

Youth and Young Adult Continuum of Care subgroup meeting

September 8, 2020

Notes

Agenda Items	Summary Meeting Notes
<p>Presentations Overview: Acute and Inpatient Services</p>	<p>Liz Venuto, Transition Age Youth Integrated Services Supervisor (Health Care Authority [HCA])</p> <ul style="list-style-type: none"> • Most funders cover some inpatient and residential services. • Service delivery models vary depending on capacity of services. • Should be developmentally appropriate, culturally relevant, designed for various levels of change readiness, and look like help to those receiving services. • Ongoing targeted work happening with CLIP team and the Dept of Commerce around youth discharges to ensure exiting into stable housing. <p>Q&A:</p> <ul style="list-style-type: none"> • Which of the facility types are under 18 vs 18-24? <i>CLIP facilities – up to age 18. E&T facilities – vary; based on facility types. Some as young as 11.</i> • Total # of inpatient beds? <i>Will get a one-page together that includes all types of facilities. Recently, 37 contracted CLIP beds, has expanded. More than half are part of CSTC. Capacity is an issue.</i> • What happens if a person under 18 qualifies for involuntary care but there are no beds available? <i>Have to find a way to house them in a hospital bed or other situation until we can house them.</i> • Are we doing single bed certs when there is no bed available? <i>We do that sometimes. It really is case-specific. That is one of the options.</i> • How many children are we sending out of state for care? <i>Will include that with the one pager.</i> • What are we to do with acute cases outside of the hospital setting? (Penny)
<p>Evaluation and Treatment (E&T) and Inpatient</p>	<p>Kashi Arora, Project Manager, Mental and Behavioral Health (Seattle Children’s Hospital)</p> <ul style="list-style-type: none"> • PBMU – short-term crisis and stabilization facility. Will include that with the one pager. • Average length of stay – 5-7 days. • 41 beds – can’t use all of them in COVID times. • Serve children ages 4-17; one of the few that takes children under age 11 years old. • Patients can be admitted voluntarily or involuntarily – FIT or ITA. • Seattle Children’s is not an E&T, but takes some. • 60% private; 40% Medicaid. During COVID: 55%/45%. • Intake through ER determination. • Admitted if imminent risk to themselves or others, or experiencing grave disability. • Attending psych/NP, clinical therapist, care coordinator. • Melieu setting – separated by age, not diagnosis – each group facilitated by a therapist or coach – learn skills – DBT based or informed. Autism spectrum – somewhat different treatment. • Seclusion and restraint-free by philosophy. Most severe cases – physical restraint. • Ask staff to think about why behavior is happening, rather than punishment. • Each patient room has 2 beds so parents can stay overnight; attend whenever they want.

- Followed after discharge by PBMU team.
- Outcomes data – clinical teams looking at symptom reduction and target behaviors.
- 75% discharged with all of the necessary appts.; 90% discharged with at least one.
- During COVID – only 55% leaving with all of the necessary appointments.
- Readmission w/in 30 days: 13%. Hypothesize – need for multiple admissions to stabilize (like physical health), inadequate community support, or different assessments at the community level.
- Multiple factors in how difficult discharges are – inadequate step-down services.
- Designed for stabilization, not long-term change.

Q&A

- Percentage of admissions that are voluntary vs. involuntary? *Can get data. More voluntary than involuntary. Children under 13 can't be admitted involuntary; considered voluntary.*
- Are you seeing people utilizing FIT? *We were using PIT before; haven't seen a change.*
- Intersections between your level of care and juvenile justice system? *Don't treat primary SUD. We have a lot of work to do to get to an anti-racist health/mental health system. Children who are at risk to themselves should be treated. Depends on ER and person who sees them. Seattle Children's has work underway regarding DEI.*
- What do you do when a child is still expressing suicidal ideation? *What medical professionals use to stabilize is not very satisfying to families. Maybe they have a strong system of support, healthy coping mechanisms that mitigate the suicidal ideation. There are discharges that happen. They will probably still be having some behaviors after discharge. Short-term goal is manageable behavior.*
- Do you track suicidal ideation? *Don't have a robust data tracking system; we try to keep contact with kids – it's hard.*
- Opportunity for feedback? *Patients/families receive a feedback form – can return or escalate, give info to escalate to ombuds.*
- Frequency of discharge into homelessness? *If we know that their family is homeless or unstably housed, connect them with a social worker. Small #. Proportion of families with economic insecurity is higher. Will try to get more info.*
- Admit kids if primary issue is mental health, and stabilize SUD, then connect them with SUD treatment.
- Treatment of suicidality? *Use CANS, DBT model and CAMS.*
- Don't use youth peers in our setting. HIPAA issues. Area for improvement for us. Do refer clients to WISE post-discharge.
- Issue: super-short authorizations from insurance (48 hrs.). What if there's a bad reaction and he's only here for 48 hours? Has that improved? *Medicaid does a lot of really short re-authorizations – 24 hrs, and never more than 5 days. Private insurers typically offer more, but not a lot. I would hope that insurance is not impacting care.*
- Has there been an increase in admitting post-COVID? *Over the past few years, 60% increase in mental health ED visits. We can't see admits increase during pandemic because there are reduced numbers in admits. EDs are seeing more – doing more triage at ED level. Not a reflection of how many kids need care. Data on ED visits and post—ED.*
- In the foster care system, there's a state ombuds office, and they can investigate trends/practices across the system if they got a lot of complaints in one area, in addition to investigate specific instances. It's helpful to have an independent body at the state level – for example, they track the hotel stay trend and publish reports and recommendations.

<p>Children’s Long-term In Patient (CLIP)</p>	<p>Melissa Olson, Program Manager (Pearl Youth Residence)</p> <ul style="list-style-type: none"> • Tacoma – one of 5 CLIP facilities across the state. 27 bed capacity. 6-9 month program in locked facility. • Serve youth age 12-17 (until 18th bday). • Typically, 1/3 voluntary. Shifted – now more 50/50, with most staying for the duration voluntarily. Whether they come in voluntary or involuntary – admitted for risk of harm to self or others, grave disability. • Exhibit learned skills/behavior in outings in the outside world. • Treatment planning, family planning, individual therapy, equine therapy. • After a time, they receive day passes; hampered by COVID. Working on ways to engage and involve families. • Then overnight visits (up to 4 nights). New ability to send staff out with kids to provide support. Talk about discharge/transition to home throughout. • Trauma, PTSD, opposition defiance disorder, autism spectrum. • School through Tacoma School District. • Multi disciplinary: medical team, residential counselors, clinical team (case managers, rec managers), youth peers, parent partners. • Made a conscious shift from a complaint-based approach to collaborative problem solving, meet kids where they’re at, develop skills and behaviors. Rely heavily on milieu treatment model – every interaction can be therapeutic. • Re-admissions are fairly rare, we have had only two re-admissions into our program in my 4 years. <p>Q&A:</p> <ul style="list-style-type: none"> • <i>Have been kids that turn 18 and have a hard time finding a placement for them. Most go back to families. One went to an adult facility (voluntary).</i> • <i>How does the court order this program? Typically happens if grave risk – hospitalized several times; starts with 72 hour hold, then 14 day, then 180 day – assessed at the hospital level. Can go through the same process at Pearl St for voluntary admits.</i> • <i>Racial breakdown of patients? Last I looked it was proportionate to the overall pop – will look into it.</i> • <i>COVID – home visits? It has been limited substantially and has extended youths’ stays. We know how important home connections are and trying to connect. Can’t have visitors.</i> • <i>Outcome data: Really hard to know what happens when kids leave here.</i> • <i>All kids improved in assessments.</i> • <i>CLIP wait lists? How much is demand outpacing supply? The wait list is long. Demand outweighing supply. Covid having a big impact; discharges are being delayed.</i> <i>Liz: Capacity was a challenge pre-covid. Covid has been overwhelming to the system. These are the things our staff are working on daily. Data? How many on the wait list? Wait times?</i> <i>Kashi: When CLIP beds are full, kids on ITA are held in hospital beds – trickle-down capacity issues.</i>
<p>Ricky’s Law/Residential programs</p>	<p>Ryan Kiely, Executive Vice President (Excelsior Wellness)</p> <ul style="list-style-type: none"> • Sole provider – Secure Withdrawal and Management (SWMs) beds + other services • In health care, patients have a range of options – primary care, urgent care, ER.

	<ul style="list-style-type: none"> • Tried to construct a continuum for BH: Outreach and engagement specialists in school, outpatient Level 1 services, wrap-around programs, intensive inpatient programs - MH and SUD, launching an E&T program, SWM program. • Believe in a continuum of care within an organization so youth and families can access at different points throughout their journey, so families can transition in and out. • Built a 32 bed facility focused on trauma-informed design – flexibility and nimbleness; each wing has 8 beds – can adjust and change for different levels of the continuum. • 2% increase in SI year over year – how do we adjust? • LifePoint program –transition living program for 17-21 – modeled after a college living environment – peer support, wrap around services, behavioral health. We have a system that is designed for those youth. In first months, saved over \$1M in hospital stays. • Another unit will be E&T. Doing assessment of what age population, based on the needs of the community. • IOP /crisis programs – future state: call and get crisis evaluation supports and get into higher levels of supports that day. <p>Barriers:</p> <ul style="list-style-type: none"> • Threat assessments – 1st question is what is their insurance? This should not be the first question when school is at risk? • Family system – insurance billing – in acute services – focus on how to support the family. • What will SWMS level of care look like? 8 beds. DBT, CBT, TF-CBT. Getting connected to the continuum. Be secure, get sober, get connected. Highly structured day and transfer into IEP program. • Overlaid OP billing model. Transition to VBP – build in flexibility around where people are at. Funding clinical with OP model. Foundation underwrites room and board piece. R&B is the cheapest component (compared to ER). <p>Q&A:</p> <ul style="list-style-type: none"> • Process to get a youth into an SUD ITA? <i>Same process – call DCR.</i> • Police interaction with your facility, how frequent an occurrence? <i>Ebbs and flows. Very few right now, very positive.</i> • Why are courts sending people of color to jail rather than SUD beds?
Inpatient SUD treatment	<p>Jered Carter, Lead Counselor, Youth Facility (Sundown M Ranch)</p> <ul style="list-style-type: none"> • 50-bed inpatient SUD – 13-18 yo. • Start with detox, review for MAT • Medicaid and private insurance • One day assessment. There are also alternatives for accepting patients. • Work with 2 dedicated SUD counselors – 12-step abstinence based treatment, motivational interviewing, DBT, other evidence-based treatment. • Strength-based indiv treatment plans. Length of stay typically 45 days. • Patients participate in education and skill building, including physical activity (to reintroduce endorphins). • 3 day family on-site program when there are not COVID restrictions. • Referral – usually step-down into IOP. • Outcome data – 2005-2017 – follow up survey 1 yr out – 40% no use; 42% - less use. 82% significant reductions in ER visits and other indicators.

	<ul style="list-style-type: none"> 60-bed capacity not filled looking at why. This has been exacerbated since there are not school referrals presently. We know there are kids that need services, but they aren't coming to our door. Courts sending POC to jail rather than SUD beds.
<p>Long-term Inpatient</p>	<p>Thomas Russell, CEO, Daybreak</p> <ul style="list-style-type: none"> Not for profit. Key values: respect, trust, safety, perseverance. Full range of E&T, co-occurring inpatient services, WISE teams. Serve 13-17 yo – residential treatment side. Get a lot of individuals POC, LGBTQ. 24 beds for females in Spokane, 44 beds at Bush Prairie. Length of stay – 45-60 days. 24/7 nursing care; DBT, motivational interview, relapse prevention, trauma focused CBT. 24/7 hour access to PNPs for medication management. GED support, IEP plans. Connect to parts of the community – inspirational service-oriented activities – outdoor adventures, trauma informed meditation classes, equine therapy, job shadowing, yoga. Behavior is indication/symptom of underlying issues. 80% of clients are Medicaid; also private insurance. Restrictions mostly from private insurance. Monthly academy week to train and orient new staff and update the skills of existing staff. Barriers: Appropriate locations for kids to return home, especially if parents are using or home environment is not appropriate. General level of funding for BH for intensive long-term services. <p>Q&A</p> <ul style="list-style-type: none"> Daybreak – unique truly person centered full-fledged co-occurring program (also Excelsior). How did you overcome licensure and funding issues? <i>Licensure and funding is a key issue; that's why low funding for BH is an issue. Licenses – BH and residential – are in conflict with each other in some ways. We find that they have to be done together. SUD issues are most often a result of trauma and MH issues that children are dealing with.</i> Have you been able to adapt your school to be able to meet the OSPI graduation requirements—less general credits allowed and more specific STEM requirements? JR also employs DBT for young people in residential facilities. I'm curious about peoples experiences with responsiveness/adaptations of DBT with young people of color and their families. Child Study and Treatment Center is completely immersed in DBT. I would love to see that in the JJ/JR system as it is a trauma induced receiving services.
<p>Discussion <i>Focus: Inpatient services</i></p>	<ul style="list-style-type: none"> A Way Home report – 2/3 of youth exiting into homelessness are coming out of behavioral health facilities. If a young person or family has the courage to go into inpatient treatment, they ought to have access to treatment and support from their community when they exit. 6560 helps in asking for money. Serious issue: missing step-up/step-down services; there aren't in-between services for families where youth can be in the home. Grant County WISE: 0-6 peer hours; state avg is 10.5 hrs. WISE: \$3200+ per person per month. Put some of these \$ into Parenting Wisely programs so families are ready to take the youth back. Programs are on westside or Spokane; some areas don't have services. (Lease empty buildings to out of state providers?) Last barrier: private insurance.

- The way someone gets to a facility is in an ambulance and only pays one way. DCRs can only detain if they can transfer them within their own county. (Locked facilities, SUD ITA). *Got that \$, part of Gov's veto – will reintroduce with smaller amt. 8 beds at Excelsior in eastern wa are only youth beds.*
- Concerns about the ability for families to access the care they need. Issue with MCOs getting authorization – MCO says they're done; provider says they need further treatment. *Maybe we can have some of the MCOs talk with us.*
- Family Initiated Treatment – families have tried to get care and providers don't seem to know about it. What sort of education is being provided?
- Develop BH continuum of care and access to that of health care. Prevent hospitalizations. WISE + a statewide infrastructure for care coordination (implementation plan with fiscal help).
- How does BH use primary care to connect the family and youth with the community resources; once connected, how do they engage them?
- Issue – judicial review of young people who are part of FIT – opp for youth to ask for judicial review; in practice – not happening because (1) youth don't get access to atty; if they get access for some other reason, the court is unfamiliar and doesn't have a process for this – potential need for statutory changes.
- Barriers: Inability to get kids in CLIP means kids stay in inpatient beds; less kids get access to inpatient beds. Also: Kids that need step-down services – waiting list for WISE Solutions: More CLIP beds; other alternatives for IOP like partial hospitalization; services that prevent children from needing more services.
- 50% of the youth releasing from JR have co-occurring needs, and our experience concurs about lack of true co-occurring serviced and silo tendencies. *Excelsior's residential/inpatient are co-occurring.*
- Barrier: Youth exits from JJ and their exit plan is not completed and therefore not executed, so they don't receive services for WISE. *Need to validate those challenges and risks with release back to the cmt. Need for partnerships and communication. The more supports we have in place, the more able we are to reduce those risks.*
- How do we have those plans and meaningful relationships in place so they're ready to engage those youth?
- Priority Recommendation #1 on the 6560 report is about transition from inpatient: https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=Youth%20Exiting%20Systems%20of%20Care_129e0702-d541-427c-be92-093024052a7f.pdf
- Recovery housing is a much needed service that is missing in the continuum. There is a licensing mechanism for SUD, but no current providers, likely because of the current Medicaid rate. We do need a recovery housing model licensing category for youth and young adults with mental health.
- Need to share info regarding FIT.
- FIT: Adolescent's court petition for release: <https://app.leg.wa.gov/RCW/default.aspx?cite=71.34.620>
- Currently Medicaid is suspended when a child is in JR, major barrier to receiving continuity of care and good discharge planning.
- Federally funded community health clinics – have counselors on staff. Can engage them right at that moment. Early identification and wrap-around services before crisis. *Issues: low reimbursement rates – bringing in additional providers is difficult.*
- Can you talk about Children's crisis services and barriers at that level to discharge planning?

	<p><i>Kashi: Most people don't want an ED to be part of the system of care, but that's currently where people receive their first BH treatment. EDs are trying to determine whether you need to be admitted to IP or you can be discharged to home – for instance, if you can get a CCORS appt the next day. In some counties that is not possible. Seattle Children's – suicide etc. – get family coaching before discharge.</i></p> <p><i>Not enough IP beds for kids under 13 – can wait for longer time in hospital beds.</i></p> <ul style="list-style-type: none"> • Options for keeping parents with SUD together with their children? <i>Rep. Davis: There is another stakeholder group focused exclusively on that.</i> • Policy, regulation and planning solns – care coordination as a policy. Requirement: if you provide a service to a child you have to transfer it to a common electronic health or community record. Once a child has been identified, there is an assigned person to follow their care.
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Attendees

- Endalkachew Abebaw (HCA)
- Kashi Arora (Seattle Children's)
- Antonette Blythe (Parent)
- Rachel Burke (HCA)
- Representative Lisa Callan
- Jered Carter (Sundown M Ranch)
- Dr. Phyllis Cavens
- Diana Cockrell (HCA)
- Representative Lauren Davis
- Kaila Epperly
- Hugh Ewart (Seattle Children's)
- Brad Forbes (NAMI Washington)
- LaRessa Fourre (HCA)
- Kimberly Harris (HCA)
- Libby Hein (Molina Healthcare)
- Andrew Hill (Excelsior Wellness)
- Mandy Huber (HCA)

- Avreayl Jacobson (King County Behavioral Health and Recovery)
- Charlotte Janovyak (Legislative staff)
- Ryan Kiely (Excelsior Wellness)
- Annette Kleinfelter (Consultant)
- Kayla Jessica Newcomer
- Melissa Olson (Pearl Youth Residence)
- Penny Quist (Parent)
- Kris Royal (HCA)
- Ted Ryle (DCYF-Juvenile Rehabilitation)
- Anne Stone (DSHS, Washington Interagency Fatherhood Council)
- Ashley Taylor (HCA)
- Jim Theofelis (A Way Home Washington)
- Liz Trautman (The Mockingbird Society)
- Bobby Trevino (Consultant)
- Liz Venuto (HCA)
- Kimberly Wright (HCA)