Washington State Health Care Authority

Children's Mental Heath Work Group

October 1, 1:00 – 4:30 pm
Hearing Room A
John L. O'Brien Building

Call information: 888-407-5039
Participant PIN: 92834822

Attendees:					
☐	Representative Noel Frame	☐	Lacy Fehrenbach	☐	Steve Kutz
☐	MaryAnne Lindeblad	☐	Dr. Thatcher Felt	☐	Amber Leaders
☐	Randon Aea	☐	Tory Gildred	☐	Nickolas D. Lewis
☐	Dr. Avanti Bergquist	☐	Camille Goldy	☐	Laurie Lippold
☐	Ruth Bush	☐	Libby Hein	☐	Representative John Lovick
☐	Representative Michelle Caldier	☐	Dr. Bob Hilt	☐	Joel Ryan
☐	Diana Cockrell	☐	Kristin Houser	☐	Mary Stone-Smith
☐	Senator Jeannie Darnielle	☐	Avreayl Jacobson	☐	Jim Theofelis
☐	Peggy Dolane	☐	Lonnie Johns-Brown	☐	Dr. Eric Trupin
☐	Jamie Elzea	☐	Kim Justice	☐	Senator Judy Warnick
☐	Representative Carolyn Eslick	☐	Judy King	☐	Dr. Larry Wissow

No	Agenda Items	Time	Lead
1.	**Introductions**	**1:00-1:10 pm**	**Rep. Noel Frame/ MaryAnne Lindeblad**
2.	**Agenda Review**	**1:10-1:20 pm**	**Rep. Noel Frame/ MaryAnne Lindeblad**
3.	**Subgroup reports & recommendations:** *15 min. for subgroups; 10 min for parent-directed referral line* • Rates *Lead: Laurie Lippold* • Partnership Access Line *Co-leads: Rep. Vandana Slatter & Laurie Lippold* • Prenatal to Five Relational Health *Lead: Jamie Elzea Reporting: Leslie Dozono* • Family-Initiated Treatment/HB 1874 *Co-leads: Kathy Brewer & Peggy Dolane* • Workforce *Lead: Laurie Lippold* • Student Well-Being & School-based Connections to BH/IDD Services & Supports *Co-leads: Camille Goldy & Lee Collyer* • Re-authorizing the parent-directed referral line *Dr. Bob Hilt*	**1:20-3:00 pm**	**Subgroup Leads**
4.	**CMHWG reauthorizing legislation**	**3:00-3:10 pm**	**Co-leads**
	BREAK	**3:10-3:20 pm**	
5.	**Next steps**	**3:20-3:50 pm**	**Rep. Noel Frame/ MaryAnne Lindeblad**
6.	**Updates:** • HB 1394 recommendations – Intensive BH/DD residential services • SB 6560 – Ensuring that no youth is discharged from a public system of care into homelessness	**3:50-4:00 pm** **4:00-4:15 pm**	**MaryAnne Lindeblad** **Regina McDouggall & SL Rao (Dept of Commerce)**
7.	**Public comment**	**4:15-4:30 pm**	**Rep. Noel Frame/ MaryAnne Lindeblad**

	Action Items/Decisions				
#	Action Item	Assigned To:	Date Assigned:	Date Due:	Status

Children's Mental Health Work Group

Vision: Washington's children, youth, and young adults have access to high-quality behavioral health care.

Mission: Identify barriers to and opportunities for behavioral health services and strategies for children, youth and young adults (prenatal to 25 years old) and their families that are accessible, effective, timely, culturally and linguistically relevant, supported by evidence, and incorporate tailored innovations as needed.

Authority: CMHWG authorized through December 30, 2020, with a report due December 1, 2020, to advise the Washington Legislature on barriers to and opportunities for children and families to access statewide behavioral health services. *Note: Work group participants have changed "mental health" to "behavioral health" to reflect that substance use disorder services have now been integrated into mental health services in Washington state. Furthermore, the work group has a stated preference to also include young adults (up to age 25), and clarified that "children" includes pre-natal.*

2019/2020 CMHWG Target "Cover Sheet"

Children's Mental Health Work Group

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
- ☐ 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):

- ☐ Workforce (e.g., development, enhancement, inclusive of diversity and cultural relevance)
- ☐ 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 services – interventions that directly address trauma, such as Trauma Informed CBT [TF-CBT] among others)

Behavioral Health Rates Committee
Brief Update – 9-30-19

Likely 2020 legislative ask: Establish a rate that would ensure competitive salaries and the ability to maintain a quality workforce.

Under the general ask to support a rate that ensures competitive salaries and a quality workforce are 3 strategies:
1. Follow up with the HCA re status of the proviso from 2018;
2. Take Medicaid rates to Medicare, where applicable, + a percentage above that (10%? Other?); and
3. Ensure that rate increases go to workforce salaries.

An example of a rate discrepancy is with the 98034 code: Medicaid = $45.00; Medicare = $95.00.

Schedule a meeting with the HCA to discuss a number of issues, including:
1. How do they set the MCO fee for service rates?
2. Who falls under the definition of behavioral health agency?
3. What language would they need in the budget in order to achieve the goal we set out?
4. What needs to happen to be able to bill Medicaid for services that take place outside of a traditional office, allow peers and other non-masters level professionals to bill Medicaid, and direct an increase to salaries?
5. Status of the 2018 budget proviso.
6. How the funds flow from the legislature to the HCA to the plans to the providers.
7. Process of determining network adequacy per HB1713.

Identify what services don't get covered by going to Medicare, or through the HCA proviso related to rates (2018).

Identify more specifically what BH codes we are talking about.

Identify services that are being provided that are not being reimbursed.

Obtain information about workforce issues in states that pay a much higher rate.

Survey providers to try to ascertain what the rate would need to be to improve access for children/youth on Medicaid.

1874 Adolescent Behavioral Health Care Act
Follow-Up Recommendations

Background

In 2018, the Parent Initiated Treatment Stakeholder Advisory Group recommended to expand parent's ability to access residential care and other less-restrictive alternatives in lieu of adolescent consent. The final version of HB 1874 did not include language regarding residential treatment.

This sub-group of the Children's Behavioral Health Work Group met three times during summer 2019 to review:

1. Whether to include access to "residential" level of care missed in the final version of HB 1874
2. Identify what information about medical necessity should be tracked for FIT in the next two years to inform recommendations.

Summary of Recommendations

1. Include **adolescent residential treatment** as a service that a parent can consent for under the Family Initiated Treatment section of RCW 71.34.600-670. Residential treatment facilities must be licensed under 246-337 WAC.
2. Explore whether to create a licensing category for Wilderness Therapy and Therapeutic Boarding Schools that would be considered residential treatment under Family Initiated Treatment, in order to ensure that these programs would be regulated and safe for Washington youth.
3. Use the same monitoring and reporting guidelines and provider/facility safeguards for residential treatment that were established for Intensive Outpatient Program and Partial Hospitalization Program under HB 1874.
4. Track data to identify opportunities to fill gaps in care, expand services, and better understand the needs of our adolescent population. Recommend that Health Care Authority develop a data reporting system to facilitate standardized collection and reporting of data about mental health and substance use services delivered to youth. Specific data that is recommended for collection includes:
    a. Type of facility including accreditation
    b. Diagnosis & severity: DSM V + ASAM Criteria
    c. Presence of co-occurring disorder
    d. Presence of developmental disability/intellectual disability/ Autism spectrum disorder
    e. Risk factors (danger to self, danger to others, grave disability)
    f. Age, race/ethnicity, gender
    g. Insurance provider (public/private)
    h. Length of stay in treatment
    i. Before and after treatment interventions (i.e. history of outpatient, inpatient, WISe treatment prior to admission; disposition after residential treatment is completed; engagement in services post residential)
    j. Assessment of family systems/conflict and family systems/cultural supports/strengths
    k. Family engagement during treatment (develop rating scale)
    l. Types of issues addressed (recommended collecting top 3 reasons for admission, including both diagnostic concerns and functional challenges). Example of types of issue includes, but is not limited to: a) inability to cease self-harming behavior; b)aggression in home or community; c) frequent elopements; d) refusing to get out of bed; e) refusal to attend school; f) catatonia; g) eating issues; h) extreme family conflict; i) not responding to out-patient care; j) inability to maintain sobriety; k) gang involvement

Issue	Workforce Development Board Recommendation?	Specific Strategies/Ask	Sector Impacted (e.g. Community BH agencies, private practitioners, other)
Barriers to hiring and/or retaining a quality, adequate behavioral health workforce			
Inadequate wages/compensation			
Lack of training for providers (e.g. counselors, social workers, BH professionals)			
Limited state subsidized support for training (currently only 6 slots per year??)			
Inability to pay for services provided by certain folks (e.g. community health workers, peer counselors)			
Lack of diversity in the field (language and cultural)			

Issue	Workforce Development Board Recommendation?	Specific Strategies/Ask	Sector Impacted (e.g. Community BH agencies, private practitioners, other)
Limited career pathways			
Quality of life (evening/weekend work, minimal pay)			
Out of date curriculum being taught in post secondary schools			
Lack of information about what employment in the BH field is really like (don't get a true sense until a practicum)			
Burnout/Stress/Demands of the job			
Lack of available consultation for therapists, especially those working non-standard hours			
Inability to include peer counselors/supports in a meaningful way			

Issue	Workforce Development Board Recommendation?	Specific Strategies/Ask	Sector Impacted (e.g. Community BH agencies, private practitioners, other)
Limited loan repayment and conditional scholarships			
Limitations around who can do what aspect of the work (need to include peers, BAs, OTs, CHWs, others in a meaningful way)			
Burdensome documentation and paperwork requirements			
Inadequate availability of quality supervision, e.g. reflective supervision			
Lack of time to supervise someone going for licensure			

Issue	Workforce Development Board Recommendation?	Specific Strategies/Ask	Sector Impacted (e.g. Community BH agencies, private practitioners, other)

From:	Camille Goldy
To:	Frame, Noel; Lindeblad, MaryAnne (HCA); HCA Children"s Mental Health Work Group
Cc:	Bulger, Ace (HCA); ailey.kato@leg.wa.gov; Templeton, Allison A (DOH); Alyssa Fairbanks; Leaders, Amber (GOV); brackenbury@comcast.net; Anissa Sharratt; avanti@alumni.duke.edu; avreayl.jacobson@kingcounty.gov; b.griffith@co.island.wa.us; Bill Cheney; bbarrett@sheltonschools.org; Cara Patrick; Drandoff, Deb (DOHi); cockrdd@hca.wa.gov; Johnson, Mona (OSPI); pcavens@pacifier.com; Eric J Bruns; ewick@esd113.org; Lewis-Lechner, Heather; Jamie.Smeland@southwestach.org; Helseth, Jennifer (DCYF); JennLee7843@gmail.com; jstuber@uw.edu; Plaja, Jenny; jvavrus@waesd.org; jill.x.patnode@kp.org; neigelj@monroe.wednet.edu; joys@multiculturalfamilies.org; Justyn Poulos; Katherine Mahoney; Kim Reykdal; Kurt Hatch; lacy.fehrenbach-marsofalvy@doh.wa.gov; Harrison, Laurie; llippold@uw.edu; Lee Collyer; Libby.hein@molinahealthcare.com; lnoahr@washingtonea.org; lyoung@washingtonea.org; Rathbone, Marissa (WSSDA); Megan LaPalm; smith.melanie@gmail.com; michelleland@gmail.com; Mick Miller; Mony, Neetha E (DOH); Nicole Klein; peggy.dolane@gmail.com; HCA Children"s Mental Health Work Group; ramadding@seattleschools.org; Hall, Zachary; Callan, Lisa; Way, Jennifer; Kilduff, Christine; Stonier, Monica; Kohout, Sarah; Soderlind, Mary; Orwall, Tina; Harris, Paul; Kira.McCoy@leg.wa.gov; Pollet, Gerry; montonr@svsd410.org; roz@awsp.org; slennon@wasbha.org; Sarah Butcher; Seikabrown16@gmail.com; Muirhead, Shanna R. (HCA); Reinert, Sigrid (DOH); susans@yellowwoodacademy.org; sidney.forrester@gov.wa.gov; toddcrooks@comcast.net; Mueller, Martin (K12); Tayler Burkhart; Haley Lowe
Subject:	School-based Behavioral Health Subcommittee Recommendations
Date:	Tuesday, September 24, 2019 4:49:24 PM
Attachments:	Target cover sheet_School-based BH.docx School-based BH Recs 9.24.19.docx Re School-based Behavioral Health Subcommittee Recommendations.msg

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Representative Frame and Ms. Lindeblad,

Please accept the attached list of recommendations from the School-based Behavioral Health Subcommittee of the Children's Behavioral Health Workgroup. Among the deliverables for our subcommittee was to include a catalog of other initiatives related to school-based bh, which is included. I'm also including a recommendation that was sent my way from Dr. Cavens regarding a community care coordination system. This recommendation is outside of the scope of the school-based committee, however, they have done a lot of work to clarify the recommendation and its impact, so I am including it for the workgroup's consideration.

Please let me know if you have any questions,
Camille

Camille Goldy, MPA
she/her pronouns
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Behavioral Health and Suicide Prevention
Student Engagement and Support
Office of Superintendent of Public Instruction (OSPI)
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New FREE online training available for educators: www.k12.wa.us/CAREModule

2019/2020 CMHWG Target "Cover Sheet"

Student Well-Being & School-Based Connections to BH/IDD Services and Supports
Children's Mental Health Work Group

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- ☐ 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)

School-based Behavioral Health Subcommittee Recommendations, submitted 9/24/2019

Short Term Recommendations (for the 2020 leg session)

	Recommendation	**Who has Authority?**	**Who is the Lead?**	**Who is responsible for implementation?**	**Deliverables**	**Accountability—what does success look like?**	**Policy Ask? (Identify RCW intended to change)**	**Budget Ask? (include cost)**
1	Establish in statute (as a subcommittee of the Children's Behavioral Health Workgroup) The School-based Behavioral Health & Suicide Prevention Subcommittee. • Establish staff support (at HCA and OSPI) • Set mission, define scope (all levels of care in the school setting (tiers 1, 2, 3)) • Define MTSS for WA and establish a WA-specific framework • Include suicide prevention, intervention, and postvention strategies • Require inclusive and participation from diverse set of stakeholders/partners (those who implement, including school-based health centers). • Outline that this will be the venue for big broad work beyond	Legislature, Children's BH Workgroup	Children's BH Workgroup	Children's BH Workgroup	Once the subcommittee is established long-term, they will be responsible for the following: • Define MTSS Framework, including guidance for data-based decision making for interventions and evaluation indicators • Identify needed resources • Identify funding models • Qualifying and quantifying what is happening and where the gaps are in K-12 and gaps in healthcare systems to promote	• Data to advise policy and funding requests that can help districts where they are at. • Diverse student needs (SpEd, IDD). • Recommendations lead to a whole-child system with rapid identification of those in need of care through the development of comprehensive, tiered systems for getting students what they need and linking to community-based systems. • A robust system that can prevent, respond, and is inclusive. • Mirrors the integrated behavioral health system	SB 5903, (at one point, 5903 included creation of an MTSS workgroup, but it was taken out in final bill) HB 1541 Integrated Student Supports Protocol Connect with the Special Education Advisory Council's	Staffing for workgroup: funding needed for agency's responsible (and workgroup participation to cover the cost of travel and substitutes for educators?) will need to check with OSPI on costs for collecting data and reports required.

	Recommendation	Who has Authority?	Who is the Lead?	Who is responsible for implementation?	Deliverables	Accountability—what does success look like?	Policy Ask? (Identify RCW intended to change)	Budget Ask? (include cost)
	the 2020 session recommendations				opportunities for continuity of care. • Equity of access • Identify systemic barriers • Guidance on HIPAA & FERPA • Catalog a curriculum of best-practices • Stigma-reduction work, including training for students, staff, and parents • Data collection		recommendations	
2	Build upon previous Suicide Prevention work in the broader work on school-based recognition and response to emotional and behavioral distress (HB 1336)—address the urgency of need across the K-12 system and foundational strength; include student voice.	Children's Behavioral Health Workgroup	OSPI?	ESDs and School districts?	• Bolster school personnel supports, require all school staff to take the 3-hour suicide prevention training • Require counselors, psychs, social workers, and nurses to take an advanced course on crisis/safety planning on second round of training (every 3	• Identification and training of a strong champion at district level to lead this process. • Require districts to submit plans to OSPI for review or accompanying fidelity checklist to focus resources on districts lacking complete plans. • The inclusion of student voice in shaping the system.	RCW 28A.320.127 from HB 1336 (2013), HB1216 HB 1221	Look at Navigator cost from fiscal note in HB 1216 and 1221 will need to check with OSPI on costs for collecting data and reports required.

	Recommendation	Who has Authority?	Who is the Lead?	Who is responsible for implementation?	Deliverables	Accountability—what does success look like?	Policy Ask? (Identify RCW intended to change)	Budget Ask? (include cost)
					years) and require them to engage trusted adults in the development of a student-informed safety plan for students who are at risk for suicide (as part of the requirement for crisis planning) • Training for family/parents and students • Build upon and refine what identification and referral should look like, clearly define roles, crisis safety plans, build up postvention. • Collect data on district implementation of RCW 28A.320.127; determine the need for resources to get to comprehensive implementation.			

	Recommendation	Who has Authority?	Who is the Lead?	Who is responsible for implementation?	Deliverables	Accountability—what does success look like?	Policy Ask? (Identify RCW intended to change)	Budget Ask? (include cost)
					• Identify district leads for suicide specific crisis response and safety planning • Provide TA and training to district leads • Peer training and supports for students, parents, and staff • Determination of who's body of work this is, and what is taken off their plate to make room for it. • Promote Crisis Text Line, investigate how to get schools to put it their websites and student IDs • Require suicide threats are included in ESD safety center response models.			
3	Fund ESD Navigators from HB 1216, further specify their role:	Legislature	OSPI and/or ESDs?	OSPI and ESDs	• OSPI report on Navigator impact,	• Navigators can provide training and technical assistance to each district in region, document	HB 1216 already includes	Look at OSPI 2020 decision package

	Recommendation	Who has Authority?	Who is the Lead?	Who is responsible for implementation?	Deliverables	Accountability—what does success look like?	Policy Ask? (Identify RCW intended to change)	Budget Ask? (include cost)
	• Define their scope of work • Determine credential requirement • Require participation in regional healthcare coordination work at FYSPRTs and ACHs • Require oversight and support at OSPI to ensure consistency across the state. • Support the recommendations included in the leg. report due Dec 1, 2019				• Documentation of each district's completion of plan in RCW 28A.320.127 • Documentation of training provided to school districts • Documentation of engagement in regional healthcare planning (school strategies showing up in ACH work). • Messaging and norming that accessing mental health prevention/intervention/treatment is supported	each district's plan, be responsive in postvention, participation in regional healthcare partnerships to bridge the communication between healthcare and education.	this position with brief job description . Provide language to refine job description and allowable activities. Need to add what is expected to be collected by OSPI	
4	Support state initiatives to integrate physical and behavioral health in the school setting (refer to broader recommendation from Dr. Cavens' group regarding a Community Care Coordination	Legislature, Children's Behavioral Health Workgroup	Children's Behavioral Health Workgroup	Children's Behavioral Health Workgroup	• Include integration in health classes by giving parity to the social emotional health learning standards	• Workgroup develop recommendations for expanding school-based health centers in wA		Staffing for workgroup

	Recommendation	Who has Authority?	Who is the Lead?	Who is responsible for implementation?	Deliverables	Accountability—what does success look like?	Policy Ask? (Identify RCW intended to change)	Budget Ask? (include cost)
	System for Integrated BH—see attached)				• Provide a library of curriculum/best practices • Promote school-based health centers • Promote strategies that support broader replication and improve sustainability of the school-based health center model.			

Catalog of other initiatives that should be supported in 2020 Session:

1. Partnership Access Line (PAL) for Schools Pilot
2. Support Staffing Enrichment Workgroup Recs
3. WA Mental Health Referral Service pilot Extension and expansion (current pilot ends Jan 1, 2021)
4. Support recommendations from FYSPRSTs to expand WISe eligibility
5. Special Education Advisory Council's recommendations related to students who need behavioral health services but services may not be in an IEP.
6. Support recommendations of the WA Action Alliance for Suicide Prevention from DOH.
7. Support/Track recommendations coming from the Center for the Improvement of Student Learning (leg. report due Dec 1, 2019)
8. Staff wellbeing initiatives (e.g.: Kaiser Thriving Schools RISE Index)

Long Term Recommendations (for once the group becomes formalized in 2020 leg session)

1. See deliverables for the School-based Behavioral Health & Suicide Prevention Subcommittee.

2. Bolstering the crisis response, triage, and postvention systems in schools.
3. Peer supports
4. Supports for educator secondary trauma

Long Term Next Steps:

1. Gather data:
    a. Big, medium, small districts from urban, suburban, and rural areas—what are their needs? What is working? What solutions do they recommend?
    b. Compare/contrast data from JLARC Study and Kaiser Environmental Scan.
    c. School funding presentation—gain understanding of school staff roles, responsibilities, and allowable activities.

From:	Phyllis Cavens, MD
To:	Camille Goldy
Cc:	Whitefield, Alex; Bulger, Ace (HCA); Kelcey Schmitz; Roz Thompson; jnye@candac.com
Subject:	Re: School-based Behavioral Health Subcommittee Recommendations
Date:	Monday, September 23, 2019 4:26:20 PM
Attachments:	Defining an Accountable Community for Health for Children and Families.pdf

Hello Camille,

Thank you for the "Short Term Recommendations for the 2020 Legislative Session" document, and the invitation to review and submit recommendations. I have been in phone conversations with Alex, Roz, Kelcey, and Ace, and have adopted the attached article entitled, "Defining an Accountable Community for Health for Children and Families" as the foundation for our recommendations. This article adapts the Accountable Communities of Health model to integrate health care (both physical and behavioral health) to "seamlessly address the medical, social, and developmental needs of children and families, with a focus on shared accountability across sectors as well as financial sustainability." Our Goal is to build a coordinated system to optimize children's health by forging structured collaborations from among multi-sector community partners, i.e., medical clinics, behavioral health agencies, schools, emergency rooms, juvenile justice, etc. who share goals and resources. In pursuit of this goal, I make the following three recommendations to Children's Behavioral Health Work Group:

Recommendations:

1) Fund a Community Care Coordination System for Integrated Behavioral Health for 1% of all youth with the most costly, complex, chronic behavioral health problems. One percent of the approximately one million children covered by Medicaid insurance in Washington State equals 10,000 children who require 100-200 case managers at a cost of $10-20 million.

2) Fund a ESD Navigator for each of nine regions to align OSPI with primary care, behavioral health agencies, and regional Accountable Communities of Health to deliver Integrated Behavioral Health for K-12 youth at a cost of $1 million.

3) Fund an inclusive and interoperable data system to measure and track behavioral health outcomes of K-12 students at a cost of $1 million.

Problem Statement: An estimated ten percent of children and adolescents in the United States have a serious emotional disturbance (SED), yet approximately 80 percent of those children and adolescents with an SED do not receive needed services. (SAMHSA Guidance to States and School systems on Addressing Mental Health and Substance Use issues in Schools, July 1, 2019). Suicide is the second most common cause of death in the 14-26 year age group. The Washington Youth Health Survey establishes by self-reporting the prevalence rates of mental health and substance use disorder issues in 6th through 12th grade.

Context: Healthier Washington, with the Medicaid Waiver, has adopted the national Triple Aim to improve health care, improve health, and decrease cost. There are nine regional Accountable Communities of Health (ACH) to carry out the Triple Aim, and all are required

to address behavioral health integration. The focus of ACHs has disproportionately addressed adult mental illness and substance use disorder in policy, program, and funding. Children's Behavioral Health Work Group is focused on children's public health policy, advocacy, education, and implementation of integrated behavioral health for Washington's youth. In 2020, funding of behavioral health transfers from Regional Behavioral Health Organizations (BHOs) to five statewide Managed Care Organizations (MCOs) who are assigned county by county.

Today's Youth Tell Us that they suffer under the cloud of fear because of climate change and violence in their personal lives, schools, and communities. They have the burden of pressure to achieve academically and from social media peer pressure. In addition, if they live in poverty, there is the fear of homelessness and hunger that make them more susceptible to mental health issues. The downward spiral or trajectory of fear and despair is suicidal ideation, suicide attempts, and then the finality of suicide occurs.

Community Based Service Organizations to Address Youth Behavioral Health are schools, behavioral health agencies, pediatric primary care clinics, emergency department outpatient care, and residential, institutional, or hospital inpatient care. All of these organizations are committed to the prevention, early identification, early intervention, diagnosis, and treatment of the whole child, and a family centered, community based approach to the student/patient/client with mental illness and/or substance use disorder.

Challenges: The pediatric primary care clinics find that 5% of their children do not have health insurance, 15% have not seen a doctor in the past year, and 50% have not had an annual comprehensive well examination with behavioral health, social determinants, and Adverse Childhood Event screening in the past year. Behavioral health agencies find that the stigmata of mental illness results in poor engagement in services, and there is a general lack of family and community knowledge of the availability of services and how to access services. Schools have the challenge of chronic absenteeism, low academic achievement, behavior that interferes with learning, and decreased graduation rates. The emergency departments many times are the first to identify a patient with mental illness when the headache turns out to be depression, and the stomach ache turns out to be anxiety. Yet, they have limited ability to provide treatment, follow up, or a long term relationship of trust. Many pediatric inpatient services are not available locally, and community inpatient services are geared for adults.

Gaps: The major gaps are 1) coordination of services, 2) collaboration of service providers, 3) an accessible database and a co-managed care plan, 4) tracking and improving outcome measures, and 5) access to a Patient Centered Medical Home.

Solutions: Establish Accountable Communities of Health for Children and Families, leading to accessible pediatric integrated behavioral health with the ability to braid funding and blend programs. "This model of integrated behavioral health care seamlessly addresses the medical, social, and developmental needs of children and families with a focus on shared accountability across sectors, as well as financial sustainability." (see attached article)

Action: Case Managers, funded by contract with Managed Care Organizations and housed in pediatric primary care clinics, will be accessible to all children and youth referred by any child-serving behavioral health organization, schools, emergency departments, or inpatient facilities. Case Managers contribute to the patient's electronic health record governed by a Release of Information, leading to bi-directional exchange of information and producing individual care plans and outcome measures.

Outcome: Healthy children, ready to learn, every year, K-12 with access to and engagement in whole child, comprehensive care resulting in zero suicides, and 100% graduation rates, or at the minimum, improvement in both.

Thank you for considering these recommendations.

Phyllis M. Cavens, MD

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Longview, WA 98632
Phone: 360-423-6140
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On 9/16/2019 4:23 PM, Camille Goldy wrote:

> Greetings,
>
> Please find attached the notes from our Sept 3rd meeting and the updated recommendations from our discussion. Please review and have your edits/additions back to me by close of business next Monday September 23rd. I will compile and submit them to the full Children's Behavioral Health Workgroup on Sept 24th.
>
> Thanks to all of you who were able to participate in the series of meetings that developed these recommendations. There is a lot of interest and passion from this group and I'm excited to see where it leads.
>
> Camille
>
> **Camille Goldy, MPA**
> *she/her pronouns*
> Program Supervisor
> Behavioral Health and Suicide Prevention
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>
> New FREE online training available for educators: www.k12.wa.us/CAREModule
>
> Suicide Prevention Lifeline: 1-800-273-8255
> Crisis Text Line: text *HEAL* to 741741
> LGBTQ+ Crisis Lines: The Trevor Project: 866-488-7386 & Trans Lifeline: 877-565-8860

Defining an Accountable Community for Health for Children and Families

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We are in the midst of a transformation of our health care system. The shift from volume to value and the corresponding changes in payment models necessitate an evolution in focus from the acute medical needs of an individual to a more holistic view of improving the health of the population. This more holistic strategy includes a recognition of the importance of the environmental, social, and behavioral determinants of health and a paradigm shift with an implicit understanding that health is a function of a health care system embedded in an interconnected community. Health happens wherever families are—at home, in schools, in child care, in medical homes, and digitally at any location in the community. Building upon a variety of community-based models funded by the federal government, states, and private funders, as well as the Center for Medicare and Medicaid Services' Accountable Health Communities Model, this paper adapts these models of integrated care to seamlessly address the medical, social, and developmental needs of children and families, with a focus on shared accountability across sectors as well as financial sustainability.

Why Focus on Children and Families?

Research has shown that the foundations of health take root in the earliest years (including the health of the mother). Young children are particularly sensitive to social determinants [1]. Additionally, adverse childhood experiences occurring in early childhood can have lifelong consequences, affecting physical and mental well-being. For example, traumatic experiences such as persistent poverty can disturb neurobiological systems that guide physiological and behavioral responses to stress and permanently increase the risks of disease [2]. "Developmental, behavioral, educational, and family problems in childhood can have both lifelong and intergenerational effects. Identifying and addressing these concerns early in life are essential for a healthier population and a more productive workforce" [3].

An Accountable Community for Health for Children and Families could significantly improve the health trajectories of children and families and promote health equity through financially sustainable, place-based, multisector partnerships.

A Vision for the Future

Prevention, early intervention, and strengthening the family unit are at the core of optimizing child health and well-being. Yet the current system is not adequately oriented toward achieving these aims in a financially sustainable manner. All too often, health care approaches focus on addressing the needs of high-cost adults rather than on the unique health and developmental needs of children. What could the future look like? It would include a system in which the following is the norm in a growing number of communities across America:

- A pregnant teen seeks health care services at an urgent care clinic and is screened for social determinants of health. She is referred to an ob/gyn for regular prenatal care. When her screening indicates that she is housing insecure, she is connected, via a community hub, with community resources to address this need, thereby avoiding the toxic stress she and her child would experience because of unstable housing. Once her child is born, her pediatric provider connects her with free parenting classes, a service offered as part of

its risk-based contract with a payer (in which the provider is rewarded for keeping patients healthy and reducing unnecessary health care utilization).

- A community database with GIS mapping capabilities reveals a cluster of problems caused by lead in a housing complex. The health department contacts all families living in the unit to get their children tested for lead exposure and works with the landlord to address abatement, thereby preventing future exposures. The health department also contacts the pediatricians/medical homes of affected children for follow-up. The abatement in the complex is covered through Children's Health Insurance Program (CHIP) administrative dollars through a health services initiative approved by the state. The medical services are covered through Medicaid.
- A child scores below the normal range on a reading-readiness screener administered at her early care and education (ECE) center. The center contacts her pediatrician's office, which refers the family to a community-based early literacy program, whose services are included as part of a risk-based contract. A nurse at the pediatrician's office and the ECE provider advise the parents about what they can do at home and suggest free tools.
- Asthma is the leading cause of absenteeism in a school system. The school nurse believes asthma can be better controlled at school and that triggers in the home need to be addressed. She reaches out to the pediatric health system to collaborate, and they also begin working with the health department. With parent permission, the school nurse is granted access to participating children's electronic health records so she can ensure she is following the child's latest asthma action plan. A community health worker employed by the health system, as part of its value-based contract, visits the homes of children who have had multiple health care visits related to asthma to educate the families about trigger reduction. The health department uses GIS mapping capabilities to identify asthma "hot spots" and collaborates with the housing department and landlords to decrease the number and frequency of asthma triggers in those areas by addressing mold and pest problems, removing carpets, and reducing secondhand smoke exposure by enforcing a ban on smoking in public housing. Additionally, a community coalition works to reduce harmful emissions near the school, thereby amplifying reach and impact on children.

How Can We Build More Coordinated Systems to Optimize Child Health?

After decades of studies, researchers have concluded that social factors (e.g., socioeconomic status, education, housing, transportation, access to food, and so on) have a powerful impact on health [4]. Given the mounting evidence regarding the importance of the early years in shaping an individual's long-term health trajectory, it is critical to address social determinants early on. Leading thinkers have posited that forging structured collaborations among multisector community partners who share goals and resources is critical to "moving health care upstream." Examples of proposed models include building a transformed 3.0 health system that optimizes health [5,6,7], funding integrators [8], anchor institutions/backbone organizations [9,10], and supporting accountable health communities [11,12], in which partners can collectively address social factors impacting health.

Various federal initiatives have taken important steps to improve community health (e.g., Promise Neighborhoods, various Centers for Disease Control and Prevention programs, and numerous community prevention programs funded by foundations). We are beginning to see the next generation of innovative population health approaches that tie more directly to the health care system to promote sustainability—Accountable Health Communities—(i.e., the Center for Medicare and Medicaid Innovation AHC model) and Accountable Communities for Health (ACH) (e.g., the State Innovation Models in Minnesota, Vermont, California, and Washington State). Future initiatives building on this work should focus on children and families, measure success across sectors, and forge stronger clinic-to community connections for geographically defined populations, all fueled by value-based payment and other innovative, cross-sector sustainable financing mechanisms.

What Is an Accountable Community for Health for Children and Families?

An ACH is a structured collaboration among health care, public health, and other partners (e.g., schools,

community-based human service agencies) to improve health, safety, and equity within a defined geographic area through comprehensive, coordinated strategies [12]. The ultimate goal of an ACH for Children and Families is thriving children and families—accomplished by a focus on optimizing health, improving quality, and reducing the total cost of care for a population over time. The model would seek to optimize health trajectories of children (prenatal to age 26) and their primary caregivers in a geographic area over time, in addition to improving care and reducing costs for high-cost users. The model necessitates a community coming together around shared health goals and a business case in which they are all held financially accountable and jointly responsible for achieving shared goals and metrics that spill over into different sectors, with an integrator serving as the glue that binds the initiative. The core of this model is identifying and addressing health-related social needs for the child and family (e.g., housing, food security, education, economic stability, and so on), creating stronger connections among key sectors to support a more efficient "community care coordination system," where the needs that are identified are addressed through existing community resources, and filling in gaps where there is no provider or service to address needs. The work that lies ahead is tailoring and applying an ACH model to children and families in a geographic area, with a focus on screening, prevention, and early intervention to optimize health and development across the trajectory.

Guiding Principles for an ACH for Children and Families Model

1. Everyone should have an equal opportunity for health according to his or her needs.
2. Improving child health necessitates a focus on the family—from addressing basic needs (housing, food, and so on) to strengthening parenting competencies to amplifying family representation in decision making. It also requires a focus on identifying and addressing developmental delays and needs through appropriate intervention across the life course.
3. There is no wrong door through which to improve child and family health; all community partners and members have a role to play.
4. Optimizing child health goes beyond health care. It means attending to the whole child's health, development, and well-being and engaging the sectors where children spend time to develop shared goals and partnerships that result in meaningful collaboration.
5. Onerous requirements and rigidity stifle innovation; initiatives designed to advance accountable health models should foster conditions for local innovation (including payment models), allow flexibility, and reduce burdensome and duplicative reporting requirements at the local level.
6. Older adults are a costlier, sicker population than children, and therefore achieving short-term wins and cost savings is a more reasonable proposition for the older adult population. Models designed to optimize child health should have a return on investment (ROI) time frame of at least 7 to 10 years. In addition, it may be prudent to design an approach focused on families that may balance a long-term ROI for the child and a short-term ROI for the adult, especially in the case of a long-term, high-cost chronic disease or condition affecting the whole family.
7. To move the needle on health over time, a mix of public and private funds is necessary and can inspire key community stakeholders to create shared ownership for a common community destination and then become jointly accountable for arriving at that destination.

Core Elements of an ACH for Children and Families

The following recommended elements represent a mix of features that are included in a paper describing the key roles of an integrator [13], existing ACH models and descriptions (e.g., the California Accountable Communities for Health Initiative [14], the Prevention Institute's paper [12]) or Accountable Health Communities models (e.g., the Innovation Center), in addition to elements added as a result of a November 1, 2016, Nemours–Aspen Institute convening and subsequent calls.

1. *Shared vision and addressing gaps:* Partners would agree upon a shared vision and goals to optimize health for children and families across the trajectory and to reduce health disparities, including a plan for addressing unmet needs.
2. *Integrator/backbone/bridge organization to connect Multisector Partners:* Communities would develop or build upon formal collaborations among health care, social services, community development

financial institutions, child and family–serving organizations, and community members and families dedicated to achieving the shared goals. An agreed-upon entity (integrator) would serve a convening role and work intentionally and systematically across sectors to improve health and well-being for a geographically based target population. The integrator would identify entities with which it would contract to provide a portfolio of interventions, as well as invest to build community capacity to provide services that are not currently available but are needed (based on the results of the community needs assessment and empirical evidence of interventions effective at meeting those needs). Additionally, the integrator would play a key role in developing and managing a cross-sector financial sustainability mechanism to pool funds across sectors and reinvest the shared savings in future prevention initiatives. Examples of lead entities could be community-based organizations, health care practices, hospitals and health systems, educational institutions, local governments, health departments), tribal organizations, and for-profit or nonprofit organizations, including payers.

3. *Trusted community leadership and governance:* Communities would identify trusted champions and develop a governance structure that describes the decision-making process and articulates key roles and responsibilities. Families would play key roles in the governance structures. Communities would be encouraged to develop innovative ways to reduce barriers to meaningful community engagement (e.g., leveraging private dollars to cover the cost of child care or transportation for parents while they attend ACH planning meetings). Over time, communities should strive to maximize equitable participation and community voice in governance, ensuring that individuals from all socioeconomic statuses and backgrounds have meaningful opportunities to contribute as equal partners to the development and functioning of the model.
4. *Two-generation approaches:* Communities would develop strategies aimed at improving the health of children (prenatal to age 26) and their primary caregivers, with special attention paid to promoting health equity and addressing health disparities. This includes addressing basic needs (housing, food, and so on for families) as well as improving parenting skills and competencies through interventions in the community, home, and/or health care setting; family engagement and family representation in decision-making and governance structures; and specific strategies designed to meet the needs of and provide supports for pregnant women, with a goal of building safe, stable, and nurturing home environments for every family.
5. *Population and patient-level metrics and outcomes to achieve a shared community destination:* Building on the IOM report Vital Signs: Core Metrics for Health and Health Care Progress and evolving work to develop pediatric core metrics, communities would select a set of short-term, intermediate metrics with long-term implications, as well as long-term metrics with spillover effects in various sectors, and would be held jointly accountable for achieving progress at the patient and population level within a geographic area, including a total-cost-of-care metric. This would include a mix of patient- and population-level clinical outcomes and nonclinical outcomes that can be achieved across various time frames (e.g., short term: reductions in unnecessary health care utilization, school days missed, improved food and housing security; intermediate term: proportion of children ready for kindergarten, reading by grade level; and long term: diminishing needs for special education with effective early intervention, changes in high school graduation rates, and reductions in health care costs). While achieving progress on long-term metrics would be an overarching goal, communities should prioritize early wins in the short term.
6. *Data analytics and evaluation:* A Technical Assistance (TA) Center (funded by either a foundation or a government agency) would help communities develop approaches and agreements for collecting, analyzing, and sharing financial, community, and population-level data across a variety of providers and organizations needed to advance common goals. In compliance with existing laws governing protected health information and student education records (e.g., the Health Insurance Portability and Accountability Act, Family Education Rights and Privacy Act) and other relevant laws, sharing of data publicly and with community partners would occur and would be used to drive change through empirically informed decision aids. The TA Center would assist in sharing best

practices, guidelines, and memoranda of understanding currently used to promote data sharing, identify barriers, and develop proposed solutions, as needed. Additionally, independent evaluators would assess progress toward achieving the goals set forth. If communities had a strong rationale for altering their metrics during the course of the award, flexibility would be granted.

7. *Community Care Coordination System:* A community care coordination system helps ensure that individuals are referred to and obtain the medical, behavioral, and social services they need across sectors without duplication, including ensuring that the referring provider is notified when services are provided.
8. *Key Portfolio of Interventions:* Communities would perform (or use an existing) needs assessment/community resource inventory; identify, refer, and treat participants through screening (including using developmental and social determinants screening tools) and early intervention strategies based on risk stratification; develop and implement prevention strategies; and incorporate health care approaches to reduce cost and utilization. Inclusion of family-centered medical homes would be required. Communities would develop and implement a portfolio of interventions tailored to meet the community's needs, based on the best available evidence, ensuring that the needs of the most vulnerable are addressed and that a full range of interventions, from clinical to policy, systems, and environmental changes are considered. Sustaining effective interventions would be critical. As such, communities would (a) develop a glide path to value-based payment with one or more payers that sustains the most effective interventions, thereby aligning incentives among health care providers, payers, and community health goals; and (b) match specific interventions to other appropriate financing vehicles, drawing from the full range of innovative financing vehicles that are emerging. (See number 10.)
9. *Value-based payment:* A glide path to value-based payment with one or more payers, managed care organizations, and providers would be required given that all parties would have aligned incentives related to cost, quality, and health outcomes. It could include clinical payment (rooted in primary care) as well as a community component, which could include incentive payments for community partners. Communities should have flexibility to experiment with different payment models. Communities would be required to link the data they collect, the metrics they are seeking to achieve, and the value-based payment model that rewards progress toward achieving the outcomes they set forth.
10. *Financial sustainability:* Communities would develop and implement a sustainable plan for securing resources to support the goals, priorities, and strategies developed by the ACH. The integrator would take the lead in setting up appropriate financial sustainability mechanisms. Examples of structures or mechanisms to be included in the plan are wellness and prevention funds; social impact investments; support from private funders (philanthropy, business and industry, and so on); support from insurance companies, managed care organizations, and health care providers (including working with community partners to reduce unnecessary health care spending and utilization); multisector, blended funding (e.g., through current and future Medicaid waiver programs); and community development banks. The goal would be the creation of shared savings and incentives across sectors to promote joint financial accountability in pursuit of the community's overarching goals and metrics.
11. *Learning Systems and Communications:* Learning and communication would occur across sites and within sites. Across sites, funded communities would be part of a learning and Technical Assistance infrastructure, including (as described above) a dedicated organization focused on (a) providing TA to awardees; (b) developing learning collaboratives to share insights and lessons, and work through challenges in real time; and (c) developing a mechanism to capture feedback from awardees (as well as participants in other related initiatives) regarding barriers they are facing to assist in creating flexibility and cutting through red tape to overcome the barriers. Within sites, communities would develop a system of ongoing and intentional communication and feedback among partners and community residents. The voice of the family would be amplified through communications' structures. The feedback loop created would inform how resources are allocated (e.g.,

when referrals for service are made but there is no community provider that can fill the need) and what federal, state, or local barriers are hindering progress.

Special Considerations for Implementation of an ACH for Children and Families

Included below are practical considerations for communities that are exploring testing an ACH for Children and Families.

Community readiness: Communities should assess where they are in the implementation of the core elements above. For communities that are just beginning to come together, the initial focus should include ensuring that a comprehensive set of partners (see next bullet) are engaged and developing a plan to work together on shared goals and metrics. For other communities that already have these partnerships in place, focal areas might include the development of the community care system and the plan to develop joint financial accountability for shared aims.

Target Population: An ACH for Children and Families is designed to optimize health for all children and families in a geographic area. Some universal interventions will impact the entire population, and risk stratification will also need to occur for targeted interventions. Although the needs of high-utilizers and high-cost populations should be specifically addressed, it will also be important to test whether costs could be averted and outcomes improved by specifically addressing the needs of medium-prevalence and medium-cost users.

Partners: Partners should include those providers with the greatest impact on child health and development. The following are examples of key partners:

- Health care, including pediatric providers and associations (e.g., health plans, hospitals, private providers or medical groups, primary care providers, behavioral health providers, dental providers, pharmacies, accountable care organizations, and community clinics)
- Payers (state Medicaid agencies, private payers, or managed care organizations)
- Early care and education (preschools, Head Start, child care centers, and so on); schools and school districts; child-serving organizations; housing agencies or nonprofits; food-systems and food-security organizations; transportation and land-use planning agencies or organizations
- Families who live in the community
- Local governments
- Government health and human services agencies/public health departments
- Grassroots, community, and social services organizations
- Businesses and local employers
- Economic development agencies
- Local, regional, or national philanthropic organizations
- Faith-based organizations
- Parks and recreational organizations and agencies
- Law enforcement and correction agencies/juvenile justice

Return on investment (ROI) time frame: Given the nature of the outcomes ACH for Children and Families models are seeking to achieve, outcomes should be tracked over 7-10 years. Communities should explore analyzing savings across sectors.

Metrics: The metrics for an ACH for Children and Families are likely to differ from those of a "traditional" ACH, though there would be some overlap. Examples of metrics that might be considered are proportion of children ready for kindergarten, school days missed, reading by grade level, number of health and developmental screenings, community resources identified and referred to, food and housing security, proportion of infants born healthy and to prepared parents, and proportion of adolescents who use alcohol or tobacco or that develop mental health conditions.

Payment model innovation: Value-based pediatric models are not as prevalent as value-based models for the adult population. Accordingly, communities should work with payers and their states to innovate and experiment with different types of payment models to enhance understanding of what works. This may require more innovation and testing than is the case with adult-focused models.

Integrating an ACH for Children and Families with other ACHs: It will be important to test whether a stand-alone ACH for Children and Families would achieve the scale

and eventual cost savings needed for success or whether an ACH for Children and Families should be embedded in a broader ACH (with some shared infrastructure, data sharing, and so on, but distinct payment models and metrics) to achieve financial sustainability. Both models should be tested and studied.

Conclusion

Given the state of the science regarding the importance of early brain development and the "foundations of lifelong health" [2] taking root in the early years, there is a need to continue to explore models of care that explicitly seek to optimize health across the lifespan, starting in the early years. An ACH for Children and Families offers the opportunity to bring together community partners to address the social, developmental, and health needs of the child and family, thereby creating the potential to reduce adverse outcomes and improve a child's trajectory. Although this model is likely to produce fewer health care cost savings in the short term than a model focused on high-cost adults, over the long term, it offers the potential to improve outcomes and reduce costs across a number of sectors, thereby building a stronger foundation to help sustain the community partnerships, data sharing, and financial sustainability mechanisms inherent in the model. Additionally, embedding an ACH for Children and Families within a broader ACH would afford communities the opportunity to address the needs of a portfolio of populations with a portfolio of interventions, using some shared infrastructure. A reorientation toward upstream prevention, community-based solutions, and value-based care through an ACH for Children and Families would support a paradigm shift and community culture explicitly focused on helping children and families reach their full potential.

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None disclosed.

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Disclaimer

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Washington's Mental Health Referral Service for Children and Teens

Overview: In March 2018, Senate Bill 6452 passed by the legislature "an expansion of Partnership Access Line services to include referrals to children's mental health services and other resources for parents and guardians with concerns related to their child's mental health."

Goal: Help families through the often-challenging process of connecting children and teens with evidence-supported outpatient mental health services in their community.

Provider information: The Referral Service created and maintains a database of community mental health providers in WA State specifically for this service. Providers may now complete an online form on the Referral Service website to proactively share information about their practices.

Guidelines allow consistent data collection from every mental health provider, which includes:

- Clinician or practice name
- Address and contact information
- Credentials
- Specific services provided
- Insurances accepted
- Fee information (sliding, pro-bono)
- Languages spoken
- Ages seen
- Availability (morning/afternoon/evening)

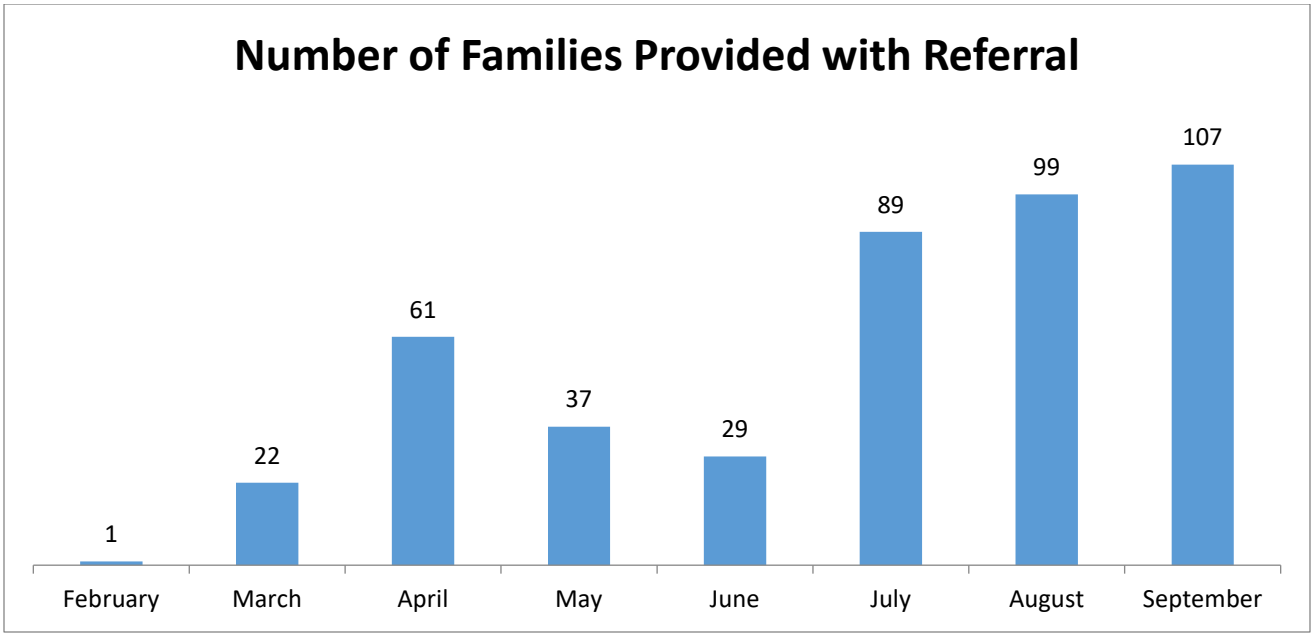
Equitable Access: A data tracking system adds reliability in service standards to ensure families receive consistent help in accessing evidence supported care with mental health providers.

Supporting a Match: Families are provided with at least 2-3 referrals that meet program guidelines, which providers who have told us that they have availability and meet families' specifications.

Data collected from every family includes:

- Demographic information (name, date of birth, ethnicity, identified gender)
- Contact information (phone, email)
- Insurance information
- Consent for contact with MCO plan and their primary care provider
- Safety questions
- Issues currently affecting the child
- Previous mental health treatment experience
- Current resource access including IEP or DDA
- Type of services requested
- Care preferences (gender of therapist, location of service, other characteristics family is looking for)
- Times/days that work well for appointments

Utilization: As of September 30, 2019, there are 459 successfully completed referrals from February – September '19. There are 103 currently open referrals the team is working on completing, and it is taking about 4 weeks to make a full parent connection to an available child therapist. We are in the process of hiring an additional referral specialist to address the community demand.



Systematic Barriers: Private insurance is a greater community referral challenge than Medicaid, in that 68% of all referrals were made for families with private health plan insurance, compared to 50.5% of the state's children having Medicaid. Also our time to identify a provider for a privately insured child typically takes us more time than for a Medicaid covered child, often calling up to 20 providers to find one with availability.

Two weeks after referrals are provided to the family, the referral specialist calls the family to check in and see if the family has made an appointment. If they have not made an appointment, we ask the family what barriers prevented them from making an appointment.

Of the first 293 families contacted for follow-up after a referral is made, the service connected with 199 families (68%) and collected the following information on their appointment outcome:

61% had scheduled or completed an appointment within 2 weeks

For the 39% for whom no appointment was made, reasons stated by the parent for this include 40% reporting family schedule/time priorities had changed which precluded therapy, 7% reported the providers' availability did not match their own, and 53% reported a wide variety of other concerns including a change in the child's condition, relocation, or working with another case worker.

Family Feedback:

Between the start of the program in February and August 30th, 2019, 46 family program surveys were received. These surveys were sent via email after the follow-up call was completed.

Comments written with suggestions and feedback:

"The referral service worked great! Share this service with parents through school newsletters. We wished we had this info earlier. I spent so much time calling around and could not find a counselor that was available."

Thank you for the fast response and assistance!

"I tried for ages to find someone in my area but wasn't able to. The referral service found a great provider when I could not. This is a fantastic service!"

"I've been looking for a mental health practitioner for years for my daughter. Thank you so much for finding us options, we are so grateful!!"

"Having searched for available therapists on my own, I know what a nearly impossible task it can be to find someone accepting clients. Thank you for all your help and support!!!"

"Thankful I wasn't alone in looking for treatment! It was overwhelming at first."

"I am so glad to see this service, I have struggled for years to get the right services for my kids as issues have arisen. I received great information and help. It would be nice if the turnaround was faster than +/- 30 days (but that is still good compared to how long it takes to track down services on your own - horrible and stressful to do it on your own - roadblocks everywhere). I am telling all my doctors about this service, so it is their first referral when they encounter families that need help. It is about time that something like this is available. I am so thankful for this service."

*"I think you guys are fabulous! The need for services with our younger population is so great and having someone to navigate some of the logistics is so helpful! Keep up the great work! PS *name* was AWESOME!"*

*"*name* gave us excellent service and listened carefully to our needs. I was very impressed."*

*"Thank you for your help!! You saved me so much time and headache :) *name* was awesome to coordinate with and very thorough in her communication with me."*

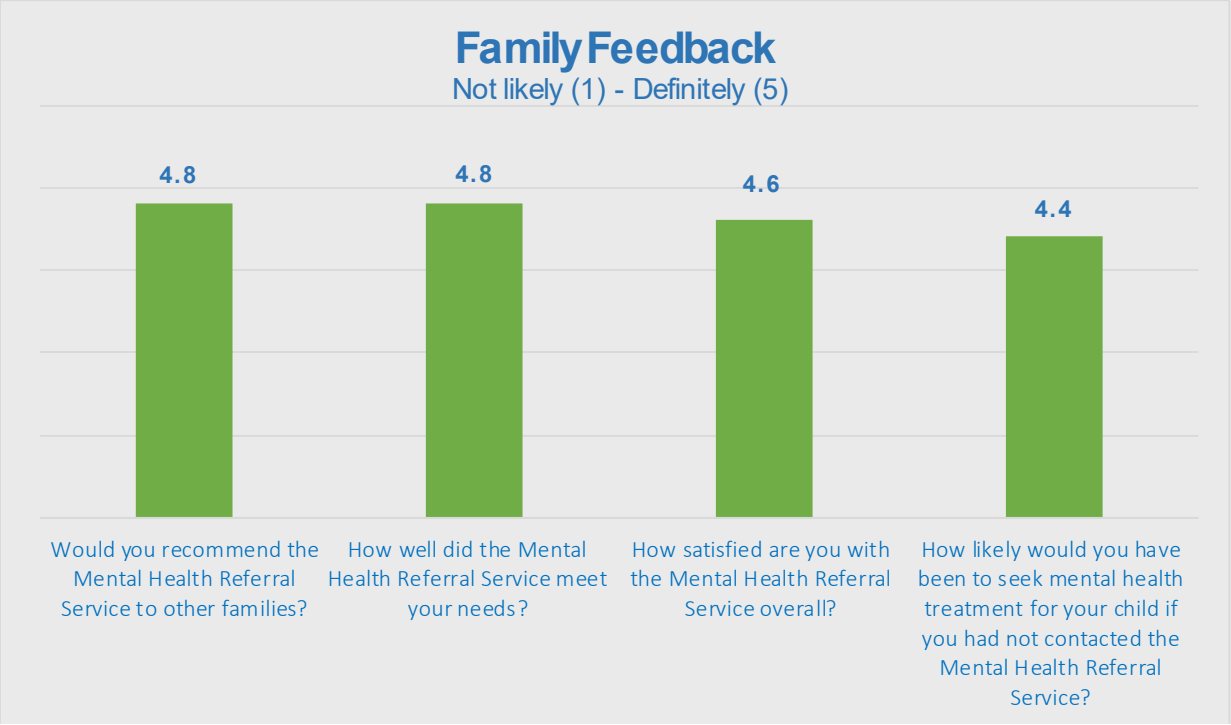
I wished we had known about it sooner. It's very hard to find a counselor that will take on teens.

**name* was fantastic. It is so hard to find help. She helped me get the help! Wonderful!*

Keep up the amazing work!!!

"Thank you. The service was helpful and informative…"

"…the recommendation provided was great and did the job! Thanks."



Funding: Current pilot supports 6.5 referral specialists; however, utilization rates are at capacity. The plan for the next phase is to increase staffing and market the service more broadly to reach more children and teens around the state. With the pilot experiences to date, we now estimate the ongoing funding support would be $987,300 per year, higher than our initial pilot service plan in which we budgeted $779,840 for year 2 support.

If no action is taken during this legislative session, this 2 year pilot referral assistance service will close on January 1, 2021.

To avoid a closure at the end of next year, one of two legislative options would need to occur this session:

1. Pursue an appropriation for Jan 1, 2021-June 30, 2021 of $493,650 to continue the service uninterrupted, and bring the program's funding on to the state's fiscal year cycle. This option would defer any longer term legislature commitment to synchronize with a state biennial budget until the next legislative session starts in January 2021.
2. Or in addition to an appropriation above for Jan 1, 2021-June 30, 2021, a decision could be made now to pursue funding support beyond June 30, 2021, to carry into state fiscal year (SFY) 2022 and 2023. As stated above, we now estimate the workforce required for continued operations in 2021 and beyond to be about $987,000 per year.

Department of Commerce

Substitute Senate Bill 6560

SUMMARY AND NEXT STEPS

SL Rao and Regina McDougall
OFFICE OF HOMELESS YOUTH

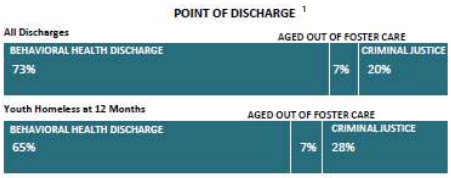
9/30/2019

Objectives for today

- SSB 6560
- Data
- Framework ~ Theory of Change
- Behavioral Health System Requests
- How You Can Help

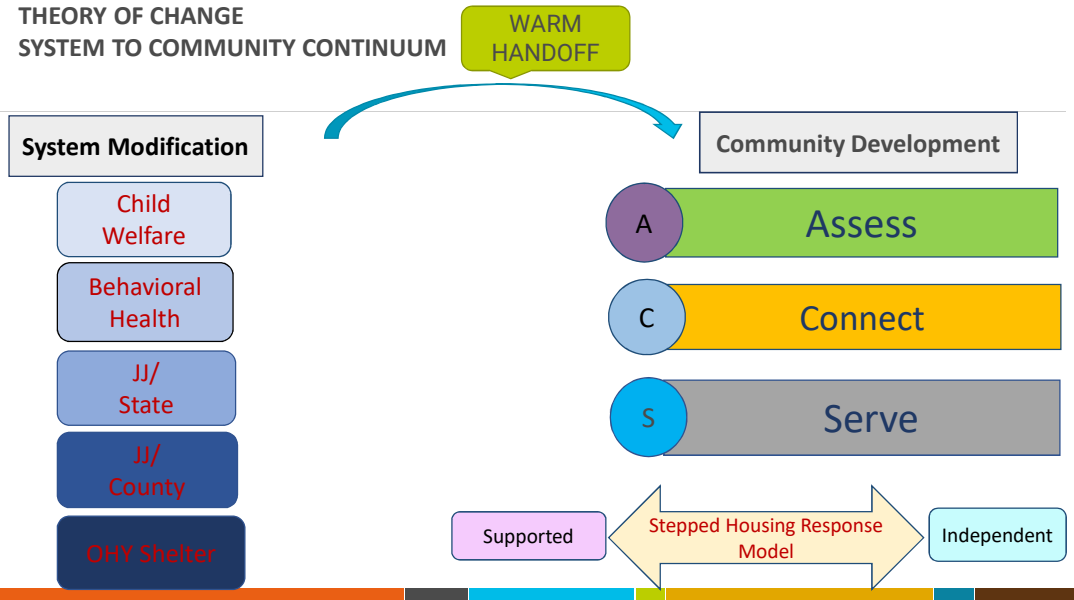
What does the data say

- Of the roughly 1,800 young people leaving all state public systems of care who subsequently experience homelessness or unstable housing, almost two thirds(1,178) of them come from inpatient behavioral health system.
- 85% of them are young adults (ages 18-24).[2]



1. Data from RDA dashboard Housing Status of Youth Exiting Foster Care, Behavioral Health and Criminal Justice Systems 2017
2. Data from AWHWA's report " from Inpatient Treatment to Homelessness" Dec 2018

THEORY OF CHANGE
SYSTEM TO COMMUNITY CONTINUUM



Requests in Plan

Round 1 Focus – 2020 Session: **Infrastructure**

Round 2 Focus – 2021 Session: **Housing**

Behavioral Health Requests

- ***New*** - RE-ENTRY PROCESS

Develop a Re-Entry Team Meeting model in all residential programs to plan for discharge to include: community ongoing treatment needs, community resources for housing and crisis intervention, education and/or employment, family and/or peer engagement (natural supports), respite options, and screening for eligible benefits using Washington Connection to apply for medical, disability, cash, SNAP or TANF (if parentings). This model will include at least one home-visit to complete the Family Services Plan (FSP) prior to discharge.

- ***Expansion*** – CONTINUITY (FUNDING AND CAPACITY)

Increase Rehabilitation Case Management Funding (State General Fund) to allow providers to bill for SUD pre-release planning. Standardize continuity of WISe assistance for families when youth transition in and out of residential programs so there is no break in support.

Behavioral Health Requests

- ***New*** - BEHAVIORAL HEALTH ACCESS
- Develop pathways to Behavioral Health access by adding system staff that specialize in transition age youth populations to the Health Care Authority, Child and Family Team with responsibility as a tri-lead to the Interagency Work Group on Youth Homelessness.
- ***Expansion*** - RESPITE
- Add capacity for respite care for families after a youth discharges from a BH residential facility. Recruit additional respite families to care for adolescents.
- ***Expansion*** - DAY TREATMENT/DAY SUPPORT
- Expand Day treatment options via schools to support youth re-engagement in K-12 education.

Thank you!

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