# Washington Thriving *(formerly the P-25)* Advisory Group Meeting Summary

**Monday, September 9, 2024**
**2:30 p.m.-5:30 p.m. Pacific Time**

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## Attendees

- **8 Advisory Group Members and 31 other attendees joined**

## OPENING, GOALS

- Diana Cockrell (co-chair of the advisory group) spoke to her appreciation at being a part of this opportunity and noted that she was joined by her co-chair Rep. Lisa Callan.
  - She then overviewed how to change one's zoom name, kicked off introductions in the chat, and briefly reviewed the Full Value Agreement.
  - As part of introductions, participants were encouraged to share things in the chat they were inspired by with regards to Washington Thriving, and things they liked in the Full Value Agreement.
- Representative Lisa Callan (co-chair of the advisory group) spoke to the goal of a system built around people's needs instead of people trying to fit their needs into an existing system built around something else.
  - She stated that the meeting's goals would include:
    - Share project updates; see how the proposed vision has changed since we last met and share additional feedback; begin to talk about the current landscape of service in Washington and how we're going to identify/quantify gaps; and next steps.

## PROJECT UPDATES

- Hanna Traphagan (project lead at HCA) then addressed the overarching project updates:
  - In the opening phases of the project the goal is to gather as much input as possible; then comes the narrowing phase where we pivot toward the end goal and further process the input we've already gathered into critical key strategies.
  - Opening part includes visioning (phase 1) and assessing current landscape (phase 2); narrowing includes identifying strategic priorities (phase 3) and moving to action (phase 4).
  - We have people-informed activities and data-informed activities.
    - People-informed activities include gathering success stories, facilitating regional in-person listening events; targeted conversations with relevant agencies and SMEs (subject matter experts); attendance and input gathering at coalition & provider meetings and workgroups; ongoing engagement & feedback from advisory groups, subcommittees and discussion groups.
    - Data informed activities include cross functional discovery sprints to further understand complex areas of system; gathering statistics and qualitative data and insights; reviewing reports and studies, peer reviewed publications, evidence-based practices, guidelines, and other literature; modeling the system to organize, clarify, and unify behavioral health knowledge into useable data; targeted discussions with SMEs to deepen understanding of key areas; and designing data dashboard responsive to ongoing insight and changing system dynamics.
  - Hanna then spoke to interdependence of information:
    - Each piece of the project is subject to ongoing incorporation, synthesis and consolidation

        - In phase 1: A shared definition of behavioral health began to form; vision and principles, "big frames" ideal array of services and supports (continuum of care) commenced development.
        - Phase 2: Current cost of care, catalogue of available services, simplified conceptual understanding of behavioral health system relationships, actors and trends; quantitative indicators of the current landscape; qualitative insight – what has and has not worked.
        - Phase 3: Gap analysis with qualitative and quantitative insight; recommendations for options to fill gaps; systems modelling insights; strategic imperative and levers for changes/tactics.
        - Phase 4: Cost benefit analysis; experience and evidence-based insights; organizing principles for strategic framework; methods and details of service delivery; strategic framework; roadmap for implementation; oversight & funding recommendations; policy recommendations; data dashboard with key indicators.
    - Hanna then reported on updates regarding communications and community engagement.
        - New name and logo: Washington Thriving
        - New site and blog
        - Newsletter
        - Community engagement: had events in July, August, virtual in September, in person in October; ongoing network building.
        - Discovery sprints: 2 completed (behavioral health in K-12, behavioral health during pregnancy); 2 launching (complex hospital discharge, transition age youth).

## FEEDBACK LOOP - VISION

- Megan Beers moved discussion towards updates on the project process and how feedback from participants is being used to evolve Washington Thriving
    - An advisory group member asked who did the discovery sprints; Daniel Honker from Bloom Works (a member of the project team) identified his organization, and noted that reports from those included are high level summary; though they don't share individual contact names, one can get a good flavor for the types of organizations Bloom Works talked to during those; they're now entering complex hospital discharge and transitional age youth discovery sprints.
    - Megan spoke to the many spaces people are already gathering that we're being invited into for conversations.
    - This site is to be a one stop shop for info: https://www.washingtonthriving.org/
    - Vision: we have 3 spaces where we're talking to young people, parents, system partners respectively.
    - We're now in phase 2 of the project.
    - Megan shared feedback we received on the vision introductory slide from last advisory group:
        - Language changes, like 'help' to 'support'; 'all geographies' to 'across the state'; less about ages and more about developmental stages.
        - Adding the context of families and communities that we all live within; added a principle focused on family and community.
        - Creating a definition of behavioral health.
        - Megan showed a new version of the Washington Thriving vision slide with language changes circled.
        - Comments reflected a positive response from the group.
        - Someone was pleased to see families, caregivers and communities as key contributors to wellbeing.
        - Another brought up developmental and co-occurring needs.
        - One attendee brought up how if one parent is an alcoholic, everyone in the family is impacted.
            - The Washington state mental health system has been far too individualized.

            - Using that specific language of connection and calling out that when one person is not well, everyone is impacted.
            - A child with a parent with an addiction may not be the primary patient but needs support; that has not been recognized in the system sufficiently in the past.
        - Megan suggested that be addressed in the description slide for that principle.
        - It was pointed out that “help” still appears in the top left of the vision slide.
        - Another advisory group member asked if principles such as “Ensures that all doors lead to support” will be broken down a little bit further, specifically into various tiers of support, so that someone reading it who thinks they don’t need a certain, high level of support will be able to see a level of support aligned with what they need and feel they can reach out for it.
            - Megan responded that the description slides will serve as a glossary to each of the principles and appreciated/noted the idea of also showing multiple tiers of available support.

## DEFINING BEHAVIORAL HEALTH

- Megan then shifted conversation to the definition of behavioral health, noting that it is earlier in the iteration process than the vision slides.
    - An attendee mentioned that education is the work of young people, and that’s what gets impacted.
    - An advisory group member made the point that family may or may not be a support, and that this is important to include.
    - Another commented that stigma can impact the support of secondary family members’ ability to support the nuclear/primary family.
    - One advisory group member drew attention to the language about ‘coincides with other things’
        - He said there are social determinants of health that contribute to behavioral health challenges, and there are some that we might think about as potential outcomes of behavioral health challenges. It may not be valuable for us to name both of those things.
        - He gets caught when thinking about the role of relationships as determinants/contributions to behavioral health challenges, as well as a pathway to healing, treatment to behavioral health challenges. How do we define this in a way that won’t preclude us from doing relationship based work, family therapy work, as an approach to healing, rather than as looking at family relationships as an outcome of treatment?
    - Another member thought the presented definition was great.
        - She noted it’s so long and yet so much is not included.
        - Could add to ‘feelings and actions that can affect one’s overall well-being’.
        - Could also include ‘and ability to be in a strict school setting where you’re expected to behave in a certain way’, and that fluctuates throughout the lifespan; she noted it’s a continuum of behaviors that changes over the lifespan.
    - One member brought up the concern that the perinatal and prenatal period gets lost in the behavioral health system, and sometimes behavioral health doesn’t describe what children go through in utero and in birth.
        - As someone who works in early childhood health, this is where he struggles. How do we make sure babies aren’t forgotten?
    - Megan noted the project team will be reworking this definition, coordinating other behavioral health efforts at the state level, and keeping people appraised of how this definition is changing.
    - Diana Cockrell expressed her appreciation for attendees weighing in, and the intentionality and nuanced nature of their contributions.
    - Rep. Lisa Callan said that the more uniform of a definition of behavioral health this group and other people doing this work are working off, the better; but acknowledged the importance of

differentiating between children and adult behavioral health. Relational health and the impact of the family unit are important components to this as well, due to how much they affect individuals.

## CONCEPTUALIZING CONTINUUM OF SERVICES

- Megan moved discussion to representing the range or continuum of services.
    - Megan spoke about the iterative process of formulating the right language to describe a robust continuum of care, or a range of services that adequately meet the needs of Washington's prenatal through 25 population.
    - She read through a list of attributes for the envisioned behavioral health continuum of care for children, youth, families and caregivers, which:
        - Includes prevention and well-being and identifies risks early; offers age-appropriate, culturally relevant mental health and substance use supports at every stage of early life; offers integrated supports that recognizes and addresses co-occurring challenges, including intellectual and developmental disabilities; offers ongoing support to prevent crisis and ongoing support for recovery after crisis; includes navigation support and coordination between services and levels of care; and integrates with physical healthcare.
    - We are trying to represent this continuum for a couple reasons:
        - It helps us organize what already exists, what we identify might be needed; and
        - What is the gap between those two.
    - Megan then showed an option for a visual depicting the continuum of existing services, broken into categories of ongoing, short term/periodic, long term; needed by all, needed by some; and needed by few.
        - She mentioned that one piece of feedback received is that some people didn't like the linear progression implied by the visual and suggested maybe a pyramid is better.
    - Megan then showed a second option for visualizing the continuum: a pyramid image, with services needed by few at the top, and those needed by all at the bottom.
        - Diana Cockrell said a couple things the visual could encompass include:
            - Nuances around what the developmental life stages look like and need that are different across the age span.
            - Then there's the systemically overarching ability to cater to these- here's what that continuum of care should look like/hold in it, thinking about components of robust system of care.
            - Under that age span are the settings; defining behavioral health in the P-25 age range is a huge thing in helping things move forward.
        - Rep. Lisa Callan spoke to the need for categorization, a way to talk about the needed services so we can frame the work/report, and logistically carry the strategic plan forward in some kind of mechanism.
            - We want to root this in those that are using the system, and make sure funders/providers see where they play their work in that.
        - An advisory group member said words on the slides like 'early intervention', 'intensive services' are those triggering; are there ways to soften the message? Keeping emotional words out of it.
            - Maybe as we soften the message, it has the twofold benefit of also making it more understandable to all ages.
            - He really liked the pyramid, thinks it's really easy for us to overexplain or be overly detailed; he likes the idea of just keeping it to a couple of bullet points, as people don't want to read paragraphs.

- Rep. Callan responded to a comment from another group member in the chat about moving away from ages by noting that legislatively we're capped at age 25, but the goal is to help kids transition from the youth system to the adult system, so people don't fall off, which is unfortunately what does happen for people with complex issues.
- The addressed member responded that we should focus on prevention work for youth and systems.
  - The foster alums she works with have lived experience and trauma but at the time didn't know it was that; if they'd had more peer support, more could have been avoided.
  - Peer support specialists can plant the seed of prevention, but if there are to be more jobs in that space, we need to emphasize the importance of lived experience experts; stepping stones for someone to move forward on their own healing process.
  - People don't talk about these issues, and peer supporters could draw them out in conversation and help her realize that certain things in her life weren't normal.
  - She spoke to going to schools, the importance of seeing leaders coming out of the system and promoting health; allowing more funding flexibility for peers doing promotion of wellbeing.
- An attendee said gatekeeping that keeps kids who need it out of care has such a detrimental effect because time for children is very different than time for adults.
  - Waiting a year can really harm them; children shouldn't have to advance through stages to get the care level they need, they should be able to get there immediately.
  - It feels at times the system was built to treat or punish instead of to prevent
  - Perhaps we need a system value of not trying to use qualification measures as gatekeeping measures
- Someone else spoke to his experience of waiting with his son in a psychiatric hospital for hours so he could be transferred to a CLIP facility because there were no other available services for him.
  - There's a disconnect between community, state, and other services – is fixing that part of our mission? How can we gather info on that and provide it to communities trying to get those services?
- Rep. Lisa Callan suggested things we may want to add to the array of services represented in the continuum visual include:
  - Pairing support, peer support, school-wide work-based interventions, social structure interventions.
  - Peer connections as a social structure that is there for you, which can also be part of community; those all also fit into short mid and long term.
  - She emphasized that we're trying to create with this a communication tool that can show what we're trying to do and frame it, and encouraged anyone who is seeing a visual in their work that is a little different to not hesitate to pass it along.

## LANDSCAPE ANALYSIS, MERCER QUANTITATIVE WORK

- Megan turned the discussion to the goals of the landscape analysis.
  - The following questions were posed: do we have the right services and supports? Does our capacity for each service meet the need? Does the system have the agility needed to adapt?
- Jeff Payne (from Mercer, a data analytics company hired by HCA to support the work of the project), spoke to Mercer's involvement.

- Quantitative work means measuring, counting, grouping things; there's power when you count and measure things; often times that power isn't centered. He appreciates and is grateful for those who emphasize equity in this; so we should talk about families that can't be present in this space as well. Make sure that we stay centered as we count, group and name, that we're talking about children, and we're thoughtful about the way that we do that.
- He acknowledged TriWest, another agency working with Mercer.
- Mercer counts and groups things in order to understand data; collectively the two agencies try to group things in a very mindful way; doing work costs money, has rates associated with it, rules associated with how that money is spent; they try to comprehend a hybrid of understanding of the money and rules.
- Brenda Jackson (also from Mercer) explained where Mercer came into the process and the role HCA contracted with it to perform.
    - From March until September, Mercer started working with data partners to understand the service needs in Washington. They will have a report written next month and will use the report they've been working with data partners on to identify the data sources, data clearances, and develop a data dictionary to put this into place to make findings to put into final analysis and gap analysis report to submit to the state November 2025.
- Mercer specializes in data and analysis; its goal is to use research and develop the best practices for kids age p-25, and compare those best practices to where services are currently; analyze selected childhood health data, and identify needs and gaps in the Washington healthcare system and develop a dashboard with meaningful data that can help drive change discussed at the meeting today.
- Brenda showed a Best Practice Research visual that portrays the child health systems array. It shows nonmedical resources; schools and other community organizations, and the way all of the services come together.
    - The figure was split into the categories: Promotion prevention & early intervention; outpatient & integrated care; intensive home & community-based service; comprehensive crisis care; inpatient care; residential treatment.
    - Quantitative data to be organized into language and visuals that are easier to represent.
    - In response to a question, she confirmed that Mercer's work on best practices taps into the work of the state funded best practices institute. Mercer uses the WISP evidence based practices institute extensively.
    - She confirmed that education assessments fall into the green 'promotion, prevention & early intervention' category. Mercer looked at WA Kids assessments and having that info available so there can be early intervention.
        - Not all of it falls into this category however – you can get to IEPs and deep end services as well. For residential treatment, there was a large number of students placed out of state because there were no services within the state with which they could be served.
    - ABA services might be in the blue (outpatient and integrated care), and out of state placements in the red (residential treatment).
    - Child welfare is also worth looking at (and especially tribal youth); when we think about family support services, or services that are very early on, we might see it in light blue and green.
    - This categorization system is about an intensity of services not just about placement. The orange (inpatient care) could be in front of the red (residential care); it just really depends on whether you're looking at it as diversionary or step-down.
    - Someone asked if Mercer included therapeutic boarding schools. Brenda replied that Mercer does talk with other states about them in the red (residential care) category; Mercer is now trying to figure out how it applies, and how it can use data sources that get at these different services, as well as gaps in services going forward.
    - Mercer has had 6 data partners who've participated in data discussions:

            - Department of Social and Health Services, and Research and Data Analysis Division, Department of Health, Office of Financial Management; Department of Children, Youth and Families; Department of Commerce; Office of the Superintendent of Public Instruction; and Office of the Insurance and Commissioner.
            - Mercer plans to add DCYF as a seventh.
            - They've talked about an all payer database, as well as sources of info for each one of these data partners so they know where the gaps and successes in WA are.
            - They ask each partner, which data source are you looking at, and which one is telling a story?
        - Mercer is looking at specific service types, access to service and capacity, reimbursement rates and utilization levels, disparities in access (race, ethnicity, culture, language, sexual orientation, and gender identity), disparities for other populations (co-occurring, foster youth), utilization of preventative vs deep end service use, school discipline (suspensions and expulsions), timeliness of service appointments and waitlists.
        - Disability services will absolutely be a part of this.
        - Tribal representation has been identified as a challenge for Mercer; they agree that tribal is a needed member at the table. They will go back to the state for this.
        - Mercer is also looking at prenatal and perinatal mental health services, and private insurance.
    - Brenda then spoke about the metric framework for the proposed dashboard design, broken into four categories: demand, capacity, access/utilization, and outcomes.
        - Demand: demographic changes in overall demographics; identification of populations of interest like unhoused, IDD (intellectual and developmental disabilities), racial/ethnic indigenous groups.
        - Capacity: workforce, urban vs rural; promotion, prevention, and early intervention, service utilization.
        - Access/utilization: holes in payer coverage; disparities in access by socioeconomic, racial, and populations of interest; delivery system of gaps by age or other populations of interest; outpatient and integrated care; intensive home- and community-based services.
        - Outcomes: juvenile justice referrals/charges/disposition; Emergency Department visits; inpatient hospitalizations; residential treatment utilization; out of home placements; access to crisis services.
    - Graduation rates have been a positive outcome we've been considering.
    - Hugh: IOP and PHP (intensive outpatient and partial hospitalization) will absolutely be looked at.
    - Mercer is now working on dashboard design and performance metrics.
        - For performance metrics, Mercer needs solid ongoing data sources; what data sources it has and which it doesn't have and would like to develop over time.
        - There is a data metric for children placed out of state by school districts; there aren't resources in Washington to serve those children, we have to send them to Idaho or Florida; how are we going to develop services in WA to serve those children?
        - Mercer is also thinking about what that framework for looking at gaps through the dashboard will be like; demographic info- what is the demand for service? e.g. are there language and interpreter needs, is there something in particular it needs to be thinking of that might change over time; the process metrics – it's going to be looking at things like capacity- workforce capacity, network capacity); also access/utilization, waiting lists, disparities in access, delivery system gaps by age, or other criteria, and finally outcome metrics.

        - Juvenile justice referrals/charges/dispositions, inpatient hospitalizations, ED visits, out of home placements, school suspension/expulsions).
    - Jeff Payne said he wants to acknowledge the needs parents have mentioned, and suggestions/acknowledgements made where there may be some gaps, and asked what story, what visualization is going to be most important for Mercer to capture, when it thinks about Washington Thriving, and supports for children in Washington?
        - Rep. Callan posed the question, are we really shifting from a crisis response system to prevention and early intervention system, and are youth outcomes improving- e.g. juvenile justice rates going down, and other rates going down?
        - Network adequacy and use of visual- geographic variations; provide a visual of the state; this takes the existing state network adequacy standards and applies them.
        - Someone suggested a better tracking system for young people after adoption from foster care.
        - Jeff Payne said a lot of the partners thus far have been suggested by people who know Washington very well. The question is how widely we cast the net.
        - Is there a way to collect concurrent resource needs to behavioral health services e.g. food housing employment education opportunities? Mercer thinks of the dashboard as master representation of all things going on in Washington; what Mercer will certainly do is bring different chapters of data, and advisory group members will be able to see progress as we make it.
        - Data dictionary: part of it is understanding the sourcing; disclosing and disclaiming any biases about the info. The Mercer team would need to come back to the advisory group to show what we think we see, then get input from the advisory group.

## CONCLUSION

- The floor was opened to public comment.
    - There were no public comments.
- Rep Lisa Callan closed the meeting by stating:
    - Next steps: advisory group members should watch for slides in the next day, summary in the next week; feedback gathered here will be incorporated into the materials; these will be shared out at discussion groups and to this group via email, on blog and at the next meeting, as well as with the broader community through engagement efforts.

## COMMENTS IN THE CHAT

- I'm inspired by the opportunity to build shared understanding of children who have struggled and help move us to family-centered care.
- I am inspired by the opportunity to truly partner with so many across the state to support well-being across our state.
- Embrace uncertainty, sit with discomfort
- listen actively for understanding
- Be open, listen actively for understanding, Be brave
- receive feedback without defensiveness, show humility, take accountability
- I'm inspired by the wealth of perspectives I've heard brought to the table in the meetings so far, and opportunity to witness much of these being integrated into a more robust system for the future.
- I am inspired by the opportunity to share my lives family experience to drive change.
- I am in awe and so inspired by everyone from all across the state coming together to create huge once in a lifetime change and improvement!  Feels like those superhero movies where everyone teams up and uses their unique abilities to save the city, but real life!

- When evaluating available services it will be important to look at programs that are technically available, but either there are not enough qualified practitioners or are underfunded and can't meet the current need.
- Or are not being delivered as promised (ex WISe isn't intensive when it's only providing 10-15 hours of service a month)
- Thanks for that point. We are looking at capacity and I appreciate you noting whether there is the workforce to meet the capacity and whether the capacity is sufficient to meet the need. Really important.
- Project Team: Deliverables for K-12: https://drive.google.com/drive/folders/1rDSIhIO_Sc1WBP7vdbx4rv8dDtcyV02A
- Project Team: Deliverables for pregnancy sprint: https://drive.google.com/drive/folders/1MptrhpSOeUGW6hJ8az8aeBcfPFiaeDNb
- Are the discovery sprints happening throughout the state?
- Are the website and blog up and running, or if not is there a timeframe for that?
- Yes! In the reports you can see an overview of the geography/demographics represented in the research.
- Website: https://www.washingtonthriving.org/
- Great q about the scope of who gave input to the first two sprints and who will give input to the next two. Something important thing to keep in mind re discovery sprints: these are intentionally narrow in scope and are just one (of many) inputs to the development of the strategic plan. They were not designed to be comprehensive consultations on the topics, and do not represent the only input Washington Thriving will take into account on these topics.
- Thrilled to see families, caregivers and communities as key contributors to well being included!
- also really glad to see developmental and co-occurring needs included in behavioral health definition
- Great job addressing all the feedback. Seems to cover all the input from the last meeting I was in.
- !! Changes In response to new information!!
- I wonder about including family systems language...
- The word "help" is still on the left should that be changed to support?
- Great catch.
- "Intellectual and developmental disabilities can intersection with and compound this." Might add -- how the community responds to and supports these disabilities...
- weaving in education- great content
- When a child is undiagnosed or improperly labeled or underserved their educational and life long outcome can be dramatically impaired
- that is the piece of the daily life that is impacted for children and youth
- Ditto on that point...stigma can impact the support of the secondary family members ability to support the "nuclear/primary" family
- add risk in addition to incarceration -- drop out, sexual trafficking, suicide
- Yes. Children's behavioral health develops.
- effectively participate within society
- And an experience that a young person may not understand is trauma…
- Thank you! Attachment disorder in adoption is a good example of what you are talking about.
- I think having a solid first sentence as a definition then a broader description below that is a good way to think about this "long" definition.
- and I think that first sentence is 90% there
- Maybe some bullet points instead of paragraphs?
- remembering that not only does toxic shame develop and lead to mental health issues (bipolar, schizophrenia), but serious mental illness can develop in young adulthood within perfectly functioning young adults and completely derail their lives.
- getting to agreement and understanding of p-25 behavioral health will be a HUGE contribution to evolving our system to one that responds to the needs.

- This is easier to understand.
- I like that it's not in a line. When we think of things in a line, it often means those children who are the highest needs have to step through hoops, and end up waiting for appropriate care, before actually getting the care needed. Specifically thinking about the process to qualify for a CLIP bed which ends up delaying services and increasing the trauma. For example when a child has cancer, we don't make them try natural interventions before bringing out the big guns. We go straight to the medically necessary care.
- Ideas to see for expansion of access to care.
- Expansion of services up to 30 years old.
- Given age fall back from covid and mental health growth being barriers for young ppl who are transitioning from transitional ages.
- If someone was in foster care, JR, adoption - even if married can have access to behavioral health services.
- Keep it simple
- I do like the examples provided in the linear version. Early intervention should also include early assessments.
- shift early intervention  language to early support language...
- what I hear you saying is there isn't integration of DCYF services into behavioral health supports.
- We are not there yet with DCYF.
- I do believe it can be better and we can wedge the space to provide understanding what has happened to the young person in the system and promote healing before they leave the system
- And the landscape is intended to look across multiples systems- HCA programs. DCYF programs, School programs, etc.
- and also an acknowledgement that even if your parents are really f'd up, you as a child need to find a life-long way to navigate your relationship with them.
- purple dots: partial hospitalization, wilderness therapy
- also, what is residential care in the short term? Also where does hospitalization for eating disorders fall
- We will be sending slides for you to continue to mull on and welcome thoughts! WAthriving@healthmanagement.com
- There is a big shortage of treatment for eating disorders.
- Re capacity: I hope everyone saw the front page article in the Sunday Seattle Times yesterday about complete lack of fentynal drug treatment for youth and the qualitative story about how one youth wound up addicted.
- Deadlier drugs, younger addiction and no help in sight
- Thank you for mentioning that, Peggy. I did see it- so aligned with our shared work.
- FAQ and resource guide
- just wondering if the work on best practices taps into the work of the state-funded Evidence-Based Practices Institute?
- do educational assessments fall into the green category?
- Happens with tribal youth. Common location is Idaho
- ABA is applied behaviorial analysis if anyone did not recognize that acronym
- Can you please share the reasoning behind the orange and red. Wouldn’t a short term residential intervention precede a longer term inpatient treatment? Am I misunderstanding?
- Do you include Theraputic Boarding Schools?
- Ok it sounds like inpatient in acute care settings vs inpatient in long term like CLIP
- We will check with our TriWest colleagues to verify but that is how I believe it is intended
- DCYF absolutely MUST be at the table. I hope it's just that they are so busy, not that it's been an effort to get them see their role in behavioral health.
- Did I miss Disability Services involvement?
- No they are part of DSHS

- What about tribal representation?
- DCYF can bring ICWA into the fold
- Prenatal and perinatal mental health services?
- ICWA?
- Indian Child welfare Act
- Private insurance?
- Office of the Insurance Commissioner
- OIC supports private insurance work
- Tribal data is hard.
- We have tons of barriers.
- Lots of trauma on reservations, barriers.
- I see youth get lost in the foster care system
- Because SA crime is kept inside tribal territory.
- The project team is working closely with the American Indian Health Commission and will work on this piece.
- What about the standards of medical necessity... that proprietary database that is not available to you until after you've been denied insurance.
- outcomes -- can you look at dropout and graduation rates?
- Intensive outpatient and partial hospitalization should be looked at as well. Not sure either automatically fall under any of the four categories reflected here.
- I hope to see the tribal community grow in services to strengthen each tribal reservations/nations.
- could you also look at parental health? note the new report from the surgeon general
- IOP= intensive outpatient PHP= partial hospital program. Both of these are intensive services provided in the community
- also the long term impact of youth trauma on adult caregiver health
- the services needed existing? how long are children and families waiting for service? And how well are youth doing? (graduation and joblessness)
- similar to Peggy's comments about wait times, an assessment of if/how/where existing state network adequacy standards for BH are being met for prenatal-25. Are there geographic variations of note between urban, suburban, rural, and/or various regions of the state?
- Ditto Hugh: what are the key performance indicators we are shooting for?
- After this conversation we will move to public comment. If you would like to offer public comment, please put your name in the chat with a note - Public Comment
- We need a measure need of access to service for adopted youth. We don't track once a young person is adopted from foster care
- YES!!!! adoption is trauma even if it is necessary.
- recognizing that for part of the population, this is part of the array.
- Such a great comment. Thinking about county services. Jeff can you speak to that?
- wondering if there are ways to measure experimental solutions -- such as what happens if we help children reconcile with their birth families instead of assuming adoption is the best option
- New Jersey has data it tracks on placement stability and transitions for families to see how their bh services are working
- Is there a way to collect concurrent resource needs to behavioral health services, e.g. food, housing, employment, educational opportunities, etc.
- We have a lot to learn from New Jersey! WE recently sent a team of folks there to learn more about their system.
- This will also help us identify in gaps where there is no existing data.
- Yes the goal is a multi-system dashboard
- need to include what happens after children leave the JR system...including county interventions and the zero youth detention movement. is it working?

- I am hopeful we will a data set that can be used similar to Oregon's OCID, in addition to a dashboard
- taking care to be clear on what is positive v. negative determinants of health. for example, I've seen the JR system tracking IEPs as a positive determinant... where in fact, qualifying is good, but needing one makes one more vulnerable.
- OCID?
- We know several of you have offered comment throughout the meeting, but want to make sure we open up again. If you are a member of the public or a member of the Advisory Group, please put your name in chat and "-public comment".
- I'm very encouraged about the work being done by the entire team. Thank you!
- Thank you, everyone. One more meeting today. Have a nice evening.
- Oregon has a awesome peer support model
- WAThriving@healthmanagement.com
- parents can join the next meeting by signing up through the WAThrives website, correct?
- Yes! Via the form on the website or by emailing WAThriving@healthmanagement.com
- Seeing a lot of folx on with us who have major life events happening around them... Just want to say THANK YOU and our hearts are with you. Take good care of yous out there - Thank you SO MUCH for being here and weighing in on this amazing opportunity for WA!!
- https://www.washingtonthriving.org/
- Im not seeing the form on the website... so I'll just share the email.
- It is via the Contact tab on the website, but email is great as well!
- https://www.washingtonthriving.org/contact
- cybhwg@hca.wa.gov