November 2024

Transforming Washington's Children and Youth System of Care: Report on System Changes and Innovations

Report to the Legislature
(Revised Code of Washington 43.06.535)

OFFICE OF GOVERNOR JAY INSLEE

Acknowledgments

The development of this report would not have been possible without the collaborative efforts and dedication of many individuals and organizations committed to improving the children and youth system of care in Washington state. We extend our heartfelt thanks to everyone who contributed their time, expertise, and perspectives to this important work.

First and foremost, we want to thank the lived experience experts and families who shared their experiences and provided invaluable feedback. Their voices were essential in ensuring that the recommendations reflect the real needs of children, youth, and families in our state.

We extend our deepest appreciation to Governor Jay Inslee for his leadership in addressing the needs of children in crisis, and to Representative Lisa Callan for her critical support as the primary bill sponsor, along with other bill sponsors who helped champion this important legislation.

We also acknowledge the ongoing support from the Office of the Governor, which made this work possible, and express our gratitude to our agency partners, including the Health Care Authority, Department of Social and Health Services; Developmental Disabilities Administration and Research and Data Analysis, Department of Children, Youth, and Families, and Office of Financial Management for their continued commitment to enhancing support and resources for children and youth. Special thanks go to Kids Mental Health Washington, Youth and Young Adult Housing Response Team, and major children's hospitals in our state, whose collaboration has been vital in shaping a comprehensive and cohesive approach.

Our appreciation extends to the 1580 core team, whose dedication and shared vision of a dynamic and responsive system drove the work forward. Their insights and tireless efforts shaped the recommendations set forth in this report.

We are hopeful for the future as we work together, guided by racial equity and social justice. By creating a human-centered, data-driven, integrated system of care, with children, youth, and families at the core of every decision, we're making real, positive changes. We're grateful for the contributions and partnerships that make this progress possible.

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I am truly grateful for the urgency and accountability that has been created through the implementation of 2SHB 1580. Woven in that gratitude is a pull towards curiosity---wondering where this urgency and accountability was, in the community, in the weeks and months of mounting crises leading up to hospitalization. What barriers, red tape, pointing of fingers, "interest lists," etc... *weren't moveable for parents/caregivers? What barriers in WA lead our behavioral health system to being more reactive than proactive, creating a burn-out-system for parents and caregivers, system partners, and providers alike*.

– Jasmine Martinez, Lived Experience Parent and Advocate

Executive Summary

The Office of the Governor prepared this report in compliance with Chapter 423, Laws of 2023, to provide data and make system recommendations to support "children in crisis" and their families. Chapter 423, Laws of 2023, directed the Office of the Governor to develop and implement a multiagency Rapid Care Team (Team) led by a Children and Youth Multisystem Care Project Director (Director) to develop a multisystem care conferencing framework and provide a platform for collaboration between state agencies and Washington's children and youth system of care.

The Team is tasked with appropriately responding to the needs of children and youth, ages 0 through 17, who are either staying in hospitals without medical necessity, at-risk of remaining in hospitals without medical necessity, or are dependent and experiencing placement instability. The Team works to develop creative, human-centered solutions tailored to the unique needs of children and youth.

Definitions (RCW 43.06.535):

- **Child in Crisis:** A person under age 18 who is (i) At risk of remaining in a hospital without medical necessity, without the ability to return to the care of a parent, and not dependent under chapter 13.34 RCW, (ii) Staying in a hospital without medical necessity and who is unable to return to the care of a parent but is not dependent under chapter 13.34 RCW, or (iii) Dependent under chapter 13.34 RCW, experiencing placement instability, and referred to the Rapid Care Team by the Department of Children, Youth, and Families.
- **Rapid Care Team:** A team, whose work is managed and directed by the children and youth multisystem care project director, working to quickly identify the appropriate services and living arrangements. A team must include a designee from the Health Care Authority (HCA), the Department of Social and Health Services (DSHS), the Office of Financial Management (OFM), the Developmental Disabilities Administration (DDA) of DSHS, the Department of Children, Youth, and Families (DCYF), and any other entities, including governmental entities and managed care organization, or individuals, including clinicians and other service providers, that the children and youth multisystem care coordinator deems appropriate to support a child in crisis.

From its inception, the Team embraced the mission: "Rooted in racial equity and social justice, we are dedicated to building a human-centered, data-driven, integrated system of care, with children, youth, and families at the core of every decision." The Team worked diligently to realize the true intent of Chapter 423, Laws of 2023. From January through August 2024, the Team received 46 referrals, with more than half of the children and youth having four or more co-occurring conditions, including behavioral health, intellectual or developmental disabilities (I/DD), and/or physical health conditions. Over two-thirds were diagnosed with autism spectrum disorder (ASD), and half had an attention-deficit/hyperactivity disorder (ADHD) diagnosis. The Team established a referral process to bring children and youth into multisystem case conferencing, which addresses immediate needs of children,

youth, and their families, coordinating with system partners in connecting them to services and settings that meet their needs.

This process also identifies systemic barriers observed during case conferences, providing data to inform strategic direction. The work includes weekly case conferencing to engage directly with lived experience experts, Managed Care Organization (MCO) Case Management teams, Department of Children, Youth, and Families (DCYF) social workers, Department of Social and Health Services (DSHS) Developmental Disabilities Administration (DDA) clinical and transition teams to triage their clinical needs, establishing standard operating procedures to guide practice and addressing systemic challenges identified by the Team.

Since its formation, the Team has identified emerging themes and recurring challenges that will guide ongoing research and analysis to develop specific, actionable solutions. The Team identified the following areas of concern in addressing the support of children, youth, and their families with respect to timely access to services:

- **Need for Post-Discharge Support:** Families are asked to explore all available options for the complex needs of their child to facilitate a timely discharge from inpatient care. However, there are often minimal services available to support their child at home once discharged, which can lead to potential setbacks and a repeated cycle of crisis.
- **Limited In-State Residential Options:** Residential treatment options out of state can create significant barriers to parent participation and engagement, which are crucial for the child's successful reintegration into the family home and community.
- **Wait Times for Critical Services:** Families often encounter waits for key preventative and transitional services and programs like, Enhanced Respite Services, Intensive Habilitation Stabilization, Applied Behavior Analysis, Wraparound with Intensive Services (WISe), psychiatric evaluations, medication management, speech evaluations, Out-of-Home Service, and Children's Long-Term Inpatient Program.
- **Needed Infrastructure for Preventative Community-Based Crisis Support:** Services designed to prevent hospitalizations such as respite services and intensive habilitation services through Home and Community Based Waiver are often requested as discharge options, but better infrastructure and capacity to handle crisis in the community setting is needed to move toward more preventative care.
- **Complex System Navigation:** Families face complicated systems to access services in their home to support their children with complex needs and often lack support, resources, and guidance to provide needed care.
- **Exclusionary Criteria for Individuals with I/DD or ASD:** Individuals with intellectual and developmental disabilities or ASD frequently encounter exclusionary criteria for crisis and behavioral health services primarily due to what they perceive as the limited availability of providers skilled in adaptive interventions suited to these populations.

- **Gaps in Adapted Intervention for Individuals with I/DD or ASD:** For individuals with I/DD or ASD and co-occurring mental health conditions, there can be gaps in services that adapt cognitive behavioral therapy to support individuals who don't use verbal communication.
- **Educational Services:** Many children in crisis referred to the Team report challenges accessing educational services entitled under the federal Free Appropriate Public Education (FAPE) law. This can impact their overall development and well-being.

The Team is committed to refining actions and solutions with agency and community partners to address emerging themes and challenges effectively. As part of this commitment, the Team has identified specific areas of focus to further explore, examine, and build upon:

1) **Streamline Access to System of Care**: Explore ways to simplify the process for families to access culturally responsive support, services, and programs by creating a centralized mechanism to access an integrated and responsive system of care to prevent children, youth, and their families from reaching a crisis point.
2) **Early Intervention Programs:** Support programs that focus on early intervention to prevent children from reaching a crisis point and reduce fatigue and burnout among parents and caregivers.
3) **Family Empowerment and Support**: Provide families with training, support, and resources to equip them with the necessary skills to effectively support their children in the home environment.
4) **Expand Workforce Capacity:** Support expansion of the provider network to address the complex needs of children in crisis by recruiting new providers through targeted outreach, particularly those to support individuals with I/DD and ASD. Collaborate with universities, training programs, and agencies to build a strong workforce pipeline and incentivize Medicaid participation for specialized services.
5) **Enhance Crisis Intervention Infrastructure:** Enhance a 24/7 community-based crisis intervention team such as Mobile Response Stabilization Service (MRSS), that can respond to children and youth prior to severe events and to reduce the need for hospitalizations.
6) **Inclusion of Education System:** Formally include public education partners into RCW 43.06.535 to address the educational challenges of children in crisis.

Increase Funding and Resources: Expand critical resources, particularly in-state residential capacity for children in crisis. Increased funding is essential to support the continued exploration and implementation of all the above-mentioned priority areas.

The primary recommendation of this report is to continue the program beyond June 30, 2025. The program has quickly become a reliable, centralized access point to provide support for children in crisis and a hub for developing creative, individualized solutions while using case data to identify and address systemic challenges. Maintaining the carefully developed program structure and supporting

its operation as an ongoing program beyond June 2025 are pivotal for Washington State to fully realize the intent of Chapter 423, Laws of 2023. Children in crisis with complex needs often default to costly, restrictive settings like emergency departments and psychiatric hospitals due to the lack of in-state service resources in communities and a centralized care coordination framework. These settings strain the state's already limited financial resources and place a significant burden on children and their families. Investing in a centralized, streamlined care coordination framework and ensuring timely access to appropriate community-based services can reduce reliance on high-cost environments, save valuable financial resources, and improve the well-being of children in crisis.

Finally, this report examines a potential model to strengthen Washington State's system of care by exploring New Jersey's three-pillar implementation approach. It also considers a concept to create a more seamless continuum of care for children and youth in Washington, hypothesizing a re-stratification of the behavioral health service continuum that incorporates New Jersey's model. Further research, including financial and policy analysis, will be needed to assess feasibility and refine these concepts.

The Team will produce a data addendum to this report by the end of calendar year 2024, presenting more robust and comprehensive data currently being gathered.

The team is focused on advancing its work through key operational efforts, including developing a Data Sharing Agreement to support case coordination and analysis, strengthening partnerships with education systems, accelerating referral processes, further exploring connections with key programs such as Kids Mental Health Washington and the Youth and Young Adult Housing Response Team, and strengthening collaboration with the Children and Youth Behavioral Health Workgroup. Efforts also include further analyzing data on children in crisis, addressing barriers and resource gaps, reviewing models from other states, and delivering a final project report with detailed findings and recommendations by the project conclusion on June 30, 2025, in partnership with DSHS RDA under contract.

Program Overview

Chapter 423, Laws of 2023 is designed to support "child(ren) in crisis" and their families. The law created a Children and Youth Multisystem Care Project Director/State Lead Coordinator to develop a framework and provide a platform for collaboration between state agencies and Washington's children and youth system of care, facilitating the development of innovative, human-centered solutions tailored to the unique needs of children and youth by:

- Directing the appropriate and timely action by state agencies to serve children and youth.
- Directing the appropriate use of state and other resources to children and youth in crisis and their families.
- Directing access to flexible funds to support safe discharge of children in crisis and appropriate long-term placements of children who are dependents of the state.
- Creating a framework for agencies' leadership and representatives to come together to remove identified systemic barriers.
- Providing gap analysis and recommendations for services lacking in Washington state.

The law also directs the Director to manage and direct a Rapid Care Team to address long-standing challenges in our state by creating a human-centered, data-driven, integrated system of care for Washington's children and youth with complex needs. The Team is comprised of members from the DCY; HCA; OFM and DSHS. Each member brings expertise and resources from their respective agencies and employs multisystem case conferencing to assess each child's unique needs and develop tailored solutions to support and identify appropriate services and living arrangements for children in crisis. These case conferences address individual needs and also provide valuable insights into systemic and policy challenges and resource and service gaps. Over time, the Team may be able to identify patterns and systemic issues, informing the development of a comprehensive Washington state children and youth system of care that addresses issues surrounding children in crisis. The Director collaborates closely with the Team whose representatives play a crucial role in the success of the program and those whom it serves.

Background

Children and youth with complex needs can often find themselves in a cycle of insufficient care. Recommended and medically necessary services are not always available or are unavailable at the time of discharge from emergency departments and acute care facilities. As a result, children in crisis can experience frequent hospitalizations for extended periods of time without appropriate follow-up care, leading to a breakdown of their natural supports or longer stays in hospitals without medical necessity.

After emergency departments or inpatient psychiatric units have stabilized the immediate crises of the child and youth, some children with more complex needs can remain in these settings due to a lack of capacity to support transition safely to their homes or community settings. This issue is compounded for state-dependent children, who experience placement instability and repeated transitions between foster care and hospital settings often because the services needed to stabilize their conditions in the community are unavailable. While these observations are informed by limited available data, gathering additional data and conducting further analysis would be valuable to assess these trends more accurately. There are indications that children and youth with intellectual and developmental disabilities who require high behavioral support are more likely to experience isolation, restraint, and expulsion from school; prolonged stays in emergency departments; and out-of-state placement for residential treatment and residential school placement.

Families face complex systems to navigate this process, and overburdened professionals such as case managers, resource managers, and care coordinators can sometimes make it challenging to access intensive services when they are most needed. Existing in-home and community-based services (e.g., mental health, Applied Behavior Analysis [ABA], speech therapy, and personal care) are not always tailored to meet complex needs or are unavailable when necessary to support individuals in remaining at or returning to their family home. The services, programs, and systems designed to support children in crisis are diffuse and often lack a clear centralized point of entry for families to access the full range of services. This creates significant challenges and can lead to delays in enrollment and access to available resources. As a result, parents and caregivers may struggle to manage their child's needs, leading to a breakdown in family stability.

Preliminary Efforts to Improve Care Coordination and Educational Access

Ensuring Washington has a comprehensive, integrated system of care is critical so children can receive timely and appropriate care which leads to greater stability and long-term positive outcomes. Children in crisis with complex needs require a tailored and coordinated approach to address their challenges.

State agencies rely on field-driven case management and MCO case managers to escalate issues for children remaining in hospitals without medical necessity. The Team introduced a centralized process for tracking and monitoring cases referred to the Team with Nurse Consultants at HCA, MCOs, DSHS DDA Central office, DCYF Central office, and OFM. This proactive approach ensures that all system agencies collaborate to explore available options and support a transition to the next best setting.

This approach has increased awareness of the overreliance on emergency departments and inpatient hospitalization, as well as the risks associated with unnecessary hospital stays. By tracking these cases, the Team has identified common diagnostic patterns, occasional barriers to accessing communication devices and schools, the availability of family supports, and occasional gaps in the continuum of care for children with complex needs.

To address these critical gaps, the Team has implemented concurrent planning that aligns with the evolving needs of the child and youth. In many cases, children experience lengthy waits for out-of-state residential treatment, only to find that their needs changed so significantly while waiting that they no longer met the necessary criteria. Consequently, case managers and care coordinators start searching for residential services months after the process could have been initiated, prolonging hospital stays sometimes up to a year. The Team has developed protocols to enhance collaboration with state agencies to improve how we concurrently plan for the ever-changing needs of a child, aiming to prevent their potential decompensation and ensuring they receive necessary care.

Additionally, the Team has initiated dialogues with system partners to address the barriers children with significant developmental disabilities sometimes face in accessing academic services and FAPE. Children recommended for residential school placement often experience prolonged waits without access to education, exacerbating their challenges. The Team is focused on ensuring the children have access to educational opportunities, supporting their holistic development and recovery, and promoting better long-term outcomes.

Through these targeted efforts, we have seen the benefits of utilizing a model with a Rapid Care Team, resulting in a responsive and integrated system of care that addresses both the immediate and long-term needs of children in Washington state.

Rapid Care Team Data Summary

Data from January 16, 2024, through August 31, 2024

Note: This summary is derived from client data sheets collected by the HCA and DSHS DDA members of the Rapid Care Team. The presentation of these results follows the Washington State Health Care Authority's small number standards to address confidentiality and reliability issues with small numbers.[1] Counts and rates are suppressed when the population is fewer than 11 individuals.

I. Referrals (n=46)

- The Rapid Care Team received referrals for 46 children and youth from January 2024 through August 2024.
- The number of referrals received per month over this period ranged from two to nine, with the average being six.
- Ten referrals did not meet eligibility criteria for Rapid Care Team support, e.g., child was neither in a dependency nor in a hospital setting. Some were referred to the Youth and Young Adult Housing Response Team (YYAHRTT) and Kids Mental Health Washington (KMHWA) for support when the case warranted.
- Nearly half of all referrals came from Seattle Children's Hospital. Other referrals came from DCYF, DDA, MCOs, other hospitals, or YYAHRT.

II. Children and Youth Served (n=36)

- Nearly all (n=34) children and youth were enrolled in Medicaid and had no other health care funding.
- Half of the children and youth served were referred by Seattle Children's Hospital. Other referrals came from DCYF, DDA, MCOs, other hospitals, or YYAHRT.
- The children and youth served ranged in age from 7–17 years. More than 80% were ages 12–17 years.
- More than three-quarters of the children and youth are white. Fewer than 20 percent had an identified race/ethnicity of Asian, Black or African American, Hispanic or Latino, or another race/ethnicity. No children and youth were identified as American Indian or Alaska Native, Middle Eastern or North African, or Native Hawaiian or Pacific Islander.
- About three out of four of the children and youth were male. None had an indicated gender identity of transgender, non-binary, or another identity.
- More than two-thirds of the children and youth had DDA involvement, and just under half had DCYF involvement. More than one-quarter of the children and youth had both DDA and DCYF involvement.

- Fewer than one-third of the children and youth were dependent under chapter 13.34 RCW.
- Fewer than one-third of the children and youth were involved with YYARHT or Kids Mental Health Washington.
- Nearly nine out of ten children and youth were in a hospital setting at the time of referral, including more than half in an inpatient setting and just under one-third in an emergency department setting.
- More than two-thirds of the children and youth had a diagnosis of autism spectrum disorder. Half of the children and youth had a diagnosis of attention-deficit/hyperactivity disorder.
- More than half of the children and youth had four or more co-occurring conditions, including behavioral health, intellectual or developmental disability, and/or physical health conditions.
- More than two-thirds of the cases staffed by the Rapid Care Team have been transitioned to a closed or monitoring status.
- Outcomes for the children and youth vary, such as admission to a DSHS or HCA facility (e.g., Children's Long-Term Inpatient Program [CLIP], Lake Burien, Out of Home Services [OHS]), return home with DSHS DDA services, placement at a DCYF Behavior Rehabilitation Services setting, or transfer to an out-of-state residential treatment facility.

III. Ongoing data analysis

The Office of the Governor has contracted with the DSHS Division of Research and Data Analysis (RDA) to support the Director and Team with data management and analysis, program monitoring, and reporting through state fiscal year 2025. RDA will integrate care coordination data across agencies for ongoing monitoring and reporting. This will include the development of regular reports summarizing client characteristics, historical service use and health conditions, and outcomes.

Flexible Funding

A total of $2,359,000 of the General Fund-State appropriation for fiscal year 2024 and $2,359,000 of the General Fund-State appropriation for fiscal year 2025 were provided for flexible funding to support children in crisis. Flexible funding use was allowed for, but are not limited to:

- Residential, housing, or wraparound supports that facilitate the safe discharge of children in crisis from hospitals.
- Support for families and caregivers to mitigate the risk of a child going into or returning to a state of crisis.
- Respite and relief services for families and caregivers that would assist in the safe discharge of a child in crisis from a hospital or prevent or mitigate a child's future hospitalization due to crisis.
- Any support or service that would expedite a safe discharge of a child in crisis from an acute care hospital or that would prevent or mitigate a child's future hospitalization due to crisis.

Approach to Flexible Funding

Philosophy: Focused on bringing funds closer to children, youth, and families.

- Partnership with hospitals:
    - Developing contracts with three major children's hospitals in the state to provide direct funding.
    - Opened the option for additional hospitals to create similar contracts to utilize flexible funding.
- Collaboration with system partners:
    - Working with YYART and KMHWA through interagency agreements to utilize flexible funding for services supporting children, youth, and families, through the established support mechanisms that are closer to them.
- Flexible funding applications:
    - Supported housing stability for single mothers caring for children with complex needs.
    - Provided communication devices for a child and parent when the child was hospitalized far from the parent.
    - Contracted with counties to offer housing vouchers for mothers frequently in and out of care for K–12 youth who are frequently admitted to emergency departments.

- Additional Contracts:
    - Partnered with A Common Voice: The Center of Parent Excellence Project to engage and support parents and provided:
        - Direct Parent Support (Planting Seeds of Hope)
        - Virtual Meeting Support for Parents (Never Attend a Meeting Alone)
        - Parent Support Groups (A Reminder That You're Not Alone)
        - Parent Workshops (Designed for Parents by Parents)
- Ongoing Initiatives:
    - Exploring supplemental in-home behavioral support services that are not ABA, through contracts with specific providers to meet urgent support needs.

Key Insights & Strategic Pathways: Emerging Themes and Focus Areas

The emerging themes and potential strategies outlined below provide a framework for addressing critical issues surrounding children in crisis and their families. Some of these themes and strategies are outlined at a high level and additional research, financial analysis, and policy evaluation are necessary to fully explore and implement these concepts. As we strive toward developing more specific, clear, and viable recommendations, it is essential to recognize the dynamic and interdependent nature of the state system of care.

How we collaborate across systems, where we focus on the continuum from prevention to intervention, and how we prioritize investments in program and service capacity will have an effect on one another and always remain fluid. Therefore, a centralized mechanism created by Chapter 423, Laws of 2023, for the real-time problem solving of complex cases, while simultaneously compiling and addressing systemic, policy, and procedural issues plays a vital role.

The Team has seen firsthand how these issues manifest through the case conferencing process. The cases addressed confirm the concerns raised by stakeholders over the years while individual cases have reinforced the need for earlier intervention and systemic change. While the work is in the early stages of implementation, all the emerging themes and concepts discussed are grounded in the Team's firsthand experience.

Recommendation for Paradigm Shift

The state should continue its effort to align the strategic visions of HCA, DSHS, and DCYF to create a cohesive, human centered system of care for children in crisis. There is both an opportunity and an urgency for the state to shift its approach from expecting children, youth, and their families to adopt and navigate our complex systems. Instead, systems and agencies must adapt and adjust to meet the needs of the children, youth, and families we serve.

Recommendation to Sustain Program Operation

The primary recommendation of this report is to continue the program beyond June 30, 2025. The program has quickly become a reliable, centralized access point to provide support for children in crisis and a hub for developing creative, individualized solutions while using case data to identify and address systemic challenges. Maintaining the carefully developed program structure and supporting its operation as an ongoing program beyond June 2025 are pivotal for Washington state to fully realize the intent of Chapter 423, Laws of 2023.

Sustaining the Team's work in this ongoing program is critical to addressing urgent crisis faced by children, youth, and their families today, while also informing long-term strategies to holistically address complex issues surrounding children in crisis. Recognizing the ongoing efforts of agencies

and community partners, implementing a comprehensive strategic plan by enhancing resources, increasing support, and building service capacity will require a gradual, steady approach. Continuous systemic improvement and the development of resources, services, and support capacity at this scale are expected to span several years and multiple biennium budget sessions. When sufficient in-state capacity to provide appropriate support is unavailable, and a clear framework for coordinating care for children in crisis, particularly those with complex needs who must navigate intricate systems to access services, is lacking, they often default to more intensive and restrictive environments, such as emergency departments and inpatient psychiatric hospitals. Reliance on these high-cost, restrictive settings incurs substantial financial burdens that strain resources. Stabilizing children in appropriate community-based environments not only reduces these significant expenditures but also safeguards their well-being by mitigating trauma, emotional toll, and loss of hope, critical impacts that cannot be measured in dollars alone.

Emerging Themes and Potential Pathways

1) **Payment rate and the cost of services**

- Stakeholders shared that current Medicaid reimbursement rates are too low to cover the actual costs of services, particularly for those with intellectual and developmental disabilities, autism spectrum disorder, and behavioral health needs. The services include, but are not limited to medication management, applied behavioral analysis, stabilization services, augmented communication assessment, psychological evaluation, and residential treatment.
- **Pathways:**
    - Conduct cost modeling of affected provider groups that identifies variables that have costs and allows flexibility based on the specific structure, staffing, and approaches employed by a program. This may result in a future request to increase Medicaid reimbursement rates and state investments to better align payment rates with the cost of providing services.
    - Couple the above with a strategic focus on enhancing key services for children with identified conditions, such as programs that support youth with co-occurring intellectual and developmental disabilities and behavioral health needs.
    - Incentivize training for behavioral health providers to improve their capacity to serve the I/DD population and review reimbursement rates to ensure they adequately support the specialized care required for these individuals.

2) **Serving Co-occurring Behavioral Health, ASD, I/DD Conditions**

- There is a need to increase capacity in state to serve youth with co-occurring ASD, I/DD, and severe behavioral health needs.

- **Pathways:**
    - Continue expansion of Out-of-Home Services, both contracted supported living options and Children's State Operated Living Alternatives (SOLA) and provide behavioral health enhancement training.
    - Explore in-state habilitative Children's Long-term Inpatient Program (CLIP) tailored to support youth with co-occurring conditions.
    - Expand adaptive intervention capacity in existing Psychiatric Residential Treatment Facilities (PRTF).

3) **Medicaid-Approved Services and Service Gaps**

- Some Medicaid CMS-approved services (e.g., ABA therapy) don't meet all the needs of a particular family. There are reported shortages in ABA providers specifically for individuals aged 12 and older, a phenomenon that is occurring nationwide.
- **Pathways:**
    - Explore pathways to enhance Medicaid coverage to include other behavioral assistance services that help the youth and the family to develop and practice positive coping strategies and techniques. These strategies should focus on addressing target behaviors and improving overall emotional, behavioral regulation abilities to address gaps when ABA is unavailable, especially for in-home family support.
    - Examine if payment rates match level of supervision required to care for individuals aged 12 and older.

4) **Contracted Capacity**

- Contracted providers at times decline admissions due to staff and other residents' safety concerns or limited capacity, especially for youth with the most complex and acute needs.
- **Pathways:**
    - Explore opportunities for rate enhancements to support specialty services or complex needs.
    - Provide workforce education to better support children with complex needs.
    - Examine creative opportunities to incentivize providers to accept more challenging cases through financial or other means (e.g., increasing required training hours for providers serving children with complex medical and behavioral needs).

5) **Early In-Home and Community-Based Support**

- There is a need to build a workforce of well-trained professionals who can provide in-home and community-based support particularly to serve children with co-occurring conditions and complex needs. These roles could include case aides, behavioral specialists, or in-home service

providers. Early intervention is critical, yet in-home and respite support services are not always available.

- **Pathways:**
    - Invest in robust workforce education and training programs to prepare staff to provide care and support in home and community settings, particularly to be inclusive to youth with I/DD and ASD.
    - Provide competitive wages and benefits to retain workers in these roles. This will improve workforce stability, ensuring that families receive consistent, high-quality support.

6) **Investing in Family Empowerment and Support**

- Intentional focus and investment in family empowerment and support is vital because families are integral to their child's development and well-being. Parents are the experts on their own children, understand their complex needs, and have navigated the complex systems to access services for their children.
- **Pathways:**
    - Offer families additional training and resources to equip them with the skills needed to care for their children at home. This should include access to peer support networks and community resources.
    - Formalize and professionalize family support and empowerment framework, developing family support organization, and create family support workforce work directly with parents and caregivers, providing guidance rooted in personal experience navigating the system and ensuring families play an active role in their child's care and decision-making processes.

7) **Access to Out-of-Home Programing and Supports**

- The current process for accessing services and programs, particularly in residential settings such as Residential Habilitation Centers (RHC), Enhanced Respite Services, Community Residential Services/Out-of-Home Service, and Children's Long-Term Inpatient Program can take several months to a year.
- **Pathways:**
    - Streamline procedures and enable concurrent service application, provider search, and planning to reduce delays caused by sequential process and ensure faster access to necessary care.
    - Simplify the referral process for accessing out-of-home services, ensuring families can easily understand the steps required to access the service.

- Establish short-term treatment facilities as a bridge between inpatient stabilization and long-term care, providing immediate support while assessing and planning for the child's long-term needs.

8) **Coordination Between Behavioral Health, ASD, I/DD Systems and Education Systems**

- There is a significant overlap and intersection between the behavioral health, mental health, I/DD, ASD systems, and education systems. Schools are often critical to supporting a child with complex needs, yet there is no clear structure or systems to coordinate effectively.
- **Pathways:**
  - Establish a clear, collaborative process statewide between cabinet agencies and the Office of Superintendent of Public Instruction (OSPI) to support children in crisis.
  - Foster connections between school districts, schools and community mental health, behavioral health, I/DD, and ASD service providers.
  - Develop a set framework outlining how agencies and schools can collaborate to support children in crisis.

9) **WA Practice on Age of Consent for Behavioral Health Services**

- Washington state allows minors aged 13 and above to independently consent to behavioral health services. However, the practice of explicitly informing them that they can opt out of inpatient or outpatient care at this age often disrupts treatment. Other states with the same law do not emphasize this notification. Our state's approach leads to disengagement from necessary services, creating barriers for continued care.
- **Pathways:**
  - Examine the current practice of explicitly notifying minors about their right to leave treatment at age 13, aligning with best practices from other states.
  - Develop protocols to address concerns where parents may force treatment inappropriately, children in crisis may object to medically necessary care, or where minors struggle to access treatment independently

10) **Behavioral Health Respite Capacity**

- Currently, Washington state needs to increase general respite capacity for children and youth. Only limited services are available through DSHS DDA or DCYF for targeted populations. Expanding behavioral health respite is essential to support children with complex needs and help maintain them in their home and community settings.

- **Pathways**
    - Continue investing in the development of Behavioral Health Respite capacity through "in lieu of" services which are state-defined alternative services that are medically appropriate, cost-effective substitutes for services in the state plan.
    - Explore development of respite capacity outside of the MCO structure.

A Potential Model for Systemic Transformation

- **Enhancing the Children and Youth System of Care Through the Three Pillars and Potential Implementation Pathways:** Implementation of the three pillars of system of care proven successful in New Jersey's Children's System of Care could strengthen Washington's local and regional capacity to resolve complex cases at earlier stages, reducing the reliance on the Team and serve as a prevention and early-intervention strategy.
- **Concurrent Implementation of Pillars:** Building on the success of New Jersey's Children's System of Care, it is strongly recommended that these three pillars: single point of contact, Family Support Organizations, and Care Management Organizations be implemented concurrently, even on a smaller scale. Enacting them piecemeal or sequentially risks reducing their overall effectiveness. A simultaneous implementation ensures a cohesive system of care from the outset, leading to better outcomes for children and families.

    1. **Single Point of Contact with Differential Response**
    A single point of contact allows for tailored responses based on the specific needs of the child and family. For example, New Jersey's PerformCare serves as a hub connecting families to essential services including behavioral health treatment, in-home care, and support for I/DD. This centralized approach simplifies access, ensuring families receive the right services at the right time, including Mobile Response Stabilization Services (MRSS). When more complex cases arise, the single point of contact can refer families to Care Management Organizations for further support.

    Potential Implementation Pathways:

    - Assess the feasibility of directly contracting with PerformCare and adopting their service model in Washington state.
    - Use PerformCare's contract in New Jersey as a template to create a Washington state version of the program and procure a similar service.
    - Continue to invest in and implement statewide the Mobile Rapid Response Crisis Teams (MRRCT) to ensure implementation with fidelity to evidence-based MRSS across Washington.
    - Clarify the role of KMHWA, particularly its function in building an access portal for individuals concerned about a child or youth to request support.

    2. **Family-Led Support through Family Support Organizations (FSOs)**
    FSOs assign family support partners who work directly with parents and caregivers, providing guidance rooted in personal experience navigating the system. These credible messengers offer peer support, helping families advocate for their needs and engage with services. By empowering parents, caregivers, and communities as key contributors to the solution, FSOs ensure families play an active role in their child's care and decision-making processes.

Potential Implementation Pathways:

- Conduct an environmental scan and asset mapping of existing peer and parent support organizations across key systems, including mental health, substance use disorder, intellectual and developmental disabilities, juvenile justice, child welfare, and education.
- Develop a unified framework for FSOs in Washington state, building on existing investments in family-led organizations through programs like WISe; Family, Youth, Systems Partners Round Table (FYSPRT); and leveraging Peer Counselor Certifications and certified peer networks.
- Maximize existing organizational frameworks, such as A Common Voice, The Center of Parent Excellence (C.O.P.E.) Project, and Washington State Community Connectors, to develop and formalize FSOs in each region of the state to ensure statewide coverage.

3. Care Management Organizations **(CMOs)**

CMOs provide comprehensive care coordination for children with complex needs. They collaborate with families to develop flexible, individualized service plans that address the child's specific needs. The current system does not include designated care managers for non-state-dependent children. Care managers should frequently meet with families in person, build strong relationships, gain a holistic understanding of the child's strengths and needs, and manage a coordinated care plan. CMOs are also responsible for ensuring timely referrals and connecting children to appropriate services, so families receive the necessary supports without delay. CMOs should focus solely on care management, without assuming financial risk or offering direct services, ensuring their primary responsibility remains on service coordination and support.

Potential Implementation Pathways:

- Clarify and streamline the roles, responsibilities, and task divisions between MCOs, Health Home Care Coordinators, Behavioral Health Administrative Service Organizations (BHASOs), WISe, and KMHWA regarding case management.
- Evaluate financial strategies and optimize the use of state, federal, and grant funding to create designated CMOs that focus solely on care management for children, youth, and their families.
- Currently, care management duties are shared across multiple entities, with MCOs bearing financial risk.

A Concept for Building a Seamless Continuum of Care for Washington's Children, Youth, and Families

This concept illustrates how a more seamless continuum could be established using the three pillars. However, further research, including financial and policy analysis, is needed to assess the feasibility of

and refine these concepts. It outlines a re-stratification of behavioral health services for children and youth in Washington state, focusing on five key areas:

- Stratification of Psychiatric Residential Treatment Facilities.
- Embedding Fidelity Wraparound Service
- Establishment of Care Management Organizations
- Expansion and integration of Kids Mental Health Washington
- Establishment of Family Support Organizations

1. **Stratification of the Psychiatric Residential Treatment Facilities (PRTF)**
   CLIP, currently the most intensive inpatient psychiatric service for children in Washington, should be stratified to provide clear tiers of care. The state-operated Child Study and Treatment Center (CSTC) will continue to serve as the highest level of care, while contracted facilities (Pearl Street, Two Rivers Landing, Tamarack Center) will offer shorter-term treatment and evaluation for youth with moderate-high psychiatric needs.
   - **Systemic Change Focus**: This stratification allows youth to access care at varying levels of intensity, reduce waiting times, and prevent crises by enabling faster access to lesser-intensive services.

2. **Embedding Fidelity Wraparound Service**
   Currently, WISe provides intensive wraparound services to children with complex behavioral health needs. WISe should enhance its partnership with the short-term facility, provide robust wraparound care and discharge planning from day one.
   - **Systemic Change Focus**: By concentrating on direct service delivery for high-need populations particularly with youth served in short-term treatment facilities, WISe will enhance the quality and timeliness of its interventions, while care coordination is improved by other entities, reducing fragmentation.

3. **Establishment of Care Management Organizations**
   Care management and coordination currently handled by WISe should be transferred to dedicated CMOs. CMOs will focus on coordinating care for children and families, ensuring that all involved parties work together to create a unified care plan.
   - **Systemic Change Focus**: CMOs will provide a streamlined approach to care management, preventing service fragmentation and ensuring that families and children receive appropriate services at the right time. CMOs will also intervene earlier in the care process, helping to prevent crises before they escalate.

4. **Expansion and Integration of Kids Mental Health Washington**
   KMHWA, operating through BHASOs should be expanded to provide lower-intensity, accessible wraparound services that families can access earlier in the care continuum. Families will no longer have to wait until a crisis to receive services, and KMHWA will provide ongoing support throughout the child's care.

- **Systemic Change Focus**: KMHWA will serve as a critical access point for early intervention, helping families receive support before behavioral health needs escalate. This will reduce the number of children needing intensive interventions.

5. **Establishment of Family Support Organizations**

   A formal FSO network should be established across Washington state to provide peer support, parent advocacy, and caregiver training. FSOs will leverage existing peer and parent support structures to build a formal organization capable of supporting families across all levels of care, including CLIP, WISe, CMOs, and KMHWA.

   - **Systemic Change Focus**: FSOs will play an essential role in supporting families at every stage of care, helping them navigate the system, advocating for their child's needs, and offering training and peer support. By formalizing the FSO network, families will have access to a consistent support system that follows their child through long-term and short-term care, care coordination, and early interventions.

Future Continuum [Illustrative]:

Level of Care	Current Program	Key Features	Care Focus	Length of Care
Highest Level of Care*	State-CLIP CSTC	State operated most intensive inpatient psych	Intensive Psychiatric 24/7	Long-Term (6–18 months)
High Intensity/ Shorter-term Care*	Contracted CLIP: Two Rivers Landing, Tamarack Center, and Pearl Youth Residence	Contracted CLIP become Children's Short-term Inpatient Program (CSIP)providing intensives, shorter-term tx, and evaluation	Mid-intense psychiatric 24/7, short-term tx, and evaluation, integrated or partner with WISe	Shorter-Term (0–6 months)
Moderate to High Intensity/ Community-based Care*	WISe	WISe model with respite, minus care management	High-intensity fidelity wraparound, work concurrently with the Short-Term Care	(4–6 months)
Moderate Intensity Care Coordination*	KMHWA	Focus solely on Care Management and Service Coordination, CFT, and Single Care Plan	Early intervention, lower intensity/fidelity wraparound	(12-14 months)
Lower to Moderate Intensity/ Navigation Support	MRSS	Access to lower intensity service pre-crisis.	Early intervention	(8 weeks)

*Care Coordination: Managed Care Organizations (MCOs) currently lead care coordination focusing on connecting children and youth with appropriate services and support, as well as developing and managing a cross-system care plan. In the future state, MCOs or designated care management organizations remain engaged with the youth, adjusting support based on their needs across all levels of care. They also collaborate with family support organizations to ensure alignment between the cross-system care plan with family goals.

Barriers Preventing Children in Crisis Who are Dependent from Maintaining an Appropriate and Stable Placement

Chapter 423, Laws of 2023 also directed the Team to identify barriers preventing children in crisis who are dependent under chapter 13.34 RCW from maintaining appropriate and stable placements. The Team has observed two primary ways that DCYF becomes involved with Chapter 423, Laws of 2023 case conferencing: First, when dependent children with complex needs cannot be supported by the existing DCYF service array or programs and second, when non-dependent children or youth are in the emergency department or inpatient care, and community partners seek DCYF assistance to resolve complex discharge plan, safe discharge home, or parents' engagement.

One key intersection between DCYF and Chapter 423, Laws of 2023, care conferencing is when children and youth are admitted to emergency departments or inpatient hospitalizations. Without appropriate community services, resources, and support, some families feel unable to safely provide the necessary care and are hesitant or unable to bring their child back home. In these situations, system partners, service providers, or families themselves have sought child welfare intervention through DCYF.

The second type of involvement occurs when children and youth with extremely complex needs, who are dependent due to child abuse or neglect under chapter 13.34 RCW, require intensive and specialized treatment or services that go beyond DCYF's current capacity or scope of work. When DCYF identifies a need for support from system and agency partners, such as the HCA, MCO, DSHS Behavioral Health Administration, or DSHS DDA, referrals are made to the Chapter 423, Laws of 2023, care conference.

It is the Team's assessment and projection that implementing the recommendations, along with expanding community-based support, services, and programs accessible to all Washingtonians through Medicaid and waiver programs, will provide timely access to care. This approach will help prevent families from reaching a crisis point, reducing the need for child welfare intervention and DCYF involvement, while also improving placement stability for dependent children and youth with complex needs.

Meanwhile, DCYF is expected to continue contributing its strengths and expertise to provide comprehensive support for children, youth, and their families in crisis. With its expertise in child protection, child abuse prevention and early interventions strategies, kinship engagements, and family team decision making facilitation, DCYF offers invaluable resources. As agencies collaborate on systemic solutions, DCYF's role remains vital, bringing its resources and expertise to support families effectively.

Current Initiatives and Strategic Efforts: Significant investments and intentional efforts are currently underway to align and collaborate among various Washington state agencies and the state Legislature. Strategic initiatives, such as the Children and Youth Behavioral Health Work Group, P-25

Strategic Planning, Family Youth System Partners Round Table and programs like the Apple Health Core Connections Program for child welfare, statewide implementation of WISe, HCA statewide implementation of KMHWA, Mobile rapid response crisis teams, DCYF YYAHRT, expansion of DCYF Service Array, enhancing DCYF Continuum of Care, DCYF FRS Re-design, HB 1188 expanding DDA waiver service to child welfare involved children, and DDA development of Lake Burien Transitional Care Facility, exemplify substantial progress. These efforts have resulted in progress and should continue, although there is still an opportunity to further enhance and refine the system of care in Washington state to create a more cohesive and effective framework.

Next Steps

Given the promising implementation, valuable information so far gathered through case conferencing, and feedback from the community, it is recommended that the multisystem rapid care team established by Chapter 423, Laws of 2023, be maintained and supported. This program plays a critical role in consistently identifying and addressing systemic barriers, policy challenges, and service gaps, which are crucial for shaping a comprehensive statewide system of care that effectively serves the needs of children, youth, and their families. By using case specific conferences to gather real-time data on the needs, challenges, and resources available to these children, the program can provide information needed to improve system performance and serve a coordinating function to improve the services and supports offered, ensuring that they meet the evolving needs of Washington's most vulnerable populations.

Over time, it is reasonable to expect the Team's focus to shift from case-specific problem solving, supported by flexible funding, to more systemic design and coordination. As the state's system of care for children and youth becomes more robust and complex cases are managed more effectively at the ground level, referrals to the Team should decrease. The Team can then utilize the most complex cases to serve as indicators for needed adjustments and continuous quality improvement.

By valuing the voices of those with lived experiences and focusing on the best interests of children, youth, and families, this program has the potential to significantly improve outcomes for Washington's most vulnerable populations. It ensures that children with complex needs receive comprehensive, coordinated care while optimizing the utilization of resources from federal, state, and other funding sources. These are necessary for their long-term stability and well-being, thereby transforming the way the state supports and cares for its most vulnerable citizens.

Placing this leadership role in the Office of the Governor has created a centralized mechanism to address long-standing issues impacting children in crisis. The governor's commitment to addressing issues surrounding children in crisis, along with collaboration with community organizations and state agencies, should be sustained.

As the Team looks to the future, there are several key operational efforts that will advance this work:

- Develop a Data Sharing Agreement between participating agencies to ensure legal compliance with policies and procedures, enabling streamlined case conferencing and data analysis.
- Enhance the working relationship with the Office of the Superintendent of Public Instruction to ensure full access to school for the children, youth, and families referred to the Team.
- Accelerate follow-up with referrers by collaborating with community partners, encouraging the submission of referrals well in advance of children remaining at the hospital without medical necessity.

- Further explore the intersection between the Rapid Care Team, Kids Mental Health Washington, Youth and Young Adults Housing Response Team, and Complex Discharge Program.
- Boost the partnership with the Children and Youth Behavioral Health Workgroup to support the ongoing development of Washington's children and youth system of care.
- Further explore the data associated with children in crisis, barriers, resources (Particularly treatment options between inpatient psych and children's long-term inpatient program).
- Explore the New Jersey model and other states' examples addressing issues surrounding children in crisis.
- A final project summary report, including comprehensive data analysis and more thoroughly developed recommendations based on above mentioned efforts in partnership with DSHS RDA, will be completed by June 30, 2025.

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Resources:

- WA HCA 1580 Children in Crisis FAQ
- 1580 Rapid Care Team Town Hall 9/18/2024 (Recording)

APPENDIX A: 1580 Rapid Care Team Mission

Mission Statement:

Rooted in racial equity and social justice, we are committed to building a human-centered, data-driven, integrated system of care, with children, youth, and families at the core of every decision.

APPENDIX B: 1580 Rapid Care Team Principles

Rapid Care Team Principles:

- Human/Person Centered
- Concurrent Planning
- Solution Focused
- Stay Curious
- Think Outside the Box
- Collaboration
- Hold Each Other Accountable
- Stay Informed
- Lead with your Strengths
- Start from "Yes"
- Mutual respect
- Assume Positive Intent

APPENDIX C: 1580 Referral Criteria

1580 Referral Criteria

Category A

- Under the age of 18; and
- Staying or at risk of remaining in a hospital without medical necessity and unable to return to the care of the parent.

Category B

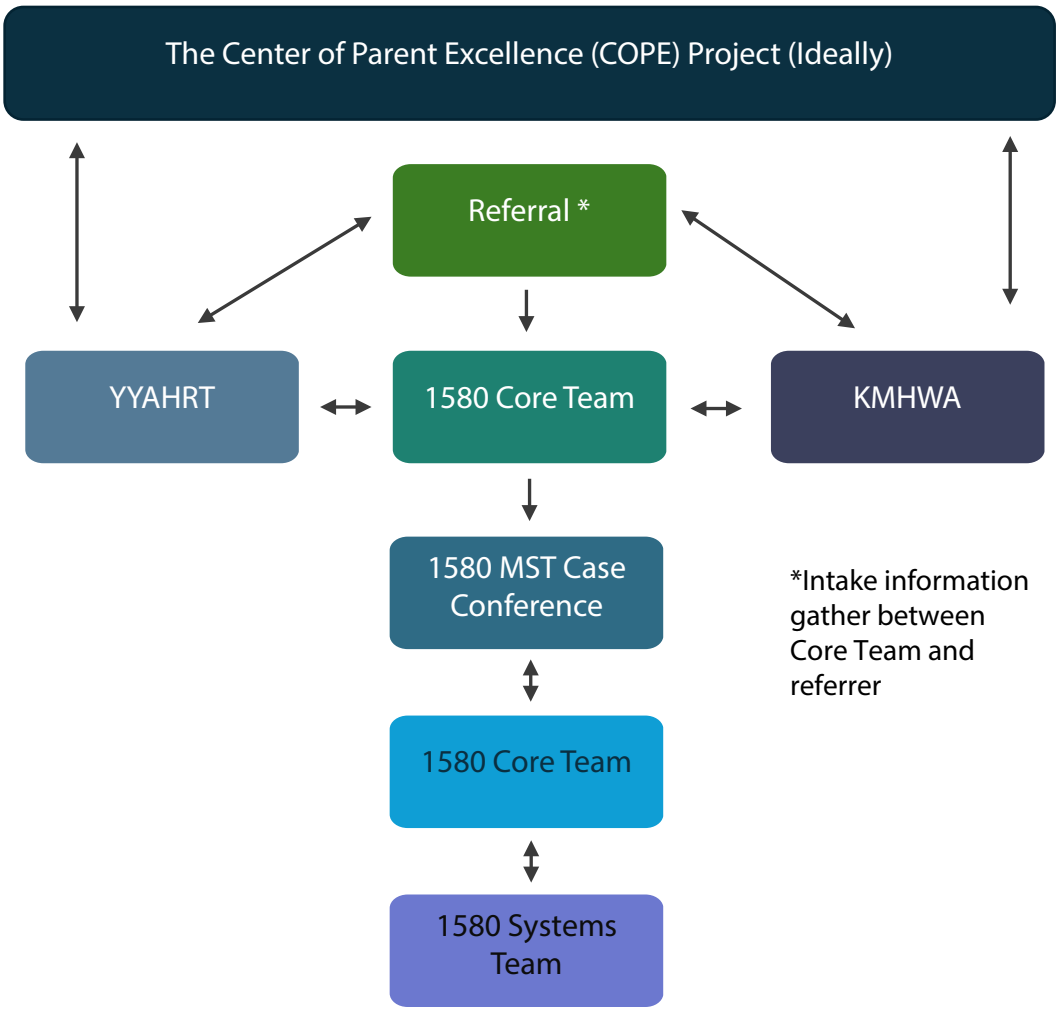
- Under the age of 18;
- DCYF dependent; and
- Experiencing placement instability and referred to the Rapid Care Team by the department.

APPENDIX D: 1580 System Flow

This is a high-level overview of the 1580 system workflow and our approach to daily operations, with a focus on integrating youth and families as early as possible. Our partnership with the COPE Project helps engage families from the start, allowing tailored solutions based on their needs. Families referred to COPE can learn about the 1580 program and provide consent for 1580 staffing, though it's not a requirement for referral.

After a referral is received, the 1580 team gathers information to assess whether other services, such as the Youth and Young Adult Housing Response Team or Kids Mental Health Washington, are more appropriate. Open communication with partners ensures youth are matched with the right services and duplication is avoided.

Accepted cases are reviewed in weekly multidisciplinary conferences, and insights from the 1580 RCT inform the State Systems Team to address broader systemic challenges. This workflow supports individual cases while driving system-wide improvements through early integration, strong partnerships, and continuous feedback.


The Center of Parent Excellence (COPE) Project (Ideally)
Referral *
YYAHRT
1580 Core Team
KMHWA
1580 MST Case Conference
1580 Core Team
1580 Systems Team
*Intake information gather between Core Team and referrer

APPENDIX E: Initial Referral

Determine whether the referral should move forward for 1580 Case Conferencing or be referred to another system. HCA1580ChildreninCrisis@hca.wa.gov

Who	What	When
• Taku Mineshita, GOV • Michelle Hill, DDA • Tammy Parvin, HCA • Breanna Ashcraft, DCYF • Max Brown, OFM • COPE	• Evaluate 1580 referrals that are sent to the 1580 team • Determine if the referral should be staffed at 1580, or sent to YYAHRT, KMHWA or another entity • Inform the referrer of the determination and next steps • If staffed by 1580, a Core Team member will gather information with referrer	• Daily

APPENDIX F: RCT Case Conferencing Meeting

Develop creative solutions and pathways, understand the unique needs and identify systems barriers to provide the child and youth with the next best step.

Who	What	When
• 1580 Core Team • DSHS/DCYF Regional Rep • DDA/DCYF Field Rep • DSHS/DCYF/HCA SME/Unit Manager • COPE • MCO • Providers • KMHWA Rep • School District Rep	• Use creative problem solving to support each child and youth with the next best step • Determine concurrent plans, provide updates on the status and identify barriers to success to be escalated at the Systems Meeting	• One, one-hour meeting with each MCO's clients per week

APPENDIX G: State Systems Meeting

Escalate patterns and systems-level issues to ask for barrier removal on identified issues from case conferencing meeting.

Who	What	When
• 1580 1580 Core Team • DCYF Leadership • HCA Leadership • DSHS Leadership • KMHWA Leadership • YYAHRT Leadership • COPE Leadership	• 1580 Core Team will discuss case escalations that require agency action to help clients transition out of the hospital • 1580 Core Team will share systems level issues that require agency action to help remove barriers across the system	• Twice a month

APPENDIX H: Additional Meetings as Necessary

Discuss 1580 process with partners to determine where adjustments need to be made and inform our work.

Who	What	When
• 1580 Core Team Members as needed	• Lived Expert advisory group and Provider advisory group for feedback into the 1580 process • CPMs or MDTs at hospitals for new referrals • YYAHRT meetings for clients that intersect • KMHWA meetings as identified for potential 1580 referral	• As necessary

APPENDIX I: RCT Case Conference Youth Background

Age/Gender	
DCYF Involvement	FVS/FRS/FAR/CPS/VPA/Shelter Care/Dependent
DDA Eligible	IFS/Basic Plus/CIIBS/CORE/Road to Community Living/None Paid Services
Living Situation (City/County of Origin)	Family Home/DDA OHS/BRS/Foster Care/Homeless/Emergent Placement
Admission Date/Hospital	
Referral Date/Source/Reason	At-risk to remain/Continue to remain/DCYF Dependent
Days Since Clear to Discharge	
Previous Services Received	
School District	District/504 Plan/Date of Last 504/IEP/Date of Last IEP
Additional Systems of Care	YYAHRT/KMHWA/Complex Discharge/CYSHCN/COPE
Flexible Funding Request	
What lead to hospitalization (including diagnosis)	
Preferred activities or environments	
Service eligibility limitations	

APPENDIX J: RCT Goal, Pathway, and Support

(YOUTH INITIALS) Goal #1: Discharge to Caregiver

Motivation for achieving the goal:

Pathway #1	Support #1
	Support #2
	Support #3
Pathway #2	Support #1
	Support #2
	Support #3
Pathway #3	Support #1
	Support #2
	Support #3

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