# Committee Members

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## Agenda Items

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<tr>
<th>Agenda Item</th>
<th>Time</th>
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<tbody>
<tr>
<td>1. Welcome and Introductions</td>
<td>1:00 – 1:10</td>
<td>Representative Noel Frame, Co-Chair</td>
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<td>(10 mins)</td>
<td>MaryAnne Lindeblad, Co-Chair</td>
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<td>2. Update on Initiatives</td>
<td>1:10 – 1:55</td>
<td>Various</td>
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<td>(45 mins)</td>
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<tr>
<td>a. E2SHB 2779/SSB 6452: Partnership Access Line Plus (PAL) – Mary Fliss</td>
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<td>b. E2SHB 1713: Standardization of Pediatric Healthcare Screens – Gail Kreiger</td>
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d. E2SHB 1713: Trauma Informed Care, Childcare Health Consultation, School Readiness Plan – Jennifer Helseth/DEL/DCYF

e. HB 2779: Parent Initiated Treatment (PIT) Advisory Group – Diana Cockrell

f. E2SHB 1713/E2SHB 2779: ESD Pilot – Mona Johnson

g. Workforce Committee – Laurie Lippold

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<tr>
<td>4. Infant and Early Childhood Landscape Analysis</td>
<td>2:25 – 2:35 (10 mins)</td>
<td>Jamie Elzea, Director, WA-AIMH</td>
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<td>5. Next steps</td>
<td>2:35 – 2:45 (10 mins)</td>
<td>MaryAnne Lindeblad, Co-Chair</td>
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<td>a. Proposed future meeting dates</td>
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<td>o December 2018 (7th or 14th)</td>
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<td>b. Proposed Topics:</td>
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<td>Public Comment</td>
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<td>Adjourn</td>
<td>3:00</td>
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NEW SECTION. Sec. 4.
A new section is added to chapter 74.09 RCW to read as follows:
(1) The authority shall collaborate with the department of children, youth, and families to identify opportunities to leverage medicaid funding for home visiting services.
(2) The authority must provide a set of recommendations relevant to subsection (1) of this section to the legislature by December 1, 2018, that builds upon the research and strategies developed in the Washington state home visiting and medicaid financing strategies report submitted by the authority to the department of early learning in August 2017.

NEW SECTION. Sec. 5.
(1) By November 1, 2018, the department of children, youth, and families must:
(a) Develop a common set of definitions to clarify differences between evidence-based, research-based, and promising practices home visiting programs and discrete services provided in the home;
(b) Develop a strategy to expand home visiting programs statewide; and
(c) Collaborate with the health care authority to maximize medicaid and other federal resources in implementing current home visiting programs and the statewide strategy developed under this section.
(2) This section expires December 30, 2018.

Activities Since June 28, 2018

July - August
Cross-agency planning and materials development for statewide community workshop meetings to explore financing options, pros/cons, and impacts.

September - October
Community Input Process: 80 participants from local home visiting programs and other stakeholders attended one of eight half-day community workshops: Spokane, Tukwila, Sequim, Lacey, Burlington, Vancouver, Yakima, and Olympia.

Workshop Participant Key Messages:
• Home visiting programs need less reporting and administrative burden and more support.
• Think big and take time to get it right; keep programs involved in the planning process.
• Consider these criteria in selecting financing option(s). Does it:
  o Promote high levels of coordination;
  o Limit (reduces, if possible) home visiting staff burden;
  o Promote sustainability;
  o Increase continuity of care;
  o Include families with kids up to 5 years old;
  o Reach more families; and,
  o Provide flexibility/equity for rural/urban and other specialized population needs.
• Finalize draft recommendations and plan for the cross-agency executive leadership review and approval meeting.

Looking Ahead

November
• Conduct cross-agency executive leadership review and approval on November 5, 2018.
• Incorporate any additional edits or changes to the recommendations as required by cross-agency leadership review and decision process.

December
• Final joint agency review and approval of the recommendations report.
• OFM review and approval of recommendations report.

January 2019
Submit recommendations report to legislature on January 8, 2019.
The Promise of Coordinated Specialty Care

Children’s Mental Health Work Group

November 1, 2018
VISION FOR WASHINGTON STATE

Screening for and early identification of psychosis among adolescents and transition-age youth will become a universal health practice and evidence-based health and recovery support interventions will be available to those in need.
Current Challenges in the Mental Health System

• Western State Hospital deficiencies and federal decertification

• Lack of inpatient beds, both short- and long-term

• *Trueblood* lawsuit related to competency evaluation and restoration
Before Stage Four

“If you catch cancer at Stage 1 or 2, almost everybody lives. If you catch it at Stage 3 or 4, almost everybody dies.

We know from cervical cancer that by screening you can reduce cancer up to 70 percent. We’re just not spending enough of our resources working to find markers for early detection.”

---Lee Hartwell, MD
Nobel Laureate, Medicine
President and Director,
Hutchinson Center
New York Times Magazine
December 4, 2005, p. 56
Common Experiences Without Early Intervention

- Obstacles, delays, trauma, isolation
- Involuntary entry, lack of evidence-based care
- Families are isolated
- Lack of supported employment or education
- High doses of medicine
- Stigma and discrimination
- Institutionalized poverty

✧ But also resilient, emerging leaders in provider agencies working with what they’ve got.
The Negative Consequences of Inaction

• The duration of untreated psychosis (DUP) in the United States is a little **over 2 years**.

• Psychosis can be **profoundly disabling**.

• People who experience psychosis have a **shortened life expectancy** of 28.5 years.

• **1 in 10 individuals with psychosis will take their own lives.**
The Promise of Coordinated Specialty Care (CSC)

- Based on early intervention models originally implemented in other countries
- Multidisciplinary
- Multi-component
- Person-centered
- Applies shared decision-making
- Some degree of collaboration with primary care
CSC Service Components

- Community Outreach & Engagement
- Assertive Case Management
- Individual & Group Psychotherapy
- Supported Employment & Education
- Family Education & Support
- Low doses of select antipsychotic medications
- Peer Support
Demonstrated Outcomes with CSC in the U.S.

Compared to clients getting treatment as usual, CSC clients:

- Were more likely to stay in treatment
- Experienced greater reductions in symptoms
- Had greater improvements in quality of life
- Participated more in work or school
- Had reductions in hospitalizations
New Journeys

Pharmacological Treatment

Family Education

Case Management

Individual Resiliency Training (IRT)

Supported Employment & Education

Peer Support Services

Serving approx.
30 clients
x2 years

Community Outreach & Education
Screening

0.25 FTE

1.0 FTE Program Director

0.5 FTE

1.0 FTE

1.0 FTE

0.5 FTE
FAMILY PERSPECTIVE ON NEW JOURNEYS
“[T]he question to ask is not whether early intervention works for FEP (first episode psychosis) but how specialty care programs can be implemented in community settings throughout the United States.”

2014 NIMH report, Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care
Next Steps for Change

• Conduct a study for the development and implementation of Coordinated Specialty Care in community settings

• The study will:
  o Develop a discrete benefit package and case rate;
  o Analyze existing benefit packages, payment rates, and resource gaps;
  o Identify costs for statewide startup, training, and community outreach; and
  o Determine the number of required teams for each region
Questions?

• Joan Miller, JD, Senior Policy Analyst
  Washington Council for Behavioral Health
  jmiller@thewashingtoncouncil.org

• Maria Monroe-DeVita, PhD, Associate Professor
  University of Washington
  mmdv@uw.edu
BACKGROUND: In 2017, House Bill 1713 directed the Office of Superintendent of Public Instruction (OSPI) to provide leadership in supporting two Educational Service Districts (ESD) to hire a dedicated staff person as a Behavioral Health Systems Navigator (BHSN).

The role of the BHSN is to increase access to behavioral health services and supports for students and families by piloting regional coordination. The primary responsibility of the BHSN is to bridge the gap between the education and behavioral health systems. In fall of 2017, Northeast Washington ESD 101 (serving 59 districts in 6 counties) and Capital Region ESD 113 (serving 45 districts in 5 counties) were selected as pilot sites to increase access to behavioral healthcare services for youth eligible for Medicaid.

RECOMMENDATIONS

Expand funds for 1.0 FTE Behavioral Health Systems Navigator at all nine regional Educational Service Districts (ESD).

Provide resources for OSPI for state-level leadership to BHSNs at the ESDs for implementation consistency and adherence to the State Medicaid Plan.

Continue funding for evaluation and expansion of the outcome-based case study.

PROJECT GOAL: To increase equitable access to behavioral healthcare and services for students in need through state and regional cross-system collaboration with schools and communities.

PROJECT PURPOSE: To investigate the benefits of a dedicated staff person networking with regional partners and K–12 school districts for the coordination of behavioral health services to students and families who are eligible for Medicaid.

1 in 5: The number of children ages 13-16 diagnosed with a significant behavioral health problem

17%: The percentage of Medicaid covered WA youth that exhibit a behavioral health need

Nationwide, WA ranks among the highest in the prevalence of mental health and substance use disorder issues, but in the bottom half in accessibility to needed services.

This project aligns with the State Medicaid Plan through a combination of state general funds and federal Medicaid-match dollars. It is an innovative approach to leveraging existing funds to increase access to behavioral healthcare services and supports for students and families through strong school-community partnerships and collaboration.
Students and adults often face multiple barriers that inhibit access to behavioral health services:
- Workforce shortage (particularly in rural areas),
- Treatment deserts (regions where services do not exist),
- Access to culturally and linguistically appropriate services, and
- Lack of service coordination and integration across systems.

The result of these barriers is lower service utilization and a lack of access to care.

**ACTIVITIES & OUTCOMES:** The Behavioral Health System Navigator (BHSN) engages in coordination, facilitation, integration, and collaboration activities that contribute to the goal of increasing equitable access to behavioral healthcare services and supports.

The BHSN coordinates behavioral health resources, supports, service providers, schools, school districts, and communities in the ESD region.

The BHSN connects with each school district to identify a single point of contact. From there, the BHSN and the district assesses the district’s capacity to:
1. Identify gaps and needs in school-based behavioral health services and supports;
2. Identify students in need of behavioral health services;
3. Refer students to needed services;
4. Deliver evidence-based services across tiered systems of support; and
5. Link students and families to community-based providers.

The BHSN supports the development or expansion of processes and procedures that increase the district’s capacity to successfully access Medicaid reimbursement programs (e.g., School-Based Health Services and Medicaid Administrative Claiming). Participation in these reimbursement programs allows school districts to use funds to bolster supports in their school health system.
The BHSN facilitates partnerships across the multiple systems of behavioral healthcare services and supports for children and families. By engaging in regional healthcare transformation, staff can advocate for services for students and connect providers with schools in need.

The BHSN ensures the adequacy of systems-level supports for students in need of behavioral health services through the integration of service delivery models. Children in need of behavioral health services are often involved in multiple systems of supports, including education, healthcare, state services (e.g. CPS, foster care, juvenile justice), and community-based services. Staff work directly with behavioral health service providers to ensure alignment with school- and community-based delivery models to reduce barriers and increase access to care.

From the individual school-level to the state policy-level, the BHSN has the opportunity to bring a diverse group of stakeholders together to increase equitable access to care for students in need. These collaborative efforts help inform the process and contribute to the development of models that can be replicated by other ESDs.

**WHAT WE KNOW:**

Healthcare transformation creates opportunity for increased regional coordination, facilitation, integration, and collaboration.

ESDs can play a critical role during the healthcare transformation process and beyond, providing districts, schools, and families support to navigate the multiple and ever-changing pathways to care.

“I tried to put myself in the shoes of a school counselor trying to connect a youth to services in this new system...Having someone at the ESD who can help schools understand and navigate this system to connect youth to care is essential.”

Sara Ellsworth
Capital Region ESD 113
Behavioral Health Systems Navigator

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Camille Goldy
Behavioral Health & Suicide Prevention Program Supervisor
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360-725-6071

The BHSN collaborates with pilot sites, OSPI, districts, schools, community partners, and other stakeholders to increase access to behavioral healthcare services and supports.