Children and Youth Behavioral Health Work Group – Behavioral Health Integration (BHI) Subgroup

July 23, 2024

Glossary of Terms

ABA: Applied Behavior Analysis
ASD: Autism Spectrum Disorder
BCBA: Board Certified Behavior Analyst
BH: Behavioral Health
BHSS: Behavioral Health Support Specialist
CDC: Centers for Disease Control and Prevention
CoCM: Collaborative Care Model
DCYF: Washington State Department of Children, Youth and Families
EMR: Electronic Medical Record
ESIT: Early Support for Infants & Toddlers
FRC: Family Resources Coordination
HCA: Health Care Authority
IBH: Integrated Behavioral Health
IDEA: Individuals with Disabilities Education Act
IDD: Intellectual and Developmental Disabilities
LCSW: Licensed Clinical Social Worker
LMHC: Licensed Mental Health Counselor
MA: Medical Assistants
MH: Mental Health
PCP: Primary Care Provider
RUBI: Research Units In Behavioral Intervention
SCCN: Seattle Children's Care Network
UW: University of Washington
WISe: Wraparound with Intensive Services
W&R: Workforce and Rates Subgroup

Meeting Topics

Research Units In Behavioral Intervention (RUBI) Project (0-5/DD), Dr. Karen Bearss (University of Washington (UW)) & Dr. T.K. Brasted (HopeCentral)
Lessons Learned on Integrated Behavioral Health Program Sustainability, Sophie King & Sheryl Morelli (Seattle Children's)
Early Support for Infants & Toddlers (ESIT) & Medicaid, Christine Cole (HCA) & Molly Stryker (WA State Department of Children, Youth and Families (DCYF))
Discussion of potential BHI workforce priorities, Subgroup leads

Discussion Summary

RUBI Project (0-5/DD)

Dr. Karen Bearss (UW) & Dr. T.K. Brasted (Hope Central)

See page 12 for slides

1. We are getting better at diagnosis autism spectrum disorder (ASD); however, there is limited access to evidence-based treatments such as Applied Behavior Analysis (ABA), since it is costly and time- and personnel-intensive, which creates barriers to wide-ranging dissemination.
    a. There is a need to expand the availability of treatments for autistic individuals that are empirically supported, time-limited, and cost-effective.
2. Parent Training:
    a. Parent training is traditionally a time-limited approach, with a very low dose of care that leads to parent empowerment and positive child behavior change.
    b. Why target parents of ASD and Intellectual and Developmental Disabilities (IDD) youth?
        i. About half of autistic and IDD youth engage in challenging behaviors.
        ii. There are adaptive skills deficits.
        iii. Challenging behaviors and lack of adaptive skills leads to high parent stress and accommodation to navigate daily life.
        iv. Parents want (good) parent training that helps them move forward towards family goals.
3. RUBI parent training program:
    a. RUBI is an established intervention specifically for parents of autistic and IDD youth that also have challenging behaviors and adaptive skills deficits.
        i. It is acknowledged in the California Evidence-Based Clearinghouse as a level 2 supported intervention.
            1. It is the only level 2 intervention for ASD that is acknowledged by the Centers for Disease Control and Prevention (CDC).
        ii. It is an evidence-based practice as denoted by the Health Care Authority (HCA) and has its own evidence-based practice code.
    b. RUBI is an 11-session program to teach parents skills across good behavior analytic strategies.
        i. RUBI helps families understand why behaviors are happening, how to prevent behaviors from happening and set up kids for success, as well as how to respond differently and teach new skills.
        ii. It works on challenging behaviors as well as working on building up adaptive skills.
    c. RUBI is delivered individually to each child's parents.
    d. The program materials include a clinician manual, as well as a parent workbook.
4. Prototypical RUBI Clinical Case:
    a. RUBI is typically appropriate for neurodiverse youth between 3-14 years old (though age is not the primary determinant) with mild to moderate challenging behaviors.
    b. The child must have an identified caregiver who can regularly attend sessions.
    c. RUBI works across the spectrum of presentation seen in autistic and IDD youth for cognitive functioning, language, and autism severity.
    d. Exclusion criteria include:
        i. Focal issues, such as pica, elopement or encopresis.
        ii. Behaviors resulting in hospitalization or tissue damage to self or others.

5. RUBI is based on foundational communication with families to help them understand their child's behaviors through the lens of ASD or IDD.
    a. When parents see challenging behaviors, it is likely rooted in communication vulnerability, sensory sensitivity, or a fine motor skill vulnerability, rather than defiant noncompliance.
6. RUBI Principles:
    a. RUBI is expert guided, family-centered, and focused on partnering (co-construction). promoting knowledge transfer, meaningful targets, new skills and behavior change.
7. The RUBI team is looking to expand into four main areas.
    a. Expanding the clinical populations that RUBI can work for:
        i. They are recruiting for a clinical trial with autistic adults (18 years or older) and their caregivers.
    b. Improving access:
        i. RUBI has been studied via telehealth, in a group format, via app-form, and has been found to work just as well through these different modalities.
    c. Expanding the context in which RUBI is delivered:
        i. The RUBI team is researching implementation in schools and the community.
            1. They have received funding from HCA to train Wraparound with Intensive Services (WISe) teams in RUBI, as well as funding from the MolinaCares Foundation to train behavioral health providers in primary care in RUBI.
            2. They have funding from the state of Maine to train 400 providers to allow access to RUBI across the state.
    d. Expanding Training:
        i. RUBI has a manual and workbook, as well as other training platforms and mechanisms for providers to easily learn RUBI.
8. Key Points:
    a. RUBI is a low-intensity, low-cost, evidence-based program designed to address pipeline access issues and allows for high clinical throughput compared to other interventions for ASD/IDD.
    b. RUBI is a structured and manualized intervention, focusing on understanding behaviors through the lens of ASD and IDD.
    c. RUBI is a billable service, benefiting from a long history of insurance billing for parent training.
    d. There is research to support flexible clinic implementation models, including group and individual, in-clinic, home, and telehealth.
    e. RUBI has been implemented by Mental Health (MH) providers of varied backgrounds & degrees, including Licensed Mental Health Counselors (LMHC), PhDs, Licensed Clinical Social Workers (LCSW), psychiatry, and Board-Certified Behavior Analysts (BCBA).
    f. RUBI is a training-friendly model, using in-clinic, webinars, and the RUBI Project ECHO.
9. HopeCentral
    a. HopeCentral is a small pediatric nonprofit primary care practice incorporating integrated Behavioral Health (BH) that opened in 2014.
        i. Within 3 months, 30% of their patient panel was comprised of kids diagnosed with ASD.

ii. In 2015, HopeCentral became an Autism Center of Excellence, offering diagnostic evaluation.

b. HopeCentral wanted greater competency in serving kids on the spectrum in the primary care and collaborative care model, within the scope of their service offering.
   i. They came across RUBI, which worked well within the collaborative care model due to its length (12-16 visits), mirroring the targeted length for collaborative care.
   ii. Additionally, it's manualized, which makes it easy to learn and scale.
      1. As HopeCentral got new clinicians, it was easy to train them up to deliver the intervention competently.
   iii. Though RUBI was developed for kids on the spectrum, HopeCentral has been able to broaden the service offering to include kids without an ASD diagnosis.

10. Next steps:
   a. RUBI would like to continue the expansion of provider training in Washington state.
      i. Maine:
         1. The model in Maine with funding for section 28 services includes a level 1 training ("RUBI 101") and then a level 2 training for formalized certification.
            a. Some of these-RUBI-trained and certified providers have been high school graduates who do not necessarily have a bachelor's degree.
         2. There is also a Pilot Site project, performing center-based training across 24 sites.
      ii. Washington:
         1. In Washington, there is a formal clinic at Seattle Children's, 12 WISe teams across the state, and over 100 providers across 20 practices who have been exposed to the "101" model of training through the MolinaCares Foundation effort.
            a. At UW, the applied child analysis in psychology master's program practicum students are learning RUBI through the Seattle Children's center.
            b. For the WISe teams, it is not always the clinician that has been the implementor of RUBI, it can also be the parent, peer, parent partner, or care coordinator, depending on interest and relationships.
         2. Excelsior has trained their WISe teams, and View has trained their team in the RUBI model, which provides examples of the various ways to train.
   b. Explore new models of implementation for RUBI:
      i. RUBI would like to explore the pathway where primary care providers (PCPs) identify development delays and then hands off to a behavioral health support specialist (BHSS) or other provider, prior to a diagnosis.
         1. This is billed as behavioral disorders, rather than autism, if RUBI is provided prior to diagnosis.

Lessons Learned on Integrated Behavioral Health (IBH) Program Sustainability

Sophie King & Sheryl Morelli (Seattle Children's)
See page 34 for slides

1. As Seattle Children's has set up IBH programs, they have learned some best practices to make them sustainable.
    a. They have split them into five main buckets: Define, engage, identify, measure, monitor.
2. Seattle Children's Care Network (SCCN) IBH Program Review:
    a. Goals of the SCCN IBH Program were to:
        i. Improve the health of children and adolescents by providing mental and behavioral health training and education for providers and implementing evidence-based universal screening and appropriate behavioral health services within primary care settings.
        ii. Reduce emergency department and inpatient utilization and increase capacity within the system.
    b. 12 clinics participated in the learning collaborative and the program included the following:
        i. Training and education.
        ii. Implementation support and ongoing project management support.
        iii. Data and technology systems support.
        iv. Access to pediatric mental health professionals.
        v. Coaching about financial sustainability.
        vi. Funding program "upstart" costs.
        vii. MOC and CME opportunities.
3. 1st Lesson Learned: Define – it is important to clearly outline your IBH program, including the following:
    a. Program goals.
    b. Roles and responsibilities:
        i. It is important to have written job descriptions and an understanding of how the IBH program interacts with the other clinic roles, such as front desk scheduling, medical assistants (MAs), and PCPs.
        ii. Having a "champion" in a variety of roles can increase buy-in.
    c. Processes and workflow:
        i. Having written standard workflows and processes allows you to identify when there is drift and how to get back on track.
    d. IBH Core Team:
        i. It is important to have regular touch points to review program operations and goal progress.
    e. Caseload size:
        i. It is important to define goals for how many patients are on the caseload and how many you are billing per month, as well as a plan to increase caseload size.
        ii. You can work backward from billing to set up a template for clinicians' time, including clinical time, supervision, clinic meetings, and consultation calls.
    f. Visit structure:
        i. How long are visits? How often are patients seen? How long is an episode of care? How do warm handoffs work?

ii. Scheduling visits can be an ongoing issue for some clinics, so it is helpful to think about ways to allow for flexibility and more appointments, such as working 4-10s, or scheduling clinic and IBH meetings and consultations for the morning and appointments for the afternoon and evening.
iii. There is tradeoff between appointment length and adequate care for patients and families – if there is the possibility of flexibility in appointment lengths, this can be helpful.
1. You need to consider environment (rural, collaborative care, etc.), as well as billing codes and rates, availability of support staff, and other factors.

4. 2nd Lesson Learned: Engage – Ensure the IBH program is visible and understood by the clinic and patients/families, by doing the following:
    a. Provide program and role-specific training.
        i. Make sure it is clear what the IBH program is and isn't.
        ii. Everyone should know their role, how their work impacts IBH, and how their work supports the BH needs of the patients and families.
    b. Utilize the psychiatric consultant.
        i. SCCN has seen that when clinics utilize their psychiatric consultant there is more engagement across the board and providers feel more confident working with BH concerns.
    c. Offer continuous education opportunities.
    d. Share program updates, learnings, and successes.
        i. Keeping a feedback loop for everyone involved influences overall sustainability.
    e. Create communication plan for patients/families.
        i. How does everyone in the clinic know about the program, and how do patients and families learn about the program? Think about how communication between clinics and patients/families will occur (i.e., through the patient portal).
5. 3rd Lesson Learned: Identify – Define the target population and standardize the referral process for the IBH Program.
    a. Early identification through universal screening.
        i. It is important to determine how patients will be identified and what screening tools are being used, as well as ensuring they qualify for reimbursement, overlap with quality measures, and to tie everything into the standard processes for billing screenings.
    b. Clear inclusion and exclusion criteria.
        i. It is helpful to start small and then add more populations as capacity allows.
        ii. It is important to consider subclinical symptom presentations that can be included, as well as defining what is appropriate for the program and what should be referred out.
    c. Triage process.
        i. Who is completing the initial assessment and is feedback given to the referrer?
        ii. Explore capabilities in the EMR for tasks, patient lists, registries, reports, and other tools that can support the triage process.
    d. Closed-loop referrals.

i. This includes having a standardized plan for how patients are referred to your program (and having this in the electronic medical record (EMR)), along with a standardized workflow for patients who are referred to specialty care.

6. 4th Lesson Learned: Measure – Evaluate the IBH Program and the patient population.
    a. Identify metrics.
        i. How will you measure if your program is meeting its goals and what does success look like?
    b. Develop processes for data collection.
        i. What can be entered into the EMR?
    c. Create standard, easily reproducible reports.
        i. Review these reports with the IBH Core Team and other potential teams with regular cadence.
        ii. Reports should include metrics that program leaders and external partners are interested in.
            1. This could include metrics such as number of patients screened, number of patients referred, percentage of patients seen/not seen in IBH, reasons why someone didn't engage with treatment, wait times between referral and intake visit, number of patients seen and what percentage of your panel is represented in IBH, ages of kids seen in IBH, data on satisfaction of care, ED/inpatient utilization, and more.
7. 5th Lesson Learned: Monitor – Pay close attention to the IBH program.
    a. Dedicate time to oversee program.
        i. For the program to be sustainable, it needs to be monitored closely.
    b. Review billing and schedule utilization.
        i. A recommendation from one of SCCN's practices was to have a multidisciplinary IBH billing team, including the PCP champion, biller, clinic manager, and therapist, that meets monthly to review the prior month's billing and overall trends and financial goals.
            1. Getting ahead of any billing problems early can help identify the root cause and direct efforts into follow-up to solve the problem sooner.
        ii. In collaborative care, are there systems of checks and balances between billing and clinicians?
        iii. For scheduling utilization, are there processes to reduce no-shows and late cancellations?
            1. Pay attention to how many appointments actually end up being full after reschedules and cancellations.
    c. Evaluate if the program is meeting financial goals.

Early Support for Infants & Toddlers (ESIT) & Medicaid

Christine Cole (HCA) & Molly Stryker (DCYF)
See page 49 for slides

1. Program mission:
    a. The purpose of the Early Support for Infants and Toddlers (ESIT) Program is to build upon family strengths by providing coordination, supports, resources, and services to enhance

the development of children with developmental delays and disabilities through everyday learning opportunities.

2. ESIT falls under Part C of the Individuals with Disabilities Education Act (IDEA) and focuses on the birth to three age group.
    a. Part C was founded as Part H in the 1980s, and then transitioned to Part C in the 1990s, where there was a natural environment collaborative teaming approach to services.
    b. In Washington, DCYF is the lead agency under which ESIT sits, and then ESIT has provider agencies within the program.
        i. DCYF helps support providers in their implementation of ESIT and any technical assistance and training they need to be effective in serving families.
        ii. One of the requirements of the program is that agencies are required to schedule and hold evaluations for kids and families within 45 days of referral, and services are required to begin within 30 days of that time.
3. The purpose of Part C of IDEA is to:
    a. Enhance the development of infants and toddlers with disabilities.
    b. Minimize the potential for developmental delay.
    c. Reduce future educational costs.
    d. Enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities.
4. Eligibility: Standardized Evaluation
    a. The program is federally required to have standardized eligibility assessments and full developmental evaluations for kids and families who enter the programs.
        i. A child must have a 25% delay or 1.5 standard deviation below age expectation in one or more of the developmental areas.
    b. Assessments take place within individual agencies, depending on where the family is situated in the state, and are completed by a multidisciplinary team of providers.
        i. Parents can self-refer to the program, so PCPs can connect families on their own by sending referrals to their local referral agency.
        ii. Help Me Grow also does screening and helps connect families to ESIT, and HopeSparks has partnered with ESIT and may provide opportunities for strengthened coordination and partnership with PCPs.
5. Eligibility: Qualifying Diagnosis
    a. In addition to the standardized evaluations, kids who are diagnosed with a condition with a high probability of resulting in a developmental delay or who are actively showing developmental delay across areas, are eligible for services.
    b. List of qualifying diagnoses for ESIT.
6. Eligibility: Informed Clinical Opinion
    a. Children who don't necessarily meet the qualifying standard on the assessments can be referred based on clinical opinion, if the clinician believes the family would greatly benefit from services.
7. Children served:
    a. At any point in time during fiscal year (FY) 2021,11,344 infants, toddlers and families were being served.
        i. This is an increase of 2,652 families from the year prior.

   ii. The cumulative number of infants, toddlers, and families receiving services was 21,396, which represents a 1.12% increase.
- b. Roughly 39% of children exiting early intervention did not qualify for special education services based on eligibility criteria and parent choice.
- c. 95% of infants, toddlers, families received services in the natural environment, including home-based settings, childcare settings, virtual services, and support to places where kids have access, like the grocery store or the park.

8. Common ESIT Services:
   - a. Family Resources Coordination (FRC), which is required and provided at public expense, and acts as a coordinator between ESIT services, as well as external services.
      i. ESIT tries to collaborate highly across external services, such as RUBI, through the FRC and as a provider team, to support the learning from both programs within the ESIT space.
   - b. Early childhood special education, which is often provided by a master's level educated special educators who hold teaching credentials in Washington.
   - c. Occupational Therapy and Physical Therapy.
   - d. Speech/Language Therapy.
9. All of the ESIT services are family-driven, so the frequency in which families are seen, and which type of providers they see varies based on a family's needs.
   - a. Some families may have one provider that is their "go-to" with other providers acting in consultation roles.
   - b. The goal is that all of the providers are working to support the parent-child relationship and caregiver-child relationship and embedding their focus area within the routines and natural environment of the family.
      i. ESIT uses this collaborative space to target early communication, early motor and play skills, exploring environment, and other targets within the scope of practice.
      ii. All ESIT providers are capable of covering functional skills across domains and collaborate to find the provider(s) that are best fit for the family
      iii. The goal is to support specific need areas rather than specific providers.
10. Anticipated Impact of ESIT:
    - a. Infants and toddlers who receive early intervention services will:
       i. Demonstrate positive social emotional skills (including social relationships).
       ii. Acquire and use knowledge and skills including early language, communication, literacy.
       iii. Use appropriate behaviors to get needs met.
    - b. Families involved in early intervention will:
       i. Know their rights.
       ii. Effectively communicate their child's needs.
       iii. Help their child learn and develop.
11. ESIT Fast Fact Sheet (2021-2022)
12. ESIT is an example of cross system coordination opportunities and challenges.
    - a. ESIT has funding from federal IDEA, as well as state and also bills private insurance and Medicaid.
       i. Some things are not paid for by Medicaid, and some things are reimbursable by Medicaid.

ii. Policy comparative analysis report
iii. Presentation on comparative analysis report

Discussion of potential BHI workforce priorities

Subgroup leads

1. The BHI subgroup needs to submit workforce and rates issues to the Workforce & Rates (W&R) subgroup by July 31st.
    a. Subgroup members should provide input to help refine the issues they'd like to discuss with W&R.
2. Medicaid rates equalizing with Medicare.
    a. There was a broad-based survey of PCPs, Federally Qualified Health Centers (FQHCs), Mental Health Providers, and Community Mental Health Centers that was completed by 172 people.
        i. Results showed that Medicaid: Medicare parity for rates for MH counseling would make a big difference.
3. Supervision Issues:
    a. MH services are being provided in primary care – what supervision opportunities or deficits are there?
        i. This can be problematic when there isn't an affiliation with a behavioral health agency to supervise.
        ii. When there is an affiliation, the agencies don't get adequately paid, which contributes to burnout.
    b. In the medical field there is a tiered system for moving up professional pathways, but in MH, once you become a licensed MH professional, that is the top tier.
        i. People have no way to help their pay by moving up and don't receive professional development on how to become a supervisor, they just end up in these roles.
        ii. There is no incentive at the agency level to ensure that someone has the pay, support and skills to be a supervisor.
        iii. This leads to people leaving the field and continuing to cycle through.
    c. Whoever takes on supervision is taking on liability for their license.
        i. This is a big deal when not being reimbursed to do so.
        ii. There is increased liability and a decreased safety net for stand-in supervisors.
        iii. How can we have coordinated support and work through different payment models?
    d. How can we incentivize our most skilled workers to work in the most difficult settings and how do we build a workforce to ensure that everyone gets the right care in the right place at the right time?
    e. The workforce is so overburdened that they aren't participating in free training opportunities that are being offered and tailored to when people are available.
    f. Can reimbursement for case-specific supervision be included in Collaborative Care Model (CoCM) billing codes?

Look Ahead: 24/25 Schedule

BHI Schedule

[Insert BHI Meeting Cadence]

8/2 meeting: majority presentations + some discussion
8/13: (1) presentation + deep draft recommendation/prioritization discussion
8/27: draft recommendation/prioritization discussion
8/28 draft recommendations due!
9/5: presentation to the CYBHWG

Parent Training for Challenging Behaviors in Autism Spectrum Disorder:

The RUBI Parent Training Program

Karen Bearss, PhD
Seattle Children's Autism Center

Associate Professor, Department of Psychiatry and Behavioral Sciences
University of Washington

Good News, Bad News

- Good News:
  - Better at diagnosing autism
- Bad News:
  - Limited access to evidence-based treatments (ABA)
    - Costly, time- and personnel-intensive
      - Challenge to wide-ranging dissemination

There is a pressing need to expand
the availability of treatments
for autistic individuals that are:
empirically supported,
time-limited,
cost-effective

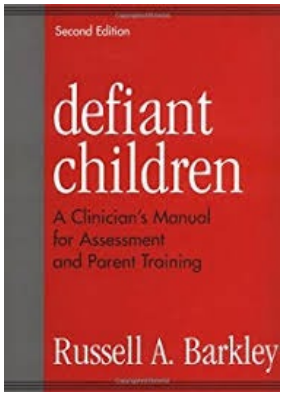
Parent Training

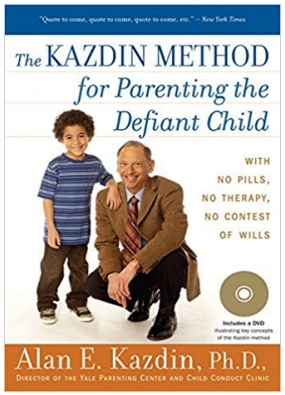
Traditionally a time-limited approach

- Few hours per week

Emphasizes role of parents as the agent of change

History as established EBT in child mental health





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UW Medicine SCHOOL OF MEDICINE

Why Target Parents of Autistic/IDD Youth?

- High rate of challenging behaviors (≈50%)
- Adaptive skills deficits
- High parent stress/accommodation
- Parents want (good) parent training

Original Investigation

Effect of Parent Training vs Parent Education on Behavioral Problems in Children With Autism Spectrum Disorder

A Randomized Clinical Trial

Karen Bearss, PhD; Cynthia Johnson, PhD; Tristram Smith, PhD; Luc Lecavalier, PhD; Naomi Swiezy, PhD; Michael Aman, PhD; David B. McAdam, PhD; Eric Butter, PhD; Charmaine Stillitano, MSW; Noha Minshawi, PhD; Denis G. Sukhodolsky, PhD; Daniel W. Mruzek, PhD; Kylan Turner, PhD; Tiffany Neal, PhD; Victoria Hallett, PhD; James A. Mulick, PhD; Bryson Green, MS; Benjamin Handen, PhD; Yanhong Deng, MPH; James Dziura, PhD; Lawrence Scahill, MSN, PhD

JAMA. 2015;313(15):1524-1533. doi:10.1001/jama.2015.3150

JAMA The Journal of the American Medical Association

CEBC

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RUBI Parent Training (RUBI-PT)

Topic Areas	Scientific Rating	Child Welfare Relevance
Developmental and Autism Spectrum Disorder Interventions (Child & Adolescent)	2 — Supported by Research Evidence	Medium

2023 REPORTING GUIDE

for Research and Evidence-based Practices in Children's Mental Health

Training Entity	Treatment Family	EBP Code	Page #	Training Information
Research Units in Behavioral Intervention (RUBI)	Parent Behavioral Therapy	148	15	https://www.rubinetwork.org/
Risk Reduction through	CBT for Trauma	224	30	

RUBI Parent Training Program

11 Core

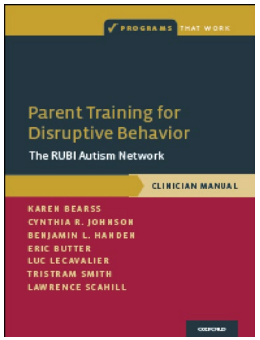
- Behavioral Principles (the ABC's)
- Prevention Strategies
- Daily Schedules
- Reinforcement 1 & 2
- Differential Attending
- Following Instructions
- Functional Communication Skills
- Teaching Skills 1 & 2
- Generalization & Maintenance

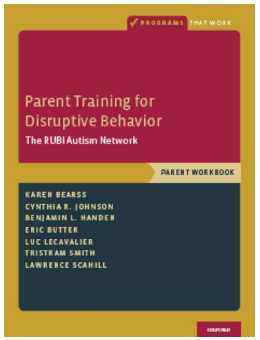
PLUS

- Home Visits
- Telephone Boosters

7 Supplemental

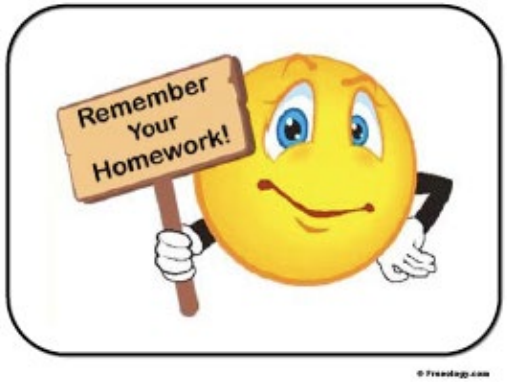
- Toileting
- Feeding
- Sleep
- Time Out
- Imitation
- Crisis Management
- Token Economies





RUBI Program

- Delivered individually to each child's parents
- Structure of Program Materials
  - Clinician Manual
    - Script, Fidelity Sheets
  - Parent Workbook
    - Activity Sheets, Video Vignettes
    - Summary Handout
    - Homework
      - Crafted in partnership between parent and clinician



RUBI in Practice

Prototypical RUBI Clinic Case

3-14* years old

- Mild to moderate challenging behaviors
  - meltdowns, aggression, transition difficulties, mild SIB, inappropriate language

This is all good…

- Identified caregiver who can regularly attend
- Broad range of autism severity and cognitive functioning
  - consider 12-18 month receptive language criteria

Exclusionary criteria

- Focal issues (e.g. pica, elopement, encopresis)
- Behaviors resulting in hospitalization or tissue damage (self or others)

Understanding Behaviors Through the Lens of Autism

- Autism presentation
  - Communication vulnerabilities (receptive/expressive)
  - Rigidities (can't vs won't)
  - Sensory sensitivities
  - Fine/gross motor skill vulnerabilities
  - Literal/linear thinking
  - Strengths in visual (vs. verbal) processing
  - Common co-occurring conditions: ADHD, anxiety
- With this in mind, and looking through the lens of autism, what are possible alternative explanations for "defiant", "noncompliant" and other challenging behaviors?

The Art of Treatment

Principles

- Expert guided
- Family-centered
- Partnering (co-construction)

Promotes

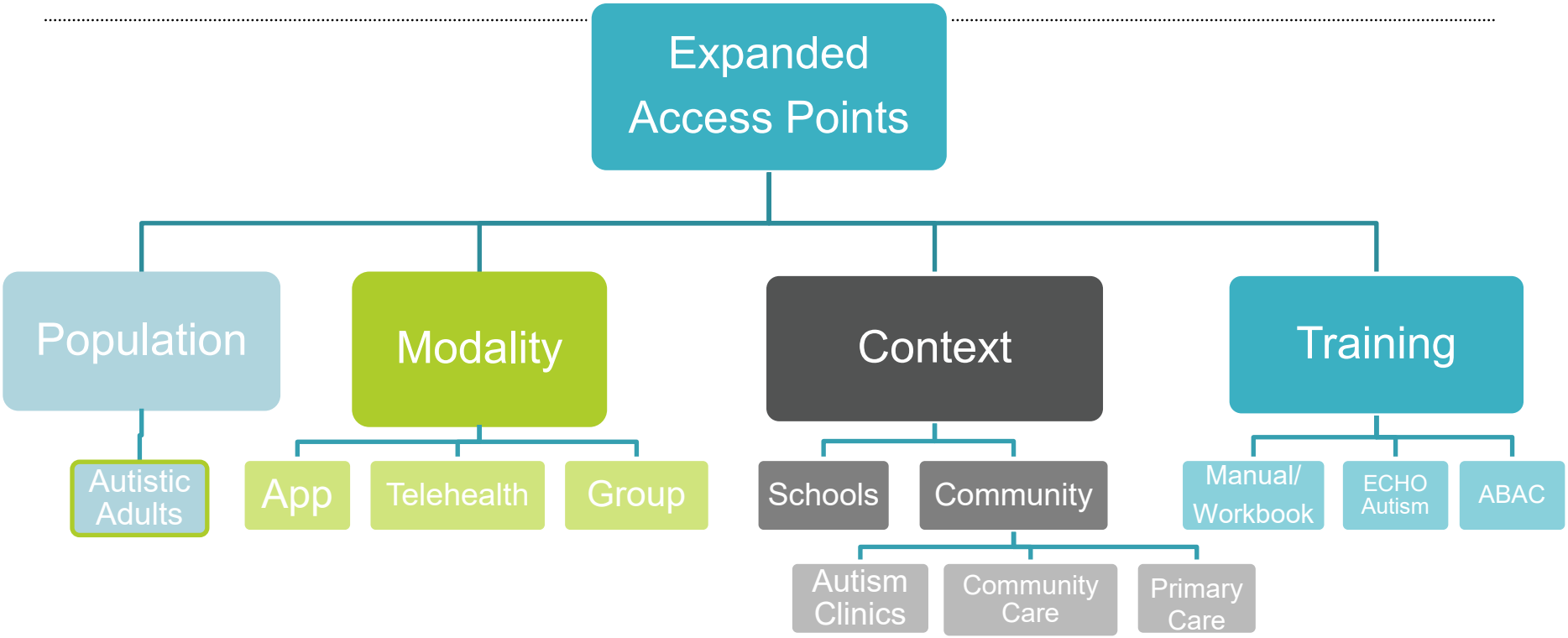
knowledge transfer

meaningful targets

new skills

behavior change

RUBI Dissemination/Implementation Targets



RUBI Dissemination/Implementation Targets

Clinical Populations

Caregivers/
Autistic Adults

RUBI Dissemination/Implementation Targets

Modality

Telehealth

Journal of Autism and Developmental Disorders (2018) 48:1020–1030
https://doi.org/10.1007/s10803-017-3363-2

S.I. : PARENTING CHILDREN WITH ASD

Feasibility of Parent Training via Telehealth for Children with Autism Spectrum Disorder and Disruptive Behavior: A Demonstration Pilot

Karen Bearss[1] · T. Lindsey Burrell[2,3] · Saankari A. Challa[5] · Valentina Postorino[2,3] · Scott E. Gillespie[2] · Courtney Crooks[4] · Lawrence Scahill[2,3]

Published online: 23 November 2017

Group

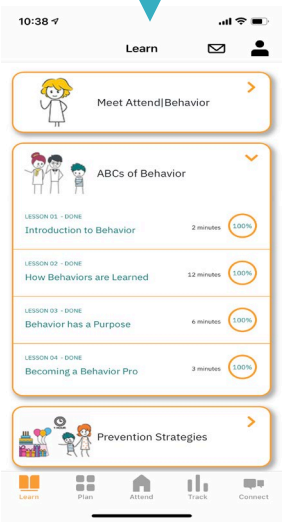
Original Paper | Published: 12 March 2020

Feasibility of Group Parent Training for Children with Autism Spectrum Disorder and Disruptive Behavior: A Demonstration Pilot

T. Lindsey Burrell, Valentina Postorino, Lawrence Scahill, Hannah M. Rea, Scott Gillespie, A. Nichole Evans & Karen Bearss

Journal of Autism and Developmental Disorders (2020) | Cite this article

App



Intervention or Psychoeducation?

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RUBI Dissemination/Implementation Targets

Context

Schools

Community

Clinics

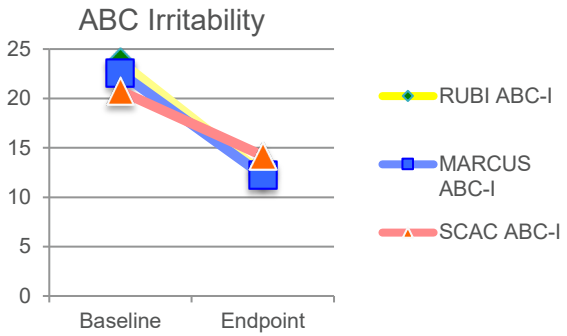
State Funded Care Systems

Primary Care

› Autism. 2022 Apr;26(3):666-677. doi: 10.1177/13623613211066644. Epub 2022 Jan 6.

Iterative redesign of a caregiver-mediated intervention for use in educational settings

Karen Bearss [1], Daina Tagavi [1], Aaron R Lyon [1], Jill Locke [1]



Department of Health and Human Services, Maine

MolinaCares
Building Stronger Communities...One Life at a Time

Washington State Health Care Authority

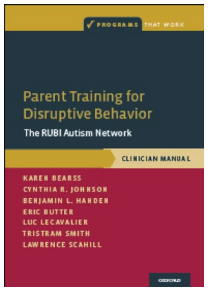
Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

UW Medicine
SCHOOL OF MEDICINE

RUBI Dissemination/Implementation Targets

Training

Manual/Workbook



ECHO Autism

Project ECHO®

ECHO Autism

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.

RUBI - ECHO RUBI is a free virtual l
help improve clinicians' comfort an
program (RUBI), shown to be effect

Provider Training

CATALIGHT FOUNDATION

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Key Points

- Low-intensity, low-cost, evidence-based program
  - Addresses pipeline access issues
  - High clinical throughput compared to other interventions for ASD/IDD
- Structured/manualized intervention
  - Focus on understanding behaviors through the lens of autism
- Billable service
  - Long history of insurance billing for parent training
    - Bill under presenting diagnosis (DBD-NOS)
    - Family with/without child: 90846, 90847
    - Multigroup family therapy: 90849
    - Adaptive behavior treatment guidance; ABA billing code 97156

Key Points

- Flexible clinic implementation models
  - Group vs. individual; in-clinic, home, telehealth
- Implementation by Mental Health Providers of Varied Backgrounds and Degrees
  - LMHC, PhD, LCSW, Psychiatry, BCBA
- Training-friendly model
  - In clinic (practicum students)
  - Webinars
  - RUBI Project ECHO

RUBI Training and Implementation in Practice

- Dr. T.K. Brasted
  - Psychologist
  - 2014-2023: Behavioral Health Director at Hope Central
  - Trained in RUBI as part of MolinaCares Foundation funding
  - Currently implements RUBI at Seattle Children's

Where to Go From Here?

- Continued expansion of provider training in WA State
  - Maine DHHS model for Section 28
    - Level 1 + Level 2
    - Pilot Site project
- Explore new models of implementation
  - PCP identifies developmental delays
    - Dispatch to trained BH Support specialists
      - Prior to diagnosis

Lessons Learned on Integrated Behavioral Health Program Sustainability

Sophie King, MHA, Behavioral Health Program Manager
Sheryl Morelli, MD, Chief Medical Officer
Seattle Children's Care Network

Children & Youth Behavioral Health Work Group
Behavioral Health Integration Subgroup Meeting
July 23, 2024

Seattle Children's Care Network

Learning Objective

At the end of this presentation, participants will be able to identify effective strategies for implementing a sustainable Integrated Behavioral Health (IBH) program.

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Five Lessons Learned

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Seattle Children's Care Network (SCCN) IBH Program Review

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SCCN IBH Program Goals

- Improve the health of children and adolescents by providing mental and behavioral health **training and education** for providers and implementing evidence-based **universal screening** and appropriate behavioral health **services** within primary care settings.
- Reduce emergency department and inpatient utilization and **increase capacity** within the system.

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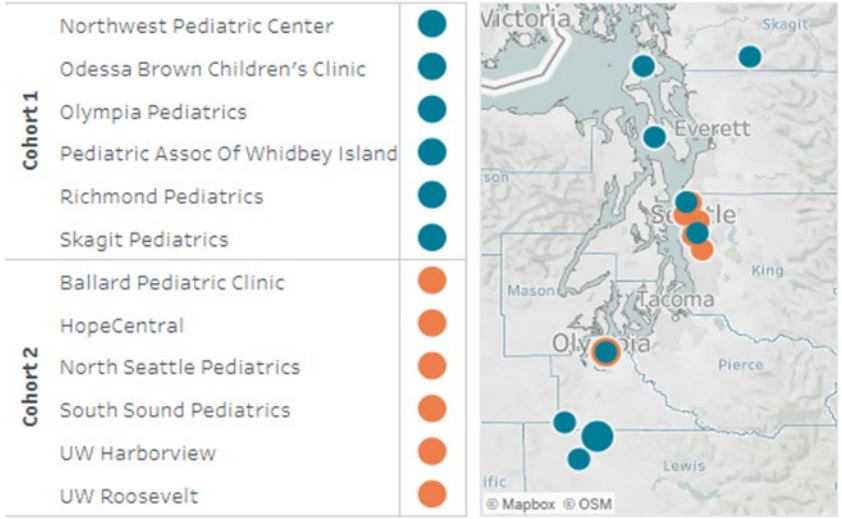
SCCN IBH Program Overview

SCCN IBH Program Includes:

- ✓ Training and education
- ✓ Implementation support and ongoing project management support
- ✓ Data and technology systems support
- ✓ Access to pediatric mental health professionals
- ✓ Coaching about financial sustainability
- ✓ Funding program “upstart” costs
- ✓ MOC and CME opportunities



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Five Lessons Learned

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Define

Clearly outline your IBH Program

Including:

- Program goals
- Roles and responsibilities
- Processes and workflows
- IBH Core Team
- Caseload size
- Visit structure

Essentials

- Intentional
- Clear
- Explicit

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Engage

Ensure the IBH Program is visible and understood by the clinic and patients/families

- Provide program and role-specific training
- Utilize the psychiatric consultant
- Offer continuous education opportunities
- Share program updates, learnings, and successes
- Create communication plan for patients/families

Essentials

- Involve
- Train
- Communicate

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Identify

Define the target population and standardize the referral process for the IBH Program

- Early identification through universal screening
- Clear inclusion and exclusion criteria
- Triage process
- Closed-loop referrals

Essentials

- Screen
- Refer
- Triage

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Measure

Evaluate the IBH Program and the patient population

- Identify metrics
- Develop processes for data collection
- Create standard, easily reproducible reports

Essentials

- Plan
- Track
- Analyze

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Monitor

Pay close attention to the IBH Program

- Dedicate time to oversee program
- Review billing and schedule utilization
- Evaluate if program is meeting financial goals

Essentials

- Supervise
- Evaluate
- PDSA

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IBH Program Lessons Learned

Define | Engage | Identify | Measure | Monitor

Clearly Outline the Program

- Intentional
- Clear
- Explicit

Ensure the Program is Visible and Understood

- Involve
- Train
- Communicate

Standardize the Referral Criteria and Process

- Screen
- Refer
- Triage

Evaluate the Program and Population

- Plan
- Track
- Analyze

Oversee Billing Outcomes

- Supervise
- Evaluate
- PDSA

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Any Questions?

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Care Network

Early Support for Infants and Toddlers (ESIT)

ESIT supports families with information and skills to ensure they are supported as the most critical influence on their child's early learning and development.

Program Mission

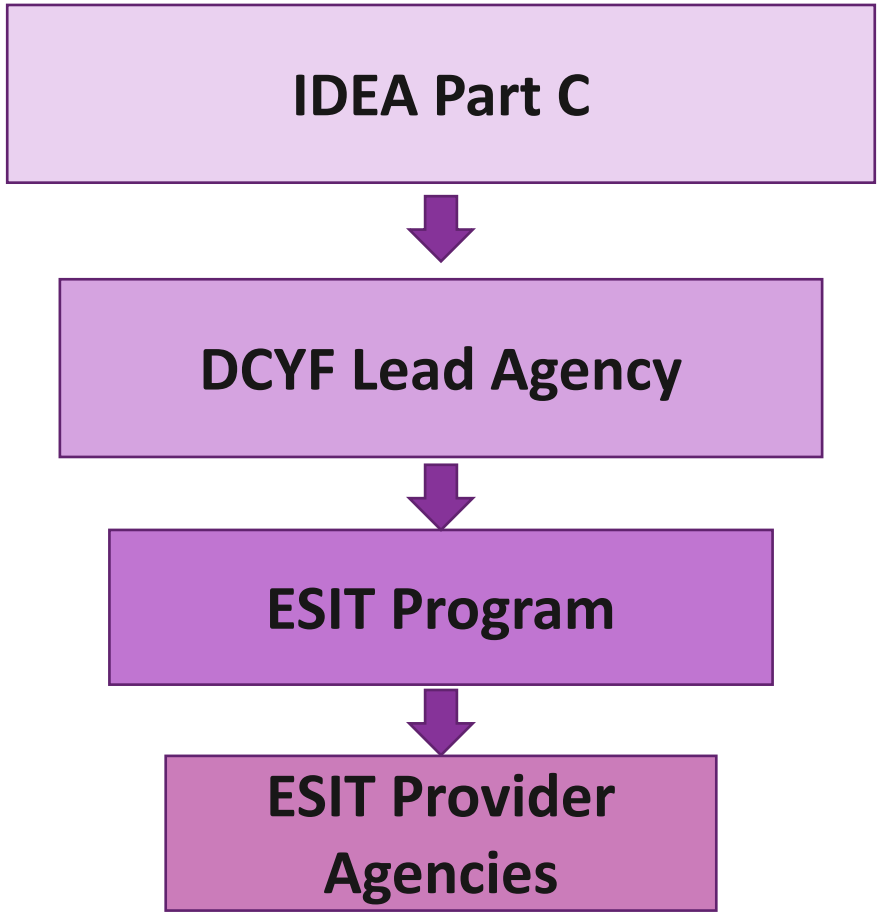
The purpose of the Early Support for Infants and Toddlers Program is to build upon family strengths by providing coordination, supports, resources, and services to enhance the development of children with developmental delays and disabilities through everyday learning opportunities.

Washington State Department of CHILDREN, YOUTH & FAMILIES

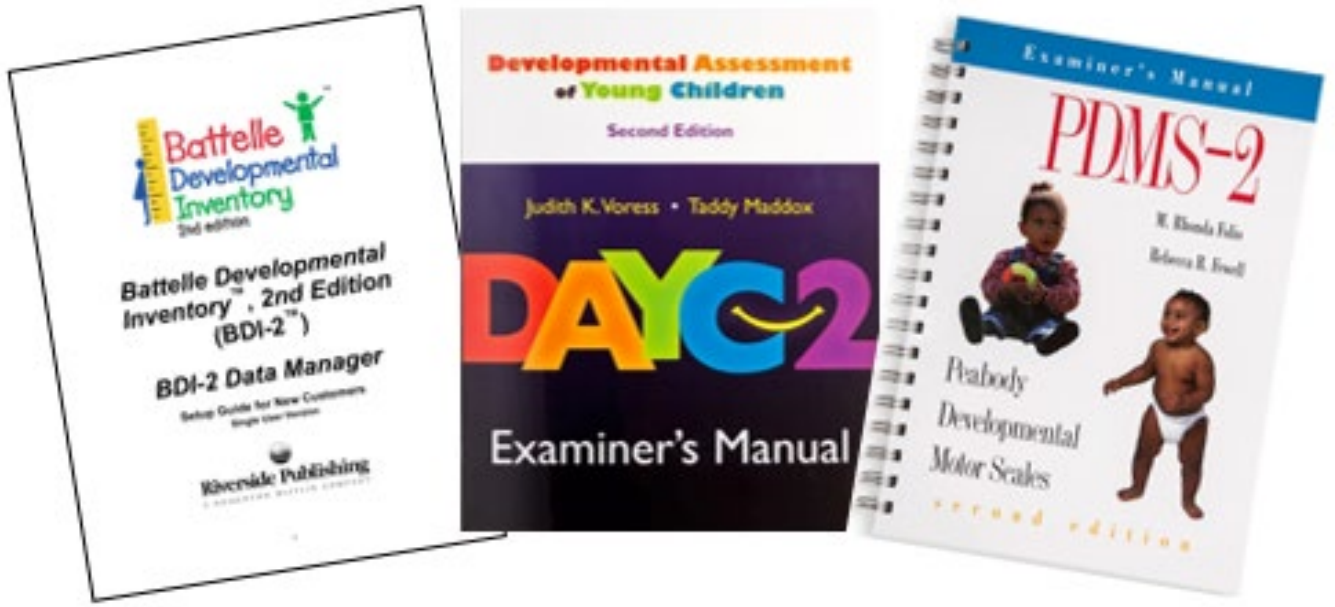
Purpose of Part C of IDEA

- To enhance the development of infants& toddlers with disabilities
- To minimize the potential for developmental delay
- To reduce future educational costs
- To enhance the capacity of families to meet the special needs of their infants & toddlers with disabilities

Individuals with Disabilities Education Act (IDEA) Part C: Birth to Three Years Old



Eligibility: Standardized Evaluation



A child must have a **25 percent delay or show a 1.5 standard deviation** below age expectation in one or more of the developmental areas.

Eligibility: Qualifying Diagnosis

A diagnosed condition with a
high probability of resulting in a developmental delay

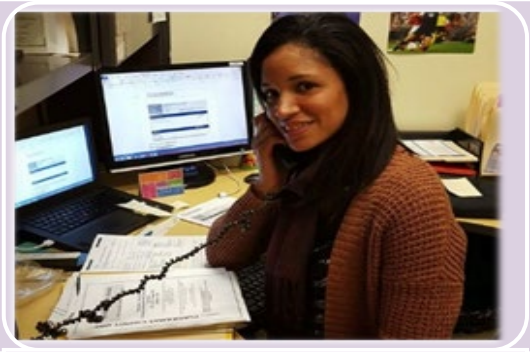
Eligibility: Informed Clinical Opinion

Children Served

At any point in time during FFY21, 11,344 infants, toddlers, and families were served, equaling an increase of 2,652 families over the prior FFY data. The cumulative number of eligible infants, toddlers, and families receiving services was 21,396, an increase of 1.12%.

Roughly 39% of children exiting early intervention did not qualify for special education services based on eligibility criteria and parent choice. 95% of infants, toddlers and families received services in the natural environment, which includes children receiving virtual services.

Common ESIT Services



Family Resources Coordination (FRC)

Required and provided at public expense

Early Childhood Special Education

Occupational Or Physical Therapy

Speech/Language Therapy

Anticipated Impact

- Infants and toddlers who receive early intervention services will:
  - Demonstrate positive social-emotional skills, including social relationships
  - Acquire and use knowledge and skills including early language, communication, and early literacy
  - Use appropriate behaviors to get their needs met

- Families involved in early intervention will:
  - Know their rights
  - Effectively communicate their child's needs
  - Help their child learn and develop

Thank you!

Early Support for Infants and Toddlers

Laurie Thomas, Service Delivery & Technical Assistance Manager

Laurie.Thomas@dcyf.wa.gov

Molly Stryker, Technical Assistance Specialist

Molly.Stryker@dcyf.wa.gov