordination (IC3)**		✓	✓	✓	✓	At risk of being placed in an intensive program in an out-of-home setting due to behavioral, emotional and functional concerns that cannot be addressed safely and adequately in the home	Center of Excellence for Children's Behavioral Health Georgia Health Policy Center
IL	**Universal mental health screenings**			✓	✓		Students in primary and secondary school	Illinois General Assembly
MA	**Community Behavioral Health Centers**		✓	✓	✓	✓	MassHealth members (MA's state Medicaid program)	Massachusetts Executive Office of Health and Human Services
MD	**Coordinated community supports**			✓	✓		Students	Maryland Department of Health, Community Health Resources Commission
MI	**Caring for Students**			✓	✓		All Medicaid-enrolled students	National Academy for State Health Policy
	Michigan Child Collaborative Care	✓	✓	✓	✓	✓	Primary care providers in Michigan who are managing patients with behavioral health problems	University of Michigan
	MI Kids Now Loan Repayment Program		✓	✓	✓		Underserved areas	Michigan Department of Health and Human Services
	TRAILS to Wellness			✓	✓		Schools where at least 40% of students have been identified as low-income	TRAILS to Wellness

1. Demographics of focus as defined in initiative descriptions, specific sources for each initiative included on profile pages that follow
Source: Program and state agency websites (details follow on initiative profile pages), interviews with SMEs identified by HCA conducted in May - June 2023

Overview: Demographics addressed of state BH initiatives reviewed (3/3)

NON-EXHAUSTIVE

✓ Covers 18+ adults, but not transitional age (19-25) specifically

		Age groups					Populations of focus	
		< 0 Prenatal	0-5 Early Childhood	6-12 Childhood	13-18 Adolescent	19-25 TAY		
State	**Program**						**Specific demographics of focus**	**Source[1]**
MN	**School-Linked Behavioral Health Grants**			✓	✓		Students	Minnesota Office of the Revisor of Statutes
NE	**Behavioral Health Education Center[2]**	✓	✓	✓	✓	✓	Mental Health Profession Shortage Areas: population to provider ratio higher than 30,000 to 1[3]	University of Nebraska Medical Center
NH	**START**			✓	✓	✓	Individuals with intellectual and developmental disabilities (IDD)	START
NJ	**Children's System of Care**		✓	✓	✓	✓	Children and youth with intellectual and developmental disabilities	New Jersey Department of Children and Families
NM	**Project ECHO**	✓	✓	✓	✓	✓	Rural health care providers	Project ECHO
NY	**NYC Well**		✓	✓	✓	✓	Underserved communities	NYC Mayor's Office
OH	**OhioRISE**	✓	✓	✓	✓	✓	Youth with complex behavioral health and multisystem needs	Ohio Medicaid Managed Care
OR	**Treatment Foster Care Oregon**			✓	✓		Adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency	National Gang Center
SC	**Center for Excellence for Evidence-Based Intervention**		✓	✓	✓	✓		
UT	**Safe UT**		✓	✓	✓	✓	K-12 and higher ed students, parents/guardians, and educators	Safe UT

1. Demographics of focus as defined in initiative descriptions, specific sources for each initiative included on profile pages that follow | 2. Serves range of populations across age groups | 3. Kaiser Family Foundation
Source: Program and state agency websites (details follow on initiative profile pages), interviews with SMEs identified by HCA conducted in May - June 2023

Example goals for state BH initiatives focused on Prenatal through 25 populations[1]

NON-EXHAUSTIVE

Potential goals along continuum of care

- Improve promotion, prevention & wellness
- Increase capacity for BH treatment
- Expand crisis treatment services
- Strengthen rehabilitation and re-integration (esp. focusing on populations with complex needs)
- Enhance wraparound services

Potential cross-cutting focus areas

- Establish new digital access channels
- Expand BH workforce / capability for care
- Provide equitable access to BH services across settings
- Expand eligibility and coverage
- Scale evidence-based and evidence-informed practices
- Enhance funding mechanisms

1. Definitions of goals included in appendix

Source: Synthesis of goals across state initiatives included in the initial overview; interviews with experts identified by HCA conducted in May - June 2023

Overview: Mapping of state BH initiatives reviewed (1/3)

NON-EXHAUSTIVE

State	Program	Goals along continuum of care: Improve promotion, prevention & wellness	Expand capacity of BH treatment	Expand crisis treatment services	Strengthen rehab. and re-integration	Enhance wrap-around services	Cross-cutting goals: Establish new digital access channels	Expand BH workforce / capability for care	Provide equitable access to BH services across settings	Expand eligibility and coverage	Scale evidence-based/informed practices	Enhance funding mechanisms	Funding level	Impact[1]
AK	Adult Home Care	✓	✓		✓				✓	✓			Funding not available	
AZ	Differential Adjusted Payments	✓	✓					✓	✓	✓		✓	Less than $10M funding	
CA	BH Continuum Infrastructure Program		✓						✓				More than $100M funding	54 total projects funded, 75% for low-income communities
	BH Virtual Services Platform	✓					✓		✓				More than $100M funding	Implementation in progress
	CalHOPE Student Services	✓						✓	✓		✓		Between $10M - $100M funding	6,000 staff engaged in Community of Practice
	Statewide All-Payer Fee Schedule for School-Linked BH Services[2]	✓								✓		✓	Less than $10M funding	Implementation in progress
	Wellness Coach Workforce	✓						✓	✓				More than $100M funding	Implementation in progress
	Youth drop-in centers	✓	✓						✓				Between $10M - $100M funding	
CO	Children and Youth Mental Health Treatment Act	✓		✓						✓			Funding not available	271 children served
	Early Childhood Mental Health support line	✓					✓		✓				Between $10M - $100M funding	

Source: Interviews with SMEs identified by HCA conducted in May - June 2023; Prioritizing Health: A Prescription for Prosperity | 1. Impact included if publicly available | 2. Funding does not include cost of services to be covered by fee schedule

Overview: Mapping of state BH initiatives reviewed (2/3)

NON-EXHAUSTIVE

- Less than $10M funding
- Between $10M - $100M funding
- More than $100M funding
- Funding not available

State	Program	Goals along continuum of care: Improve promotion, prevention & wellness	Expand capacity of BH treatment	Expand crisis treatment services	Strengthen rehab. and re-integration	Enhance wrap-around services	Cross-cutting goals: Establish new digital access channels	Expand BH workforce / capability for care	Provide equitable access to BH services across settings	Expand eligibility and coverage	Scale evidence-based/informed practices	Enhance funding mechanisms	Funding level	Impact[1]
CO	I Matter	✓	✓				✓		✓				Between $10M - $100M funding	2,600 Colorado youth served
CT	Mobile Response and Stabilization Services			✓			✓		✓		✓		Between $10M - $100M funding	25% reduction in ED visits among youth
GA	Intensive Customized Care Coordination (IC3)				✓	✓					✓		Funding not available	1,000 youth served annually
IL	Universal mental health screenings	✓							✓				Between $10M - $100M funding	
MA	Community Behavioral Health Centers	✓	✓	✓	✓	✓			✓				More than $100M funding	
MD	Coordinated community supports	✓							✓				Between $10M - $100M funding	
MI	Caring for Students	✓								✓		✓	Funding not available	
	Michigan Child Collaborative Care	✓					✓	✓					Funding not available	15,000+ youth served over 10 years
	MI Kids Now Loan Repayment Program	Workforce development trains workers across the continuum						✓	✓				Less than $10M funding	84 total recipients of loan repayments in 2019
	TRAILS to Wellness	✓						✓	✓	✓	✓		Between $10M - $100M funding	10,000 staff trained

Source: Interviews with SMEs identified by HCA conducted in May - June 2023; Prioritizing Health: A Prescription for Prosperity, McKinsey Global Institute, July 2020 | 1. Impact included if publicly available

Overview: Mapping of state BH initiatives reviewed (3/3)

NON-EXHAUSTIVE

State	Program	Goals along continuum of care: Improve promotion, prevention & wellness	Expand capacity of BH treatment	Expand crisis treatment services	Strengthen rehab. and re-integration	Enhance wrap-around services	Cross-cutting goals: Establish new digital access channels	Expand BH workforce / capability for care	Provide equitable access to BH services across settings	Expand eligibility and coverage	Scale evidence-based/informed practices	Enhance funding mechanisms	Funding level	Impact[1]
MN	School-Linked Behavioral Health Grants	✓	✓						✓	✓		✓	◔	60% of school districts covered by grant program
NE	Behavioral Health Education Center[2]	Workforce development trains workers across the continuum						✓	✓				◑	5,189 students exposed to BH careers
NH	START	✓			✓	✓	✓	✓	✓		✓		○	4,029 individuals served in 2021
NJ	Children's System of Care			✓	✓	✓	✓	✓	✓	✓	✓	✓	●	70% reduction in child out-of-home placement
NM	Project ECHO	✓					✓	✓	✓		✓		○	
NY	NYC Well	✓					✓		✓				◑	1M calls answered
OH	OhioRISE			✓	✓	✓			✓	✓	✓		◑	21,000+ total enrolled children and youth
OR	Treatment Foster Care Oregon	✓			✓	✓		✓	✓		✓		○	½ number of arrests for boy participants
SC	Center for Excellence for Evidence-Based Intervention	✓						✓			✓		◔	
UT	Safe UT	✓		✓			✓						◔	30,000 unique users

◔ Less than $10M funding
◑ Between $10M - $100M funding
● More than $100M funding
○ Funding not available

Source: Interviews with SMEs identified by CYBHWG leaders and staff conducted in May - June 2023; Prioritizing Health: A Prescription for Prosperity, McKinsey Global Institute, July 2020 | 1. Impact included if publicly available

Overview of state BH initiatives

1. Overview mapping of initiatives
2. **Initiative summaries**
3. Initiative deep dives

AK: Adult Home Care

In 2023, Alaska passed legislation establishing a new alternative for individuals with disabilities in foster care when they age out of the foster care system, allowing them to stay in a familiar surrounding while transitioning to adulthood and receiving care

Population of focus: TAY[1] in foster care system

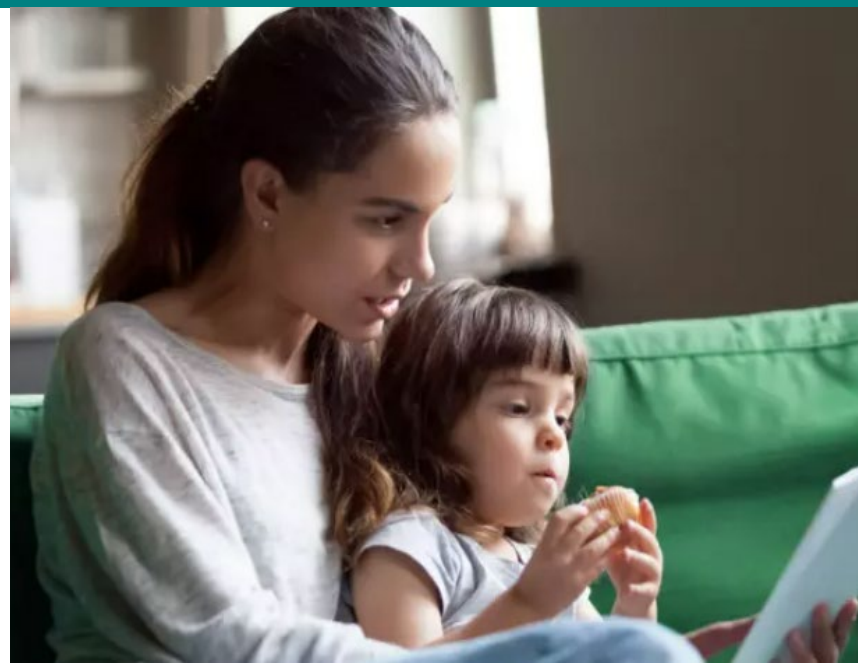
Description

- Part of Alaska's Healthy Families Initiative, HB58 establishes **adult home care as a new service type** and adult care home as a new residential license type
- Enables someone caring for an adult foster child at home to license their **home as an adult daycare**, allowing them to **receive Medicaid payments to cover the cost of care**
- Provides incentives for caregivers to continue to offer support for **individuals in foster care with severe disabilities (including intellectual disabilities) who are moving into adulthood** and would like to continue to **reside in their familiar home setting**
- The new service would be **reimbursed through a 50/50 federal Medicaid match**

Initiative goals

"This legislation [provides] … a new option for home care for … people with disabilities, with fewer administrative burdens than existing options. This legislation will keep families together, provide critical in-home support to Alaskans who need it and simplify the state bureaucracy that helps support all Alaskans through every stage of their life."

- Heidi Hedberg
Commissioner at Alaska Department of Health



1. TAY = Transitional age youth (19-25 yro.)

Source: Office of Governor, Alaska, Alaska House Bill No.58, Alaska Behavioral Health (Image)

AZ: Differential Adjusted Payments (DAP)

In 2020, Arizona implemented a differential payment rate for selected providers that have committed to partner with schools to provide behavioral health services

Population of focus: Students in primary / secondary school

Description

- Arizona's Health Care Cost Containment System **increased differential adjusted payments (DAP) by 1%** for all providers that meet one of the following milestones:
  - Have accepted **at least 10 referrals from a school** that led to subsequent service provision for the student
  - Have provided **services on a school campus**
- Part of initiative to improve patients' care experience and members' health while reducing growth in cost of care
- Enabled by legislation that created the **Children's Behavioral Health Services Fund**, allocating **$8M of funding** toward the coverage of BH services for uninsured and underinsured students through

Initiative goals

Enlist enough providers so that services are available at least to the same extent that they are available to the general population

Incentivize providers that **improve patients' care experience and members' health**

Distinguish providers that have committed to **reducing cost of care growth**

Source: AZ DAP Increase, AZ Children's Behavioral Health Services Fund, Jake's Law

CA: Behavioral Health Continuum Infrastructure Program (BHCIP)[1]

In 2021, California Department of Health Care Services (DHCS) launched BHCIP to help youth access care without delay by building up sites where they can receive BH services and expanding the community continuum of behavioral health treatment resources

Population of focus: Children and youth at risk of institutionalization

Description

- Invest in the expansion of beds, units, or rooms by building new behavioral health continuum infrastructure and expanding capacity
- Address historic gaps in healthcare delivery by enhancing and establishing a wide range of options including community wellness/youth prevention centers, outpatient treatment for substance use disorders, school-linked health centers and outpatient community mental health clinics
- Provide alternatives to incarceration, hospitalization, homelessness and institutionalization by better meeting the needs of vulnerable populations who face the greatest barriers to access
- **Total funding of $2.2B**, with **$480.5M of funding specific to children and youth**

Results to date

Utilization	Targeted populations	Project examples
54 total projects funded in Round 4 of 6 total grant rounds	**75%** of projects for Medi-Cal (low income) services	**$57.4M** for psychiatric acute care hospital in Los Angeles with 36 beds
16 county projects awarded	**4** projects granted to tribal entities	**$27.6M** for adolescent SUD treatment facilities in Orange County with 32 beds and 2,626 slots

1 Part of the California Children and Youth Behavioral Health Initiative

Source: CYBHI 101, CYBHI January 2023 Progress Report, BHCIP Data Dashboard, Office of Governor

PRELIMINARY; DRAFT as of June 27, 2023

CA: BH Virtual Services Platform[1]

California Department of Health Care Services (DHCS) will launch the Behavioral Health Virtual Services Platform, a new technology-enabled services solution for all children, youth, and families in California starting in 2024

Population of focus: Youth aged 0 - 25

Description

- Key functions include **screening** for mental health or substance use disorders; **pre-clinical coaching** services available by chat, text, video, phone; and **connecting users to off-platform clinical services**
- Offerings also include interactive digital education, self-monitoring tools, application-based games, mindfulness exercises, and access to free, **on-demand one-on-one coaching and counseling supports**
- Available as a downloadable smart phone application and via a website portal and telephone
- **$632.7M in funding total**, with **target launch in January 2024**
- Announced **external vendor Kooth** to launch the new platform; announced **$75M contract with The Child Mind Institute (CMI) to implement Next-Generation Digital Supports**, which supports accessibility

Initiative goals

"This platform will increase access to early, upstream supports that over time will reduce the overall need for services delivered in emergency departments and psychiatric hospitals, as well as through crisis services, by providing young people with an outlet to address loneliness, sadness, anxiety, school and family stressors, and other issues affecting children, youth, and young adults."

- Dr. Mark Ghaly
Secretary of the California Health & Human Services Agency

1 Part of the California Children and Youth Behavioral Health Initiative

Source: CYBHI 101, CYBHI January 2023 Progress Report, California MAT Expansion Project, State of Reform

CA: CalHOPE Student Services[1]

Begun in 2022, CalHOPE Student Services establishes a statewide Social Emotional Learning Community of Practice (SEL CoP) that builds the SEL capacity of school districts, preparing educators to be first-line responders to enrich the psychological well-being of children and youth

Population of focus: Students enrolled in K-12

Description

- Convenes leaders from all 58 County Offices of Education (COEs) in a **Community of Practice to share SEL training, evidence-based practices, and cultural adaptations** which address opportunity gaps and disproportionality; COEs then disseminate these learnings to school districts to build capacity and a common language of the importance of **positioning schools as "Centers of Wellness"**
- **$45M in funding total** with $6.8M provided by Federal Emergency Management Agency (FEMA); more than **80% of funds directly passed to 58 COEs**
- Implemented through partnership between Department of Health Care Services (DHCS), Sacramento County Office of Education (SCOE), Orange County Department of Education (OCDE), UC Berkeley, and FEMA

Initiative goals

Building a statewide network/infrastructure that allows COEs to share SEL best practices and build collective capacity

6,000 school staff have already participated in SEL CoP

1 Part of the California Children and Youth Behavioral Health Initiative

Source: CYBHI 101, CYBHI January 2023 Progress Report, CalHOPE Student Support, CalHOPE About the Project

PRELIMINARY; DRAFT as of June 27, 2023

CA: Statewide All-Payer Fee Schedule for School-Linked BH Services[1]

DHCS and the Department of Managed Health Care (DMHC) will maintain a school-linked statewide all-payer fee schedule to allow students (25 years or younger) to receive outpatient mental health and substance use disorder services at or near school sites starting in 2024

Population of focus: Students aged 0 - 25

Description

- Initiative aims to bring together the healthcare and education sectors to **reimburse for a predefined set of services for all children, regardless of payer status, in a school-linked setting**
- The supporting workgroup is composed of partners representing K-12 education, institutions of higher education, Medi-Cal managed care plans, commercial health plans, county behavioral health departments, behavioral health providers, associations, advocates, youth and parents/caregivers
- Plan to **launch in January of 2024**

Initiative goals

Create a more **approachable billing model for schools** and local educational agencies

Ease burdens related to contracting, rate negotiation, and navigation across delivery systems

Reduce uncertainty around students' coverage

1 Part of the California Children and Youth Behavioral Health Initiative

Source: CYBHI 101, CYBHI January 2023 Progress Report, CYBHI Fee Schedule Working Group Session 3

PRELIMINARY; DRAFT as of June 27, 2023

CA: Wellness Coach Workforce[1]

California Department of Health Care Access and Information (HCAI) is creating a new certified position of Wellness Coach in 2024-2025 to help support the behavioral health needs of California youth in a wide variety of settings

Population of focus: Youth aged 0 - 25

Description

- Wellness Coaches will offer **non-clinical services** that support youth behavioral health, such as wellness promotion and education, screening, care coordination, individual and group support, and crisis referral
- Wellness Coaches will serve youth aged 0 - 25 as part of a care team in a **wide variety of school, health, and community settings**
- Wellness Coaches will earn either a **Wellness Coach I or II certification**, which each require completion of 52 hours of classroom education, 400 hours of on-the-job training, and either an AS or BS degree, respectively
- HCAI received **$338M in funding** to design and build the Wellness Coach workforce
- Training of Wellness Coaches is expected to begin in 2024 with coaches in the field in 2025

Initiative goals

Build a diverse BH workforce with lived experience to serve vulnerable populations

Fill gaps in BH workforce – currently few roles cater to professionals with 1-4 years of education

Ensure the role is both a **desirable occupation** in and of itself and a stepping-stone to more advanced BH roles

1 Part of the California Children and Youth Behavioral Health Initiative

Source: CYBHI January 2023 Progress Report, CYBHI December 2022 Update, HCAI Wellness Coaches Model

CA: Youth drop-in centers

Launched in 2018, California's allcove™ youth drop-in centers aim to increase accessibility to affordable mental health and wellness services for youth aged 12 - 25, including behavioral health, physical health, housing, education, and employment support, and linkage to other services

Population of focus: Youth aged 12 - 25

Description

- Helps detect, prevent, and treat **mild to moderate mental health needs**, and connect young people to their local community behavioral health system for more intensive interventions; **services are free or low cost**
- Provides **culturally competent and relevant services for vulnerable and marginalized youth populations** including, but not limited to, LGBTQ+, homeless, and Indigenous youth
- Engages youth through **direct-to-youth marketing strategies**
- Developed by **Stanford's Center for Youth Mental Health and Wellbeing**
- **Received $15M in funding over 4 years** to launch
- Two prototype centers already implemented, with five more centers already receiving seed funding

Initiative goals

Educate the public about the importance of mental health, and reduce negative stereotypes, bias, and stigma around mental illness

Implement **evidence-based programs** that promote healthy development, support children, youth, and their families

Address the unique mental health **needs of at-risk youth**, such as racial minorities, LGBTQ+ youth, and youth with disabilities

Source: Allcove white paper, Mental Health Services Oversight & Accountability Commission

CO: Children and Youth Mental Health Treatment Act

In 2018, CO passed the Children and Youth Mental Health Treatment Act (CYMHTA) to help families access residential treatment for children with mental illness and avoid out-of-home placement

Population of focus: Low-income families with youth up to age 21

Description

- CYMHTA assists families who are uninsured or underinsured to **pay for residential treatment, community-based treatment, and transitional services for youth up to age 21** with a mental illness
- Under CYMHTA, **families only pay for 7% of the cost** of mental health treatment for their children
- CO's Behavioral Health Administration contracts with four Mental Health Agencies, to operationalize CYMHTA: Signal Behavioral Health Network, Rocky Mountain Health Partners, Beacon Health Options and Beacon Health Options on behalf of Health Colorado, Inc.
- In SFY22, **total funding for CYHMTA was $6.9M**

Results to date

Utilization

271 children and youth served in SFY22

97 children served were new to CYMHTA in SFY22

Growth

10% growth in children and youth served from SFY21

Outcomes

83% of youth discharged had reduced risk of out-of-home placement

Source: CYMHTA SFY22 Annual Report

CO: Early Childhood Mental Health support line

In 2022, the Colorado Department of Human Services announced a new Early Childhood Mental Health (ECMH) Support Line to connect parents and caregivers of children under age 6 with the mental health resources they need

Population of focus: Parents and caregivers of children under age 6

Description

- The support line enables parents and caregivers, including early childhood professionals, to **speak with an early childhood mental health consultant**
- Consultation available through the support line can help families and caregivers to better understand and support the emotional well-being of young children in their care by discussing needs, brainstorming appropriate support resources, and connecting parents and caregivers to local community resources
- The support line is a **no-cost, confidential service** that is available statewide M-F from 10:30am to 5:30pm
- Funding is allocated through a **three-year $33.5M grant** from the state to improve children's preparedness for kindergarten

Initiative goals

"All families may benefit from reaching out to the Early Childhood Mental Health Support Line … The support line aims to increase the knowledge and confidence of caregivers in a way that supports positive mental health early and creates a foundation for lifelong health and well-being."

- Lisa Schlueter
Preschool Development Grant Birth through Five ECMH strategy lead

Source: Colorado Department of Human Services

CO: I Matter

In 2021, Colorado State Legislature launched the I Matter program to provide access to mental health and substance use disorder services for youth, including addressing needs that may have resulted from the COVID-19 pandemic

Population of focus: Youth ages 0-18 or 21

Description

- Provides up to **six free mental health sessions with a licensed provider** for youth 18 years of age or younger or 21 years of age or younger if receiving special education services
- Partners with Signal BH as a primary provider, which also has a **provider-friendly subcontracting mechanism** for independent providers
- Implements statewide public awareness and outreach campaign that includes **digital ads on social media platforms**, and **on-the-ground outreach to schools and youth organizations**
- Pilot **initial funding of $10M** (catalyzed by federal COVID funding); received **$6M in additional funding** to extend services until at least June 2024

Results to date

Utilization

2,600 Colorado youth have participated in at least one therapy session

7,500 therapy sessions have been completed or are upcoming

Feasibility

$10-50M of funding necessary to implement including extension rounds of support

<2 years to impact and address

Source: I Matter, Colorado Department of Human Services

CT: Mobile Response and Stabilization Services

Connecticut's nationally recognized Mobile Response and Stabilization Services (MRSS) program, launched in 2009, provides 24/7 mobile children's mental health crisis services free of charge to all children in the state

Population of focus: Children and youth under 18

Description

- Serve children in their homes and communities, **diverting children from high-end interventions (such as hospitalization or arrest) if a lower level of care is a safe and effective alternative**
- Trained mental health clinicians are deployed to homes, schools and community locations to provide in-person crisis stabilization services and linkage to ongoing care for children in Connecticut
- **Call center: Centralized, toll-free phone number serves as point of entry** and to provide person-to-person assistance and connection to crisis services; **accessible 24/7, 365 days per year**
- Receives grant-funding from Department of Children and Families (DCF) – **$10.7M in funding in 2016**
- Mobile Crisis Performance Improvement Center (PIC) delivers **strong continuous quality improvement**

Results to date

Utilization

16,776 total calls fielded by the Call Center in 2016

90% rate of face-to-face contact with families that request services

Outcomes

25% reduction in ED visits among youth who utilize the service

8.5% decline in child problem severity following mobile crisis involvement

Source: CT Mirror, Child Health and Development Institute, SFY 2016 EMPS Report Card, Child Health and Development Institute

GA: Intensive Customized Care Coordination (IC3)

In 2017, Georgia launched Intensive Customized Care Coordination (IC3) as a provider-based High Fidelity Wraparound model intervention designed for youth ages 4-21 with complex needs

Population of focus: Youth ages 4-21 with complex needs

Description

- Wraparound[1] is facilitated through **two state-contracted Care Management Entities (CMEs)**, which engage team members to identify resources for youth with Severe Emotional Disturbance (SED)
- Goals of the CME include assisting families with developing formal and natural supports, **minimizing out-of-home placements** and assisting with the **transition from institutional to community-based care**
- Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), Medicaid, and federal grants support Wraparound for youth who are at-risk for institutional level of care (LOC)
- Deemed by Substance Abuse and Mental Health Services Administration (SAMHSA) as achieving "maintenance of fidelity and program standards and established markers of competency"

Results to date

Utilization	Services	Outcomes
1,000 youth served through IC3 / Wraparound annually	**1:10** care coordinator to child/family ratio	**90%** of caregivers reported positive responses for cultural sensitivity
	12-18 months of average service duration	**56%** of youth demonstrated improved levels of functioning

1. Wraparound is a process building on the collective action of a team to mobilize resources from a variety of sources to support families in their communities

Source: SAMHSA ICC State and Community Profiles, Georgia State University High Fidelity Wraparound

IL: Universal mental health screenings

In 2017, Illinois passed legislation integrating mental health screenings into K-12 school physicals statewide

Population of focus: Students in primary and secondary school

Description

- Requires **social and emotional screenings** for children as part of their school entry examinations
- The standards for the screenings are to be **developed in the Office of Women's Health and Family Services** in consultation with statewide organizations representing school boards, pediatricians, and educators along with mental health experts, state education and healthcare officials, and others
- Aims to cultivate the most up-to-date, evidence-based screening formats to identify potential issues early on and help students receive the support they need
- Currently exploring ways to fund these screenings—including grants legislated this year which provide funding for mental well-being checks

Initiative goals

"[The effort is] aimed at identifying potential mental health problems in school-age children, removing the stigma of mental illness and reducing teen suicide by identifying their needs and providing early intervention"

- Kimberly A. Lightford
Assistant Majority Leader and Vice Chair of the Illinois Senate's Education Committee

Source: The Kennedy Forum, Illinois Department of Human Services

MA: Community Behavioral Health Centers

Launched in 2023, Community Behavioral Health Centers (CBHCs) are one-stop shops for a wide range of mental health and substance use treatment programs, offering immediate care, both in crisis situations and the day-to-day

Population of focus: Medicaid recipients

Description

- The statewide network includes 25 CBHCs in communities across Massachusetts
- **Team model of care**: **teams that specialize in serving children and adolescents**; involves a clinician, care coordinator; peer specialist or family supporter
- **Bundled billing**: For those who are covered for care at a CBHC, there is just one rate for their combined services, compared to typically when insurance companies bill for every individual service a patient receives
- **Services are insurance-blind**, meaning anyone can access services, no insurance needed
- **$200M in funding** for implementation

Initiative goals

Expanded access, including **same-day access to assessment/referral** and crisis/urgent treatment

Community-based crisis intervention integrated with full OP continuum of services

Focus on equity through **culturally competent, accessible treatment**

Source: Mass.gov, Western Massachusetts News, WGBH News, Massachusetts Behavioral Health Partnership

MD: Coordinated community supports

The Maryland Consortium on Coordinated Community Supports, established in 2022, is a 24-member entity responsible for developing a statewide framework to expand access to comprehensive behavior health services for Maryland students

Population of focus: Students

Description

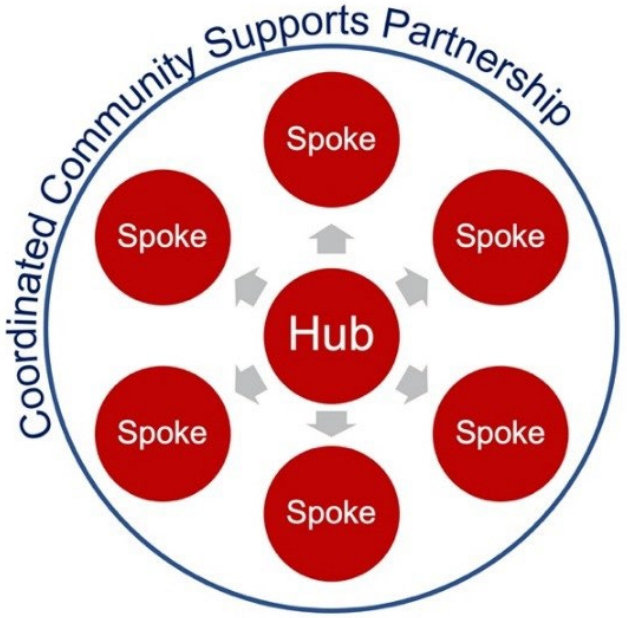
- The Consortium was created by the Maryland General Assembly as part of the Blueprint for Maryland's Future
- Uses a **Hub and Spoke framework** for local Community Support Partnerships:
  - **Spokes**: Providers of BH services to students and their families – may be existing providers of school-based services, or providers not currently operating in schools.
  - **Hubs**: Responsible for tasks including coordinating service providers, distributing Partnership grant funds to Spokes as subgrantees, and collecting and reporting data.
- **$50M in total grant funding** in 2023, $85M in funding in 2024
- Future **grants will go to Hubs only**, who will distribute funding to Spokes as subgrantees.

Initiative goals

Expand access to high-quality behavioral health and related services for students and families

Improve student wellbeing and readiness to learn; foster positive classroom environments

Promote sustainability through revenues from Medicaid, commercial insurance, hospital community benefit, and other **funding sources**



Source: Maryland Community Health Resources Commission, Consortium April 2023 Presentation

MI: Caring for Students (C4S)

In 2019, Michigan expanded its school-based Medicaid program in an effort called Caring for Students (C4S), which enabled the State to seek federal Medicaid match funding for all Medicaid-enrolled students

Population of focus: Medicaid-enrolled students

Description

- Allowed MI to seek Medicaid **reimbursement for services provided to all Medicaid-enrolled students**
- **Expanded the types of providers who can bill for Medicaid services in school-based settings** (and for all Medicaid-enrolled students) to include physician assistants, certified nurse specialists, marriage and family therapists, behavior analysts, school social workers and school psychologists
- During implementation, the **state health agency supported schools** by:
  - Updating the State Medicaid Provider Manual
  - Holding site visits and webinars to educate school staff about the newly approved providers

Results to date

Financial investment: The State legislation dedicated funding to support the planning and implementation of C4S. Over time, due to new federal investment through Medicaid, the C4S program will have a dedicated revenue stream to sustain it

Strong collaboration: The State team included key partners from Medicaid, education and intermediate school districts (ISDs) which led to buy-in and resulted in concrete, workable policy solutions

Source: Case Study: Expanding Michigan's School-based Medicaid Program, Healthy Students, Promising Futures

MI: Michigan Child Collaborative Care (MC3)

Only 1 county in Michigan has an adequate number of pediatric and perinatal psychiatrists. In response, the state launched the Michigan Child Collaborative Care (MC3) in 2012 as a statewide telepsychiatry consultation program to support primary care providers

Population of focus: Prenatal mothers, children / youth under age 26

Description

- Through the MC3 program, psychiatrists are available to offer **guidance on diagnoses, medications and psychotherapy interventions** so that primary care providers can better manage patients in their practices
- The treating provider initiates the consult with a call to the Behavioral Health Consultant (BHC), a master's-level mental health professional based locally, or submits a consultation request through a secure web-based form
- The BHC triages the referral, responds to any questions that are within the scope of his/her expertise, and forwards appropriate cases to the MC3 psychiatrist for **same-day phone consultation**
- **Written summary of the consultation is sent to the provider along with local resources**
- **Funded by the Michigan Department of Health and Human Services**

Results to date

Utilization

18,000+ services provided over 10 years

15,000+ patients served over 10 years

Outcomes

"This program has been a lifesaver. I can call and get help with behavioral health issues within a day. MC3 providers have enabled me to better care for patients that would otherwise be somewhat outside of my practice 'comfort zone'; unfortunately, these children have no easy access to pediatric psychiatric services and we primary care providers are 'it' in rural Northern Michigan."

- Pediatrician in Michigan's Northern Lower Peninsula

Source: Psychiatric Services Journal, MC3, MC3 (2), Western Michigan University, University of Michigan

MI: MI Kids Now Loan Repayment Program

Begun in 2022, the MI Kids Now Loan Repayment Program (MKN LRP) is a debt repayment program focused on incentivizing behavioral healthcare providers to practice in underserved areas across the state

Population of focus: Students in professional school

Description

- MKN LRP funds loan repayment of up to $300,000 to those who agree to **provide mental health services in eligible nonprofit practice sites or public school-based systems for at least 2 years**
- MKN LRP partners with local orgs to gain access to unique communication channels to market the program
- Loan repayment agreements are funded by a **federal/state/local partnership:** 40% funded by federal dollars, 40% funded by state dollars, 20% funded by employer contribution
- Federal funds awarded by National Health Services Corps (NHSC)
- **$3M in total funds** obligated in FY 2019

Results to date

Utilization	Growth	Retention
185 applications received in 2019	**236%** increase in applications from 2013 to 2019	**55%** retention rate following fulfillment of service obligation
84 total recipients of loan repayments in 2019	**2nd** largest state loan repayment program in 2019	

Source: MKN LRP FY 2023 Program Guidance, MSLRP FY 2018-2019 Report

MI: TRAILS to Wellness

Launched in 2013, Transforming Research into Action to Improve the Lives of Students – TRAILS to Wellness – aims to bring proven mental health strategies to the school setting, helping staff provide the support students need

Population of focus: Students in K-12

Description

- TRAILS offers the **training, materials, and implementation support** schools need to provide their students with evidence-based mental health supports that are appropriate for the school setting; **$50M funding** in 2023
- TRAILS offers **3 tiers of programming** that correspond to differing levels of student need:
  - **Tier 1, Universal Education and Awareness:** Social and emotional learning (SEL) for all students to promote resiliency and build self regulation skills; self-care strategies for staff to prevent stress and burnout
  - **Tier 2, Targeted Intervention:** CBT and mindfulness for students with symptoms of depression / anxiety
  - **Tier 3, Suicide Risk Management:** Accurate, timely identification of students at risk of suicide
- Currently operating in Michigan, Colorado, and Massachusetts – goal of expanding to 10 states by 2040

Results to date and initiative goals

Results	Goals
10,000 school staff and mental health professionals have accessed TRAILS trainings and resources	**50%** of Title I designated schools (where at least 40% of students have been identified as low-income) have access to TRAILS resources in at least 10 states by 2040

Source: TRAILS to Wellness, TRAILS Program Overview, Our Impact, University of Michigan

MN: School-Linked Behavioral Health Grants

Established in 2022, Minnesota's School-Linked Behavioral Health program helps schools and families identify and treat BH needs by providing assessments, counseling sessions, and tools for teachers to help support students – all while keeping students close to home and in school

Population of focus: Students in K-12

Description

- School-linked behavioral health grants are issued through a Request for Proposal (RFP) process to licensed **behavioral health providers who are embedded in or located close to schools** to screen for behavioral health concerns, deliver services to students and build capacity of school personnel
- Providers offer behavioral health services to **all students, regardless of insurance status**
- The school-linked **grant program funds approximately 20-30% of the total costs** of comprehensive school behavioral health services
- **$6M in annual investment** proposed by Governor and Lieutenant's Governor

Results to date

Utilization	Goals
60% of school districts in the state covered by grant program	**~50%** of youth served through the grant program received behavioral health care for the first time
1,000+ schools participate in the school-linked grant program	

Source: Minnesota School Boards Association, PolicyLab

NE: Behavioral Health Education Center

88 of 93 counties in NE are designated Mental Health Profession Shortage Areas. In 2009, the Behavioral Health Education Center of Nebraska (BHECN) was established to address the shortage of BH professionals in rural and underserved areas of the state

Population of focus: Students in high school, college, and professional school

Description

- BHECN is a partnership among the NE state legislature, academic institutions, and community organizations dedicated to improving access to BH care across the state by developing a skilled and passionate workforce:
  - **Engage & Recruit**: BHECN's Ambassador Program aims to engage interest in BH careers for students, especially those in rural and underserved areas
  - **Prepare & Train**: BHECN connects students to training for psychiatric residents, psychiatric nursing, psychology, counseling, social work, marriage & family therapy, and addiction counseling
  - **Retain & Support**: BHECN provides professional development, training opportunities, and connectivity
- **$25M in funding** in 2022 by the Nebraska Legislature using funding from the American Rescue Plan Act

Results to date

Engage & Recruit	Prepare & Train	Retain & Support
5,189 students exposed to careers in BH	**1,439** students completed interprofessional training in rural sites	**327k+** hits on free BH jobs website
13 of 20 psychiatry residents stayed in NE	**139** students completed BHECN supported internships and clinical rotations	**4,914** people participated in BHECN live and online training programs

Source: University of Nebraska Medical Center, BHECN 2021-2022 FY Legislative Report

NH: Systemic, Therapeutic, Assessment, Resources & Treatment (START)

In 2009, The National Center for START services was established to implement an evidence-based, community crisis prevention and intervention service model for individuals aged 6 and older with intellectual and developmental disabilities (IDD) and mental health needs (IDD-MH)

Population of focus: Individuals 6+ with IDD

Description

- The National Center for START Services develops innovative training, conducting research, and implementing the START model in communities across North America
- START program implementation follows a **three to four-year development process** of ongoing support in the form of **START model tools, training, strategic planning, consultation, and technical assistance**
- The local START teams provide: 24-hour case coordination to improve supports and service outcomes, whole-person assessment, individualized map of individual's connections to others/systems, cross-system linkage, community education, and family/staff/provider support and education (in-home therapeutic coaching)
- All START programs work together as a **national community of practice** facilitated by the National Center

Results to date

Utilization	Outcomes
4,029 people with IDD and mental health needs served in 2021	**71%** of individuals had a reduction in mental health symptoms as measured by Aberrant Behavior Checklist
2,650 crisis calls received in 2021	**73%** of crisis contacts in 2019 resulted in individuals remaining in their current community-based setting, avoiding potential ED visits / psychiatric inpatient admissions

Source: START Model, START 2021 Annual Report, CA Department of Developmental Services, The Center for START Services, Institute on Disability (Image)

NJ: Children's System of Care

In 2000, New Jersey redesigned its children's mental health system to ensure services are available regardless of a child's insurance status and without involving the child welfare or juvenile justice systems

Population of focus: Youth under 21

Description

- NJ adopted a "system of care" — a framework that aims to make a wide array of culturally competent services available in a coordinated, easy-to-navigate way
- **Reduces use of institutional-based care** by providing children at risk of out-of-home placements with services in their homes / communities: reserves residential placements for the children who truly needed them
- **Services go beyond medical intervention** – offers peer support groups for kids and parents; access to sports, clubs and other activities that provide opportunities for positive social interactions and mentorship
- PerformCare is the single portal for access to care available 24/7/365
- Investment of over $100 million from 2020-2022

Results to date

Outcomes

70% reduction in number of children living in out-of-home settings between 2006 and 2022 (10,000 to 3,000)

9,700 fewer youth in juvenile detention from 2003 to 2008 (12,000 to 2,300 a year)

297 fewer youth in out-of-state behavioral care from 2007 to 2012

DIVISION OF CHILDREN'S SYSTEM OF CARE

Source: New Jersey Department of Children and Families, WBUR, New Jersey's Children's System of Care

NM: Project ECHO

Created in 2003 to empower rural health care providers with expert knowledge and best practices, Project ECHO (Extension for Community Healthcare Outcomes) uses videoconferencing to build virtual communities of practice

Population of focus: Children and youth in rural / under-served communities

Description

- Project ECHO is a **hub-and-spokes and learning collaborative model** that uses telehealth technologies to build a virtual collaboration between Primary Care Physicians (PCPs) and multidisciplinary specialists
- Participants attend **virtual case-based sessions with subject-matter experts**, empowering them to lead positive, sustainable change in their communities
- Project ECHO fosters growth in PCPs' abilities to provide care for children with **mild to moderate mental health disorders** while extending the reach of Child and Adolescent Psychiatrists for more seriously ill youth
- Currently helping early childhood educators learn how to be culturally responsive to their students' unique needs through **social-emotional learning awareness and strategies**

Initiative goals

Use technology to leverage scarce resources

Share best practices to reduce disparities

Apply case-based learning to master complexity

Evaluate and monitor outcomes

Source: Project ECHO 2022 Annual Report, Project ECHO Explainer, American Psychiatric Association

NY: NYC Well

Launched in October 2016, NYC Well is a free and confidential mental health pipeline offering phone, text, and online chat-based support; expanded service offerings also include crisis counseling, peer support, information and referral, and follow-up services for BH concerns

Population of focus: All NYC residents

Description

- Launched as part of ThriveNYC, a citywide behavioral health initiative overseen by the Mayor's Office of New York City; operated by Vibrant Emotional Health
- Aims to provide a **single point of entry** to individuals seeking access to behavioral health support and treatment
- Services provided include suicide prevention and crisis counseling; peer support and short-term counseling via telephone, text and web; referrals and warm transfer to other services; follow-up to check on care
- The service is available in **over 200 other languages at all times, 24/7/365**

Results to date

Utilization	Outcomes
1M calls, texts, and chats answered as of August 2020	**90%** of participants say the service helped them at least a little, with nearly two thirds saying the service helped them a lot
74% of users are repeat contacts	**20%** of participants say they may have utilized emergency services if NYC well did not exist

Source: Evaluation of NYC Well, NYC Well Evaluation

OH: OhioRISE

In 2022, Ohio's Department of Medicaid launched OhioRISE (Resilience through Integrated Systems and Excellence), a specialized managed care program for youth with complex behavioral health and multisystem needs

Population of focus: Children and youth ages 0 - 20

Description

- OhioRISE aims to shift the system of care and keep more kids and families together by creating **new access to in-home and community-based services – e.g., Intensive Home-Based Treatment (IHBT)**
- Primarily designed for children and youth with **significant BH treatment needs**, as measured by the Ohio Child and Adolescent Needs and Strengths (CANS) assessment
- **Aetna Better Health** of Ohio serves as the **single statewide specialized managed care plan**
- Features multi-agency governance to drive towards improving cross-system outcomes
- Serves the most in need and vulnerable families and children to **prevent custody relinquishment**

Results to date

Tech Enablement	Applications	Utilization
2,600+ Ohio assessors registered in CANS IT system	**36,000+** CANS assessments submitted in CANS IT system as of May 2023	**21,000+** total children and youth enrolled in OhioRISE as of May 2023

Source: Ohio Medicaid Managed Care, OhioRISE Launch Report (May 30, 2023)

OR: Treatment Foster Care Oregon

In 1983, Treatment Foster Care Oregon (TFCO) was developed as an alternative to institutional, residential, and group care placements for children and youth with severe emotional and behavioral disorders

Population of focus: Children ages 7-17

Description

- The two main goals of TFCO are to **create opportunities for youth to successfully live in a family setting** and to simultaneously **help parents provide effective parenting**
- Adolescents are placed in a **family setting for nine months**; community families are recruited, trained, and supported to provide well-supervised placements and treatment
- Youth in TFCO receive weekly support to navigate the program, practice of problem-solving and coping skills along with other skills individualized for their particular needs
- TFCO is currently implemented throughout the United States, Australia, Sweden, Norway, Denmark, The Netherlands, United Kingdom, and New Zealand

Results to date

Outcomes

½ the number of arrests for boy participants

3x less likely to run away from foster care

⅔ fewer days incarcerated for boy participants

$3.15 in benefit for every $1.00 spent on TFCO when considering child welfare and criminal justice involvement

Source: TFCO About, TFCO Evidence, National Gang Center

SC: Center for Excellence in Evidence-Based Intervention

Since 2020, South Carolina's Center of Excellence in Evidence-Based Intervention has helped identify and support the use of evidence-based practices for children, youth, and families

Population of focus: Children, youth, and families

Description

- Mission is to support agencies and organizations in the **selection and implementation of evidence-based interventions to promote youth and family well-being** and to address challenges related to behavioral health problems and substance use
- Serves as an intermediary organization
  - Create **training and technical assistance** plans for identified evidence-based interventions
  - Support **high quality implementation** of evidence-based interventions with fidelity
  - Establish mechanisms for **data collection and feedback**

Initiative goals

Make evidence-based support and intervention available when and where youth and families need them

Promote excellence and accountability in service provision

Encourage BH workforce readiness

Source: South Carolina Center of Excellence in Evidence-Based Intervention – Homepage, Presentation

UT: Safe UT

Youth suicide was the leading cause of death for young people aged 10-24 in Utah. In response, the state commission launched the Safe UT app in early 2016 as a way for youth to access help with any sized problem at any time

Population of focus: Students K-12 & higher ed

Description

- Safe UT is a mobile app that provides a way for students, parents/guardians, and educators to confidentially connect to a licensed counselor **24/7, 365 days a year**
- Users start a **real-time, two-way messaging exchange** with master's level counselors via chat or call
- **Use is confidential**, and crisis counselors do not inquire about identifying information except in emergencies
- Users can submit a tip on behalf of someone else for concerns regarding bullying, self-harm, and school safety
- **$1.2M of funding** requested in FY 2023
- Commissioned by Safe UT & School Safety Commission, services provided by Huntsman Mental Health Institute

Results to date

Access

96% of school districts enrolled

882k+ students with access

Utilization

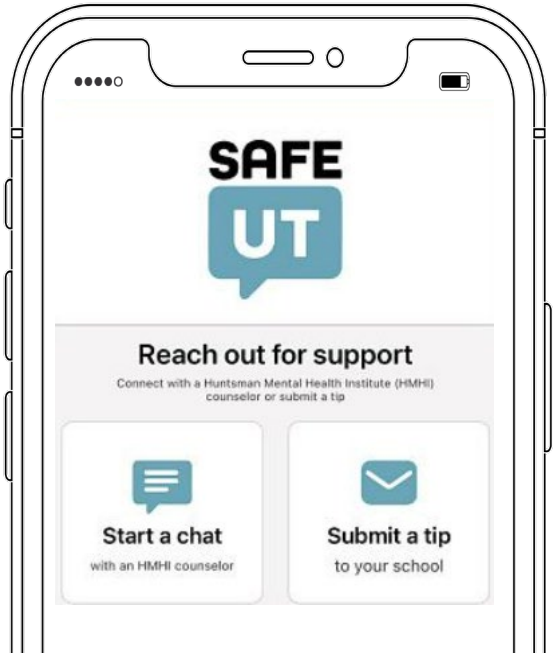
30,000 unique users

12% projected growth in FY 2023

Outcomes

85% of administrators agree that mental health stigma has improved since enrolling in Safe UT

349 lifesaving interventions



Source: 2022 Safe UT Annual Report, Safe UT FY23 Funding Letter of Support

Overview of state BH initiatives

1. Overview mapping of initiatives
2. Initiative summaries
3. **Initiative deep dives**

Potential lessons in BH service delivery from selected initiatives

Initiatives included in deep-dives, based on guidance from interviewed SMEs: CT's Mobile Crisis and Stabilization Services, MI's TRAILS to Wellness, NJ's Children's System of Care

Considerations from initiatives included in deep-dives

Deep community involvement: CT, MI, and NJ involved community agents (e.g., parents, principals) and individuals with lived experience in program design to craft services that appropriately meet the needs of those who need it

Robust workforce: NJ has extended the total BH workforce by rethinking roles for Bachelor's level staff and peer support. CT has also discovered that providing training can help make workers feel prepared for their roles and reduce attrition

Easy-to-navigate user experience: Both CT and NJ have found that establishing a single point of entry may increase navigability of services for youth and families with complex needs. Moreover, adopting a "just go" mentality for crisis response in CT has helped states win credibility and legitimacy among families

Tech enablement & infrastructure: Both CT and NJ have highlighted the importance of establishing a data-sharing platform across organizations to support continuous monitoring and process improvement

Sustainable funding: NJ has experienced that leveraging Medicaid for its Children's System of Care (CSOC) may help to make funding more predictable. Reinvesting cost savings have also helped NJ and CT support program sustainability

Source: Based on discussions with HCA in May - June 2023; summarized from initiative overviews contained in this document

Questions for discussion

How has WA thought about engaging community stakeholders and individuals with lived experience to create a strategic plan that is most reflective of needs?

How has WA contemplated expanding BH roles to accommodate non-clinicians (e.g., Bachelor's level staff, peer support)? In what ways might WA support the training of clinicians, especially in underserved communities (e.g., rural, tribal settings)?

How has WA thought about the prospect of establishing a single point of entry for BH services (e.g., similar to NJ's System of Care for individuals with complex needs)? In case of multiple points of entry, how might WA ensure that youth and families have the support they need to navigate the system effectively (e.g., "no wrong door" approach)?

How has WA thought about establishing the underlying data capabilities to support a robust performance infrastructure for continuous tracking and improvement of service delivery?

How has WA thought about the role of Medicaid in funding BH services? What other sources of funding may the working group consider to support the strategic plan?

Deep Dive: Mobile Response and Stabilization Services (CT)

Key system elements

Workforce strategies: To increase exposure, CT offers internship experience to 2nd year clinical Master's students. CT also maintains a training program with full toolkit of treatment skills to reduce uncertainty and burnout; every year, a training plan and assessment of gaps is conducted to assess areas of need. Individuals who stay for 2-3 years are typically retained long-term from past experience in CT

Funding mechanism: CT mainly leverages funding from state general fund for its MRSS program; achieves sustainable funding by demonstrating ROI metrics to state – e.g., CT calculates cost savings from diverted inpatient beds from community care being used instead

Governance and collaboration: CT is divided into six regions, each with its own contractor; each contractor is broken down into smaller subgroups – must know every school in district and track every referral from every school building. Legislation has also been instrumental for CT – each school has a Memorandum of Agreement (MOA) with mobile crisis provider to report student crises

Source: Based on expert interview in June 2023, Child Health and Development Institute

Potential takeaways for WA as shared in SME interviews

Cross-applicable principles:

1. "Just go" mentality: Minimize time on phone and send someone immediately for face-to-face contact with crisis caller
2. Rapid response: Guarantee face-to-face contact within 60 minutes of call
3. User-centric approach: Minimize screening out of calls, assure caller that crisis is important
4. High-touch assistance: Stay involved with family until handoff to stabilization service

State-specific considerations:

1. Sizing and staffing: Adequate staff capacity within a region to achieve face-to-face interactions on a reliable basis – gives parents confidence, increases credibility of the system
2. Remote geographies: Difficult to provide coverage for large areas with little population; may require telehealth that is rapid and reassuring to parents

Deep Dive: TRAILS to Wellness (MI)

Key system elements

Equity-focused services: TRAILS engages underserved communities with higher touch implementation support. Recognizing that schools in these areas demonstrate higher workforce turnover, TRAILS focuses on building long-term protocols to ensure continuity of training. TRAILS also develops culturally sensitive materials for its training curriculum designed to be reflective of lived experiences in communities

Funding mechanisms: TRAILS uses combined funding from multiple sources: funding from philanthropies and social impact funds, state appropriated dollars, revenue from direct service contracts; initially partnered with University of Michigan to receive matched Medicaid funding – spun out from University of Michigan in 2022

Community engagement: TRAILS hires teachers to partner with clinical team and design program structure. TRAILS also regularly convenes student groups to gather feedback on curriculum content

Source: Based on expert interview in June 2023, University of Michigan Medicine

Potential takeaways for WA as shared in SME interviews

Cross-applicable principles:

1. Implementation science: Training that goes beyond one-time demonstrations – including collaborative partnership with local districts, on-the-ground champions, and long-term consultation

2. Community engagement: Continuously engaging communities to ensure BH service delivery is tailored to unique cultural needs and reflective of lived experience

State-specific considerations:

TRAILS is actively considering additional states for expansion – looking for several criteria:

1. Funding – States with capacity and willingness to earmark funding from state budget to support BH training efforts (e.g., Michigan allocated $50M in state funding to TRAILS in 2022)

2. Workforce – States with workforce capacity necessary to support TRAILS school-based training program

Deep Dive: Children's System of Care (NJ)

Key system elements

Workforce strategies: NJ extends its BH workforce by employing Bachelor's level workers and peer support; roles for non-clinicians include mobile responders, care managers within care management organizations, and behavioral assistance providers. NJ also contracts Rutgers University Behavioral Health Care as a center to provide training, technical assistance, and coaching – 30 courses per month, free of charge

Funding mechanism: Funding for NJ's Children's System of Care (CSOC) is built into Medicaid. Specific funds are earmarked for individuals with IDD – CSOC covers the full array of services for this population segment

Governance and collaboration: PerformCare functions as Administrative Service Organization (ASO) that coordinates services. Care management entities (CMEs) function as independent non-profit organizations to implement high fidelity wraparound in communities – actively engage community stakeholders, such as parents, principals, judges, and Boys & Girls Clubs

Source: Based on expert interview in June 2023, Children's Initiative Concept Paper, CSOC Presentation, Rutgers

Potential takeaways for WA as shared in SME interviews

Cross-applicable principles:

1. Single point of access: Serves as convenient way for parents to access care and navigate services
2. Mobile response and stabilization system: Meets parents' and schools' needs in cases of crisis
3. Intensive care coordination by CMEs: Having entity embedded into the community allows for local accountability
4. Community engagement: Involving parents in the conversation, running support groups, and conducting education sessions for the community facilitates appropriate service design

State-specific considerations:

1. Degree of service decentralization: Differing level of siloes and fragmentation in different states
2. Community organizational infrastructure: Differing level of presence of nonprofits owned by communities to facilitate service delivery

Appendix

Unique stakeholders engaged to support overview of state initiatives

Name	State	Role
Elizabeth Koschmann	MI	Executive Director, TRAILS to Wellness
Deb Pinals	MI	Medical Director for Behavioral Health and Forensic Programs, Michigan Department of Health and Human Services
Denise Sulzbach	CT	Director, University of Connecticut Innovations Institute
Eric Bruns	WA	Associate Director, School Mental Health Assessment, Research, and Training (SMART) Center
Hugh Ewart	WA	Senior Director of State and Federal Relations, Seattle Children's Hospital
Jessica McClure	OH	Medical Director of Behavioral Health, Cincinnati Children's Hospital
Jill Fragos	IL	Vice President of Government Relations, Lurie Children's Hospital of Chicago
Jim Theofelis	WA	Founder, NorthStar Advocates
Kashi Arora	WA	Mental and Behavioral Health Program Manager, Seattle Children's Hospital
Liz Manley	NJ	Assistant Commissioner (Former), New Jersey Children's System of Care
Melissa Saladonis	OH	Vice President Government Relations, Cincinnati Children's Hospital
Sarah Walker	WA	Director, CoLab for Community and Behavioral Health Policy
Sharon Hoover	MD	Co-Director, National Center for School Mental Health
Susan Hayes Gordon	IL	Senior Vice President and Chief External Affairs Officer, Lurie Children's Hospital of Chicago
Suzanne Fields	MA	Senior Advisor for Health Care Policy and Financing, University of Maryland's Institute for Innovation and Implementation
Tim Marshall	CT	Director of Community Mental Health, Connecticut Department of Children and Families

Subject matter experts to consider for additional interviews

Potential contacts identified by interviewed SMEs for future connection

NON-EXHAUSTIVE

Name	State	Role
Cindy Beane	WV	Commissioner for the West Virginia Bureau of Medical Services
Dana Weiner	IL	Senior Policy Fellow, Chapin Hall of University of Chicago
Marisa Weisel	OH	Deputy Director, Ohio Department of Medicaid
Michelle Zabel	MD	Executive Director, University of Maryland's Institute for Innovation and Implementation
Mollie Greene	NJ	Assistant Commissioner (Current), New Jersey Children's System of Care
Kelly English	MA	Deputy Commissioner, Massachusetts Child Youth & Family Services
Robert Putnam	MA	Executive Vice President of Positive Behavioral Interventions and Supports, May Institute
Sheamekah Williams	OK	Director, Children, Youth, and Family Services at Oklahoma Department of Mental Health and Substance Abuse Services

Source: Expert interviews with SMEs identified by CYBHWG leaders and staff in May – June 2023

Perspectives on the current state of BH services in WA as shared by SMEs

While SME interviews were primarily conducted to gather examples of emerging BH initiatives from other states, several qualitative insights were shared regarding the current state of BH services for children/youth in WA. Below is a list of perspectives on the current state of the BH system in WA as shared by SMEs

NON-EXHAUSTIVE

Age-specific opportunities:

- Early childhood: Potential opportunity to strengthen care services for young children under the age of 5
- Transitional age youth (TAY): Potential opportunity to strengthen developmentally appropriate resources for TAY population (19-25 years old). As one SME shared, "Right now, Washington puts 18-year-old's and 50-year-old's in the same treatment program, even though they navigate the system very differently"

Culturally responsive opportunities:

- Potential opportunity to strengthen services in languages other than English
- Potential opportunity to recruit more BH workers whose life experience reflects the populations they serve (e.g., LGBTQ+ youth, youth of color, individuals who have experienced homelessness)

Care continuum opportunities:

- Potential opportunity to develop capacity for intensive care serving individuals with more complex needs
- Potential opportunity to fortify support and resources for individuals returning to their communities following inpatient BH treatment – e.g., community building, workforce training, well maintained discharge facilities

Cross agency collaboration:

- Potential opportunity to improve coordination mechanisms across agencies. As one SME shared, "It's easy for HCA to fall into project-based work because of its structure – when in reality the focus should be on system level reform"

Source: Expert interviews with SMEs identified by CYBHWG leaders and staff in May – June 2023

Potential methodological considerations as shared by SMEs

While SME interviews were primarily conducted to gather examples of emerging BH initiatives from other states, several methodological considerations were also shared regarding exercises that may enrich the strategic planning process:

NON-EXHAUSTIVE

Quotes shared from SMEs

Data investment

My hope is that the Strategic Plan makes recommendations to invest in robust data systems so we can see what's happening. Right now, we cobble together a lot of anecdotal reports to make a case to the State

Fund and eligibility mapping

Children and youth served by public systems are a shared population – they are not receiving services from just one location. Where we see states making inroads is in recognizing this sharing of dollars and accountability to understand how each system contributes to a single plan of care and a holistic view of what each family needs

Integrated care planning

There is more work to be done with integrated managed care plans to ensure consistency in approach across multiple health plan partners … People change between health plans – sometimes families are in multiple health plans, or children are moving in and out of foster care – so there isn't a long-term ownership of wellbeing of child. The question is: How do we think about that continuity for individuals in these situations?

Care pathways

I always recommend starting with identifying the care pathway for children and families - what are their current experiences? Where are there missed opportunities? You could have existing services but might not be offering at the right time or place … This can then point to system level responsibilities

Source: Expert interviews with SMEs identified by CYBHWG leaders and staff in May – June 2023

States pursue a broad range of behavioral health (BH) initiatives focused on several goals (1/2)

NON-EXHAUSTIVE

Goals along continuum of care

Improve promotion, prevention & wellness	Proactively reduce risk factors for BH conditions and improve general mental health and wellbeing
Increase capacity for BH treatment	Increase the total infrastructure available to provide clinical treatment to individuals with BH conditions
Expand crisis treatment services	Assess, triage, and provide real-time support to individuals experiencing acute crises, including crisis prevention, response and stabilization
Strengthen rehabilitation and re-integration	Assist with holistic support, especially for populations with complex needs and co-occurring intellectual and developmental disability (IDD) and BH needs
Enhance wraparound services	Expand suite of services that assist individuals and families to initiate, stabilize and maintain long-term recovery from mental and substance use disorders

Source: McKinsey Health Institute

States pursue a broad range of behavioral health (BH) initiatives focused on several goals (2/2)

NON-EXHAUSTIVE

Cross-cutting goals

Establish new digital access channels	Utilize technology to create virtual entry points for children and youth to use along all stages of the BH spectrum
Expand BH workforce / capability for care	Build a sustained, sufficient, and diverse BH workforce by expanding workforce recruitment, retention, training, and other initiatives
Provide equitable access to BH services across settings	Enhance BH infrastructure across settings such as schools and community organizations to improve coverage for populations with challenges to access
Expand eligibility and coverage	Address gaps in eligibility and coverage across the BH care continuum
Scale evidence-based and evidence-informed practices	Create mechanisms for consistently identifying and scaling across different settings and populations empirically proven interventions and interventions with emerging evidence
Enhance funding mechanisms	Effectively utilize federal funding, identify alternative funding sources, and ensure funding availability over time

Source: McKinsey Health Institute

KAUFFMAN AND ASSOCIATES INCORPORATED

PN25 Behavioral Health Strategic Plan Advisory Group

FULL VALUE AGREEMENT

Updated based on discussions at the May 2023 Advisory Group meeting.

This agreement is intended to create a space where everyone – feels heard and valued, ideally striving for a safe space for families, youth, and system partners to share their experiences, knowledge, and ideas together. We acknowledge that what makes a space feel safe may be different for each person and that open and honest dialogue is a combined effort of creating space for varying perspectives and how comfortable a participant is sharing their perspective.

- Be respectful of each other
- Speak your truth, from your own experience
- Keep an open mind; listen to understand
- Honor this time as a space for you and others to share perspectives across differences without judgement
- Use plain language (explain acronyms, if used)
- Use first names
- Stories stay private, but the lessons may carry forward
- Practice patience with ourselves and each other
- Step up then step back so that everyone has a chance to be heard – one at a time when speaking & give attention to facilitators/speakers
- Be mindful of trauma and recognize the impact of that trauma.
- Your experience matters; so does your knowledge and expertise
- Encourage grace, compassion and kindness for self

As part of this agreement, the PN25 Behavioral Health Strategic Planning Advisory Committee Leads want to be transparent about how these agreements will be supported during the meeting.

- At the beginning of meeting – The facilitators will review the Full Value Agreement and gain agreement to support **all voices having equal value**. This agreement applies to the chat and dialogue in the meeting.

- During the meeting – The facilitators will provide a general reminder, if needed, that supports the agreements of the group, for example, “I’m hearing a lot of system heavy language – how can we use more every day, conversational language”.
- A reminder more specific to an individual may also be provided, for example, “[name of person] I am continuing to notice use of system heavy language, is there a way to express the information in more every day, conversational language?”
- Participants could say “ouch” or type “ouch” in the chat at any point during the meeting if the space is not feeling safe to share thoughts or experiences.
- Leads and administrative support will monitor the chat – if someone feels a part of the agreement has not been followed and it is missed by the facilitators in the previous steps, they can private chat “911” to the designated person and include what the person is saying and who is saying it. The designated person will send the information to the facilitators to address with a strengths-based approach.