Notes

Children and Youth Behavioral Health Work Group – Youth and Young Adult Continuum of Care (YYACC) Subgroup

June 11, 2024

Glossary of Terms

APM: Alternative Payment Model
DOH: Washington State Department of Health
EMR: Electronic Medical Record
HCA: Washington State Health Care Authority
IECMH: Infant and Early Childhood Mental Health
MCO: Managed Care Organization

Meeting Topics

Breakout Rooms for Introductions
Update on DayBreak Youth Services facility
New Journeys + Peer Support Services - Becky Daughtry, HCA
Youth mobile response and stabilization services (MRSS) - Sherry Wylie, Vashti Langford, & Sonya Wohletz, HCA
Group discussion of YYA workforce & rates priorities

Contact Paul Bryant, Madrona Recovery, pbryant@madronarecovery.com

Discussion Summary

Breakout Rooms for Quick Introductions

Update on DayBreak Youth Services facility

John Thornton & Paul Bryant pbryant@madronarecovery.com , Madrona Recovery
Reopening Brush Prarie campus that used to be Daybreak now as Madrona Recovery, several programs there

1. Next 6-8mos: licensing, hiring, trying to get program up and running
2. Oregon services rather overwhelmed in last year = great community need
    a. Currently operating in Oregon and now transitioning model to Washington branch
3. New facility with expanded capacity, currently patients waiting weeks to get care in Oregon.
    a. Looking at Vancouver and Portland as different communities but some patient crossover to alleviate current Oregon access burden
    b. Offer:
        i. Integrated substance use treatment
        ii. Mental health treatment
        iii. Youth detox – usually is a hard to access service
    c. Goal to provide good access with high quality care

   d. Want to create outpatient programming synced up with inpatient services the facility provised
   e. 50 bed, large campus available for this work
      i. Quick turnaround for permiting and securing space, thanks to help from state and community partners.
4. Budget passed, contracts with state → when is the facility opening?
   a. Madrona ready as soon as building acquired and moved
   b. Signed budget proposal is for state to acquire property and then state to contract with Madrona as provider – new kind of state purchase/sale agreement that hasn't been done before
   c. Hoping beds and services can be back online by first part of next year
      i. Currently moving a little slower than planned
5. Have we discussed what the facility will be named? Can't keep using Daybreak
   a. 30 miles distance between the Vancouver/Portland campuses
   b. Portland high acute psychiatric treatment
   c. Vancouver might be called Madrona Washington for continuity
6. Age and genders accepted in the new facility?
   a. 13-17, but case by case review for accepting 12s and helping live at home 18s
   b. Co-ed model, accepting for gender fluidity and gender expansive youth
   c. High level of security so hasn't been an issue to treat mixed gender
7. How to manage youth getting to both locations? And providers coming from where?
   a. Expectation that is part of whole state continuum of care
   b. Contract with Madrona is service requirements for who is served, who is serving, etc – still being figured out now
      i. 60% Washington Medicaid by contract
   c. Want to add capacity in WA instead of moving behavioral health workforce around the state
      i. Exploring supportive services like housing for workforce
   d. Relationships with 7 graduate program internships for counselors, fellowship programs as well
      i. Expansive beyond Oregon or who already live in/near Washington
      ii. Interns paid entry-level wages, not just a stipend

New Journeys + Peer Support Services

Becky Daughtry, HCA
Presentation: First Episode Psychosis (FEP) New Journeys
Manual www.hca.wa.gov/assets/program/new-journeys-manual.pdf
HCA Website Early signs of psychosis | Washington State Health Care Authority

1. Goal is to make early identification and treatment of psychosis as a universal approach
   a. Psychosis is a disconnect of mind, many symptoms
   b. 100k youth experience an episode of psychosis
      i. The average duration of untreated psychosis is 2 years
      ii. Recommendation to start treatment <3 months of illness onset to prevent long term disfunction

2. Early intervention works: more likely to stay in treatment, greater symptom reduction, greater quality of life improvement, participate more in work or school (2008 RAISE Study)
3. Coordinated Specialty Care in Washington:
    a. 2015 success in Yakima lead to 2SSB 5903 (2019)
        i. Statewide plan with New Journeys teams and expansion
4. New Journeys (NJ): 20 teams, multidisciplinary and created from HCA, WSU, UW collaboration
    a. Provide services at home, work, school, clinical or community settings, online
    b. Referral Criteria:
        i. Ages 15-40
        ii. Pyschotic symptoms 1 week to 2 years
        iii. Primary diagnosis of set list
        iv. IQ over 70
        v. Referrals made online, reviewed by UW SPIRIT Lab and routed to appropriate team
    c. Screening usually happens within 72 hours, using person-centered treatment plan
    d. Measurement based care – data platform to assist in treatment planning
    e. Average time to graduation/program completion is 21 months
    f. Access: affluent neighbourhoods have highest, decreases with rurality
        i. Spacial location of services has heavy impact on what populations can access – can see in Health Professional Shortage Areas (HPSAs)
        ii. How to address:
            1. Expand Medicaid Encounter Rate (start 7/1/2024)
            2. Expand admission criteria to include affective psychosis (start 7/1/2024)
            3. Develop hub and spoke / virtual options when cannot do full in person
            4. Referral network and teleconsults
            5. WSU ….
    g. Certified Peer Counselors: 11 peer support specialists in New Journeys network
        i. Importance of adequate supervision training, funding
    h. Community Awareness Resources Education (CARE) kickoff conference had 979 registrations for awareness, resources and education
    i. Needs:
        i. Commercial insurance parity – unbundled Medicaid
        ii. Curriculum development (peer support, case management, virtual options when full in person not feasible)
        iii. Funding for training and model development for Peers
5. Questions:
    a. How often should clinician/providers on team meet with individual receiving treatment and their family? Up to participant. Full dose 8+ contacts by attested NJ team member per month.
        i. Encounter rate allows someone to maintain same level of service even if out of town, hospitalization, work, etc.
    b. Is NJ peer education different from others? That background but also coached and trained by UW for being a peer in coordinated care model
        i. More focus tends to go to credentialed service, so no one working directly on this yet

Youth Mobile Response and Stabilization Services (MRSS)
Sherry Wylie, Vashti Langford, & Sonya Wohletz, HCA

http://www.newjourneyswashington.org/locations-and-careers
County crisis line phone numbers (wa.gov)

1. MRSS partnership with SPARK, A Common Voice COPE Project, WA State Community Connectors, Statewide Family Network, hoping ot involve more youth via SPARK
    a. Resources: regional crisis lines, youth teams, involuntary treatment services
2. History of crisis services:
    a. More restrictive – adult model with acute presentations
        i. Facility based crisis intervention and stabilization
        ii. Loss of income during treatment – jobs, child/pet care impacted
    b. Involuntary Treatment Act – Designated Crisis Responders
        i. Legal process for danger to self, danger to others, or gravely disabled
    c. Frequent contact with Law Enforcement and Justice System
        i. Acute presentations – often require law enforcement response
        ii. Symptoms appear as non-compliance – arrests delay treatment
        iii. Incarceration and justice system involvement
3. 988 = suicide crisis lifeline established in 2020
    a. ESSHB 1477 (2021) CRIS Committees
    b. SB 5092 (2021) YYACC
    c. SAMHSA release best practices in crisis care in 2020 for Adults and 2022 for Youth
4. Went from 2 youth teams across state to 14 in last 2 years
5. MRSS:
    a. Adult best practice:
        i. Someone to Call
        ii. Someone to come (20/80)
        iii. Having a place to go
    b. Youth: opposite to adults → don't want to have to move youth
        i. Someone to call
        ii. Someone to come (80/20)
        iii. A safe place to be
    c. Approach to care: outreach to all Open Referrals
        i. Initial response (up to 3 days crisis intervention) all payors
            1. Voluntary intensive outpatient, so will make sure has consent and 24/7 access to care and a MRSS contact representative
        ii. If need more support, stabilization in home up to 8 week of intensive, in-home services
    d. System of care partners so family/youth driven, linguistically available, community based
        i. Peer support offers validation, support, and understanding to a crisis → allows for compassion, self-empowerment, hope to create a plan
    e. Care pathway: best pathway for youth is to stay at home, and have crisis team come to them
        i. Calling 911/emergency department admission can impede youth crisis response and recovery

   ii. Now all system partners → regional crisis line → MRSS team → delivers right level of service at right time and intensity to youth
      1. In person delivered behavioral health care providers
   iii. Future: Regional Crisis team via MRSS will have tech contact hub partnered with 988
      1. 988 also provides text and call options
      2. Teen Link is also text/call/chat support operated by youth: Home - Teen Link
6. Question: plan for rural outreach since light/no coverage?
   a. Some rural teams are the ones who have put forth the most youth teams
   b. CRIS Committee also doing work for rural resources
      i. Collecting stories of lived experience: Crisis Response Improvement Strategy (CRIS) committees | Washington State Health Care Authority
   c. Interest in tracking calls coming from rural communities and what has resulted (i.e. detention center from youth not responding to facility or calling recommended line)
      i. HCA working on quantitative data
      ii. Partners working on qualitative data and how to collect and integrate into system

Group discussion of YYA workforce & rates priorities

Collaboration document: 06/11 YYACC workforce & rates brainstorm - Google Docs

1. Workforce and Rates Subgroup starting prioritization at next meeting so gathering input now

Elevating family & youth voice through Mobile Response & Stabilization Services (MRSS)
Washington State
Washington State Health Care Authority

MRSS Youth, Family and System partnership

- Cece Byrd, LGBTQIA2S+ Liaison
- Jazmaine Wong, Tribal Liaison
- Shiyah Grant

- Janice Schutz, Executive Director
- Richelle Madigan, Grant Project Manager

- Sherry Lyons, Executive Director
- Jasmine Martinez, Assistant Director
- Andee Martinez, Grant Project Manager

What is a "Crisis" when a Caregiver Calls?

- “My child was just suspended from school.”
- “My child is having outbursts and destroying things in my home.”
- “The therapist said my teen is suicidal and needs to be inpatient.”
- “I keep having to get my child from daycare for hitting.”
- “I don’t know what’s wrong, but my kid is moody and isolating.”
- “I can’t get my kid to wake up and go to school.”
- “My child grabbed a pizza cutter and tried to cut their arm."
- “When my kids return from their dad, they won’t listen to me.”

Behavioral Health Administrative Services Organizations and Regional Crisis Lines

North Sound: 1-800-584-3578

King: 1-866-427-4747

Pierce: 1-800-576-7764

Salish: 1-888-910-0416

Thurston/Mason: 1-800-270-0041

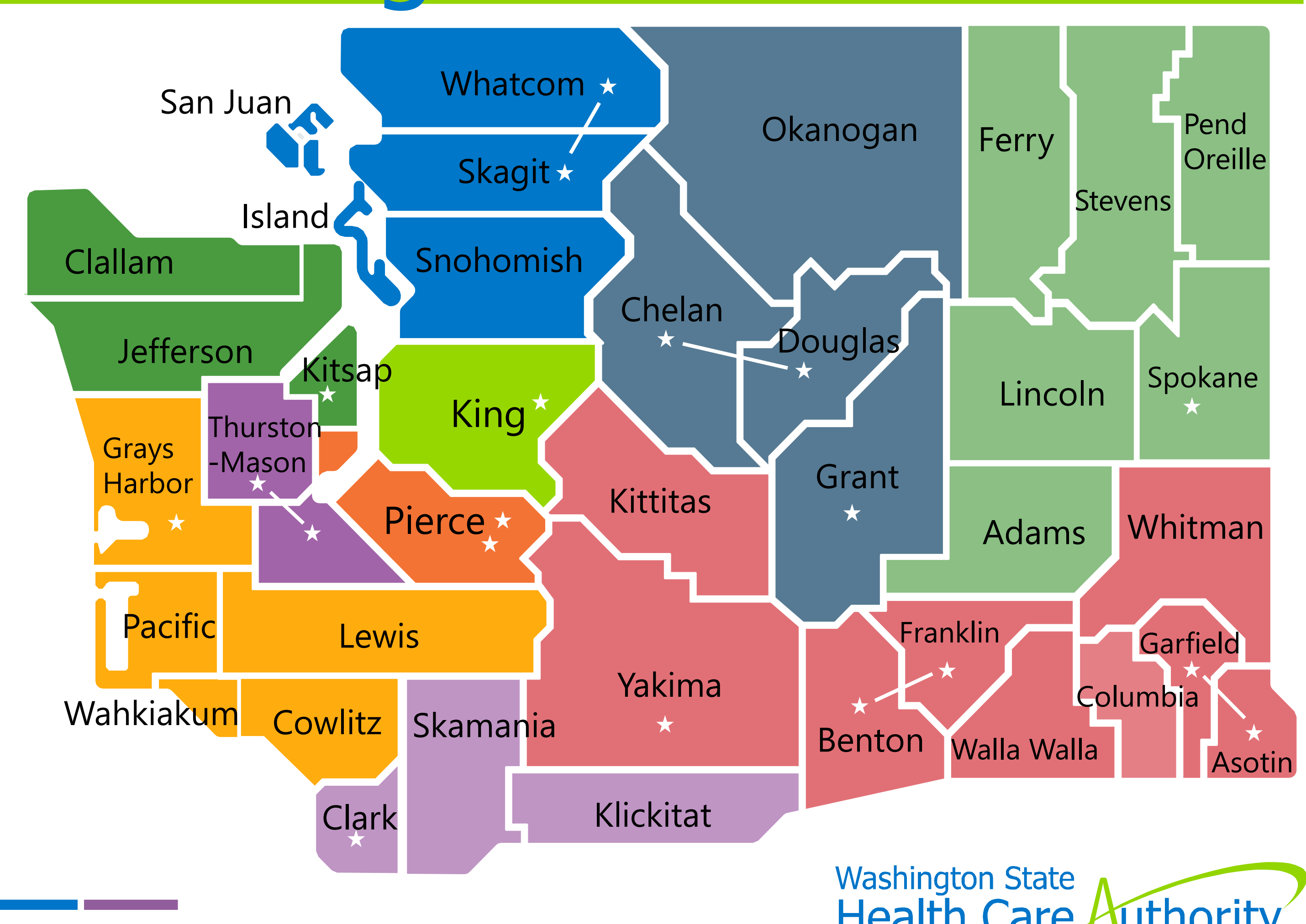
Great Rivers: 1-800-803-8833

Southwest: 1-800-626-8137

North Central: 1-800-852-2923

Spokane: 1-877-266-1818

Greater Columbia: 1-888-544-9986



☆ Location has youth teams

Washington State Health Care Authority

History of Crisis Services

- More restrictive - Adult model with acute presentations
  - Facility based crisis intervention and stabilization
  - Loss of income during treatment – jobs, child and pet care impacted
- Involuntary Treatment Act – Designated Crisis Responders
  - Danger to self, danger to others, or gravely disabled = legal process
- Frequent contact with Law Enforcement & Justice System
  - Acute presentations – often require law enforcement response
  - Symptoms appear as non-compliance – arrests delay treatment
  - Incarceration and justice system involvement

Background

2020 – Federal legislation – **988**

2021 – Washington Legislation:
- **ESSHB 1477** – Crisis Response Improvement Strategy Committee & subcommittees (CRIS Committees)

- **YYACC -** Proviso funding (SB 5092) – expand teams

2022 - **988** calls answered in Washington
- **All regional crisis lines remain operational**

SAMHSA releases best practices in crisis care
- **2020** - Adults
- **2022** - **SAMHSA & NASMHPD - Youth**

Mobile Response and Stabilization Services – Youth Teams

Greater Columbia
- Comprehensive Healthcare – Benton/Franklin (NEW)
- Quality Behavioral Health – Garfield/Asotin (NEW)
- Comprehensive Healthcare – Yakima (NEW)

King
- Children's Crisis Outreach Response System (CCORS)

North Central
- Renew – Grant (NEW)
- Catholic Charities – Douglas (NEW)
- Catholic Charities – Chelan (NEW)

North Sound
- Compass Health – Whatcom (NEW)
- Compass Health – Skagit (NEW)
- Compass Health – Snohomish (Pending)

Pierce
- Catholic Community Services – Tacoma
- Seneca Family of Agencies – Tacoma (NEW!)

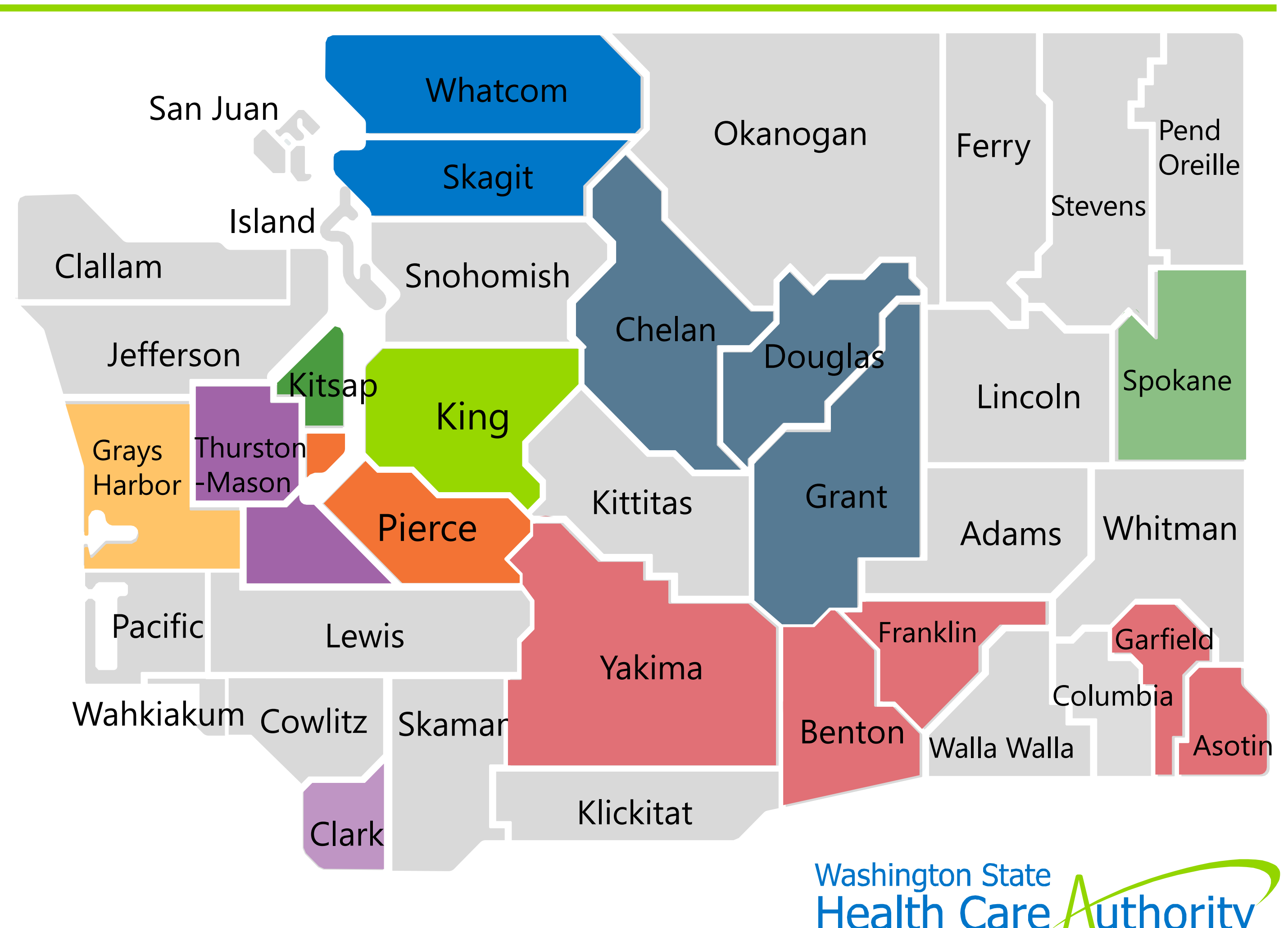
Salish
- Kitsap Mental Health – Bremerton (NEW)

Spokane
- Frontier Behavioral Health – Spokane (NEW)

Southwest
- Catholic Community Services - Clark

Great Rivers –
- Columbia Wellness (NEW!)

Thurston/Mason
- Catholic Community Services –Thurston
- Catholic Community Services - Mason



Washington State Health Care Authority

Mobile Response and Stabilization Services (MRSS)

Youth Crisis Continuum

SAMHSA
Substance Abuse and Mental Health Services Administration

Self-Defined Crisis

YOUTH FAMILY

988

SOMEONE TO TALK TO

SOMEONE TO RESPOND

A SAFE PLACE TO BE

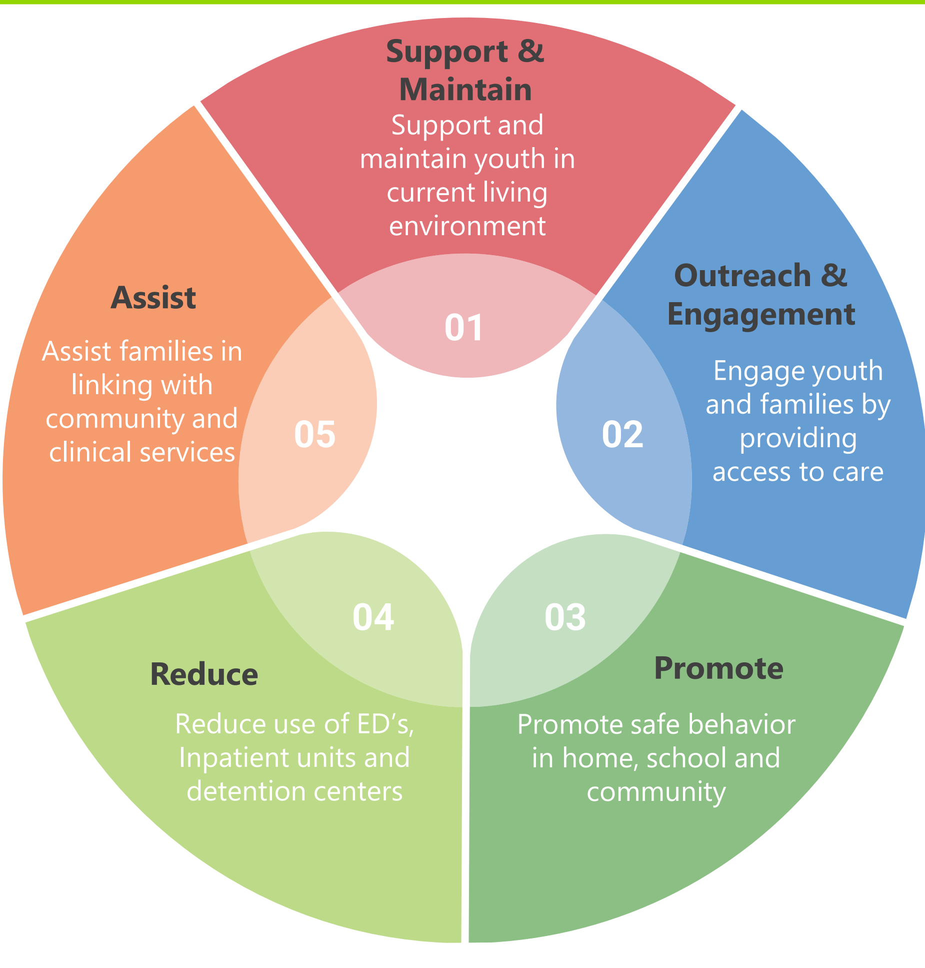
CORE PRINCIPLES
Safety • Equity • Trauma-informed • Peer Support
Culturally and Developmentally Appropriate
No Wrong Door

Best Practices:

- Adult
  - Someone to call
  - Someone to come – 20/80%
  - **Somewhere to go**

- Youth
  - Someone to call
  - Someone to come – 80/20%
  - **A safe place to be**

Goal of Mobile Response & Stabilization



MRSS Offers Outreach to all Open Referrals

Initial Response (*up to* 3 days of crisis intervention) all payors

Family or youth define the crisis, in person response, at home, school, community

Developmentally appropriate engagement, crisis de-escalation, assessment

Keep youth in homes, safety planning, securing the home, increase supervision

Brings the Crisis Continuum to the family

Stabilization in-home (*up to* 8 weeks of intensive, in-home services)

Intervention and stabilization phases are distinct but must be connected

In home, schools, community. In person 24/7 access to treatment team

Link families with natural and community supports, arts, activities, parent groups

Care coordination and warm handoffs to existing systems of care and clinical supports when clinically appropriate

MRSS Improves Outcomes

Youth stabilized in the home and community, preventing return to crisis phase

Youth and families trust the system – they will reach out in their lifetime

Reduces use of 911, unnecessary contact with law enforcement or going to the ED to get help

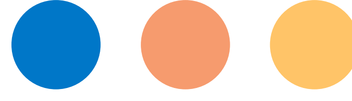
Connected to systems of care, peer networks, and the right level of clinical supports

Improved outcomes and downstream supports through wraparound principles

MRSS Teams are System of Care Partners

- Behavioral Health Systems
- School systems, Youth Shelters
- Department of Children Youth and Families/ Foster Care Networks
- Law Enforcement, Juvenile Justice, and Family Courts
- Intellectual and Developmental Disability Systems
- Emergency Departments, 23-hour Crisis Receiving Centers and Inpatient Stabilization Facilities/Hospitals
- Family and Youth, Young Adult Peer Run Organizations
- Poison Control and Emergency Medical Services

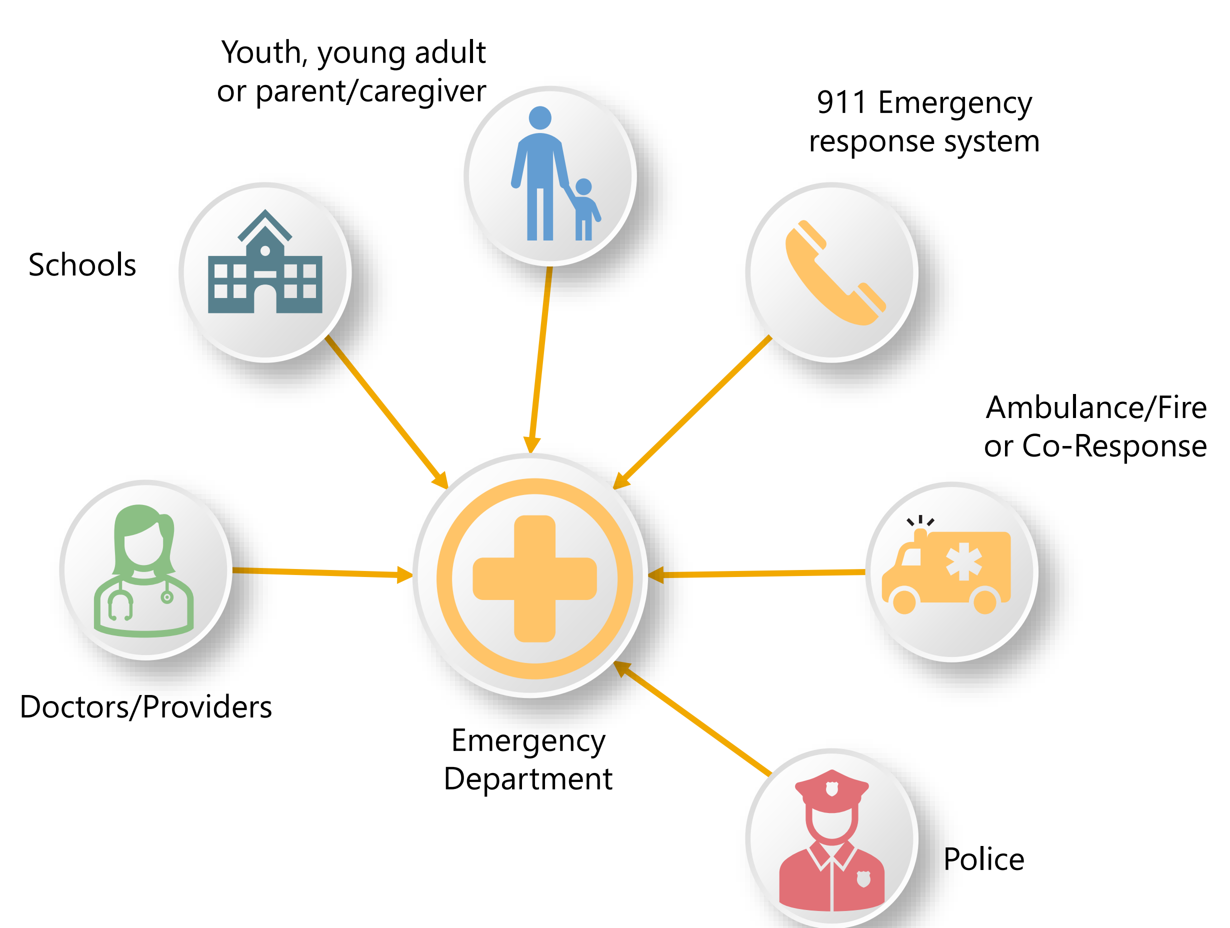
Importance of Peers in MRSS



Peer support (Youth Peer or Family Peer) is important for MRSS because Peers offer validation, support, and understanding to a crisis that has not always been found in other professional relationships.

This is due to the lived experience and allows for compassion, self-empowerment and provides hope while helping the family create a plan.

Care pathway via 911 & the medical model



- How do families access services?
- Caregivers call 911 in a crisis
- ED remains primary access point – rarely results in downstream supports
- Can result in hospital boarding
- SSHB 1580 – Children in crisis
- 23-hour Crisis Receiving Centers

MRSS is designed to create care pathways for youth

Regional crisis lines connect callers to the crisis system including MRSS teams

Youth, young adult or parent/caregiver

School

Doctors/Providers

Ambulance/Fire or Co-Response

Police

Regional Crisis Line

MRSS team

Responds in person where youth is

Youth and parent led

Wraparound principles

Warm handoffs to clinical care

Improved outcomes

Youth crisis care pathway

Least restrictive

*Regional Crisis Lines - Behavioral Health Response System (HCA)

*In-person response prioritized for youth

Regional Crisis System and 988 Suicide Lifeline

Regional Crisis Lines and Crisis System

Can ask demographics to determine response

RCL

MRSS team

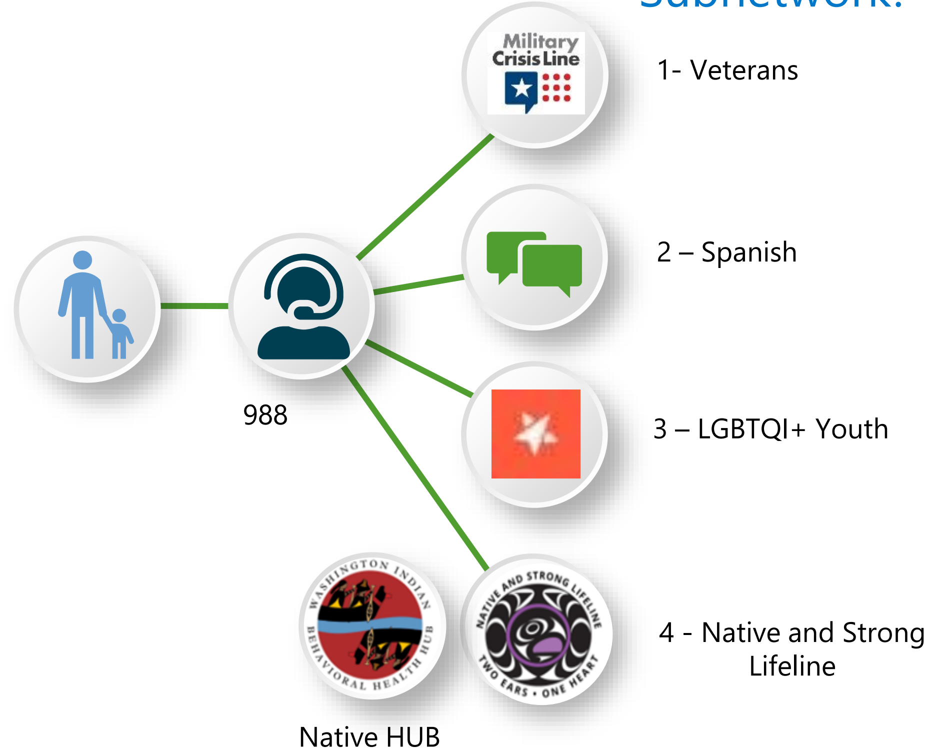
988 Hub

988 Contact Hub & Tech Platform (future state)

988 Network – Answered In-State

(Confidential Support)

Subnetwork:



988

1- Veterans

2 – Spanish

3 – LGBTQI+ Youth

4 - Native and Strong Lifeline

Native HUB

*Regional Crisis Lines - Behavioral Health Response System (HCA)

*In-person response prioritized for youth

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- “When my kids return from their dad, they won’t listen to me”

Mobile Response and Stabilization Services (MRSS)

- Provides rapid in-person support for youth and families during a crisis
- Follow up for 1-3 days
- The stabilization phase is a medically necessary service that begins on day 4.
- Families have access to the MRSS team 24/7

Contact us:
Vashti Langford, MRSS Family Liaison
Sonya Wohletz, MRSS Project Director
Liz Venuto, Prenatal – 25 Supervisor
Sherry Wylie, Youth Mobile
Crisis Team (MRSS) Administrator

Questions?

June 11, 2024

New Journeys helped me to live independently without the trials of mental illness. To be strong in the face of adversity.
– New Journeys graduate

First Episode Psychosis New Journeys

Becky Daughtry, MSW, LICSW

HCA FEP Inbox

Overview

- What is psychosis?
- Brief history of first episode psychosis work
- Summary of legislation and statewide expansion
- Brief review of the model & how to make referrals
- Measurement & Data Collection
- Future planning, needs and direction
- Questions

Symptoms Associated with Psychosis

- Hallucinations
- Delusions/Ideas of Reference
- **Disorganized Behavior and/or speech**
- Confused Thinking and Other Cognitive Deficits
- **Negative Symptoms**
  - **Lack of energy, motivation, and/or expressiveness**
  - Decline in social functioning
- **Depression**
- **Anxiety**

THE FACTS

3 OUT OF EVERY 100 YOUNG PEOPLE WILL EXPERIENCE AN EPISODE OF PSYCHOSIS IN THEIR LIFETIME, MAKING IT **THE 3RD MOST DISABLING CONDITION IN THE WORLD**

THE AVERAGE DURATION OF UNTREATED PSYCHOSIS IN THE U.S. IS MORE THAN 2 YEARS.

UNTREATED PSYCHOSIS CAN LEAD TO:

- INCREASED SUBSTANCE USE
- MORE HOSPITAL VISITS
- LEGAL TROUBLE
- RISK OF HOMELESSNESS
- PREMATURE DEATH

Early Intervention Works

2008 RAISE Study

- 34 Clinics across 21 states
- Randomly assigned between NAVIGATE and regular outpatient care
- Compared to treatment as usual youth and young adults participating assigned to the NAVIGATE group:
  - Were more likely to stay in treatment
  - Experienced greater reductions in symptoms
  - Demonstrated greater improvements in quality of life
  - Participated more in work or school

Kane et al., (2016). Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. *The American journal of psychiatry*, *173*(4), 362–372. https://doi.org/10.1176/appi.ajp.2015.15050632

Coordinated Specialty Care in Washington

- International research supports Evidenced Based Treatments for FEP
- **2008** RAISE trials conducted in the U.S.
- **2014** U.S. Congress directs MHBG funds for FEP
- **2015** New Journeys is piloted in Washington
- **2019** 2SSB 5903 is passed into legislation
- **2023** 17 New Journeys teams statewide

2nd SSB 5903 (Sec. 6), 2019

For the purposes of developing a statewide plan to implement evidence-based coordinated specialty care programs that provide early identification and intervention for psychosis, HCA will:

Legislative Direction	Policy Implementation
Statewide Plan	The Statewide Implementation Plan of Coordinated Specialty Care for Early Psychosis
Team Based Rate for Medicaid	New Journeys Team Based Rate Implemented beginning July 1, 2022; Encounter Rate beginning July 1 2024.
One team in each region	20 New Journeys teams in 10 regions
Statewide access	Future expansion based on incidence and population

New Journeys

Washington's model of coordinated specialty care

Reference: New Journeys Policy and Procedure Manual

New Journeys organization chart

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First Episode Psychosis Initiative Manager

Dawn Miller
SEE Trainer

Darren Paschke
SEE Trainer

Health Care Authority Program and Policy Administration Team

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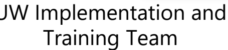
Psychiatric Care Provider Trainer

UW Implementation and Training Team



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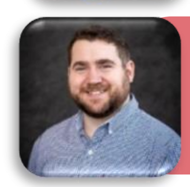
Lead Evaluator

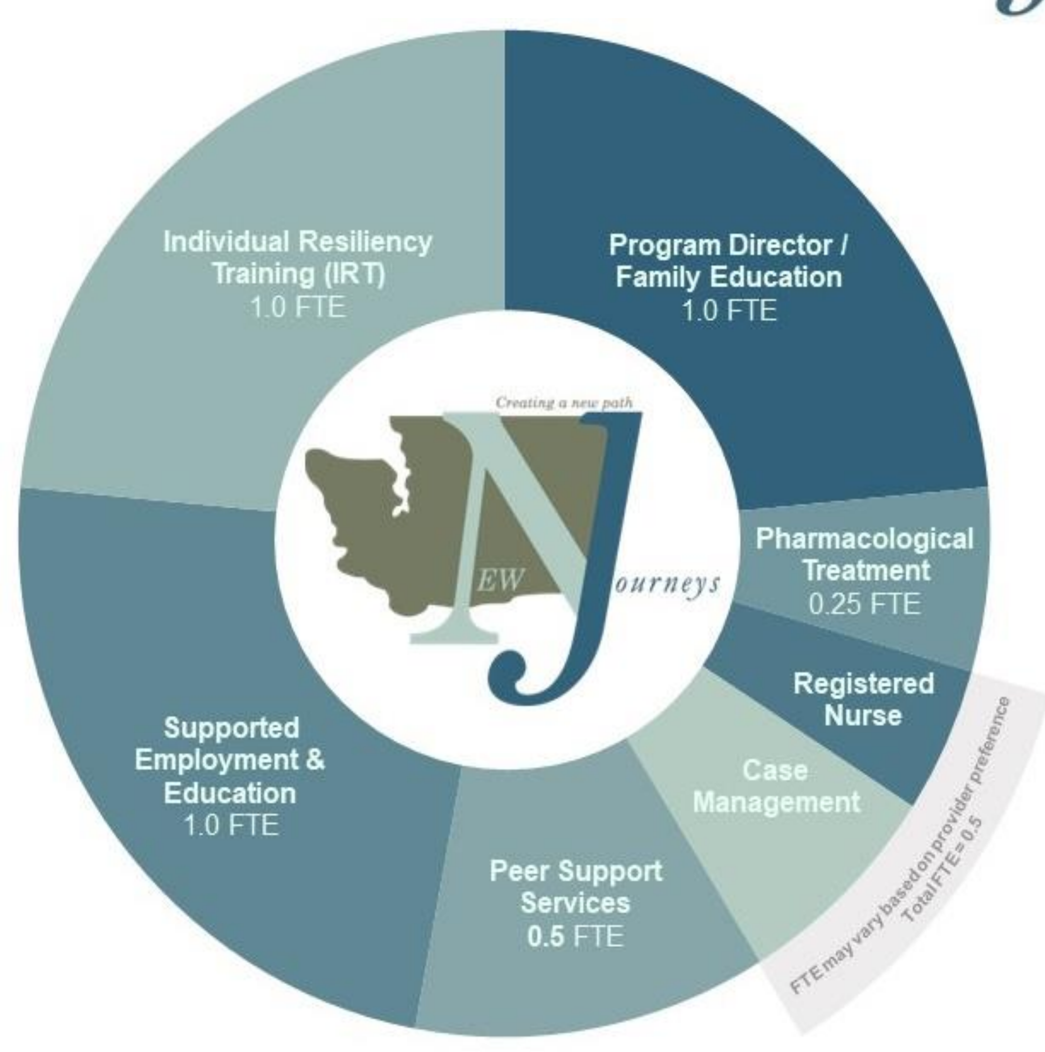

Sheldon Stokes, BA
Research Coordinator

Bryony Stokes, BA
Research Coordinator

WSU Evaluation Team

New Journeys

- The New Journeys team members include:
  - Program Director/Family Education Provider (1.0 FTE)
  - Psychiatric Care Provider (0.25 FTE)
  - Individual Resiliency Training (IRT) Clinician (1.0 FTE)
  - Supported Employment and Education (SEE) Specialist (1.0 FTE)
  - Peer Support Specialist (0.5 FTE)
  - Case Manager and/or Registered Nurse Care Manager (0.5 FTE)
- Teams may choose to substitute a nurse care manager (~0.2 FTE) for all or part of the case manager FTE count.



Referral to New Journeys

Admission criteria

1. **Ages 15-40**
2. Psychotic symptoms have been present between 1 week & 2 years
3. **Primary diagnosis of one of the following**:
   - Schizophrenia
   - Schizoaffective disorder
   - Schizophreniform disorder
   - Brief Psychotic disorder
   - Delusional disorder
   - Major Depressive disorder with psychotic features*
   - Bipolar disorder*
   - Other specified Psychotic disorder
4. IQ over 70

Psychosis is NOT known to be caused by:

- Pervasive developmental disorder and/or Autism Spectrum disorder
- Psychotic disorder due to another medial condition including medication induced psychotic disorder
- The temporary effects of substance use or withdraw

Make a referral

- Referrals can be made directly to a New Journeys team
- Referrals are reviewed by a member of the UW SPIRIT lab
- They will ensure the referral is routed to the appropriate team

Make a Referral

New Journeys is for youth and adults between the ages of 15 to 40 years old. The person should have experienced psychotic symptoms for more than or equal to 1 week and less than or equal to 2 years. If this describes you or a loved one, and you need assistance finding care in Washington State, please complete the form below and staff will direct your inquiries to your nearest New Journeys provider.

Referral Form

A A A

Please complete the survey below, and a member of our team will contact you within a week, although we are often able to respond within 2 business days.

Relationship to Referral
* must provide value
What is your relationship to the referred individual? (E.g. Outpatient therapist, parent, self, inpatient social worker))

Referrer's Name
* must provide value

Name of business or program, if applicable

Referrer's Phone

Referrer's Email Address

Referral's Name
* must provide value

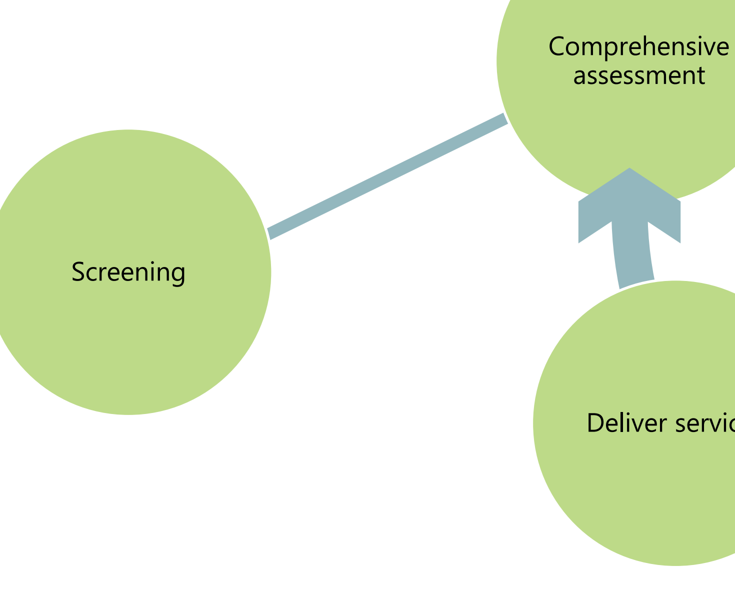
Referral's Phone Number
* must provide value

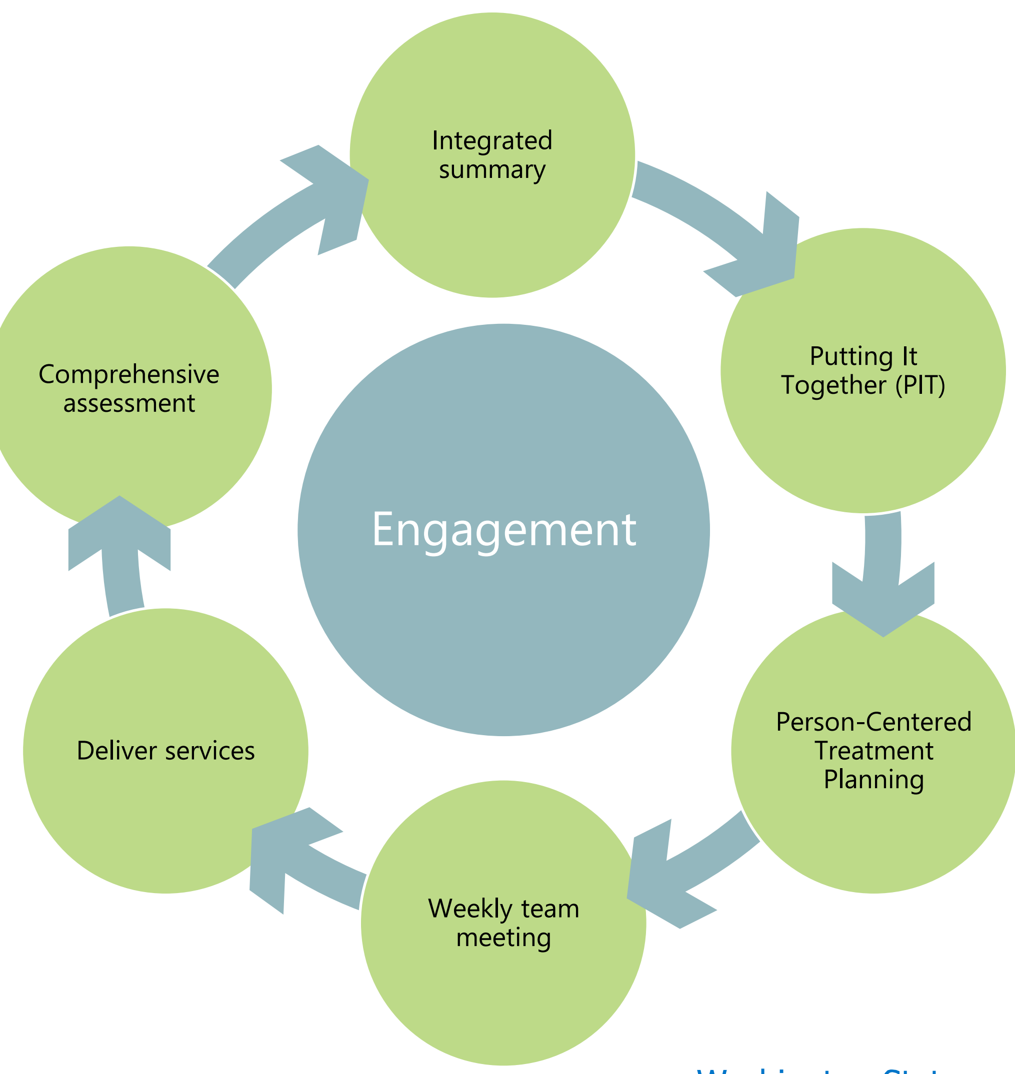
Referral's Date of Birth (or age if unknown)

Zip Code of Referral's Primary Address

How the team works together

Flow of clinical & communication process

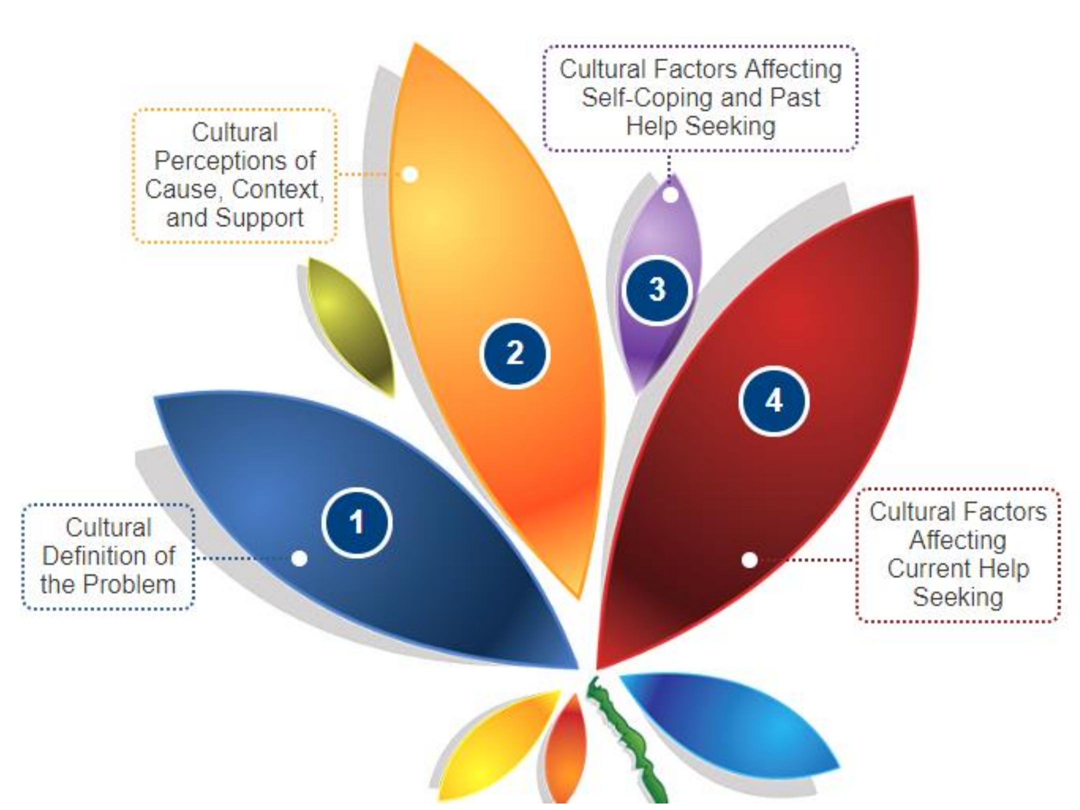




The New Journeys Approach

- Focus is on hope, getting back on track with your life
- Participants choose their own path
- Services provided at home, school, in the community
- Honors the interconnectedness of family & works to preserve those relationships
- Emphasis on community education
- Rapid assessment and extraordinary efforts to engage

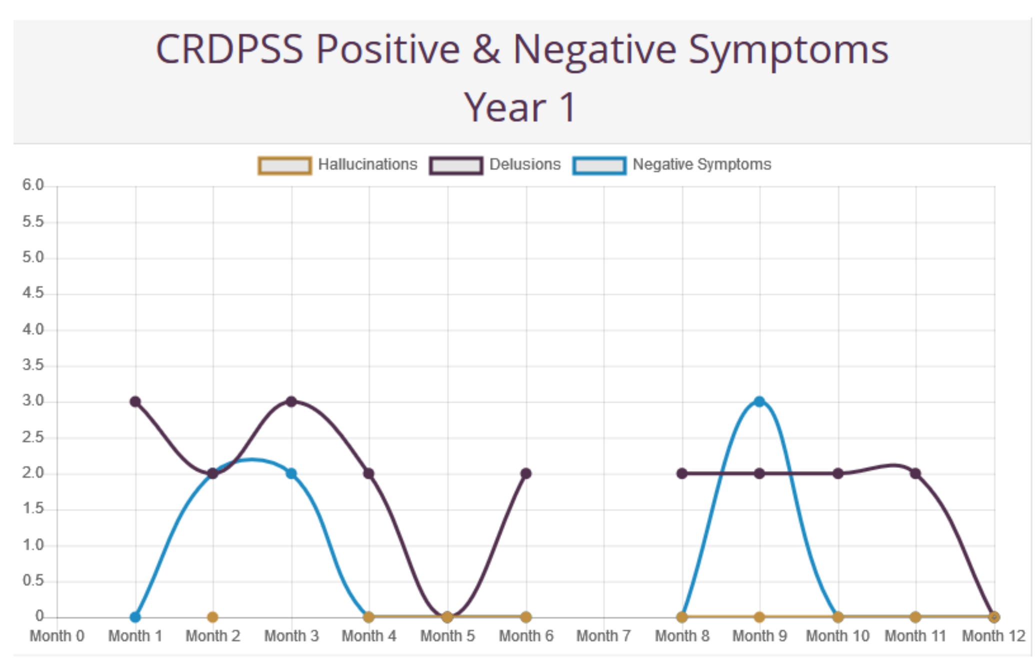
Culturally informed care

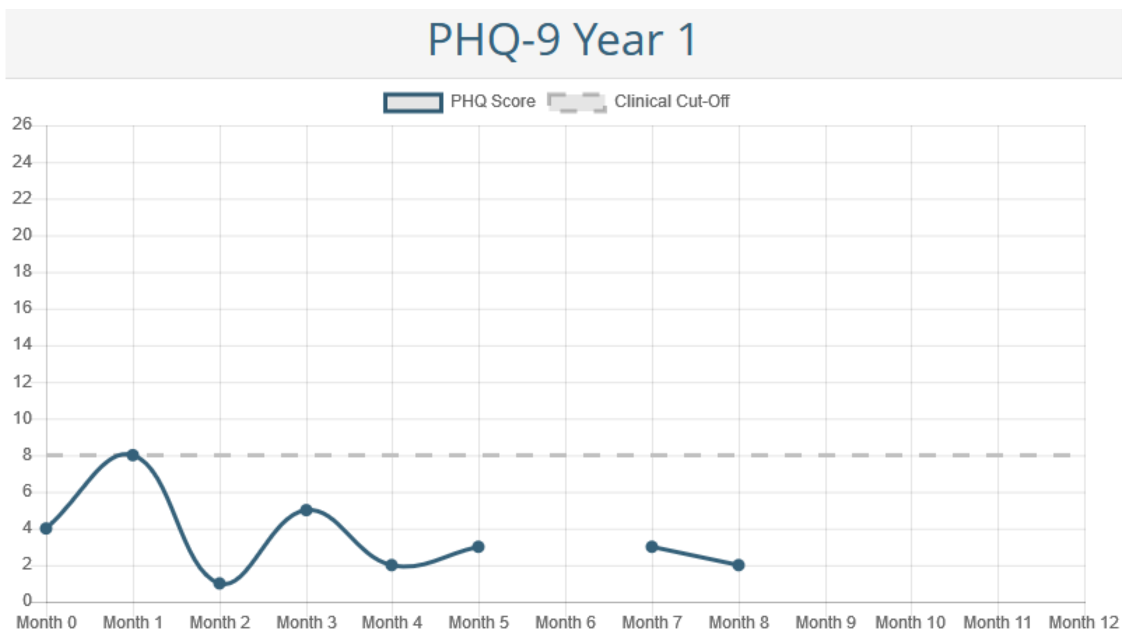


- Culturally informed care by using cultural assessment tools.
- Peer support specialists and family peer specialists.

Measurement-based care

- New Journeys measurement delivery and data platform





2023 New Journeys Evaluation Outcomes

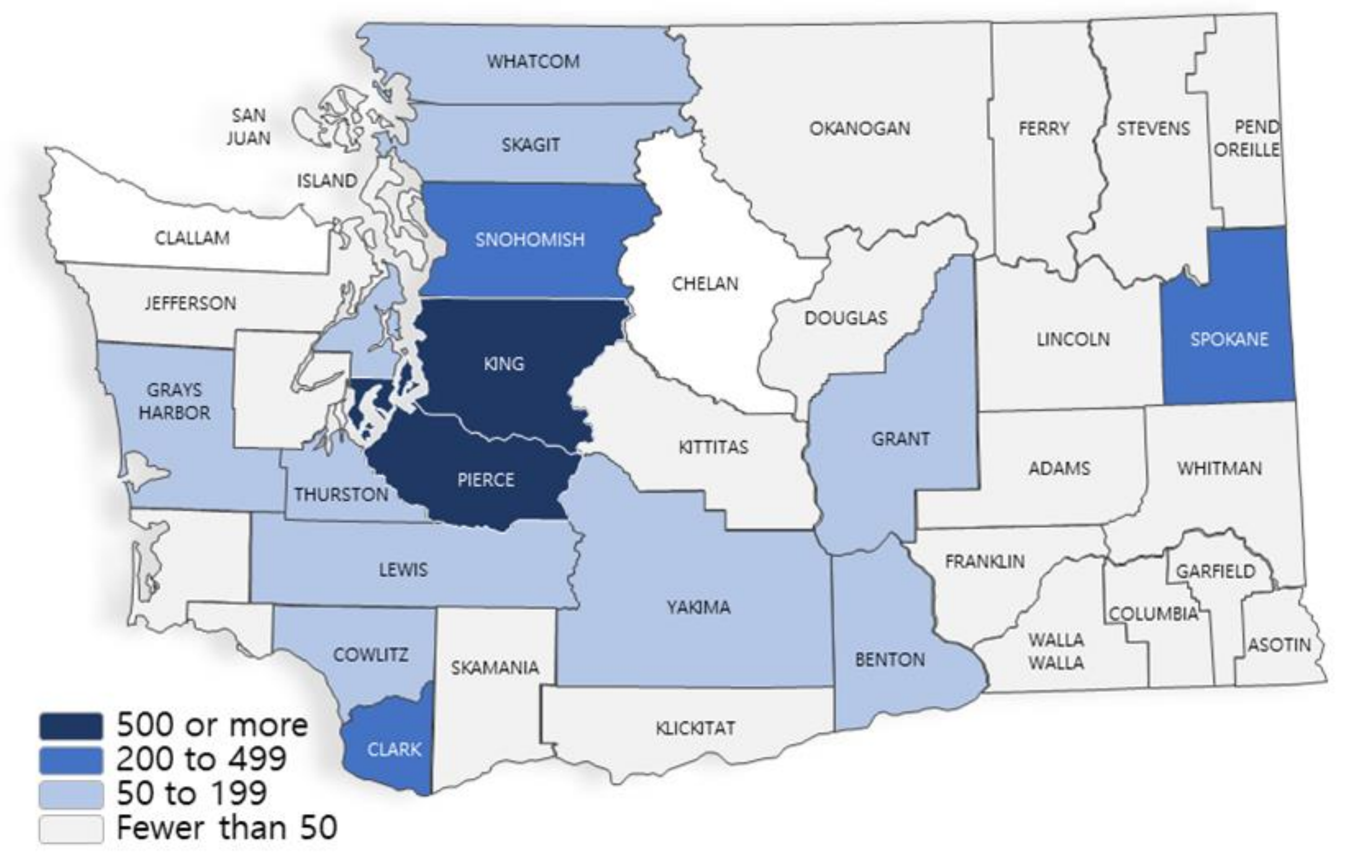
New Journeys participants reported:

- Decreased experiences of psychosis
- Significant decrease in depression
- Significant decrease in anxiety
- Improvements in quality of life
- Increase in school enrollment from 27% to 55% post-enrollment
- Gradual increase in the number of people served each year

Average time to Graduation/Program completing
21 months

WA Incidence of Early Psychosis

MEDICAID ENROLLEES WITH FIRST EPISODE PSYCHOSIS IN SFY 2021 (age 0 – 64), TOTAL = 4,388



Hong, G., Lin, Y., Lucenko, B., & Felver, B. (2022). First Episode Psychosis: Estimating Annual Incidence Using Administrative Data.

New Journeys Teams

Sea Mar Community Health Centers
Clínica de la Comunidad
Exceptional service. Every person. Every time.

Lummi Nation
Treaty of 1855

Lifeline Connections

Ryther

Peninsula Behavioral Health

Kitsap Mental Health Services

UW Medicine
Harborview Medical Center

Valley | Cities
Behavioral Health Care

Lucid Living

Pathways of Washington
People. Passion. Service.

BHR Behavioral Health Resources

Cascade Community Healthcare

- ● Established Site
- ★ Startup Site
- ▲ Pilot Site

Sea Mar Community Health Centers
Clínica de la Comunidad
Exceptional service. Every person. Every time.

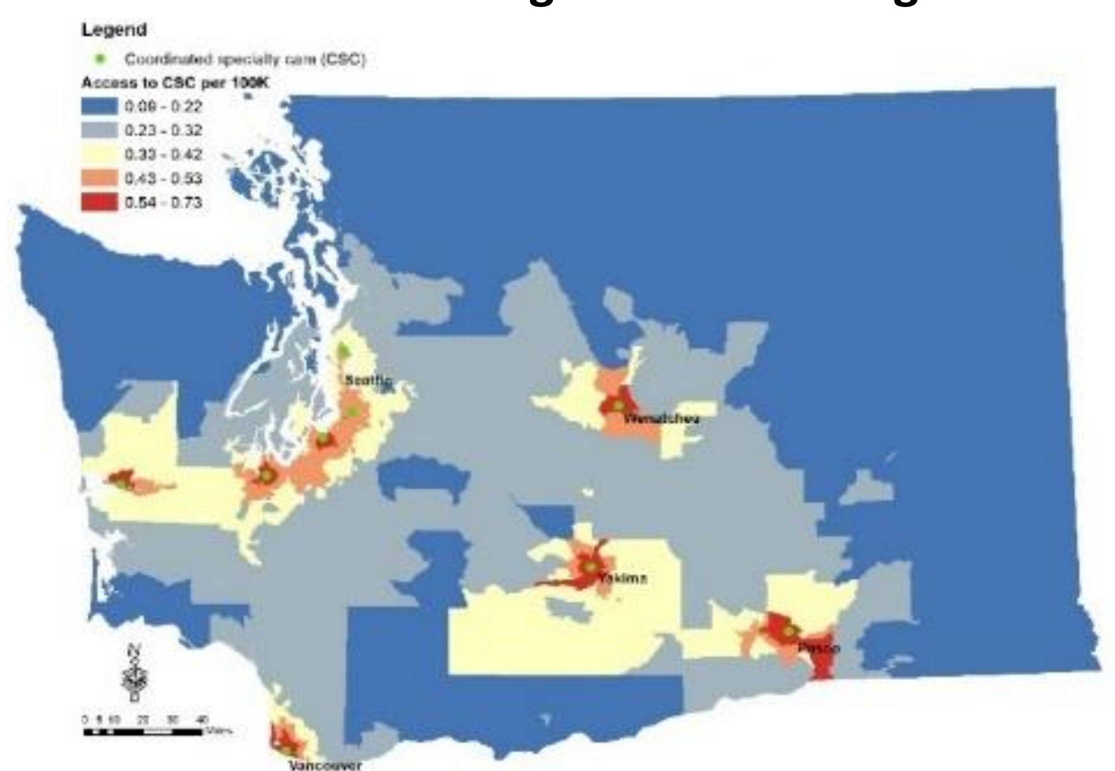
Comprehensive Healthcare

Catholic Charities
Serving Central Washington

Frontier Behavioral Health

Access to services

Distribution of CSC Programs in Washington State

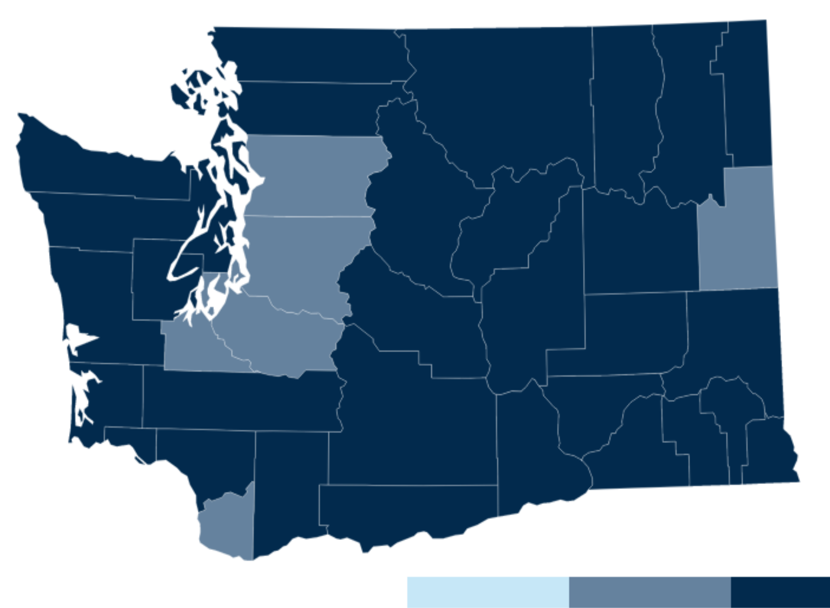


- More affluent neighborhoods had the highest accessibility to CSC
- Accessibility decreased as rurality increased
- Spatial location of services contributes to referral decisions and treatment delays

Oluwoye et al., 2021 Geographic disparities in access to specialty care programs for early psychosis in Washington State.

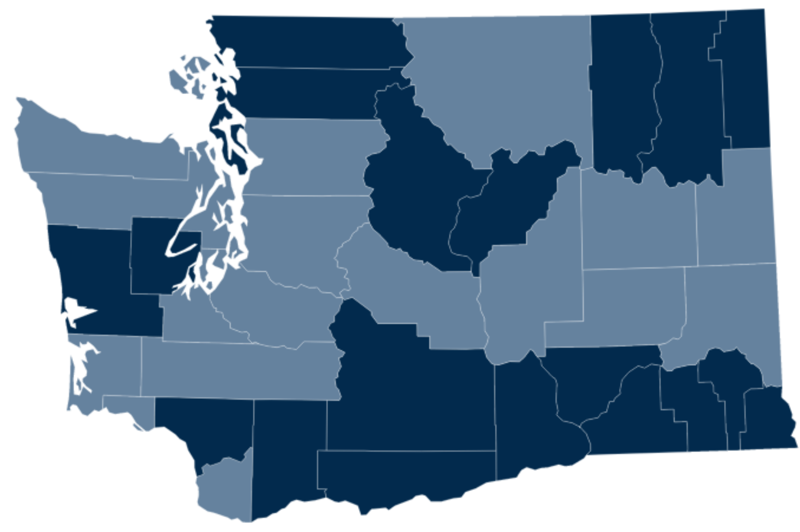
Shortage areas

Mental Health Shortage Areas (HPSAs)



Source: data.HRSA.gov, May 2023.

Primary Care Shortage Areas (HPSAs)



Source: data.HRSA.gov, May 2023.

How many more teams do we need?

Statewide Regions	Estimated # of teams low to high	Annual incidence FEP estimated	2024 existing /planned teams	Projected Future need
Salish	1-2	82	2	
Thurston-Mason	1-2	77	1	
Great Rivers	.5 -1.5	57	2	
Pierce	2.8 -5.4	218	2	1+
King	4.7 - 14.2	561	4	1+
North Sound	2.5 - 7.3	294	3	1+
North Central	.5 - 1.4	57	1	.5
Spokane	2- 3.5	142	2	1
Southwest	1.5- 3	113	1	1
Greater Columbia	1.5- 4.5	189	3	1

*per Statewide Implementation Plan 2020 82

* based on incidence and population data RDA 2018

Rural

Urban

North Sound
North Central
Spokane
Salish
King
Thurston-Mason
Pierce
Great Rivers
Greater Columbia
Southwest

Washington State Health Care Authority

Activities to address access to services

- Expand Medicaid funding to include an Encounter Rate
- Expand admission criteria to include affective psychosis
- Develop Hub-and-Spoke CSC model and virtual options where full in-person CSC isn't feasible
- Central Assessment of Psychosis Services (CAPS) (Kopelovic et al., 2022) developing a referral network & Tele-consultation
- Native American cultural adaptations (Oluwoye et al., 2023)

New Journeys Certified Peer Counselors

- Can be youth, family/parent, and adult peers
- 11 peer support specialists in the NJ network
- Current Training & support:
  - OnTrack NY manual & Pat Deegan Recovery Library
  - Participate in monthly coaching calls though UW
- Current feedback:
  - Importance of adequate supervision training (Gehring 2024)
  - Gradually Peers are involved and integrated into the teams more-used as case aides less (Gehring 2024)
- Needs identified:
  - New Journeys Peer Support manual
  - funding and support for CEU's beginning in 2025
  - Motivational interviewing and Hearing Voices Network training
  - training for supervisors in how to supervise peers

Power Statements

- "My experience with New Journeys was life changing. My schizophrenia was really bad before I came to New Journeys, it was so bad that I tried to commit suicide. But now that I've been going to New Journeys, I'm not suicidal anymore. I won an award for best mentally improved, thanks to New Journeys, and I'm better than before I went to New Journeys."
- "New Journeys means an extra opportunity at something important."
- "My goal is to work with animals in the medical field. If I hadn't gotten diagnosed, medicated, or hadn't had the support of New Journeys, I would likely not be able to pursue my goal to the place I want to be. Their support is invaluable to me."
- “New Journeys is ‘to live independently without the trials of mental illness. To be strong in the face of adversity.’”
- "New Journeys has helped me put my life and my mind in perspective and got me ready for the work force in a crucial time of need for myself."

Join us for the Psychosis CARE Virtual Conference Dedicated to Community Awareness, Resources, and Education

April 30th & May 1st, 2024

Community Awareness Resources Education

979 Registrations!

Needs

- Commercial Insurance parity
  - Sustainability of Medicaid funding depends on not “unbundling” the rate
  - Duration of untreated psychosis
- Curriculum development for Peer Support, Case Management and virtual options where full in-person CSC isn’t feasible.
- Funding for training and model development for Peers

Financing strategy for Medicaid

- If provider's contract specifies a team-based case rate payment structure, the below procedure codes should be used choosing between two separate reimbursement structures based upon threshold of intensity and 24 months of intervention.
  - Option A: H2041 HT-New Journeys Encounter rate
  - Option B: T2022 HT Tier 1 Team Based Rate (TBR)

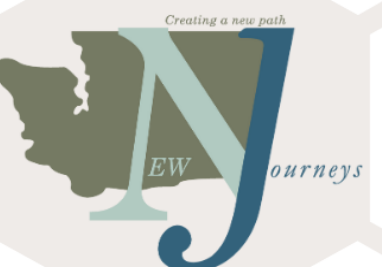
    T2023 HT Tier 2 Team Based Rate (TBR)

NEW JOURNEYS MODEL

Personalized therapy

Support and education for families

Employment/ Educational Support



Help with medications

Symptom and stress management

Peer support and counseling

MADRONA RECOVERY

From Crisis to Opportunity

ABOUT US

Madrona Recovery is a leading recovery organization committed to compassionately serving youth struggling with mental health and substance use. With a focus on healing relationships, comprehensive care, and support for caregivers, Madrona Recovery empowers individuals and their families to navigate the path from crisis to opportunity.

WHO WE SERVE

We serve adolescents ages 12-17 who are struggling with mental health and/or substance use challenges at our Tigard campus

GENERAL OVERVIEW OF SERVICES

- Secure facility
- Access to outdoor recreation areas
- Garden
- Goats
- Focus on youth-driven community living
- Psychiatry, Individual and Family therapy, Group Therapy and Process Groups
- Substance Use Disorder Counselling
- Nursing care
- 24-hour supervision by trained Wellness Counsellors

CLINICAL OFFERINGS

- Psychiatric Evaluation at Intake, 30-minute weekly consults, and medication management with a certified Child Psychiatrist
- History and Physical at Intake and access to nursing staff 10 hours/day
- Biopsychosocial Evaluation
- Weekly Individual and Family Therapy with a Qualified Mental Health Provider
- Substance Use Screening and evaluation
- Substance Use Disorder Counseling with a certified Alcohol and Drug Counselor
- Skills coaching to increase efficacy and well-being
- Relapse Prevention and Safety Planning
- Case Management
- Collaborative treatment and discharge planning and coordination for aftercare transition

MILIEU THERAPIES

- **Group Therapies:**
  - **Daily Community Meeting**
  - **7 Hours of psychoeducation and process groups daily**
- **Milieu Wellness Counseling:**
  - **3:1 ratio of youth to supervising Wellness Counselors**
  - **Counselors trained in the Community Resiliency Model (Trauma Resource Institute)**
- **Partnerships:**
  - **4D (Youth recovery center)**
  - **Harmony Academy and Rivercrest Academy (local recovery high schools)**
  - **The Recovery Gym (Alano Club of Portland)**

PROGRAM CURRICULA

- Art Therapy
- DBT
- Collaborative Problem Solving
- Seeking Safety
- Social and Emotional Skills
- Motivational Enhancement
- Refusal Skills/Relapse Prevention
- Recreational Therapies
- Life Skills

TEAM A GROUP SCHEDULE

Wednesday	Team	Group	Counselor(s)	Room
10:00 a.m.	Both	Community Meeting	Giuliana	Community Room
11:00 a.m.	Both	Recovery Meeting	Kelsey	Group Room
	North	Lunch	Wellness	Dining Hall
1:00 p.m.	Both	Recreation	Wellness	Recreation Room
2:00 p.m.	Team A	Tx Theme	Giuliana	Class Room
3:00 p.m.	Team A	Recovery Skills	Chris	Group Room
4:00 p.m.	Both	Art Therapy	Melissa	Art Room
	North	Dinner	Wellness	Dining Hall
6:00 p.m.	Team A	Life Skills	Chris	Group Room
7:00 p.m.	Team A	Art Therapy	Melissa	Art Room
8:00 p.m.	North	Chill Time	Wellness	North Building

TEAM B GROUP SCHEDULE

Wednesday	Team	Group	Counselor(s)	Room
10:00 a.m.	Both	Community Meeting	Giuliana	Community Room
11:00 a.m.	Both	Recovery Meeting	Kelsey	Group Room
	South	Lunch	Wellness	Dining Hall
1:00 p.m.	Both	Recreation	Wellness	Recreation Room
2:00 p.m.	Team B	Recovery Skills	Chris	Group Room
3:00 p.m.	Team B	Tx Theme	Giuliana	Class Room
4:00 p.m.	Both	Art Therapy	Melissa	Art Room
	South	Dinner	Wellness	Dining Hall
6:00 p.m.	Team B	Art Therapy	Melissa	Art Room
7:00 p.m.	Team B	Life Skills	Chris	Group Room
8:00 p.m.	South	Chill Time	Wellness	South Building

SAMPLE DAILY SCHEDULE

ADMISSION CRITERIA (AT LEAST TWO OF THE FOLLOWING)

- Recent symptoms of a psychiatric disorder and co-morbid substance use.
- Suicidal ideation or non-lethal threats or gestures may be present.
- Recent history of self-harm and other risk-taking or endangering behavior requiring 24-hour supervision.
- Disordered behavior or psychomotor agitation that interferes with activities of daily living to the extent that psychiatric structured living and 24-hour supervision are required
- As a result of psychiatric disorder, the client can maintain adequate nutrition or self-care only with structure and supervision for a significant portion of the day.
- The client has sustained side effects of atypical complexity resulting from psychotropic substances.
- There is severe, sustained, and pervasive dysfunction which has failed to respond to an adequate course of interventions at a lower level of care.

EXCLUSION CRITERIA

All referrals are reviewed on a case by case basis, however the following can be referenced as possible exlusion criteria for our program

- Medically unstable conditions requiring 24-hour nursing care in a medical/ surgical facility (including life-threatening anorexia and medically dangerous detoxification).
- Acute psychiatric disturbances requiring the intensive surveillance and structures of an acute care hospital.
- Age less than 13 (except on a case-by-case basis). Age equal to 18 or older (except on a case-by-case basis)
- Intellectual disability (IQ below 70), Severity of disability > Moderate
- Delirium with no other coexisting psychiatric condition
- Autism Spectrum Disorders with no other coexisting psychiatric condition
- Eating disorders with no other coexisting psychiatric condition
- Active fire setters
- Active sex offenders
- Recent history of serious physical violence to clients or staff in another comparable, structured treatment setting

THANK YOU

Paul Bryant LCSW, CADC III
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www.madronarecovery.com

Please call 503-749-0200 x530 to
speak with our Admissions Team