CYBHWG Youth & Young Adult Continuum of Care (YYACC) subgroup

Friday, September 10, 2021
2:00 – 3:30 p.m.

Zoom link: https://zoom.us/j/97217569996
(see next page for more details)

#	Agenda Items	Time	Lead
1.	Introductions/Agenda review • Quad leads • YYACC members introduce themselves in Chat	2:00 – 2:10 pm	Rep. Lauren Davis Rep. Carolyn Eslick Michelle Karnath Lillian Williamson
2.	Overview: YYACC mission and scope	2:10 – 2:20	Rep. Lauren Davis
3.	2021 recommendations & legislation • Expand youth mobile crisis services statewide • Youth and family peer access, support, and workforce • Support: HB 1349 establishing licensed peer specialists • Support: Care transitions from inpatient behavioral health and juvenile justice (SB 6560 work group) • Respite care for youth with behavioral health challenges	2:20 – 2:45	Rep. Carolyn Eslick Lillian Williamson Rep. Lauren Davis Michelle Karnath
4.	Updates: Implementation of 2021 legislation • Youth mobile crisis services • Peer-related legislation • Respite care for youth and families	2:45 – 3:15	Liz Venuto Maureen Bailey & Patty King Enos Mbajah

5.	2022 priorities
	• Proposals that have come to quad leads:
	  ○ Neuropsych eval proposal (FYSPRT)
	  ○ Behavioral health parent portal (Healthy Minds and Futures)
	  ○ Improvements to HCA information sharing/communications
	• Survey (Google doc) – Members' priorities for 2022
		3:15 – 3:30	

Join Zoom Meeting
https://zoom.us/j/97217569996

Meeting ID: 972 1756 9996
One tap mobile
+12532158782,,97217569996# US (Tacoma)
+13462487799,,97217569996# US (Houston)

Dial by your location
- +1 253 215 8782 US (Tacoma)
- +1 346 248 7799 US (Houston)
- +1 669 900 6833 US (San Jose)
- +1 929 205 6099 US (New York)
- +1 301 715 8592 US (Washington DC)
- +1 312 626 6799 US (Chicago)

Meeting ID: 972 1756 9996
Find your local number: https://zoom.us/u/abLRvubmc0

Children & Youth Behavioral Health Work Group: *YYACC*

Youth mobile crisis services

Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

☐ Prevention

☐ Early Intervention

☐ Identification

☐ Screening

☐ Assessment

☒ Treatment & Supports

Age continuum (check all that apply):

☐ Prenatal - 5

☒ 6-12

☒ 13-17

☒ 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

☒ **Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)

☒ **Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)

☐ **Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)

☐ **Network adequacy** (Medicaid and private insurers)

☒ **Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.

☐ **Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)

☐ **Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)

☒ **Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

☐ **Legislative-policy only** ☒ **Budget ask** ☐ **Agency policy change** ☐ **Rule change**

Is this a previous priority of the work group or is it new?

☐ **Previous recommendation** ☒ **New recommendation**

YYACC Subgroup Recommendation Brief

Youth mobile crisis services

Policy Brief: Youth mobile crisis services

Request: Expand youth mobile crisis services statewide and ensure existing teams can meet the significant increase in demand exacerbated by the pandemic

In regions that have youth mobile crisis services, the services work well and can divert youth from both emergency departments as well as the juvenile legal system. However, not all regions have youth mobile crisis services. Even in the regions that do have it, the capacity of the service is being pushed to its limits due to the significant increase in volume and acuity due to the pandemic, including in youth with no previous behavioral health history. Also, if our system moves toward a third 911 portal beyond police/fire, we will need to ensure that youth mobile crisis teams can respond quickly in order to avert law enforcement engagement.

Behavioral health administrative service organizations (BHASOs) are tasked with administering crisis services within their region. Designated crisis responder (DCR) services are required, but youth mobile crisis services are not. Due to an array of issues, including BHASOs having to spend more on local E&T beds due to the state hospital backlog and crisis response not necessarily matching the 70/30 Medicaid/private insurance split (particularly in children where the payer mix is 50/50), BHASOs have less discretionary funds available.

Needs:

- Expand youth mobile crisis services statewide and ensure existing teams can meet the significant uptick in demand exacerbated by the pandemic
- Provide ant-racism, implicit bias and cultural humility training to mobile crisis teams
- Track and publish data based by race on which youth are diverted vs referred to hospitals and law enforcement
- Create and implement a coordinated communications plan to ensure all parents, caregivers, primary care providers and schools are aware of youth mobile crisis services so that unnecessary ED visits and law enforcement interaction are avoided
- Ensure sufficient mobile crisis team staffing such that teams can debrief a previous call and have a moment to recover before heading to the next one
- Promote widespread inclusion of youth and parent peers on youth mobile crisis teams
- Come up with a solution to address the issue of many youth with private insurance presenting for mobile crisis services and the BHASOs picking up the tab. Partner with commercial carriers to devise a solution.
- Allow and encourage the use of youth mobile crisis teams that do not require an MHP. For example, the recently popular CAHOOTS model in Eugene does not require MHPs, but rather highly trained crisis workers with varying educational backgrounds. The MHP workforce crisis presents limitations on scalability if the MHP requirement is maintained.
- Create regional youth mobile crisis teams within counties with a vast geography and/or traffic congestion that causes delays in response times
- Partner with youth-serving behavioral health agencies to determine a mechanism other than an ED visit to generate a crisis care from the agency
- Explore the possibility of requiring a youth mobile crisis visit in the ED before youth admission to a psychiatric inpatient unit, as a means of promoting less restrictive alternatives and diverting unnecessary hospitalizations (this used to be a requirement prior to fully integrated managed care)

Children & Youth Behavioral Health Work Group: *YYACC*

Youth and family peer access and workforce

Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

☐ Prevention

☐ Early Intervention

☐ Identification

☐ Screening

☐ Assessment

☒ Treatment & Supports

Age continuum (check all that apply):

☐ Prenatal - 5

☐ 6-12

☒ 13-17

☒ 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

☒ **Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)

☒ **Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)

☒ **Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)

☐ **Network adequacy** (Medicaid and private insurers)

☐ **Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.

☐ **Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)

☐ **Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)

☐ **Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

☐ **Legislative-policy only** ☒ **Budget ask** ☐ **Agency policy change** ☐ **Rule change**

Is this a previous priority of the work group or is it new?

☐ **Previous recommendation** ☒ **New recommendation**

YYACC Subgroup Recommendation Brief

Youth and family peer access and workforce

Policy Brief: Youth and family peer access and workforce

Request: Expand the availability of youth and family peer services across the continuum of care, remove barriers to entry and improve retention of peers in the workforce, enhance diversity in the peer workforce, and ensure peers are supported in their own recovery and the secondary trauma they experience on the job.

Note: The items enumerated below are all needed system changes, but not all require statutory change and/or funding. What is presented below is a reflection of as far as our group was able to get given the time constraints. Further discussion is needed to distill which elements would be incorporated into a bill or budget proviso and what those precise asks would be.

Expand youth and family peer services across the continuum of care

In some regions of the state, access to youth and family peers has largely been limited to WISe teams. The demand for youth and family peers transcends families engaged in WISe. Some WISe families cite the youth/family peer as one of the most beneficial component of the program. Access to peer services improves engagement in treatment and ensures continuity of care across levels of care.

- Provide access to youth and family peers for all interested families in traditional outpatient behavioral health settings
- Provide access to youth and family peer bridgers for all interested families in inpatient behavioral health settings
- Allow WISe families to access both a parent and a youth peer, not either/or

Remove barriers to entry and improve retention of youth and family peers in the workforce

- Amend background check procedures for youth peers who wish to enter the peer workforce and have a history of criminal legal system involvement
- Shorten and streamline the peer application process
- Improve wages of youth and family peers to reflect their value, allowing them to earn a livable wage
- Provide training to help agencies:
    - Shift their culture such that peers are recognized as an equal and exceptionally valuable part of the care team. This includes creating a culture wherein other staff do not patronize peers or disclose a peer's personal narrative on their behalf.
    - Ensure everyone in the agency understands what is within and outside of a peer's scope of practice and how to collaborate with youth and family peers within the agency
    - Offer peers adequate, supportive coaching/supervision that is not "one size fits all." This coaching should include support from highly trained, seasoned peers.
    - Help peers feel supported in their roles, and that their agency "has their back"
    - Support peers in being a part of macro-level systems change, in addition to direct service
    - Support peers in taking paid time off for self-care when needed and have clear policies to support this aspect of employee support and retention
    - Note: These elements could be incorporated into the Operationalizing Peer Support training, if they are not already included
- Enhance opportunities for peer professional development, continuing education and educational pathways
- Create a career ladder for peer advancement

Enhance diversity in the peer workforce

- Support agencies in the structural and cultural change processes necessary to create a work environment that welcomes and supports employee diversity and is actively anti-racist
- Require regular trainings in anti-racism, cultural humility and implicit bias to all staff, including examples of how implicit bias shows up in the behavioral health field
- Ensure agency leadership, management and board of directors includes people of color and reflects the communities being served

Ensure peers are supported in their own recovery and the secondary trauma they experience on the job

- Create a statewide mechanism to provide peer support groups for employed peers, led by highly trained, seasoned peers
- Create a mechanism for newly hired peers to complete an optional confidential crisis trigger plan to have a coping plan and be aware of times when they might need extra support
- Create a mentorship program for youth and family peers

Children & Youth Behavioral Health Work Group: *YYACC*

Respite care for youth with behavioral health challenges

Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

☐ Prevention

☒ Early Intervention

☐ Identification

☐ Screening

☐ Assessment

☒ Treatment & Supports

Age continuum (check all that apply):

☐ Prenatal - 5

☒ 6-12

☒ 13-17

☐ 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

☒ **Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)

☐ **Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)

☐ **Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)

☐ **Network adequacy** (Medicaid and private insurers)

☒ **Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.

☐ **Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)

☐ **Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)

☐ **Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

☐ **Legislative-policy only** ☒ **Budget ask** ☐ **Agency policy change** ☐ **Rule change**

Is this a previous priority of the work group or is it new?

☐ **Previous recommendation** ☒ **New recommendation**

YYACC Subgroup Recommendation Brief

Respite care for youth with behavioral health challenges

Policy Brief: Respite care for youth with behavioral health challenges

Request: Direct HCA to explore Medicaid waiver options for respite care for youth with behavioral health challenges, without adversely impacting the DDA and DCYF respite waivers

The Statewide FYSPRT initially moved the need for youth behavioral health respite forward in 2017 after identifying this as a need statewide for youth and families. In 2017, only one region had behavioral health respite for youth ages 10-18, paid for by regional sales tax dollars. The remaining nine regions identified no access to respite through behavioral health services. Up to July 1, 2012, respite services were provided through Medicaid as part of the 1915(b) waiver. When this waiver was terminated due to Legislative action and proposed budget cuts, funding for respite became dependent on other funding available in the regions. For example, Regional Service Networks could identify state or block grant funds to be utilized for respite services if outlined in their expenditure plans for state or block grant funding.

Since 2017, youth behavioral health respite services continues to come up as a need/theme in many dialogues at the Statewide FYSPRT. One area of need is around community resources to support youth and families in the home to prevent hospitalization or placement in a Children's Long Term Inpatient Program (CLIP) or juvenile detention facility. It has also come up as a need to support long term success for youth who are discharging from CLIP or other institutional placements. In addition, youth behavioral health respite was identified as a recommendation from the Substitute Senate Bill (SSB) 6560 workgroups. These workgroups were formed to develop recommendations to make sure that no youth is discharged into homelessness from a system of care (such as behavioral health, juvenile rehabilitation, foster care). Currently, there is an active Cross-Agency Coordination of Children in Complex Situations workgroup that has identified respite (with ABA trained providers) as a potential service to meet the needs of youth and families.
Per information gathered by the Statewide FYSPRT in 2020, respite services as part of behavioral health are not available and when respite services are available [through Developmental Disabilities Administration (DDA) and the Department of Children, Youth, & Families (DCYF)], they are very limited and difficult to access.

Additional information gathered by the Statewide FYSPRT in 2020 is below identifying who has the most critical need for respite:

- Families and youth that experience complex behavioral/medical health needs (or other complex diagnosis – for example developmental disabilities and mental health).
- Single parent families or families with multiple children in services.

The Statewide FYSPRT also gathered information about what situations or circumstances behavioral health respite would be helpful to keep youth with their families and in their communities:

- To prevent use of emergency departments or higher level of care (such as CLIP, juvenile justice, or behavioral rehabilitation services) or prevent escalation (police involvement).
- To assist with transitions from inpatient or CLIP back home to increase long term success.
- Assist children/youth having a difficult time with family dynamics/environment.
    - Respite provides a break from volatile home situations that allows for time to learn and practice skills in safe environments (for both children and parents), to improve family functioning, avoid family conflict, stabilize the household, and support safety in the household.
    - Prevent running away and youth becoming homeless.

• To manage or prevent crisis through planned, routine breaks while knowing your child is safe.

  - Avoid burnout and help caregivers stay healthy and able to better meet the needs of their child/youth.
  - Opportunity for learning and practicing skills when not in crisis.

Potential cost savings from supporting youth and families in the community and avoiding the cost of hospitalization or being placed in an institutional setting such as CLIP or juvenile rehabilitation facility.

Children & Youth Behavioral Health Work Group: *YYACC*

Care transitions from inpatient behavioral health and juvenile justice

Recommendations proposed from sub groups must either be legislatively-directed or fall into a minimum of one component of each of the following sections.

Service continuum (check all that apply):

☐ Prevention

☐ Early Intervention

☐ Identification

☐ Screening

☐ Assessment

☒ Treatment & Supports

Age continuum (check all that apply):

☐ Prenatal - 5

☐ 6-12

☒ 13-17

☒ 18 up to 25

Strategies to increase access & parity (check primary focus of your recommendations):

☒ **Capacity and access to services** (Remove barriers to access, provide services in regions where they are not available; expand capacity or access to services)

☐ **Equity/Disparities** (i.e., addresses systemic inequities and health disparities of people of color, indigenous people, LGBTQ+, and others. Addresses social determinants of health.)

☐ **Workforce** (e.g., development, enhancement, inclusive of diversity and cultural relevance)

☐ **Network adequacy** (Medicaid and private insurers)

☐ **Payment and funding** (e.g., rates, structures, requests, adjustments to improve effectiveness. To avoid duplication of effort – please ensure coordination with potential non-CMHWG already working on rates.

☐ **Quality of services and supports** (e.g., evidence based and supported strategies, culturally relevant, young person- and family-centered)

☒ **Cross-system navigation and coordination** (e.g., improve/ address efficiencies between state agencies, innovative approaches, community partners, young person serving entities to move toward service options that are young person- and family-centered)

☐ **Trauma-informed care** (e.g., trauma informed approach – creating physical and psychological safety in how services are delivered; and trauma informed services – services that directly address trauma, such as trauma-informed CBT [TF-CBT], parent-child interaction therapy (PCIT), and cognitive-behavioral intervention for trauma in schools (CBITS), among others)

Type of Recommendation

☐ **Legislative-policy only** ☒ **Budget ask** ☐ **Agency policy change** ☐ **Rule change**

Is this a previous priority of the work group or is it new?

☐ **Previous recommendation** ☒ **New recommendation**

YYACC Subgroup Recommendation Brief

Care transitions from inpatient behavioral health and juvenile justice

Policy Brief: Care transitions from inpatient behavioral health and juvenile justice settings

Request: Improve transitional care for youth discharging from inpatient behavioral health and juvenile justice settings

The YYACC is highly interested in supporting the work of the SB 6560 work group in improving care transitions for youth, including ensuring that young people do not end up experiencing homelessness post-discharge. Many of the recommendations that will arise from the 6560 work are not yet ready for legislative consideration, but the YYACC stands ready to support these forthcoming recommendations in future legislative sessions.

Two recommendations to better serve young people discharging from these settings are contained in other YYACC recommendations:

- Offer youth and family peer bridgers for discharges from inpatient behavioral health settings
- Direct the HCA to explore Medicaid waiver options for behavioral health respite care

Two care transition recommendations not currently captured elsewhere are:

- Expand access to app-based recovery support services that leverage evidence-based practices (e.g. contingency management) for youth exiting these systems
- Select and support a mobile application and a website to show available resources for youth and young adults exiting these systems. This could be a public-private partnership, as there has been work done to solicit private funding.