Washington State Health Care Authority

September 1th, 2021 -9:30 am – 3:00 pm
Microsoft Teams

Behavioral Health Advisory Council

Attendees:					
☐	Ahney King	☒	Keri Waterland	☒	Ruth Leonard
☐	Beth Dannhardt	☐	Kimberly Conner	☐	Sandra Mena-Tyree
☐	~~Brian Briggs~~	☐	~~Kristina Sawyckyj~~	☐	Sharon McKellery
☒	Carolyn Cox	☐	Lateish De Lay	☐	Shelby M Satko
☐	~~Dennis Swennumson~~	☒	Maricia Mongrain-Finkas	☐	Shelli Young
☒	Dixie Grunenfelder	☐	Mari Huesman	☐	Steve Kutz
☒	Haley Tibbits	☒	Maria Nunez	☒	Stu Parker
☒	Jeff Spring	☒	Mary O'Brian	☒	Susan Kydd
☒	Jenni Olmstead	☒	Melodie Pazolt	☐	Taku Mineshita
☐	Jimsy Chorath	☒	Michael Langer	☐	Tana Russell
☐	John Tuttle	☐	Michael Reading	☒	Vanessa Lewis
☐	~~Jorden Rosa~~	☒	Nelson Rascon	☒	Janet Cornell
☒	Josh Wallace	☒	Pamala Sacks-Lawler	☒	Louise Nieto
☐	Karen Huber	☐	Paul Neilson	☒	Julirae Castleton
☒	Katie Mirkovich	☐	Payton Bordley	☐	
☐	Kelly Boston	☒	Richelle Madigan	☐	
☐	**Facilitator**: Tori McDermott Hale	☐	**Guest:**	☐	
☐	**Guest:**	☐	**Guest:**	☐	**Minutes:** Tori McDermott Hale
☐	**Guest:**	☐	**Guest:**	☐	**Guest:**

Main Outcome: *The Behavioral Health Advisory Council mission is to advise and educate the Division of Behavioral Health and Recovery, for planning and implementation of effective, integrated behavioral health services by promoting individual choice, prevention, and recovery in Washington State*

September 1st, 2021 – time tbd
Microsoft Teams

Behavioral Health Advisory Council

No	Agenda Items	Lead	Summary Meeting Notes
1.	**CALL TO ORDER** - **Welcome/Introductions and Attendance** - **Approve July Minutes** - **Legislative Letter**	Josh Wallace and Susan Kydd	• Legislative letter was approved by the meeting membership. • Tori to change priorities (area, type and goal). • Minutes approved by membership. • Josh – How can we make BHAC more engaging, interesting? ○ Break up meeting by having activities and giving opportunities to get to know each other better and share what we do as work. ○ Roundtable – going around and doing highlights of our work. ○ Nelson -List of activities that can be done ▪ Playing an online Jeopardy that have MH or SUD related questions. ▪ Breaking into small groups to have discussions about our own story. ▪ Sharing something unique about ourselves. ▪ Setting aside time at each meeting to talk and introduce a group or individual and their work. ○ Dixie – 9-3to long of a meeting time. It is hard to stay engaged for that duration. Condense things down, make the meeting more meaningful. ○ 1 major presentation, a few smaller topics to follow. To much info can be overwhelming. ○ Dialogue is the most important – these meetings can happen in 3 ½ hrs max ○ Executive team to discuss further
2.	**Directors Dialogue**	Keri Waterland & Dr. Charissa Fontinos	• How do we support the workforce that supports the programs that are being used? • Starting the 988 and Blake bill committees that DBHR are becoming involved in. • Really focused right now our relationship with DOH and their role with BH • Had a call with BH providers to address the hospitalization crisis due to COVID - providers might have some capacity to help free up beds in hospitals for crisis patients. • Starting to role out some of the investments that the legislature gave DBHR last session. • • Pam - BH positions, DBHR use to do minority grants to reach out to them to bring them into the BH field? Is that something DBHR is considering? - DBHR lost this funding during the great recession, however DBHR tried to do this with BG but it is prohibited. BG enhancement funds waives a lot of restrictions, DBHR is using this money to help with workforce recruitment and retention • Michael to share workforce list with BHAC membership • Josh - Is there a process on how funding decisions are made throughout the state? When DBHR knows funding is a

			continuation, for sake of timing DBHR goes through BH-ASO to continue the same work. DBHR has a lot of contracting going through currently, DBHR's contract department is working closely with the funding streams- there is still a lot of work to be done. What does it look like for our contracting work? We want to figure out how we look at all contract relationships to make sure it is open and available to as many individuals as possible. Communities do not have the availability to wait around for the funding. Bigger dialogue to come… • Nelson - If you read the funding opportunities, a lot seems written to be intended for a particular group, it is only being put out because it has to be. "We hear you, but it's not working yet". Unintentionally excluding BIPOC individuals from funding and working opportunities. RUNI Rule? • How do we reach where we have not been successful before? The balance is always between fairness and efficiency - we can sometimes get money out faster to go through existing systems. • Youth Fentanyl use - used social media to inform about the dangers as well as how to get Narcan out to youth. • DBHR has been asked to put together responses to fentanyl overdose and use. If money is not an obstacle for Narcan, what would we do with it? How can we get it expanded upon to a greater extent? • Dr. Fotinos - Acting Medicaid director. Recruitment is ongoing, good applicants are being interviewed. Family Med and addiction med provider. Since at the state, her focus was initially on the whole of Medicaid but more recently on BH integration. We need to work on harm reeducation and public education. Most fentanyl is being smoked, not injected - we need to broaden our resources. • Questions - Josh - rarely do we find a single drug type users. Often there are single drug funding, continuous cycle of help someone just to drop them. • It is difficult to treat all needs due to timing issues, patient centered focus would be best. • How are we best addressing Trauma? Community health centers are seeing the need to become a community trauma facility. Trauma informed care - our legislature implemented a lot of language within the policy bills. This is something that DBHR will continue to push on. Something we focused more on the children's side, however it is involved in all crisis work. • Josh - When we get into recovery, particularly co occurring, when a diagnosis is given, there has to be a list of meds to

Behavioral Health Advisory Council

			try, we go down the process. How many medications do not work well together?? Why do we not require this test before we prescribe psych meds to people. • Charissa, this is a test that has promise but it is not necessarily ready for prime time. Some challenges with genetic testing is that genetics alone do not influence how people respond to things. We do not understand enough about it yet. These test give you an idea, but it has not been shown to be 100% accurate.
3.	**Healthy Minds, Health Features (A children's behavioral health advocacy group)**	Peggy Dolane & Richelle Madigan	Please see powerpoint.
4.	**Break**	All	
5.	**Guest: Healthcare Cost Transparency Board**	Annalisa Gellerman & Richelle Madigan	Please see powerpoint.
6.	**Section Update: Recovery Support Services (RSS)**	Melodie Pazolt, Mo Bailey, & Nicole Mims	Please see powerpoint.
7.	**Action Item Recap November Agenda Items Adjourn**	All	○ Executive committee to determine how to shorten. ○ Agenda items

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Behavioral Health Advisory Committee

September 1, 2021

AnnaLisa Gellermann, HCCT Board Manager

Washington State Health Care Authority

Agenda

1. Background
2. Legislation
3. Update on Washington activities
4. Questions?

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What is a Cost Growth Benchmark?

What is a cost growth benchmark?

- A health care cost growth benchmark is a per annum rate-of-growth benchmark for health care costs for a given state.

Why pursue a cost growth benchmark?

- To curb health care spending growth.

Per Capita Cost Growth 2017-2018: 4.0%[1]	GDP Growth Q4 2018: 2.6%[2]	Nominal Wage Growth Dec 2018: 3.38%[3]

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Average annual growth rate for commercial, Medicaid, and Medicare

Payer Type	Average Annual Growth	Since 2016
Commercial	4.9% (2014-2018)	6.7%
Medicare	2.4% (2008-2018)	2.1%
Medicaid	6.7% (2015-2019)	7.3%

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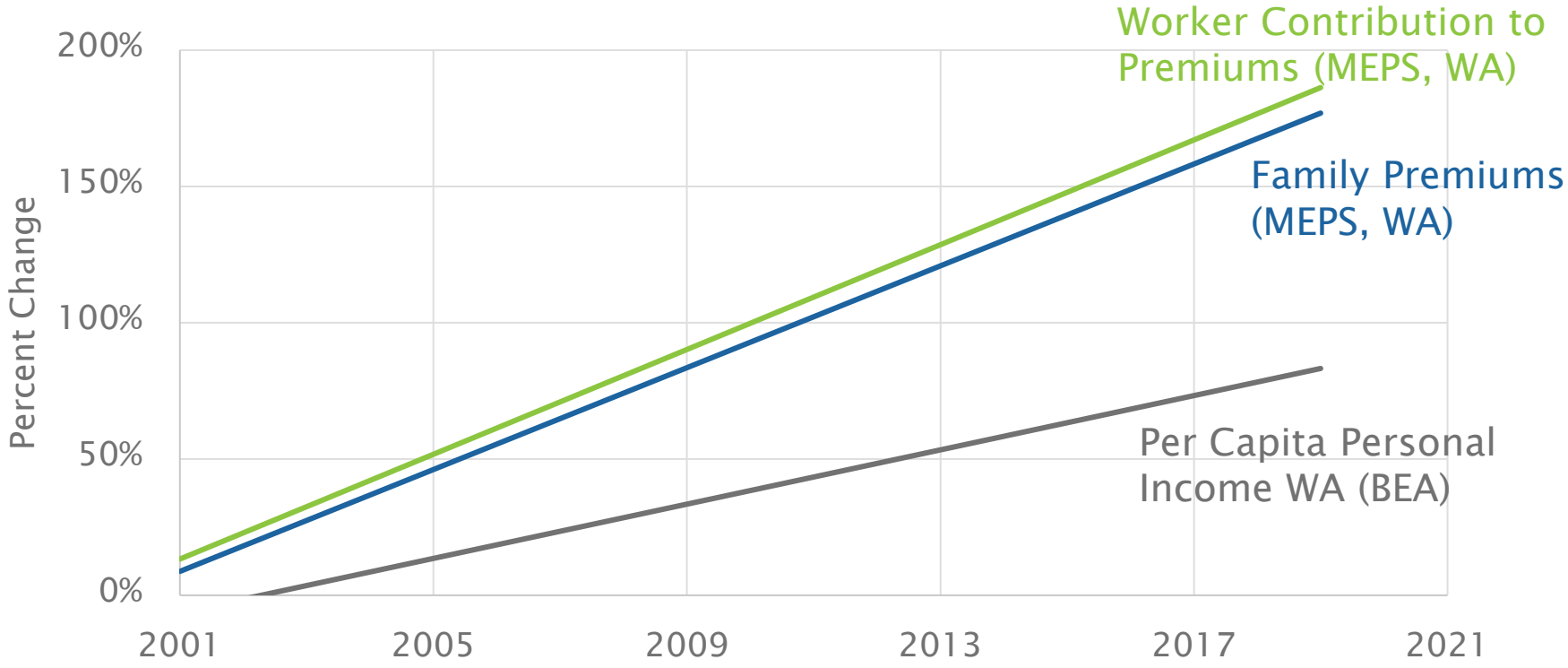
Health Care Premium Spending is Outpacing Income



*Graphs are linear trendlines of the data

Sources: AHRG's Medical Expenditure Survey, Tables D.1 and D.2 for 2001-2019 and Bureau of Economic Analysis

Cost Benchmark Purpose

- Increase affordability for the people of Washington through lowering the growth of health care costs to a sustainable rate.
- Board identified considerations include:
  - Quality
  - Access
  - Spending on health-related social needs

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Historical growth in health care expenditures in other states with cost growth benchmarks

	5-Year Average (2010-2014)	10-Year Average (2005-2014)	20-Year Average (1995-2014)	Cost Growth Benchmark
Massachusetts	3.0%	4.7%	5.1%	3.6% for 2013-2017 3.1% for 2018-2022
Delaware	5.1%	5.7%	5.6%	3.8% for 2019 3.5% for 2020 3.25% for 2021 3.0% for 2022-2023
Rhode Island	2.6%	3.7%	5.3%	3.2% for 2019-2022
Oregon	5.3%	5.9%	5.7%	3.4% for 2021-2025 3.0% for 2026-2030
Connecticut	2.4%	3.9%	4.8%	3.4% for 2021 3.2% for 2020 2.9% for 2023-2025
Washington	**4.1%**	**5.8%**	**6.7%**	**TBD**

- States started with benchmark values that were **59-70%** of their 20-year growth, and dropped those values over time to **52-60%**, except for RI which kept a steady benchmark at **60%** of the state's 20-year growth.
- Averages reflect data not available to MA when it set its benchmarks.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: National Health Expenditures by State of Residence, June 2017.

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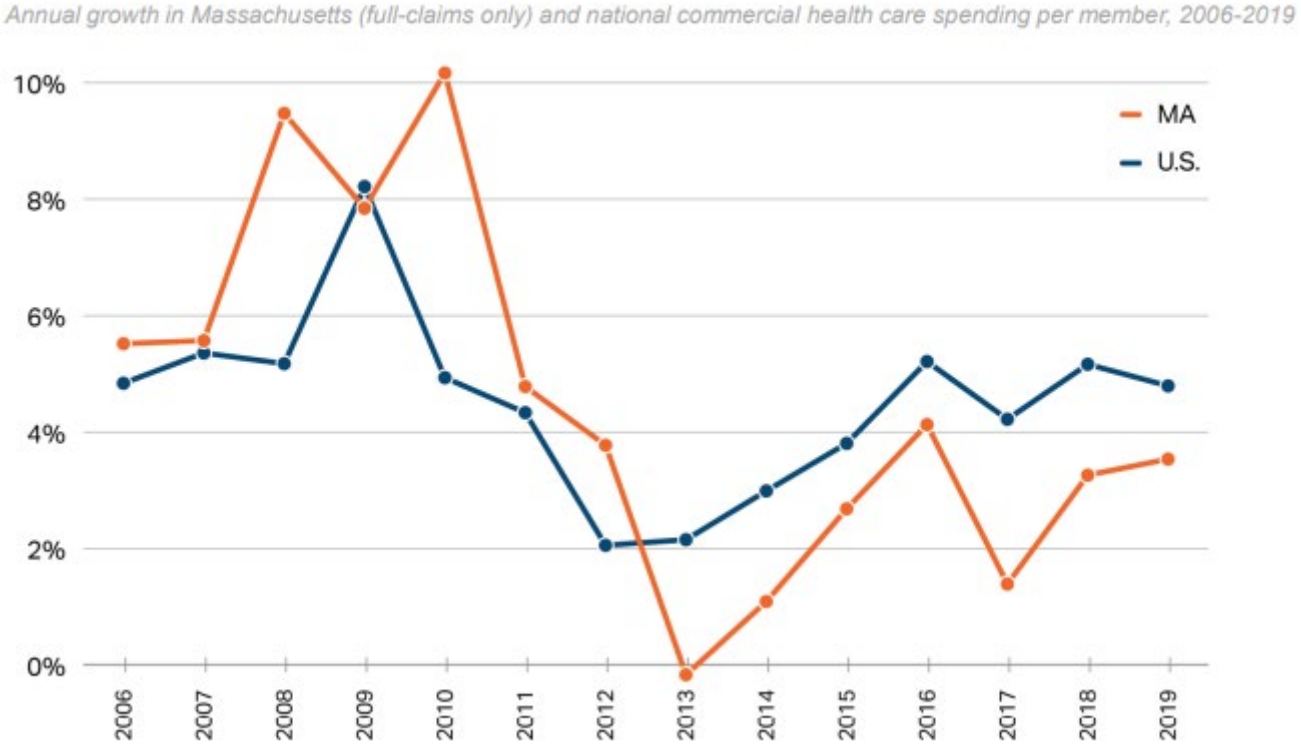
2021 benchmark values for other cost growth benchmark states

MA	DE	RI	OR	CT
3.1% (PGSP-0.5%)	3.25% (PGSP+0.25%)	3.2% (PGSP)	3.4% (roughly...average annual change of nominal per capita gross state product and median wage over the last 20 years)	3.4% (20% PGSP/80% Median Income + 0.5%)

- MA previously dropped its benchmark from 3.6% to 3.1%.
- CT will drop to 2.9% by 2023.
- DE will drop to 3.0% by 2022.
- OR will drop to 3.0% by 2026.

PGSP = potential gross state product, a forecast of state economic growth years 5-10 into the future

Massachusetts' cost growth benchmark experience



Commercial spending growth in MA has been below the national rate every year since 2013.

SOURCE: Auerbach, David. "Report on State Spending Performance," Presentation at the 2021 Health Care Cost Growth Benchmark Hearing, March 25, 2021.

HB 2457 (2020)

Health Care Cost Transparency Board (the Board) must:

1. Appoint **two required advisory committees** to provide input to the board.
2. Establish a health care cost growth **benchmark** or target percentage for growth.
3. Analyze total **health care expenditures.**
4. Identify **trends** in health care cost growth.
5. Identify **entities** that exceed the health care cost growth benchmark.

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Health Care Cost Transparency Board Members

Sue Birch, Director, HCA (chair)
Lois Cook, owner/operator, America's Phone Guys
John Doyle, CFO, Starr Ranch Growers
Bianca Frogner PhD, Director of Center for Health Workforce Studies, UW
Sonja Kellen, Sr. Dir. Global Health and Wellness, Microsoft
Pam MacEwan, CEO WAHBE
Molly Nollette, Deputy Commissioner for Rates and Forms, OIC
Mark Siegel, Director of Employee Benefits, Costco
Margaret Stanley
Kim Wallace, Medical Administrator, L&I
Carol Wilmes, Director of Member Pooling Programs, Assoc. of WA Cities
Edwin Wong PhD, Research Associate Professor, UW
Laura Kate Zaichkin, Dir. of Health Plan Performance, SEIU 775 Benefits Group

Jody Joyce, CEO, Unity Care NW (Advisory Committee Representative, non-voting member)

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Board Activities

Collect and analyze data

- Payer data: aggregate, high level
- Cost drivers: APCD, others?

Annual Report to the Legislature

- Performance against the benchmark
- Policy recommendations to curb cost.

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Key Design Considerations

1. Defining total health care expenditures
   - What types of spending should be included?
   - What sources of coverage are included?
2. Establishing the benchmark methodology
   - How to identify the benchmark value?
   - How often should the benchmark be modified? Trigger?
3. Measuring performance
   - Whose performance should be assessed?
   - What are the criteria for reporting payer and provider performance?

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Defining Total Health Care Expenditures

Sources included	Sources in consideration
Medicare Fee-for-service Medicare Advantage Medicaid Fee-for-service Managed care Medicare & Medicaid "Duals" Commercial Fully-insured Self-insured	WA Labor and Industries State Workers Compensation Self Insured WA Dept. of Corrections IHS and Tribal spend Public Health

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Cost Benchmark

- Formula based median wage and PGSP
- Initial period of 5 years
- Assess annually
- Change if extraordinary circumstances
- Specific Value: TBD

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Questions?

Thank You!

Contact: AnnaLisa Gellermann, HCCT Board Manager

annalisa.gellermann@hca.wa.gov

Board Website:

https://www.hca.wa.gov/about-hca/health-care-cost-transparency-board

Washington State Health Care Authority

Advisory Committee of Health Care Providers and Carriers

Name	Title	Place of Business
Patricia Auerbach	Market Chief Medical Officer	United Healthcare
Mark Barnhart	Chief Executive Officer	Proliance Surgeons, Inc., P.S.
Bob Crittenden	Physician and Consultant	Empire Health Foundation
Bill Ely	Vice President of Actuarial Services	Kaiser Permanente
Paul Fishman	Professor, Dept. of Health Services	University of Washington
Jodi Joyce	Chief Executive Officer	Unity Care NW
Louise Kaplan	Associate Professor, Vancouver	WSU College of Nursing
Stacy Kessel	Chief Finance and Strategy Officer	Community Health Plan of Washington
Ross Laursen	Vice President of Healthcare Economics	Premera Blue Cross
Todd Lovshin	Vice President and WA State Executive	PacificSource Health Plans
Vicki Lowe	Executive Director	American Indian Health Commission
Mike Marsh	President and Chief Executive Officer	Overlake Hospital and Medical Center
Natalia Martinez-Kohler	Vice President of Finance and CFO	MultiCare Behavioral Health
Megan McIntyre	Pharmacy Director, Business Services	Virginia Mason
Byron Okutsu	AVP Network Management, Pacific NW	Cigna
Mika Sinanan	Surgeon and Medical Director	UW Medical Center
Dorothy Teeter	Consultant	Teeter Health Strategies
Wes Waters	Chief Financial Officer	Molina HealthCare of Washington

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Advisory Committee on Data Issues

Name	Title	Place of Business
Megan Atkinson	Chief Financial Officer	Health Care Authority
Amanda Avalos	Deputy, Enterprise Analytics, Research, and Reporting	Health Care Authority
Allison Bailey	Executive Director, Revenue Strategy and Analysis	MultiCare Health System
Jonathan Bennett	Vice President, Data Analytics, and IT Services	Washington State Hospital Association
Purav Bhatt	Regional VP Operations, Management, and Innovation	OptumCare Washington
Bruce Brazier	Administrative Services Director	Peninsula Community Health Services
Jason Brown	Budget Assistant	Office of Financial Management
Jerome Dugan	Assistant Professor, Department of Health Services	University of Washington
Leah Hole-Marshall	General Counsel and Chief Strategist	Health Benefit Exchange
Karen Johnson	Director, Performance Improvement, and Innovation	Washington Health Alliance
Scott Juergens	Division Director, Payer Analytics and Economics	Virginia Mason Franciscan Health
Lichiou Lee	Chief Actuary	Office of the Insurance Commissioner
Josh Liao	Medical Director of Payment Strategy	University of Washington
Dave Mancuso	Director, Research and Data Analysis Division	DSHS, Research and Data Analysis
Ana Morales	National Director, APM Program	United Healthcare
Thea Mounts	Senior Forecast Coordinator	Office of Financial Management
Hunter Plumer	Senior Consultant	HealthTrends
Mark Pregler	Director, Data Management and Analytics	Washington Health Alliance
Julie Sylvester	Senior Consultant, Contracting and Payer Relations	University of Washington Medicine

Introducing

Healthy Minds
Healthy Futures

BHAC, September 1, 2021

Agenda

- Overview Healthy Minds Healthy Futures
- Who we are and why we exist
- Parent Portal
- Understanding SB 5412: Family Care Act

We Believe

Healthy Minds and Healthy Futures Members Believe:

- Our state lacks a comprehensive family behavioral healthcare infrastructure to adequately care for our most vulnerable youth.
- A primary caregiver's right to make medically necessary decisions for their minor children must be recognized and supported by those assisting families in their education and healthcare treatment.
- Youth have the right to seek treatment without parental consent
- Family-centered/natural support systems are best practice for positive life outcomes.
- Parents/primary caregivers are a critical asset for recovery.
- Dependent children and young adults develop behavioral health decision-making capacity on a continuum; for some vulnerable children standard consequences and corrections do not deter impulsivity
- We need more trauma-informed residential centers located in nature and in community, instead of more juvenile jail cells.
- No parent should have to relinquish their parental rights for their child to receive adequate behavioral health care.

Problems that are detrimental to our children's survival odds and long term health

- System policies prevent families from accessing behavioral healthcare
- Developmental age is not considered in age-of-consent practices
- The FYSPRTs are not functioning
- No clarity for parents on how to navigate the complex child-serving systems (child welfare, health care, disability, juvenile justice, education)
- Legislators do not understand the chronic nature of the behavioral health and educational needs of our children (8-12), youth (13-17) and young adults (18-25).
- There is no safety net!

We are allied with by not fully represented by:

- NAMI
- ARC
- League of Education Voters
- PAVE
- SEL for WA
- Black Lives Matter
- No Youth Jail
- WAAA
- Equity in Education Alliance
- Special Education PTAs
- FYSPRTs
- Birth-5
- Partners for our Children
- CCYJ

What is Behavioral Health?

What is Behavioral Health?

Adults Recover from

BH = Mental Illness + Substance Use Disorder
(including process disorder)

Ages 25+

Say “yes” to recovery!

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Say “yes” to recovery!

- Children, Adolescents & Young Adults develop in stages
  - 0-5 safety pt/ot
  - 5-12 family skills SEL

  - 13-17 guidance DBT
  - 18-25 independence parent skills

What is Behavioral Health?

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Ages 25+

Say "yes" to recovery!

- Children, Adolescents & Young Adults develop in stages
  - 0-5 safety pt/ot
  - 5-12 family skills SEL

  - 13-17 guidance DBT
  - 18-25 independence parent skills

Neuro-atypical developmental challenges:

- Sensory processing disorder/Interoception
- Anosognosia
- Attachment disorders
- Emotional regulation
- Language processing
- Executive function delays
- Trauma

Services:
Schools (FAPE/IEP), NGOs, PCP, DD, JR, ARY, FIT, CHINS, PT/OT, Children's Clinics, BHRD, DCYF et al.

Who falls through the cracks?

Developmental capacity for information sharing & consent

Developmental Criterial for Consent

Behavior:

- Behavioral intervention required in school including repeated episodes of school refusal/truancy
- Eloping incidents
- Illegal substance use of any kind (including tobacco)
- Perpetrates physical violence in the home or community
- Preadolescent (9-14) anti-social behavior including oppositional behavior, aggression, theft, physical fighting, fire setting, bullying and vandalism
- Indications of serious mental health condition onset, ex. dramatic drop in school performance
- Prior history of hospitalizations or juvenile justice involvement
- More than one law enforcement intervention
- Prior suicide attempts, repeated self-harm
- Behaviors that contribute to unintentional injuries and violence
- Sexual behaviors related to unintended pregnancy and sexually transmitted infections, including HIV infection and involvement in CSEC outside the home

Diagnoses or Life Events:

- RAD
- FASD or suspected fetal trauma
- Life trauma
- Foster care placement and adoption
- Family homelessness
- Early episode psychosis
- ODD, DMDD, Conduct Disorder
- Autism
- Minor does **not** meet Washington's "Mature Minor Standard" as defined by meeting one or more of these criteria:
    - The youth is living apart from their parents or guardians and is managing their own affairs
    - The youth is able to provide reliable information and make important decisions with good insight and judgment
    - The youth is financially independent from parents or guardians or is involved in a work-training program
    - The youth has sufficient training and experience to make knowing and intelligent healthcare decisions
    - The youth demonstrates the general conduct of an adult

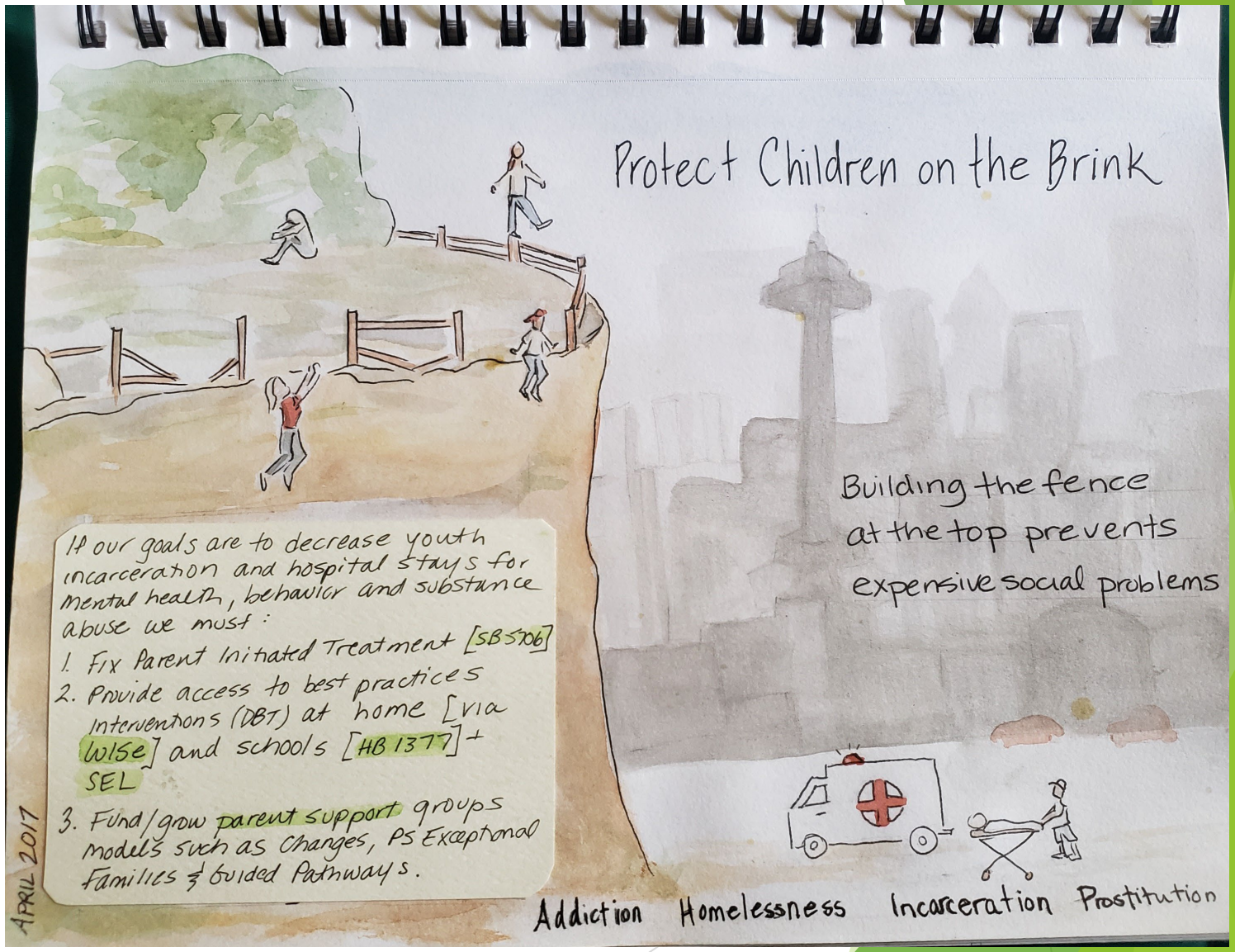
Caveats

- There is no prohibition that an adolescent seeking care must have parent consent. This only pertains to Family Initiated Treatment.
- Not required when the parent refuses involvement, there are clear clinical indications to the contrary exist and are documented in the treatment record, there is identified sexual abuse in home.
- The minor has been emancipated from the parent for at least 90 days

HMHF Priorities

BH Infrastructure

Creating a vision for preventative care



2021 Priorities

Parent Portal

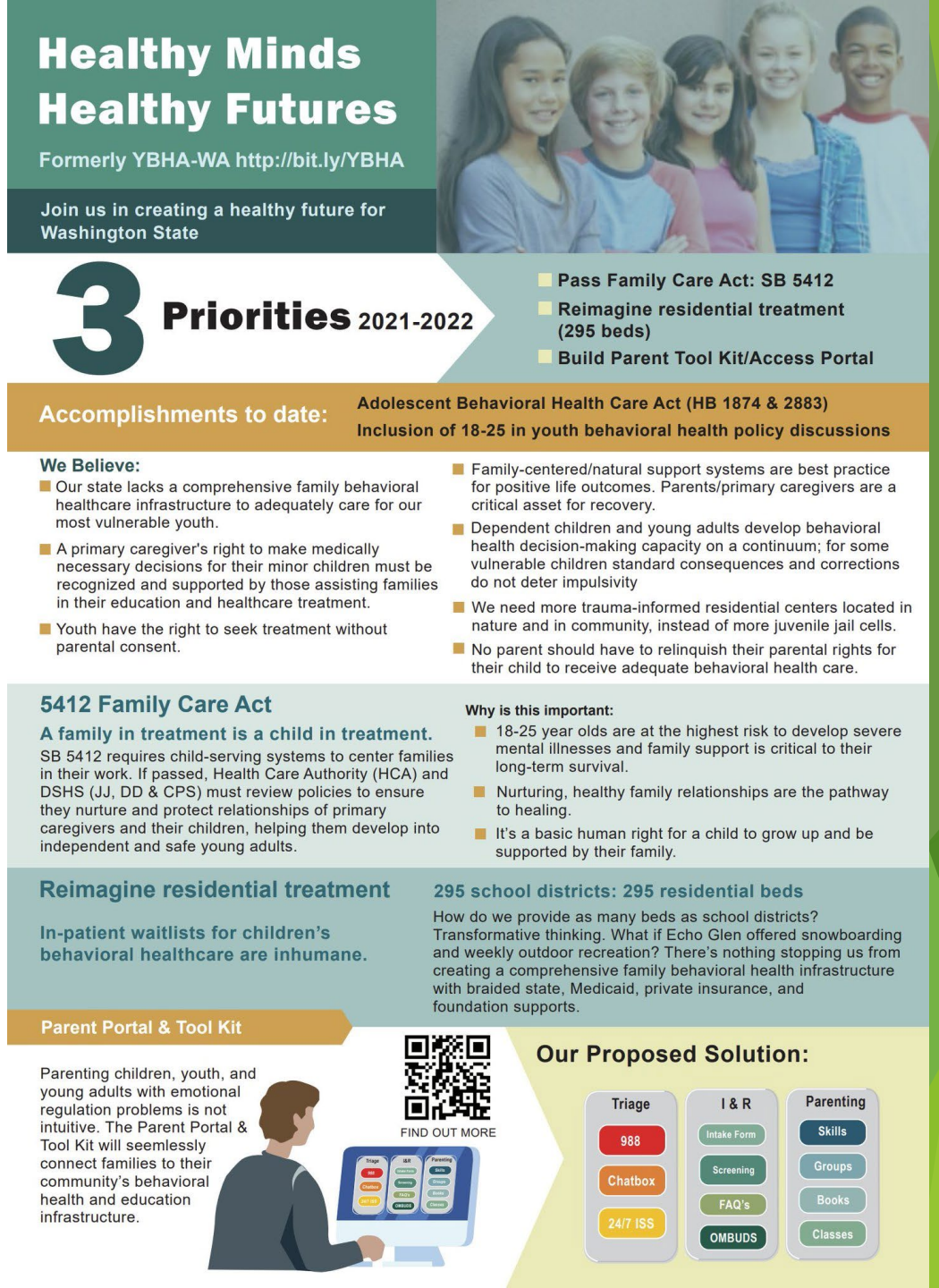
SB 5412 Family Care Act

295 Residential Beds

Hold System accountable

- 1874/2883: beyond 30 days, DCR role
- Capacity for mature consent
- Information Sharing

(Support)



Parent Portal & Tool Kit

Washington State Mental Health Summit
Delayed: ~~October 28, 9-4:30~~
Husky Union Building

(registration is not yet open)

Ideal Future State: access & infrastructure

Parent Portal provides on time resource and information access

Family centered care

Safe transition to adult independence

No youth jail (evaluation & placement)

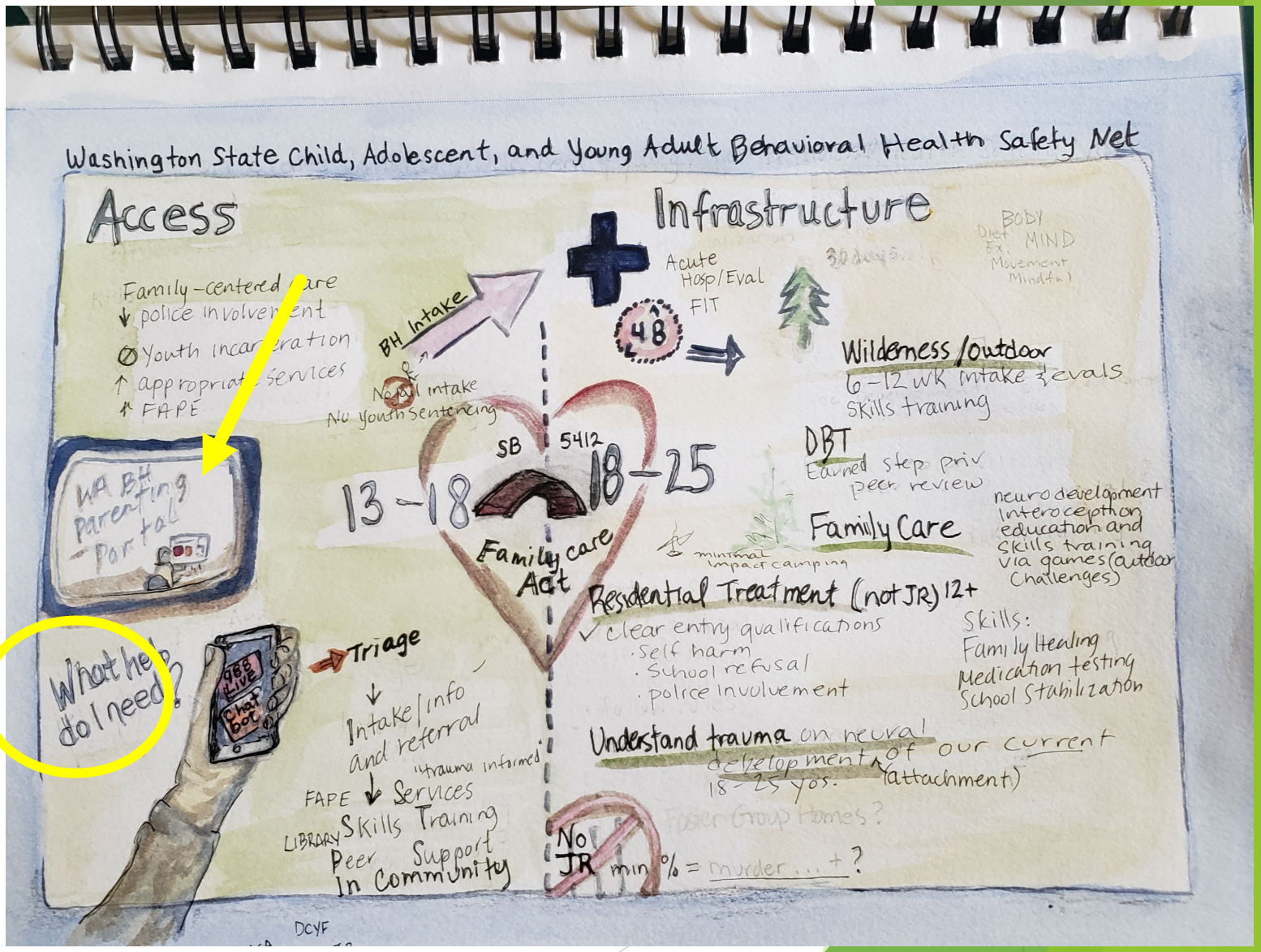
Behavioral health evaluation includes educational evaluation (FAPE)

Wilderness therapy not hospital beds

Trauma, DBT & Attachment training

Robust WISe, i/o & partial hospitalization options

295 beds



Overview

Parent Portal & Tool Kit

Parenting children, youth, and young adults with emotional regulation problems is not intuitive. The Parent Portal & Tool Kit will seemlessly connect families to their community's behavioral health and education infrastructure.

Our Proposed Solution:

Triage	I & R	Parenting
988	Intake Form	Skills
Chatbox	Screening	Groups
24/7 ISS	FAQ's	Books
	OMBUDS	Classes

Next step: recruiting partners now

5412: Family Care Act

SB 5412: Family Care Act

- 5412 requires the Health Care Authority (HCA) and Department of Social and Health Services to develop policies that protect significant relationships in the lives of children, youth and young adults.
- *Prime sponsor: Senator Warnick: 2nd substitute coming out in fall*

- We hope SB 5412 will
  - allow vulnerable people an advocate who knows them well, including their medical history, and can help with unexpected side effects
  - strengthen family bonds so that the person in crisis has long term support
  - shift to whole family assessments when a child is evaluated and provide referrals other family members impacted by the situation

Pass SB 5412 in 2022

- Young people who are experiencing behavioral health emergencies are vulnerable. When we excluding families within our child-serving systems, we are undermine their natural supports.
- Allowing people who love them to be part of their care team just makes sense. The Family Care Act moves our child-serving systems towards centering families in the work.

"A family in treatment is a child in treatment." Penny Quist

SB 5412 brings family support to young people in crisis

Mark is 22 years old. As a teen he developed a substance abuse problem. His mom, Anette, has done all the right things – sought help from experts, got him into a great substance abuse program, got him set up with supports. He was in college and doing well until the pandemic hit.

The isolation and stress of the pandemic caused Mark to relapse. He had a psychotic episode and crashed his car. He was taken to the hospital. But because he is over 18, his mom had no rights for getting information or advocating for him. She didn't even know where he was. All she knew was that he hadn't come home.

Mark wasn't able to advocate for himself in the hospital and was released to a homeless shelter with a plan to go to a drug rehab program sometime in the future. Unsurprisingly, he promptly relapsed with drugs and did not make it to that program.

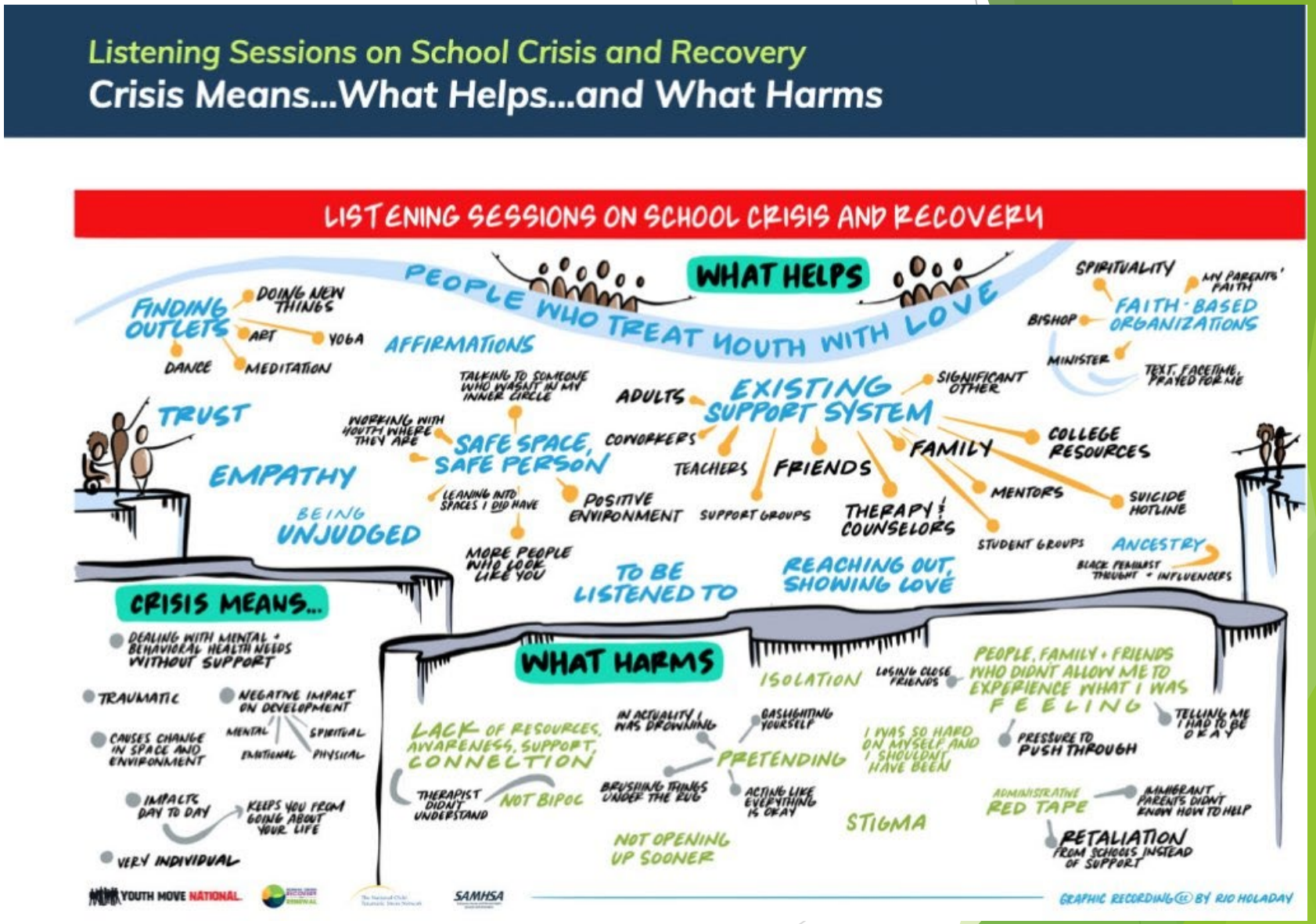
Nobody knows more about Mark and his needs, or cares about him more than his mom. Had Annette been involved in the planning and decision making when he was in the hospital, she could have advocated for a stronger treatment plan.

How do we create united policies with so many oversight bodies and workgroups?

- Children & Youth Behavioral Health Work Group (joint legislative)
- Behavioral Health Advisory Board
- DCYF Oversight Board
- FYSPRTS
- ACHs
- Public Health Committees including Gov's Interagency Council on Health Disparities
- Regional ASOs, BHRDs and advisory groups and councils
- Children, Youth and Families Oversight Board
- Gov's Commerce Department Office of Youth Homeless Committee
- Youth Move/Cities Rise
- DCYF Behavioral Health and JR re-entry, Juvenile Justice Partnership,
- Governor's Committee on Disability Issues & Employment (GCDE), Developmental Disabilities Council, Family Medicine,
- State board of education committees including early learning, special education advisory boards, school safety, etc.
- Governor's workgroups on Poverty Reduction, Police use of force, improvement in state hospitals
- Local school boards, individual school principals

Healthy Minds Healthy Futures

Youth Move


Listening Sessions on School Crisis and Recovery
Crisis Means...What Helps...and What Harms
LISTENING SESSIONS ON SCHOOL CRISIS AND RECOVERY
WHAT HELPS
PEOPLE WHO TREAT YOUTH WITH LOVE
FINDING OUTLETS
DOING NEW THINGS
ART
YOGA
DANCE
MEDITATION
AFFIRMATIONS
SPIRITUALITY
MY PARENTS' FAITH
FAITH-BASED ORGANIZATIONS
BISHOP
MINISTER
TEXT, FACETIME, PRAYED FOR ME
TRUST
EMPATHY
BEING UNJUDGED
TALKING TO SOMEONE WHO WASN'T IN MY INNER CIRCLE
WORKING WITH YOUTH WHERE THEY ARE
SAFE SPACE, SAFE PERSON
LEANING INTO SPACES I DID HAVE
MORE PEOPLE WHO LOOK LIKE YOU
POSITIVE ENVIRONMENT
ADULTS
EXISTING SUPPORT SYSTEM
SIGNIFICANT OTHER
COWORKERS
TEACHERS
SUPPORT GROUPS
FRIENDS
FAMILY
COLLEGE RESOURCES
THERAPY & COUNSELORS
MENTORS
SUICIDE HOTLINE
STUDENT GROUPS
ANCESTRY
BLACK FEMINIST THOUGHT + INFLUENCERS
TO BE LISTENED TO
REACHING OUT, SHOWING LOVE
CRISIS MEANS...
DEALING WITH MENTAL + BEHAVIORAL HEALTH NEEDS WITHOUT SUPPORT
TRAUMATIC
NEGATIVE IMPACT ON DEVELOPMENT
MENTAL
SPIRITUAL
EMOTIONAL
PHYSICAL
CAUSES CHANGE IN SPACE AND ENVIRONMENT
IMPACTS DAY TO DAY
KEEPS YOU FROM GOING ABOUT YOUR LIFE
VERY INDIVIDUAL
WHAT HARMS
ISOLATION
LOSING CLOSE FRIENDS
PEOPLE, FAMILY + FRIENDS WHO DIDN'T ALLOW ME TO EXPERIENCE WHAT I WAS FEELING
TELLING ME I HAD TO BE OKAY
LACK OF RESOURCES, AWARENESS, SUPPORT, CONNECTION
IN ACTUALITY I WAS DROWNING
GASLIGHTING YOURSELF
PRETENDING
I WAS SO HARD ON MYSELF AND I SHOULDN'T HAVE BEEN
PRESSURE TO PUSH THROUGH
THERAPIST DIDN'T UNDERSTAND
NOT BIPOC
BRUSHING THINGS UNDER THE RUG
ACTING LIKE EVERYTHING IS OKAY
STIGMA
ADMINISTRATIVE RED TAPE
IMMIGRANT PARENTS DIDN'T KNOW HOW TO HELP
NOT OPENING UP SOONER
RETALIATION FROM SCHOOLS INSTEAD OF SUPPORT
YOUTH MOVE NATIONAL
SAMHSA
GRAPHIC RECORDING BY RIO HOLADAY

Sample WISe Service Array Menu

Identify family goals	Supports
Better school attendance and achievement	• Increased recreation excursions & opportunities for AJ • Request IEP evaluation • Develop graduation plan • Ensure appropriate social media/internet usage balance with school
Reduce concerning behaviors at home	• Collaborative problem solving techniques • Agreed upon rewards/consequences • Family skills training (DBT, co-dependency, boundaries, polyvagal system response, • AJ establish personal safety goals • Family group skills practice • Peer supports in establishing family routine during stress points (ex. Dinner time, weekends, bed)
Create safe environment for AJ's Sisters	• Carve out 1:1 time for younger sisters • Identify sibs-support group opportunities
Mom time for self-care & nurture relationship with husband	?
Eliminate ARY (AJ's goal) Eliminate false CPS complaints (Mom's goal)	Hearing March xx Identify steps towards showing adults confidence ARY is not needed
Improve mother/daughter relationship	Weekly family therapy sessions
Assess medication & ensure compliance	?
Eliminate suicide attempts	Create a better safety plan that does not involve ER visits
Family plan for when AJ is in a psychotic episode	Safety plan beyond calling 911
Address truth telling and reporting consequences (esp. CPS)	Identify consequence for AJ when she doesn't tell the truth
Electronics usage disagreements	Need family electronics use agreement
AJ doesn't practice self-care	Provide functional daily living support
Struggling in school when in active psychosis, not on time for graduation	Create graduation plan and secure special education supports and accommodations
Not taking medication consistently (in the past)	Establish 6 week base line of medication maintenance and determine if it's the appropriate medication
Substance use	SUD assessment and services if appropriate

Parent Portal Next Steps

Convene Curriculum Development Guidance Council/Project Leadership	Include parent stakeholders representing a wide range of families Identify community partners (MCOs, UW, Foundations, IT experts, etc.)	ASAP
Identify existing culturally-appropriate, evidence-based programs and secure funding for parent participation	Ex: Parenting Wisely, Sanity School (Impact Parents), & FLIP-IT) Funders: MCOs, foundations	ongoing
Identify and develop additional parenting materials & tool kit components **Build wireframe and identify source links**	Website should have automated question & referral program with live chat triage option staffed by 211 & 911/988 24/7 Tool kit menu to include: • Links to existing support groups • How to access behavioral health services • How to get help when you aren't being served • How to fight against punitive approaches to addressing, but not treating, a child's inappropriate behavior • How to identify and access advocacy resources • Teaching your child how to learn to backward chain desired behavior for themselves • Overview of treatment basics including neurodevelopmental psychology, Interoception, vagal nervous response, de-escalation, collaborative problem solving, DBT, etc.	Nov-Jun 2022
Build web portal		Jun-Oct 2022

Recovery Support Services Update 9/1/21

Division of Behavioral Health and Recovery

Washington State Health Care Authority

Hurricane of change

- Integration of BH and Managed Care
- Governor's plan to transition individuals from the state hospitals to local community inpatient needs
- Trueblood Settlement of Contempt
- Blake Bill
- 988 Bill
- Covid Stimulus Funds (CRSSA & ARPA)

Recovery Support Services Activities – September 2021

SAMHSA Definition of Recovery

- A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
  - Health –overcoming or managing one's disease or symptoms and making healthy choices
  - Home –a stable and safe place to live
  - Purpose –meaningful daily activities (independence, income, resources)
  - Community –relationships and social networks (friendship, love, and hope)

DBHR is creating a continuum of Recovery Support Services that addresses

- Health
  - Social Determinants of Health – Housing, Employment, Income, Nutrition, Transportation
  - Foundational Community Supports
- Home
  - PATH/F-PATH
  - Peer Pathfinders
  - HARPS/F-HARPS
  - Foundational Community Supports
  - Recovery Residences/ Oxford
  - Peer Bridgers
- Purpose
  - Peer Services
  - FCS - Supported Employment
  - Recovery Café/Clubhouse
  - Community Recovery Support services
- Community
  - Peer Services
  - Recovery Café/ Clubhouse
  - Peer Respite
  - Consumer/Peer Operated Services

What is unique about Certified Peer Counselors?

The Power is in Our Stories!
Self Disclosure = Hope & Inspiration

- Lived experiences create connections
- Actively promotes Principles of Recovery & Resiliency
- Work to reduce stigma in community and systems

WAC 182-538D-0200 BH Services Definitions

"Peer counselor" means a person recognized by Medicaid agency as a person who:

(a) Is a self-identified consumer of behavioral health services who:

(i) Has applied for, is eligible for, or has received behavioral health services; or

(ii) Is the parent or legal guardian of a person who has applied for, is eligible for, or has received behavioral health services;

(b) Is a counselor credentialed under chapter **18.19** RCW;

(c) Has completed specialized training provided by or contracted through the Medicaid agency. If the person was trained by trainers approved by the department of social and health services before October 1, 2004, and has met the requirements in (a), (b) and (d) of this subsection by January 31, 2005, the person is exempt from completing this specialized training;

(d) Has successfully passed an examination administered by the Medicaid agency or an authorized contractor; and

(e) Has received a written notification letter from the Medicaid agency stating that the Medicaid agency recognizes the person as a "peer counselor."

For Medicaid reimbursement of Peer Support Services:

- Agency Affiliated Counselor
- Agencies add Peer Support Services Certification to their DOH Community BH agency license

Washington State Health Care Authority

Peer Support Credentialing Process

- Complete the online prerequisite course and send a copy of the certification to HCA
- Complete the peer counseling application
  - (recently moved to online application – prior to December 2019 all applications were handwritten/submitted).
- Application contains self-declaration of lived experience and information about being in recovery for at least one year.
- Individual is then prioritized and added to the HCA-approved CPC training list.
  - HCA contracts with agencies to conduct the training – Trainers must be approved by HCA
- Take and pass the state oral and written exams.
  - Conducted by a separate organization from the trainers

Two ways to look at Peers:

- Peer Support Services:
  - are based on sharing the peer counselor's own life experiences related to their Behavioral Health that will build alliances that enhance the individual's ability to function in the community
  - Peer Services can be provided in a setting most convenient for the individual
  - May not be provided prior to an intake for Medicaid reimbursable services

- Certified Peer Counselors are also a 'provider type' that can provide:
  - Peer Services
  - Outreach and engagement
  - Individual tax Services
  - Day Support
  - Medication monitoring
  - Rehab Case Management
  - Therapeutic Psychoeducation
  - Care Coordination Services
  - Supportive Housing
  - Supported Employment
  - Recovery Cafes
  - And much more!!!

DBHR Peer Support Team

- Medicaid reimbursable service for individuals with MH diagnosis since 2005
- SUD Peer Support services became a Medicaid reimbursable service July 2019
- Robust credentialing program – certifying over 4700 CPCs since 2005
- Continuing education curriculums:
  - SH 4-part Continuing Education Curriculum
  - SE 5-part Continuing
  - Trauma informed approach online training curriculum
  - Intersection between BH and the legal system continuing education – In development
  - Outreach Academy – In development
  - Peers working in crisis settings – In development
- Support for agencies to operationalize peer support

Peer Bridger transition from state hospitals to local

Peer Bridger transition from SUD TX

Peer Bridger/Peer Pathfinder transition from jails

Operationaling Peer Bridger toolkit for Host Agencies

Fidelity

Results WA in partnership with JRA

Peer Services Activities

- Peer Dashboard
- Intentional Peer Support
- Advocacy Training
- Continuing Education Online training modules
- Peer Wellness Coaching
- CCAR continuing education for CPCs

Peer Emotional Support Program

Balmer Position

Strategic Planning

Contracting with an organization to increase BIPOC peers

Operationalizing Peer Support

Seed grants for agencies/Job Development for TX agencies

Crisis Services

Expand MCR

Peer Respite

Crisis peer Curriculum

TB Services

Phase 1

Phase 2

BH & the Law Peer Curriculum

Trauma Informed Training for Jails

Preparing for SH/SE benefits

- Preparing the workforce
  - Peers as a provider type
  - SH/SE continuing education curriculums
- Preparing agencies
  - Learning collaborative approach to fidelity
  - Seed grants
- Partnerships
- Providing tools & Resources
  - Pathways to Housing
  - Pathways to Employment
- Creating a network
  - Provider map

HCA Foundations
Homes | Jobs | Health

- Training, Training, Training
  - https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/news

Washington State Health Care Authority

Homeless Outreach

- Projects for Assistance in Transition from Homelessness (PATH)
- Forensic PATH
- Peer Pathfinders
- Homeless Outreach Stabilization Teams (HOST)

Housing Supports

- Housing & Recovery through Peer Services (HARPS) $ + Services
- Forensic Housing & Recovery through Peer Services (HARPS) $ + Services
- Foundational Community Supports $ + Services
- Recovery Residences
- Oxford Houses
- Community Recovery Supports (AKA ATR) $
- BHASO Rent Assistance $

Process Improvements

- BH Housing Action Plan
- Supportive housing institute
- D/C planner's toolkit
- Expanding FCS into IMDs
- Fidelity Incentives
- Seed grants for SUD agencies
- Housing resource estimator – Pathways to Housing
- Training catalog
- Implicit bias training for landlords
- Outreach and engagement training modules
- Mobile Devices
- Homeless Risk Adjustment
- Regional Recovery Plans

Purpose

- FCS Supported Employment Sustainability/Fidelity
- CWIC training and staffing costs for a provider to attend the training
- FCS - Converting core training to online modules
- FCS SH/SE 'fidelity reviewer certification'
- HWD Marketing, Education, Training & public dashboard
- Clubhouse Expansion
- Fidelity Incentives
- Seed grants for SUD agencies

Community

- Recovery grant enhancements
- White paper/Toolkits/Medicaid academy for peer run-peer operated agencies
- **Expand Peer-run/Peer-operated organization T/M site
- Expand Community recovery support services (ATR) Sites
- Recovery Advocacy Training
- Recovery Café Expansion
- Clubhouse Expansion

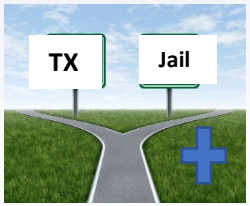
Elements of Trueblood Settlement

Transforming Lives

Intensive Case Management – Case Finding based on RDA HU List

3 Mobile Crisis Teams

Enhanced Crisis Stabilization



4 Housing & Recovery through Peer Services (HARPS)

Outpatient Competency Restoration + MH Outpatient Treatment

Increase competency evaluations by increasing number of evaluators

Court Ordered DSHS Navigators

Transition Maple Lane, Yakima Inpatient Competency Facilities

Increase inpatient competency restoration beds at WSH, ESH

Enhanced Peer Support Curriculum – Justice Involvement

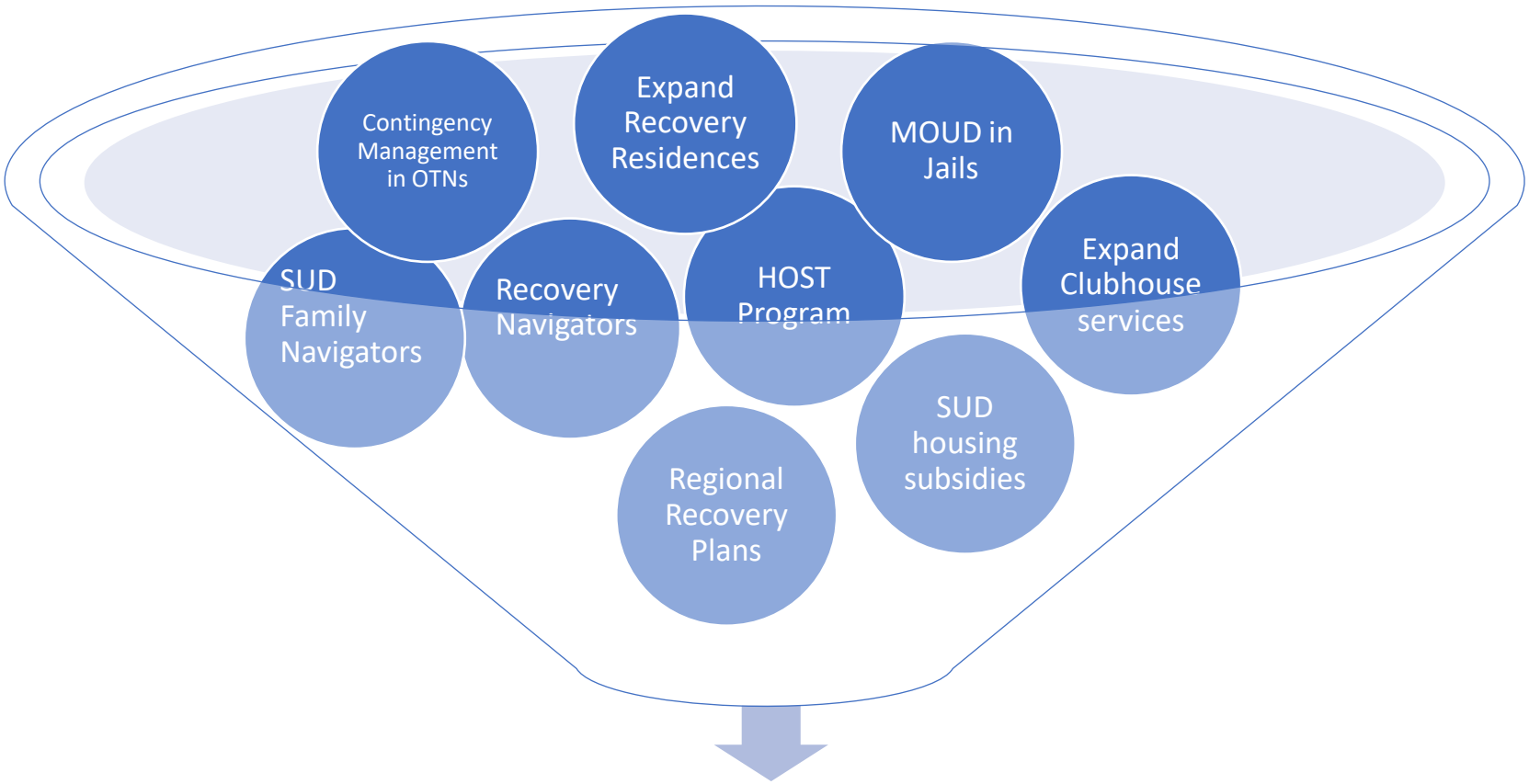
Behavioral Health Workforce Development

Co-Responder Program WASPC

Crisis Intervention Training

Washington State Department of Social & Health Services
Transforming lives

Washington State Health Care Authority



ESB5476 aka Blake Bill

Recovery Services Advisory Committee

Questions?

Washington State Health Care Authority